

medicaid  
and the uninsured

**Strategies to Keep Consumers Needing  
Long-Term Care in the Community and  
Out of Nursing Facilities**

*Prepared by*

Laura Summer  
Georgetown University Health Policy Institute

*for the*

Kaiser Commission on Medicaid and the Uninsured

# kaiser commission medicaid and the uninsured

**The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bipartisan group of national leaders and experts in health care and public policy.**

James R. Tallon  
*Chairman*

Diane Rowland, Sc.D.  
*Executive Director*

**kaiser**  
commission on  
**medicaid**  
and the **uninsured**

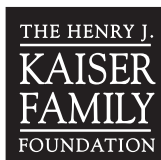
**Strategies to Keep Consumers Needing  
Long-Term Care in the Community and  
Out of Nursing Facilities**

*Prepared by*

Laura Summer  
Georgetown University Health Policy Institute

*for the*

Kaiser Commission on Medicaid and the Uninsured



**October 2005**



## **Table of Contents**

<b>Executive Summary .....</b>	<b>1</b>
<b>Introduction.....</b>	<b>7</b>
Table 1: Percent of Medicaid Long-term Care Spending for Home Care .....	9
<b>Findings.....</b>	<b>11</b>
Table 2: Strategies to Promote Diversions.....	12
Expediting Eligibility Determinations .....	13
Ensuring Immediate Care is Available in the Community .....	16
Tracking and Managing Placements.....	18
Assuring that Financing Arrangements Support Community-Based Care .....	22
Providing Support to Maintain or Obtain Community Residents.....	24
Informing People About Options for Care.....	28
<b>Conclusion .....</b>	<b>29</b>
<b>Appendix 1: Efforts to Promote Diversions in Eight States.....</b>	<b>31</b>



## Executive Summary

The majority of expenditures for long-term care financed by Medicaid are for institutional care, but the trend over the last decade for Medicaid long-term care services has been away from institutional care toward more community-based care. As part of efforts to rebalance long-term care systems, states have used nursing home “transition” and “diversion” strategies. “Nursing home transition” generally refers to activities to move individuals from institutional settings to alternative community placements. “Diversion” refers to efforts to provide choices and assistance for consumers who are at risk of admission to nursing facilities unless alternate community-based care can be arranged quickly.

The state Medicaid programs that are most successful at keeping people in the community do not operate separate “transition” or “diversion” programs. Rather they have made systemic changes to increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care. Even these states, however, have not addressed all of the Medicaid rules and practices that traditionally have favored institutionally based long-term care. Nursing home care is a mandatory Medicaid service, but the provision of most community-based care is optional for states. Most states still limit the number of people served through home and community-based waiver programs.

In the majority of state Medicaid programs, the prevailing approach to promoting community-based care is not to completely revamp long-term care systems, but to change some of the established practices that favor institutional care. This report examines policies and practices in eight states. It provides a sense of what state Medicaid programs are doing or could be doing to promote diversion, but it does not identify particular “best practices.” Four of the states have made sweeping changes to their Medicaid long-term care systems, where almost half or more of Medicaid long-term spending is for home-based care (Maine, Oregon, Vermont, and Washington) and four have made incremental changes to keep more people who need long-term care in the community. These four states—Indiana, Nebraska, New Jersey, and Pennsylvania—spend smaller proportions of Medicaid funds on home-based care. Regardless of the approach that states take, however, some consistent themes emerge regarding efforts to divert consumers from nursing homes.

**A philosophical commitment and legislative direction.** The importance of these factors in facilitating change is commonly expressed by state officials. In Vermont, community coalitions have been an integral part of the long-term care system since 1996 with the passage of Act 160, which required reductions in nursing home care and increases in community-based care across the state. States with a mandate for change from the leadership have an advantage as well. For example, the Governor’s Office of Health Care Policy in Pennsylvania considers the rebalancing of long-term care a priority and this fosters cooperation among state agencies.

**State Example: Oregon’s Legislative Commitment**

Language in the original legislation to promote community-based care in Oregon laid out a vision for a new system of care and the transition to community-based long-term care became the focus of state program management. Since 1981, when Oregon received the first home and community-based services waiver, the philosophy and standard practice in the state has been to provide as much long-term care as possible in community-based settings. Thus, all program operations are essentially geared to promoting diversion from nursing homes and relocation for nursing home residents who request care in the community.

**Fast eligibility determinations.** A Medicaid eligibility determination process that takes weeks or months is incompatible with diversion efforts. Commonly, nursing facilities are willing to assume some financial risk and provide services even before Medicaid financial eligibility determinations have been completed. By contrast, many community-based providers are less experienced and therefore less willing to take a risk. “Fast track” systems used in Washington and in a pilot program in Pennsylvania allow applicants to make initial self-declarations about their financial circumstances so that arrangements for care can be made quickly for applicants if they are judged potentially eligible for Medicaid coverage. States have also established standards to ensure that functional eligibility determinations are conducted in a timely manner, but without an expedited financial eligibility determination, this approach is limited.

**State Example: Pennsylvania’s Rapid Assessment**

Applicants or agencies making referrals for Pennsylvania’s Community Choice program can call a state hotline which operates seven days a week, 24 hours a day, to request assessment for long-term care services. The hotline operator contacts an “on call” assessor who talks with the caller to determine the urgency of the situation. Assessment interviews can be conducted within 24 hours of the call for people in the community who are at risk of immediate admission to a nursing facility. Assessors are employed by Area Agencies on Aging or other subcontractors. Assessors use a four-page form to make determinations about the level of care needed and to create an interim service plan. Subsequently, a more comprehensive plan of care is developed. The initial application asks for basic information about income and assets. The assessor faxes the completed form to the Medicaid office using a dedicated fax number. At the office, a caseworker makes a preliminary determination about eligibility and enters information about the individual in the system if it appears that he or she will be eligible. The information submitted must be verified in 45 days.



**Making community care available immediately.** Recognizing that community-based providers may be reluctant to assume the financial risk associated with serving consumers whose Medicaid eligibility has not yet been confirmed, the President’s proposed budget for fiscal year 2005 would provide federal reimbursement when states opt to grant “presumptive eligibility” to individuals discharged from a hospital to a community-based waiver program, even if they were later found to be ineligible for Medicaid. Although federal reimbursement for services is not available currently, some states guarantee payment. In Washington and in Pennsylvania’s pilot program, state funds can be used, if necessary. Officials note that although there is some risk to these arrangements, the potential financial benefit of serving people in the community rather than in nursing homes is great. Experience to date indicates that such arrangements do not pose substantial financial burdens for states.

Even if community-based providers are willing, their ability to provide services may be limited by an inadequate supply of workers, which can be a barrier to diversion efforts.

#### **State Example: Nebraska’s Waiver While Waiting Program**

Nebraska’s program allows service coordinators to authorize waiver services for individuals who will likely be eligible for Medicaid coverage. Based on simple financial information provided by the applicant, the service coordinator consults with a Medicaid eligibility worker who can judge whether it appears that the applicant will be eligible for Medicaid. If ultimately the applicant is not eligible, the state uses funds from the Social Services Block Grant to pay for services. The need to use block grant funds has occurred only twice over a two year period. The Waiver While Waiting program was established in response to findings from market research conducted by the state which indicated that the time lag between consumer’s needs for home and community-based services and the availability of the services were a major barrier to the choices consumers make about where they want to receive care.

**Procedures to track and manage placements.** Decision-making about long-term care is a dynamic process. The logical time and place to help consumers avoid nursing home admissions would seem to be in the community or at the hospital just prior to discharge. Some states mandate that anyone seeking admission to a nursing home have a pre-admission assessment so that they will be informed about all options for long-term care. With the trend towards shorter hospital stays, some states maintain that there is a need and an opportunity to counsel consumers early in their nursing facility stay.

#### **State Example: New Jersey’s Pre-admission Screening**

During the pre-admission screening process for all nursing home admissions in New Jersey, Medicaid beneficiaries are designated as “Track One” or “Track Two” depending on whether they are likely to remain in the facility for a long or short-term period of time. All short-term residents receive a letter indicating that they are certified for six months or less. They are contacted by Community Choice counselors who work with them to develop a relocation plan.

In an effort to ensure that short-term nursing home stays do not become long-term stays, another practice is to certify individuals for nursing facility care for specific periods of time, after which reassessment must occur. Indiana, Maine, Nebraska, New Jersey, Oregon, and Pennsylvania’s pilot program all have policies that distinguish between short and longer-term stays. Regardless of whether consumers are diverted from nursing homes entirely or spend a short time in a facility, the key to successful placements in the community is to ensure that a plan for care is formulated early in the decision process and that the consumer has support throughout the process.

**Assuring financing for community care.** States that have legislative mandates to reinvest cost-savings from reductions in institutional care have increased their capacity over the years to provide community-based care. A related approach, in which “money follows the person” from a nursing home to the community can also enhance community capacity, but unless the funds remain in the budget for community-based care, the enhancement is temporary. State Medicaid programs’ ability to show that, on average, the cost of long-term care is lower in the community than in nursing homes has been important in making the argument that some initial investment may be required to increase community capacity. In states such as Oregon and Washington that have pooled funds for all long-term care services, limited funding for home and community-based services relative to institutional services is not problematic. In other states, however, limited budgets for community-based care can hamper diversion efforts. Some states with waiting lists for community-based care have policies that favor diversion.

**State Example: Indiana, Washington And Pennsylvania—Serving People In The Community Can Be Less Expensive Than Institutional Care**

Cost estimates from Indiana indicate that three people can be served in the community for every two who receive services in nursing homes. Officials in Washington estimate that the cost of caring for people in a nursing home is equal to the cost of providing services for two to four people at home. Estimates from Pennsylvania indicate that under the state’s Aging Waiver, on average, 2.2 people can receive services in the community for each aged individual receiving services in a nursing home.

**The availability of accessible and affordable housing.** Sometimes there is a need to make modifications or repairs so that an existing home will be livable or it may be necessary to move to a more appropriate residence to stay in the community. Consumers who enter institutions, but ultimately wish to receive services in the community on an ongoing basis must be able to maintain or secure appropriate housing. Medicaid rules that allow states to pay for services such as home modifications before consumers leave an institution to return home can be very helpful in arranging for community-based care. When Medicaid eligibility is pending, however, consumers may not be able to return to the community immediately from a hospital or other institutional setting unless funding for modifications is available on a “presumptive” basis.

In addition, when people with Medicaid coverage enter nursing facilities they are at risk of losing their homes unless they can keep some income to maintain them. States do have the option under Medicaid rules to exempt some income for this purpose. When this approach is used, as it is in Maine, New Jersey, Washington, and Pennsylvania’s pilot program, the resident’s payment is lowered and the amount that Medicaid pays to the nursing facility is higher. Some states have

also increased the asset disregards used in calculating financial eligibility for Medicaid. As a result, consumers can retain assets to pay for home maintenance. These accommodations are particularly useful when short nursing home stays are part of a plan to return to the community. Finally, without efforts in most states to increase the supply of appropriate housing, diversion will continue to be problematic for many consumers.

**State Example: Pennsylvania, Vermont, And Maine’s Increased Asset Disregard**

Pennsylvania increased the resource disregard used in determining financial eligibility for Medicaid from \$2,000 to \$8,000 for individuals receiving home and community-based waiver services through the Community Choices program. Under Vermont’s 1115 waiver proposal, individuals who are single, own their homes, and wish to stay in them could keep additional assets above the current \$2,000 level. Vermont will start at the \$3,000 level, but has permission to go as high as \$10,000. The higher asset rules would also apply for short nursing home stays so that consumers can maintain their homes and move back to the community. Maine has increased the disregards for assets so that beneficiaries can have assets of \$10,000 or less. This has the effect of allowing individuals to retain assets that can be used to maintain homes or for other purposes.

**Consumers and professionals need information about the options for care.** The alternatives to nursing homes are better known in states that have been promoting community-based care for some time, but in most states, systems are evolving quickly and community-based options for long-term care are relatively new. State officials are stressing the importance of publicizing the availability of community-based alternatives both to consumers and to the professionals who work with them.

**State Example: Vermont’s Outreach Program**

Vermont mounted an Options Education campaign to publicize the availability of options for long-term care services. A set of outreach materials that can be used statewide and locally was developed for immediate and ongoing use. They urge state residents to call the Senior HelpLine and talk with Information Assistance Specialists. Grant funds were used to develop the materials and mount the initial campaign. The state anticipates that maintaining the campaign should be less costly now that the materials have been developed. In the future, the campaign will be financed with funds from the long-term care budget.

**Conclusion**

Regardless of whether state Medicaid programs have undergone major restructuring to promote community-based care or whether they have made changes in certain practices that traditionally have favored institutional care, there has been an increase in efforts to divert people from nursing homes by providing options for care in other settings initially or to move individuals from institutional settings to alternative community placements. Although states continue to consider policy changes to promote community-based long-term care in Medicaid, the issue

that overshadows all others for state Medicaid programs is the challenge posed by the growing need for services at a time when funding is limited. Most states already were considering plans to reduce the growth of Medicaid spending, but with the passage of the Congressional budget resolution for fiscal year 2006, which calls for a \$10 billion reduction in federal spending for Medicaid over the next five years, there is even more emphasis on controlling program costs. It is worth noting, however, that many of the innovations to rebalance long-term care services and provide more care in the community were initiated at times when budgets were tight precisely because policy makers were willing to consider plans presented as lower cost alternatives.

## Introduction

The Medicaid program pays for about 43 percent of long-term care expenditures in the United States.<sup>1</sup> Historically, much of that care has been provided in institutions. The trend over the last decade, however, has been away from institutional care toward more community-based care for Medicaid-financed long-term care. The shift has occurred as consumers express strong preferences for receiving care in the community and directing their own care. The option of providing community-based care has gained appeal among policy makers as well as they attempt to respond to consumers' requests and as they seek to control the cost of long-term care.

In federal fiscal year 1994, about 18 percent of Medicaid long-term care expenditures were for community-based care compared to almost 36 percent of expenditures in 2004.<sup>2</sup> Some state Medicaid programs have been more aggressive than others in promoting community-based care. The proportion of Medicaid long-term care funds spent for community-based care ranges from 5 percent in Mississippi to 70 percent in Oregon in federal fiscal year 2004.<sup>3</sup> For the most part, Medicaid program rules still favor institutional care and substantial effort is required on the part of states to change traditional practices and make community-based care more readily available.

Since the mid-1990's, the federal government has played an active role in providing some support for rebalancing the Medicaid long-term care system to shift spending from institutional to community-based care. The current *New Freedom Initiative* was established in 2001 to continue the work of removing barriers to community living for people of all ages with disabilities and long-term illnesses. The Centers for Medicare and Medicaid Services (CMS) sponsors several activities under the initiative, many of which are relevant to promoting diversion.

- *Real Choice Systems Change Grants* have been awarded to states since 2001 to help develop programs to support community living. Among the grants are a group designed to support nursing home transition efforts and a group to promote the concept of "money follows the person," which provides flexible financing for long-term care so that funds can move with the individual to the most appropriate setting as needs and preferences change.
- *Aging and Disability Resource Center Grants*, jointly sponsored by CMS and the Administration on Aging, are used by states to develop consumer-centered single entry points into the long-term care system at the community level.
- *The Independence Plus Initiative*, which builds on an earlier *Cash and Counseling Demonstration* waiver program, expedites 1915(c) waiver or 1115 demonstration requests for programs that give individuals a budget and allows them to manage their own care.
- *A Demonstration to Improve the Direct Service Community Workforce* provides grants to states to help increase the supply of paid caregivers.
- The *Money Follows the Person Rebalancing Demonstration* is a key component of the *New Freedom Initiative* proposed in the President's 2006 budget. Under the demonstration, federal grant funds would pay for one year of home and community-based waiver services for individuals who move from institutional to community-based care in states that agree to continue supporting the care after the first year at the regular Medicaid matching rate.

As part of efforts to rebalance long-term care systems, nursing home "transition" and "diversion" strategies have been tried. "Nursing home transition" generally refers to activities to move

individuals from institutional settings to alternative community placements. “Diversion” refers to efforts on the part of states to provide choices for consumers before they become nursing home residents. Diversion efforts usually are geared to critical situations or points in time when individuals need immediate assistance and are at risk of admission to nursing facilities unless alternate care can be arranged quickly. In practice, however, the distinctions between diversion and transition are becoming less clear as systems evolve.

Diversion efforts, in the strictest sense, require that consumers get information, make choices, and arrange for services immediately – often in a crisis situation – to avoid admission to a nursing home. With changes in the larger health care system, hospital stays have become shorter and the practice of discharging patients to nursing facilities for rehabilitative services is more common. As a result, the range of settings where critical decisions about long-term care can be made have increased and opportunities to counsel consumers and provide choices, including community-based care options, are more varied. As state Medicaid programs have developed the capacity to deliver more long-term care in the community and have experimented with methods to encourage community-based care, some have concluded that diversion efforts will be successful not only if nursing home admission can be avoided entirely, but also if short stays in nursing homes are regarded as part of the process for establishing a long-range plan for long-term care in the community.

The desire to avoid isolation in institutions and to be active participants in their communities has led many individuals with long-term care needs and their families to advocate for opportunities to receive care in a variety of settings. Although diversion efforts are geared to all types of beneficiaries, the availability of appropriate alternative settings for care is one factor that determines who will be targeted for diversion. Community-based living options for individuals with mental retardation and developmental disabilities have become much more common since the 1990s, when large numbers of people made the transition from institutional to community-based care. Now there is an increased emphasis among many state Medicaid programs on diverting the frail elderly and adults with physical disabilities from nursing homes.

The state Medicaid programs that are most successful at keeping people in the community do not operate separate “transition” or “diversion” programs. Rather they have made systemic changes to rebalance the delivery system for long-term care services. There are differences, however, with regard to states’ willingness and ability to make substantial program changes. Therefore, it is instructive to consider not only broad efforts to change systems, but also incremental efforts to keep more people in the community by changing established practices that favor institutional care.

This background paper examines some of the issues that must be addressed if diversion efforts are to be successful:

- Expediting program eligibility determinations
- Ensuring that community-based service providers are willing and able to provide immediate care
- Developing procedures to track and manage placements
- Assuring that financing arrangements support community-based care
- Providing support to maintain or obtain community residences
- Informing people about options for care

The background paper also describes how some states are addressing these issues. The report provides a sense of what state Medicaid programs are doing or could be doing to promote diversion efforts, but it does not identify particular “best practices.” Descriptions of state practices are based on interviews with officials in eight states including states that have made sweeping changes and those that are making incremental changes to their long-term care systems. States were chosen because they are engaged in efforts to keep consumers out of nursing homes and in the community. In four of the states – Maine, Oregon, Vermont, and Washington – almost half or more of Medicaid spending for long-term care supports home-based care. In the other four states – Indiana, Nebraska, New Jersey, and Pennsylvania – spending for home-based care represents considerably less than half of all Medicaid spending for long-term care and less than the national average of almost 36 percent of Medicaid long-term care spending for home care.<sup>4</sup> All of the states have had a substantial increase in the proportion of Medicaid long-term care spending for home and community-based care over the five years since 1999 (see Table 1). The states were chosen to provide a broad range of examples of practices, but they are not the only examples of innovation related to diversion in states. A summary of activities in each of the states is provided in Appendix 1.

Table 1. Percent of Medicaid Long-term Care Spending for Home Care

	FY 2004	FY 1999
Oregon	70	56
Vermont	58	49
Washington	55	42
Maine	47	39
Nebraska	32	23
New Jersey	32	25
Indiana	27	11
Pennsylvania	22	15

Source: State Tables from Burwell, Brian; Kate Sredl, Steve Eiken (2005) *Medicaid Long Term Care Expenditures in 2004*, available at <http://www.hcbs.org>.

## Public Financing of Community-Based Long-Term Care

Three benefits that account for most Medicaid spending on community-based care are:

- Home health services, a mandatory Medicaid service which includes nursing services or home health services provided by certified home health agencies, and medical supplies, equipment, and appliances suitable for use in the home. States set functional eligibility criteria for the services.<sup>5</sup>
- Personal care services, an optional Medicaid service which provides assistance to persons with disabilities and chronic conditions to help them perform activities that they normally would perform themselves if they did not have a disability. States set the eligibility criteria for the benefit and define the specific services to be provided, but the same services must be available statewide for all eligible beneficiaries.<sup>6</sup>
- Home and community-based service waivers, or 1915(c) waivers, allow states to provide long-term care services in a community-based setting to individuals who otherwise would require institutional services reimbursable by Medicaid. States must apply to the federal government for specific waivers, which indicate what population will be served, what services will be provided, and how much will be budgeted for the waiver program. If waivers are approved, federal matching funds are available for services provided under the waiver. States must ensure that the cost of care under the waiver is no higher than the cost of institutional care. A few states also provide community-based long-term care services under 1115 research and demonstration waivers.

Optional Medicaid state plan services such as rehabilitation services, private duty nursing, physical therapy, occupational therapy, or transportation services are also part of some plans for community-based long-term care.

Public support for community-based long-term care also is available from the Medicare program's home health benefit for beneficiaries who need intermittent skilled care. The Medicare skilled nursing facility (SNF) benefit provides skilled care in a post-acute setting if it is required after a hospital stay of three days or more. Medicare also pays for medical social work and discharge planning services following a stay in a skilled nursing facility.

State-funded home and community-based programs play an important role in many states. Federal funding available through the Older Americans Act, Community Development block grants, Community Action Program grants, and Social Services block grants also provide some support for community-based care.



## Findings

In the majority of state Medicaid programs, the prevailing approach to promoting community-based care to those at risk of admission to nursing facilities is not to completely revamp long-term care systems, but to change some of the established practices that favor institutional care. The more common strategies used by state Medicaid programs to encourage community-based care are listed in Table 2. The table also indicates which of the study states uses each of the strategies.

No state employs all of the strategies. Decisions about which strategies to employ depend to a great extent on the overall design of states' Medicaid long-term care programs. Given the differences among states, there is no "best formula" for diversion. States that employ the greatest number of strategies are not necessarily the most successful. Discussions with state officials do suggest, however, that if efforts are to be successful, every aspect of the enrollment and service delivery processes should be considered and amended in some way if necessary to promote diversion. The discussion below provides detailed information about actions that each of the states has taken in this regard.

**Table 2: Strategies to promote diversion**

<b>States</b>	OR	VT	WA	ME	NE	NJ	IN	PA <sup>1</sup>
Percent of Medicaid long-term care spending for home care, 2004	70	58	55	47	32	32	27	22
Percent of Medicaid long-term care spending for home care, 1999	56	49	42	39	23	25	11	15
<b>Expediting program eligibility determinations</b>								
Expedited Medicaid financial eligibility determination			*					*
Self-declarations of financial circumstances accepted initially			*					*
Established timeframes for initial functional assessments		*	*	*		*	*	*
Provisional plans of care used								*
<b>Ensuring that community-based service providers are willing and able to provide immediate care</b>								
Payment assured for those with “presumptive eligibility”			*		*			*
Consumer option to hire independent providers		*		*				*
Nurse Practice Acts or delegation programs allow less skilled providers to deliver services	*		*	*	*			
<b>Developing procedures to track and manage placements</b>								
Mandated nursing home pre-admission assessment for <i>all</i> individuals	*			*			*	
Requirements for hospitals or nursing homes to inform Medicaid of admissions			*	*				
Initial Medicaid nursing facility certifications for limited time periods	*			*	*	*	*	*
Case managers continue to monitor community placements for a period after diversion or transition							*	
<b>Assuring that financing arrangements support community-based care</b>								
One budget for all long-term care services	*	* <sup>2</sup>	*					
Waiting list priority for diversion or transition		*					*	
<b>Providing support to maintain or obtain community residences</b>								
State funds used to help finance moves or home modifications		*	*		*	*		*
Home maintenance allowance for Medicaid beneficiaries in institutions, likely to return to the community			*	*		*		*
Increased resource disregards for individuals receiving long-term care in the community		* <sup>3</sup>		*				*
<b>Informing people about options for care</b>								
Publicity campaigns		*	*		*	*		*
Training with hospital discharge planners				*	*	*	*	*

<sup>1</sup> Characteristics of pilot program

<sup>2</sup> 1115 proposal

<sup>3</sup> 1115 proposal

## **Expediting eligibility determinations**

One of the factors that most affects the success of diversion efforts is states' ability to quickly make determinations about Medicaid eligibility.<sup>7</sup> Regardless of whether they receive services in institutions or the community, applicants for long-term care services financed by Medicaid must have an assessment to determine whether they meet the state's criteria for a nursing facility level of care. In addition, home and community-based waiver services cannot be furnished until a written plan of care has been developed.<sup>8</sup> If applicants do not have Medicaid coverage already, a financial eligibility determination is also required.

Commonly, nursing facilities provide services even before Medicaid financial eligibility determinations have been completed. They often have the staff and the experience to make an initial assessment that an individual will be found eligible for services financed by Medicaid. They then help applicants complete the Medicaid application process. Although the facilities assume some financial risk, they receive retroactive payments for the services they provide to individuals who are ultimately determined eligible for Medicaid. By contrast, many community-based providers are less familiar with the Medicaid eligibility rules, are not as well equipped to make initial assessments about eligibility, and therefore are less willing to provide community-based services before Medicaid eligibility is established. Thus, the development of procedures to expedite eligibility determinations for community-based care is critical.<sup>9</sup>

## **Quick responses**

It is not unusual for states to report that it takes months to complete a Medicaid eligibility determination for long-term care services.<sup>10</sup> One reason for this is that traditionally functional and financial eligibility determinations are made by different agencies or individuals and communication among agencies can be slow. In response to this problem, some states have established timeframes for the initiation of assessments and have either facilitated communication among the parties or have granted authority to one assessor to make preliminary determinations about functional and financial eligibility. In addition, some states rely initially on self-declarations about applicants' financial circumstances, which can be verified later.

The required tasks of conducting pre-admission screening to determine whether applicants meet the nursing facility level of care criteria and developing plans of care for waiver services also can be time-consuming. The development of computer-based tools has been helpful in this area and a number of states have taken advantage of the CMS policy allowing states to make a provisional written plan of care to identify the essential Medicaid services that will be provided in the person's first 60 days of waiver eligibility while a more complete plan is developed.<sup>11</sup>

### ***“Fast track” eligibility determinations***

A few states have developed systems to make efficient Medicaid eligibility determinations for community-based long-term care services, but the systems operate differently, reflecting differences in the broader long-term care systems.

In **Washington**, face-to-face interviews must be conducted within two days of a case assignment and Medicaid nursing facility clients must be seen within seven days of admission. Washington has developed a computerized assessment tool that is used to determine functional eligibility and develop care plans. Applicants whose financial circumstances are not complex can make self-declarations about their finances and initial eligibility determinations are made based on this information. They are required to complete a full application for Medicaid within 10 days. With this system, Medicaid coverage can be approved in one day.

Applicants or agencies making referrals for **Pennsylvania's** *Community Choice* program can call a state hotline which operates seven days a week, 24 hours a day, to request assessment for long-term care services. The hotline operator contacts an "on call" assessor who talks with the caller to determine the urgency of the situation. Assessment interviews can be conducted within 24 hours of the call for people in the community who are at risk of immediate admission to a nursing facility. Assessors are employed by Area Agencies on Aging or other subcontractors and use a four-page form to make determinations about the level of care needed and to create an interim service plan. Subsequently, a more comprehensive plan of care is developed. The initial application asks for basic information about income and assets. The assessor faxes the completed form to the Medicaid office using a dedicated fax number. At the office, a caseworker makes a preliminary determination about eligibility and enters information about the individual in the system if it appears that he or she will be eligible. The information submitted must be verified in 45 days.

### ***Faster functional eligibility determinations***

Established standards can ensure that Medicaid functional eligibility determinations are conducted in a timely manner. This approach facilitates authorization of community-based long-term care services for individuals who already have Medicaid coverage. Without an expedited financial eligibility determination the effectiveness of this approach is limited for those who also must establish financial eligibility for Medicaid, however.

In **Maine**, assessments for people in the hospital who may need long-term care services must be conducted within 24 hours prior to discharge. If people living at home request an assessment, it must be completed within five calendar days. Nurses employed by an agency that is independent of the state conduct the assessment, establish eligibility for care, and authorize a service plan. A standard automated system is used to collect and track assessment information.

Staff from Area Agencies on Aging or home health agencies in **Vermont** complete a short priority assessment in homes, hospitals, or nursing facilities within seven working days of being notified of a request for home and community-based care. The assessments are then sent to the state for a "level of care" determination. The state's proposed 1115 waiver includes plans for the department to have nurses in the field who can make "level of care" determinations and develop transitional care plans to speed the process.

In **Nebraska**, proposed regulations would mandate that the *Senior Care Options* pre-admission screening process occur within 48 hours for individuals in immediate need of long-term care services who wish to receive services in the community. Currently, the 48-hour rule refers only

to hospital patients being referred to nursing homes or individuals who request admission to a nursing home.

*Community Choice* counselors in **New Jersey** see anyone referred from a hospital for Medicaid pre-admission screening within 72 hours. Referrals from nursing homes are seen within 30 days. Counselors also visit people at home, but only after they have been determined to be financially eligible for Medicaid.

### **Streamlined eligibility determinations**

Most state Medicaid programs cannot ensure that services can be authorized immediately for consumers seeking community-based long-term care, but many are taking steps to facilitate faster program enrollment. **Indiana** has established a central enrollment unit to assist with expediting eligibility determinations for all waiver programs; eligibility determinations are made at the county level, however, and can be lengthy. The state's Aging and Disability Resource Center grant will help two Area Agencies on Aging develop a team approach to expedite eligibility determinations. In an attempt to expedite financial eligibility determinations, **Vermont** is consulting with the Vermont Bankers Association to develop a system to conduct electronic searches to verify financial information. The goal of **Maine's** three-year Aging and Disability Resource Center grant is to improve connections between formal and informal resources in the state and to enhance the interface between Medicaid financial and functional eligibility. **New Jersey** also has an initiative underway to integrate functional and financial eligibility determinations. Although **Oregon** does not have special rules that pertain to expediting eligibility determinations, the fact that functional and financial eligibility determinations are done by the same agency makes it easier to track individuals' cases and case managers can provide assistance when it is needed to expedite financial eligibility determinations.

### Financial eligibility rules may affect diversion efforts

Individuals who already have Medicaid coverage are financially qualified for long-term care services. In about half of the states, other individuals with low incomes can “spend down” by subtracting out-of-pocket medical expenses from income to meet the “medically needy” income limits and qualify financially for Medicaid long-term care services.<sup>12</sup>

States also have the option of using a “special income rule” to set the income standard for nursing homes or for home and community-based long-term care services as high as 300 percent of the federal SSI payment level (\$1,737 per month for a single individual in 2005).

State	Use of Special Income Limit	
	Institutions	HCBS Waivers
IN	Y	N
ME	Y	Y
NE	N	N
NJ	Y	Y
OR	Y	Y
PA	Y	Y
VT	Y	Y
WA	Y	Y

In states that use different income eligibility limits for institutional care and home and community-based care, the type of care with lower income limits may not be an option for some individuals and diversion efforts can be affected. Of the eight states examined for this report, six use the special income limit for both institutional and home and community-based waiver eligibility, but Indiana uses it just for institutional care and Nebraska does not use it for either type of care.

### Ensuring that immediate care is available in the community

Community-based providers in most states are reluctant to assume the financial risk associated with serving consumers who ultimately may not be found eligible for Medicaid. This is a well-recognized problem. In fact, the President’s proposed budgets for fiscal year 2006 includes a provision that would allow states to opt to grant Medicaid presumptive eligibility and therefore receive federal reimbursement for services that were provided for individuals being discharged from a hospital to a community-based waiver program for a certain period of time, even if they were later found to be ineligible for Medicaid.<sup>13</sup> Although this type of federal reimbursement is not available currently, some states have designed systems that use other funding sources to

guarantee payment for services. Experience to date indicates that such arrangements do not pose substantial financial burdens for states.

### **Guaranteed payment for immediate care**

In states that have “presumptive eligibility” policies, service payments are authorized for a short period after an initial review indicates that the person will likely qualify for Medicaid coverage. In **Washington**, for example, services can be authorized for up to 90 days while the Medicaid application is completed and reviewed. The state guarantees payment for service providers during an initial authorized period. Applicants are asked to sign an agreement with the state during the application process, indicating that they will pay for any long-term care services they receive if they are found ineligible for Medicaid. Presumptive eligibility is not used, however, when finances are complicated. Each month the presumptive eligibility provision is used for about 100 people. It is very rare that “fast track” beneficiaries are later found to be ineligible for Medicaid coverage.

When people apply for **Pennsylvania’s** *Community Choice* program they are asked to sign a form indicating that they will be responsible for payments if they are not eligible for assistance. There is also a possibility, however, that they can receive services from the state-funded long-term care program if they do not qualify for Medicaid. Program experience indicates that more than 80 percent of the financial information provided by applicants can be verified internally. Among 3,500 program participants, only one person has been found to be ineligible; in that case, the value of resources had been underestimated.

**Nebraska’s** *Waiver While Waiting* program allows service coordinators to authorize waiver services for individuals who will likely be eligible for Medicaid coverage. Based on simple financial information provided by the applicant, the service coordinator consults with a Medicaid eligibility worker who can judge whether it appears that the applicant will be eligible for Medicaid. Applicants are not asked to sign forms indicating that they will pay for services if they are denied Medicaid eligibility because policy makers believe that practice could discourage consumers from requesting community-based care. If ultimately the applicant is not eligible, the state uses funds from the Social Services Block Grant to pay for services. The need to use block grant funds has occurred only twice over a two year period. The *Waiver While Waiting* program was established in response to findings from market research conducted by the state which indicated that the time lag between consumer’s needs for home and community-based services and the availability of the services were a major barrier to the choices consumers make about where they want to receive care.<sup>14</sup>

In states that do not guarantee payment for waiver services until Medicaid eligibility has been established, state-funded home and community-based programs can sometimes be used to fill the gap and keep some people in the community while they wait for Medicaid benefits.

### **Provider experience**

Provider supply and experience may also affect providers’ willingness to accept risk. Most agencies in **Vermont** have been willing to provide services to consumers even before their

financial eligibility for Medicaid has been established. They examine applicants' finances to make their own assessments about whether the person is likely to qualify for Medicaid. The agencies ask consumers to sign written agreements indicating that they will pay for the services they receive if they are not determined eligible for Medicaid coverage, but the agencies are experienced at making informal assessments and so there is almost never an occasion when providers have to bill individuals for services. The fact that the certificate of need process limits the number of home health agencies in Vermont means that home health agencies have to serve individuals regardless of their source of payment. And since the providers are members of the strong community coalitions in the state they may be more inclined to provide care.

### **Provider shortages**

Even if community-based providers are willing, their ability to provide services may be limited if the supply of workers is not adequate. All states report that provider shortages affect the availability of community-based care, though the extent to which this occurs varies by state and can vary by geographic region within a state.

Giving consumers the option to hire independent providers is one strategy used to increase the pool of caregivers. In **Vermont**, for example, over half of the personal care provided under the home and community-based waiver is delivered under either the consumer or surrogate directed options. Consumers are the employers and recruit, hire, and supervise their own personal care attendants. This approach also saves money for the state since the rate for people hired by beneficiaries is lower than the home health agency rate. Nurse Practice Acts or nurse delegation programs in **Maine, Nebraska, Oregon, and Washington** make it possible for caregivers who are not licensed or highly trained to receive training and then perform tasks normally performed by a nurse. In Oregon, for example, lay caregivers who receive teaching and support can provide services in all settings except nursing facilities. Increases in payment rates for providers also have been tried as has the provision of health insurance benefits for caregivers, though current budget shortfalls in states may make these approaches less popular.

### **Tracking and managing placements**

In long-term care systems that provide little choice regarding the setting for care, people are routinely admitted to nursing facilities and expected to stay there. As systems evolve and options for care become available, state Medicaid programs must consider how and when choices about long-term care are presented and must determine how to best facilitate community-based care for those who choose it.

The logical settings for diversion efforts would seem to be in the community, in the hospital, or in a skilled nursing facility after a short stay for rehabilitation in anticipation of discharge. Focus groups of consumers in **Pennsylvania** consistently identified hospital stays as the most critical time to make decisions about long-term care.<sup>15</sup> Officials from **New Jersey, Vermont, and Washington** note, however, that early experiences assigning case workers to hospitals and working with discharge planners demonstrated that many hospital patients, particularly those who need rehabilitative services, are unable to fully discuss and consider their options while they are in the hospital.<sup>16</sup> Therefore, in states where people are commonly sent to skilled nursing



facilities for Medicare-financed rehabilitative care after relatively short hospital stays, counseling about community-based options for long-term care occurs shortly after nursing home admission. Regardless of whether consumers are diverted from nursing homes entirely or spend a short time in a facility, the key to successful placements in the community is to ensure that a plan for care is formulated early in the decision process and that the consumer has support throughout the process.

### **Assessments for all applicants**

States such as **Indiana, Maine, and Oregon** mandate that consumers seeking long-term care services in a nursing facility have a pre-admission assessment. The purpose behind this requirement is to guarantee that everyone seeking long-term care is told about all of the options for care. There is also recognition that many people who enter nursing home as private-pay patients become eligible for Medicaid later and so the point of entry to the nursing home is seen as a critical decision point for everyone. In **Maine**, consumers are required to sign a “choice” letter after the assessment, which indicates the type of care they have chosen. Initially, applicants were only required to sign if they chose community-based care, but that process was seen as biased in favor of nursing facilities. Therefore it was changed so that signatures are required regardless of the type of care chosen.

### **Promoting short stays**

Length of stay in a nursing facility is an important predictor of the likelihood that an individual will move back to the community. Research from **Nebraska** indicates, for example, that people living in a nursing facility for longer than a few months are reluctant to relocate because they may not have a place to live and may no longer be in touch with others in the community who might provide supports. In addition, many are anxious about the prospect of leaving a facility once they establish ties and become comfortable there. Without a plan to return to the community and some assistance with arrangements for community-based services, there is a risk that short-term nursing home stays will become long-term stays.<sup>17</sup>

### ***Requirements to notify the state of nursing home admission***

Recognizing that private-pay patients may become eligible for Medicaid during the course of a nursing home stay, states are developing other early notification requirements. Without such rules, the first indication that individuals have been admitted to a nursing home may be when a state receives a Medicaid application. There is a 90 day period when nursing homes can help people submit applications for Medicaid and then receive retroactive payments for a services provided prior to Medicaid approval. At that point in time, nursing home residents may be reluctant or unable to return home.

Some states have established notification requirements so that case managers can see new nursing home residents early in their stay to avoid the type of situation that can occur when individuals are admitted to nursing homes for rehabilitative services covered by Medicare and

are not discharged.<sup>18</sup> Hospitals in **Washington** are required to let the state know within 24 hours of a nursing home placement and then residents are seen within seven days. Case managers are based at nursing homes to provide counseling about long-term care options shortly after admission. **Maine** defers the mandatory assessment when people are admitted for rehabilitation services until the end of the skilled rehabilitation stay and then assessments for long-term care services are conducted. Although **Indiana** does not require notification from hospitals, the Area Agencies on Aging have worked with local hospitals to establish referral systems.

A proposed regulation in **Pennsylvania** requires that anyone who will likely need Medicaid coverage within 12 months have an assessment. Nursing homes would have to advise individuals of this requirement as part of the admission process. And in **New Jersey**, state regulations require that nursing homes notify local long-term care field offices if a person is eligible for Medicaid or is likely to be eligible within 180 days of admission. *Community Choice* counselors are then sent to work with the newly admitted person.

### *Limited certification*

One strategy to keep options for care open is to certify that consumers meet the Medicaid nursing facility requirements for specific periods of time after which a reassessment must occur. The implicit assumption in this approach is that circumstances may change and that the institutional stay is part of an ongoing planning process for long-term care.

In **Nebraska**, for example, the initial Medicaid eligibility period for nursing facility care is based on an assessment of when an individual's needs are likely to change. Those who are flagged as "short-term" residents are referred to case managers who work with them and conduct reassessments for continued coverage. Similarly, in **Oregon** the eligibility review period is set depending on the person's condition at the time of admission to a nursing home.

Although specific certification periods are not used, distinctions are made between short and long-term nursing facility stays in some other states. During the pre-admission screening process for all nursing home admissions in **New Jersey**, for example, Medicaid beneficiaries are designated as "Track One" or "Track Two" depending on whether they are likely to remain in the facility for a long or short-term period of time. All short-term residents receive a letter indicating that they are certified for six months or less. They are contacted by *Community Choice* counselors who work with them to develop a relocation plan. In **Indiana**, the approval notice for nursing home care indicates that individuals are being admitted as "short-term residents" who are expected to leave within 45 days.

In **Maine**, the initial classification period is up to, but generally not longer than 90 days. Another assessment is conducted during that period to determine whether nursing home care is still appropriate or desirable or whether the consumer could be served in the community. In an effort to expedite the movement of consumers to the requested care setting for which they are certified, the state assigns a "waiting placement" status to some individuals who are in institutions but are waiting to leave. The reimbursement rate for patients in hospitals awaiting placement in nursing homes or community placements is equal to the lower average nursing

home rate. The reimbursement rate for residents in nursing homes awaiting community placements is equal to the lower average residential rate paid by Medicaid in Maine. Thus, it is in the institutions' interest to help consumers move to the next level of care.

### **Single entry point systems**

Single entry point systems, sometimes know as Aging and Disability Resource Centers, are operated by one agency or organization such as an Area Agency on Aging or Center for Independent Living to provide a source of information about long-term care services for consumers. They can perform a range of functions, which include providing information and assistance, making functional eligibility determinations, conducting preadmission screening for nursing homes, making Medicaid eligibility determinations, developing and monitoring plans of care. Some 32 states and the District of Columbia operated single entry point systems in 2003.<sup>19</sup> The concept is becoming more popular among states and a number are using Aging and Disability Resource grants to experiment with establishing single entry points or broadening the services available at existing entry points.

### **Case management support**

During the period when people are making decisions about long-term care options and making arrangements for a significant change in daily living, case management or care coordination is a crucial service. As with other services, the approaches state Medicaid programs take to providing case management differs, but the goal of supporting the consumer does not. For example, case managers in **Vermont** and **Indiana** work with individuals until a home or community-based care situation is established, even if a short nursing facility stay is required until community care is available. In other states, such as **Washington**, case managers specialize by setting.

Some states have developed procedures to ensure that consumers returning to the community from hospitals or nursing homes are well settled. Caseworkers in **Pennsylvania** call individuals within 24 hours of their return the community with long-term care services, either after a hospital or nursing home stay. They continue to work with the person if there is a need for assistance and follow-up in establishing community-based care. Once care is established, however, the consumer receives case management from the waiver program. And, after people are relocated to the community, *Community Choice* counselors in **New Jersey** follow them for 30 days even if they are also receiving waiver-related case management services. **Indiana** plans to develop quality measures, based on some of the best practices identified at community agencies in the state, for assistance provided at the critical point when consumers return to the community after a hospital or nursing home stay.

## Early assistance for people with potential long-term care needs

On the theory that relatively small investments for the early provision of some basic supportive services can help people live independently in the community for a longer period of time and eliminate or put off the need for more costly care, **Vermont** is proposing, as part of the 1115 waiver, to define a new level of care for a “moderate prevention” group of people who do not qualify for the Medicaid nursing facility level of care, but whose quality of life and health could be enhanced through minimal interventions. They would be enrolled for a limited package of services including case management, adult day care, and homemaker services. Initially, the group would be limited to 750 people. A certain amount of money would be allotted to each agency across the state that provides adult day and homemaker services. Applicants would be enrolled on a first-come, first-served basis and enrollment is tied to the amount of available funds. This cautious approach will help state officials determine how great the demand for the new service is.

## Assuring that financing arrangements support community-based care

States such as Oregon and Vermont that have legislative mandates to reinvest cost-savings from reductions in institutional care into the development of a home and community-based care have increased the capacity to provide community-based care over the years. A related approach, in which “money follows the person” from a nursing home to the community can also enhance community capacity, but unless the funds remain in the budget for community-based care, the enhancement is temporary.

## Demonstrating savings

Changes in the way funds are allocated and used to pay for long-term care services have occurred, in great part, because of concerns about the overall cost of care. State Medicaid programs’ ability to show that on average the cost of long-term care is lower in the community than in nursing facilities has been an important factor in efforts to rebalance systems. Officials in **Washington** estimate, for example, that the cost of caring for people in a nursing home is equal to the cost of providing services for two to four people at home. In **Pennsylvania**, the budget was adjusted to fund additional waiver slots in anticipation of the implementation of the *Community Choice* program. Pennsylvania estimates that under its aging waiver, on average, 2.2 people can receive services in the community for each aged individual receiving services in a nursing home. In **Indiana**, cost estimates indicate that three people can be served in the community for every two who receive services in nursing homes.

States that use a capitated reimbursement system to pay for long-term care services provide an incentive for diversion given that long-term care services generally are less expensive on a per person basis if they are delivered in the community rather than in an institutional setting. It is in

the financial interests of managed care plans receiving capitated payments to keep people in the community, but to do that, community services must be available.<sup>20</sup>

### **Budgeting for long-term care**

In states such as **Oregon** and **Washington** that have pooled funds for all long-term care services, funding for home and community-based care relative to institutional care is not limited. Most states, however, are authorized to serve a limited number of people through their waiver programs, which have separate budgets. By contrast, an applicant who meets the financial and functional eligibility criteria is entitled to nursing facility care. Nursing home diversion programs cannot be successful if funds to provide community-based care are not available.

### ***Managing waiting lists***

When funds to support community-based care are not sufficient, state Medicaid programs must develop policies that indicate who will be served first. Often waiting lists for home and community-based services are kept on a first-come, first served basis, but some states have developed waiting list policies designed to promote community-based care. Since 1996, the waiting list for home and community-based waiver services in **Vermont** has been based on level of need instead of date of application. Priority is given to applicants who want to leave a nursing facility for the community and need waiver services to do so, applicants in the hospital who want to return to the community instead of entering a nursing facility and need waiver services to do so, applicants in the community at risk of significant harm without waiver services, and applicants at risk of moving to a more restrictive setting. The *Priority Diversion Initiative* in **Indiana** gives priority to people in hospitals at risk of direct admission to nursing facilities and people living in the community at risk of an emergency admission to a facility. A physician must certify that the individual needs services within 72 hours. Waiting lists had been managed locally, but now they are managed at the state level to achieve greater consistency in policies.

### **New rules for Medicare Part D subsidies may affect diversion efforts**

The Medicare Modernization Act of 2003 specifies that beginning in 2006, prescription drug coverage (Part D coverage) will be available for Medicare beneficiaries. In addition, subsidies will be available to help low-income Medicare beneficiaries pay for some of the costs associated with coverage. Individuals who have Medicare and full Medicaid coverage, including long-term care benefits, will receive subsidies for premiums, deductibles, and co-payments associated with the benefit. The rules for co-payments differ however, depending on whether a person receives services in an institution or in the community. Institutionalized individuals have no cost-sharing for drugs covered under their prescription plans, but individuals living in the community must make co-payments: \$1 for generic drugs and \$3 for brand-name drugs for individuals with incomes up to 100 percent of the federal poverty level and \$2 for generic drugs and \$5 for brand-name drugs for individuals with incomes over 100 percent of the federal poverty level. Although these co-payments are nominal for each drug, they can be significant for consumers with low incomes who take multiple medications. The differences in co-payment rules for drug benefits may not play a major role when consumers are making decisions about the setting for long-term care, but they will be another factor for individuals to consider, and in some cases could have an influence on decisions about care. Similarly, decisions about settings for long-term care could be influenced to a certain extent by differences among formularies available in institutions and for community-dwelling beneficiaries and by the extent to which assistance regarding the choice and use of drug plans is available to beneficiaries. States that actively promote community-based care may be faced with decisions about whether to add a drug co-payment benefit for waiver programs or for state-funded programs.

### **Providing support to maintain or obtain community residences**

People's ability to remain in the community often hinges on the availability of accessible and affordable housing.<sup>21</sup> Sometimes there is a need to make modifications or repairs so that an existing home will be livable or it may be necessary to move to a more appropriate residence to stay in the community. Individuals who enter institutions, but ultimately wish to receive services in the community on an ongoing basis must be able to maintain or secure appropriate housing. As a general rule, Medicaid cannot pay for housing.

### **Assessments for accessibility and home modifications or repairs**

Assessments for accessibility and modifications for homes or vehicles can be covered as a Medicaid administrative expense. These and other services associated with making a transition from a hospital or nursing home to the community also can be covered as waiver expenses.<sup>22</sup> For example, some waivers cover services to make the home livable such as pest control, or one-time cleaning. Waivers can also cover moving and related expenses such as security deposits, or deposits for utility services. Some state waiver programs also pay for assistive technology that people need to stay at home.

Recognizing that these services, particularly home modifications, often must be provided before consumers needing long-term care can live at home, Medicaid rules allow states to pay for services provided up to 180 days before individuals leave an institution to return home.<sup>23</sup> These rules are very helpful for peoples who have Medicaid coverage and have received approval for waiver services. Applicants whose Medicaid eligibility is pending, however, do not have access to these services and therefore, may not be able to stay in the community or return to the community immediately from a hospital or other institutional setting. Thus, current Medicaid rules make diversion efforts difficult in some cases.

As noted earlier, the option of allowing states to pay for community-based services on a “presumptive” basis under Medicaid has been proposed. Currently, however, if states choose to provide waiver services on a presumptive basis, they must have a source of funds that can be used to finance services if individuals who receive the services are determined to be ineligible for Medicaid. Commonly, states have other funding sources that can be used to finance the assessment, modification, or repair of home, but funds are limited.<sup>24</sup> In **New Jersey**, *Community Choice* counselors can request up to \$600 in state funds to pay for security deposits, furniture, or other expenses related to moving. If a situation requires more funding, a process is in place to waive the cost cap to assist with transition. The funds can also be used to pay for transportation to visit a community living setting or for a short trial stay in the community. The **Nebraska** Medicaid program has an Assistive Technology Partnership with the Department of Education’s Office of Vocational Rehabilitation, which can conduct accessibility assessments and facilitate home modifications efficiently by pooling funds from a number of different programs in the state that require the services. **Vermont’s Home Access Program** provides some funds for home modifications and the state’s long-term care coalitions can use the state funds they receive to pay for home modifications. **Washington’s Residential Care Discharge Allowance**, which is financed using state general funds, pays up to \$816 for rent, utilities, furniture, and minor home modifications for individuals relocating from institutional settings, including hospitals. An *Assistive Technology Fund*, which is funded by the state, can also be used to pay for as much as \$10,000 per person each fiscal year for necessary equipment.

The time required to make home modifications or repairs is another factor that can impede diversion efforts. In response to this problem in **Pennsylvania**, the state pre-certified certain bidders for particular services such as building ramps provided under the physical disability waivers. The more time-consuming practice had been to get three bids for every modification before the state would pay for it through the waiver program.

### **Retaining income and resources for community living**

Consumers who receive Medicaid coverage for institutional long-term care, are required to contribute a substantial portion of their income to the nursing facility. States do have the option under Medicaid rules, however, to exempt income so it can be used to maintain a home. This home maintenance allowance can be authorized for up to six months if a physician certifies that the individual is likely to be able to return home in that period.<sup>25</sup> When this approach is used, the resident’s payment is lowered and the amount that Medicaid pays to the nursing facility is higher.

In recognition of the fact that people who want to return to the community may have financial obligations related to housing, the **Maine** Medicaid program does not require co-payments from nursing facility residents during the months of admission or discharge. In **New Jersey**, nursing facility residents who are designated “Track Two,” or short-stay residents, are allowed to keep up to \$150 each month for rental assistance while they are in the nursing facility. Nursing home residents in **Pennsylvania** may keep up to \$659 per month to maintain a home or fund a move. **Washington’s Medical Institution Income Exemption** allows nursing facility residents to keep income up to or equal to 100 percent of the federal poverty level for a six-month period to maintain a community residence. For example, the money can be used to pay for rent, mortgage, utility, and other payments. Case managers verify the use of income by examining canceled checks, bills, or receipts.

Some states have made changes to Medicaid financial eligibility rules, in recognition of the fact that people who stay in the community will likely have ongoing expenses related to maintaining a home. **Pennsylvania** increased the resource disregard used in determining financial eligibility for Medicaid from \$2,000 to \$8,000 for individuals receiving home and community-based waiver services through the *Community Choices* program. Under **Vermont’s** 1115 waiver proposal, individuals who are single, own their homes, and wish to stay in them could keep additional assets above the current \$2,000 level. Vermont will start at the \$3,000 level, but has permission to go as high as \$10,000. The higher asset rules would also apply for short stays in nursing homes so that consumers can maintain their homes and move back to the community. **Maine** has increased the disregards for assets so that beneficiaries can have assets of \$10,000 or less. This has the effect of allowing individuals to retain assets that can be used to maintain homes or for other purposes.



### Use of Nursing Home Spousal Impoverishment Rules for Community-Based Care

Federal Medicaid rules provide some financial protections for the spouse of an individual who receives long-term care services in an institution. The spouse remaining in the community can keep a portion of income and assets to maintain a reasonable standard of living in the community. The federal government establishes minimum and maximum levels and for income and resources and states set limits within those parameters. States have the option of applying nursing home spousal impoverishment protections when a married individual applies for home and community-based care. Thirty-nine states did so in 2001.<sup>26</sup> Six of the eight states featured in this report use spousal impoverishment rules for all Medicaid beneficiaries receiving long-term care services, regardless of the setting, thus removing a barrier to community-based care for some married individuals.

State	Use of Nursing Home Spousal Impoverishment Rules
IN	Y
ME	N
NE	Y
NJ	Y
OR	Y
PA	N*
VT	Y
WA	Y

\*Pennsylvania is in the process of seeking legislation to make spousal impoverishment rules the same for nursing home and home and community-based care.

### Efforts to increase the housing supply

It is important to note that even when financial support to modify or maintain homes is available, efforts to promote community-based care will fail if the supply of accessible and affordable housing is not adequate. Provisions for repairing and maintaining existing homes are important, but there are instances when a move to a different setting may be necessary. Some states have established Medicaid waiver programs for the delivery of services in group residential settings such as assisted living facilities and adult family homes, but in other states there are no group housing options that can be used by waiver clients. One issue that states must contend with is that Medicaid can cover room and board costs in nursing homes, but not in group residential settings.<sup>27</sup> Another complicating factor in some states is that the state licensing requirements and Medicaid waiver requirements for certain types of facilities may differ. When one agency oversees both functions, as is the case in **Oregon and Washington**, the rules can be aligned more easily. In other states, communication between the agencies is vital. States that pay for community-based care in group residential settings also must develop effective means to monitor the quality of care.<sup>28</sup>

Some states also attempt to identify existing appropriate housing. For example, **Pennsylvania** recently established a statewide database so that housing managers can report the availability of units subsidized by the Pennsylvania Housing Finance Authority. The Authority is required to insure that at least five percent of vacant units are held for 30 days for people with disabilities, but prior to the establishment of the database, it was difficult to identify available units. **New Jersey** has a grant to develop an interactive housing site that will help people learn about available housing.

### **Informing people about options for care**

The alternatives to nursing homes are better known in states that have been promoting community-based care for some time, but in most states, systems are evolving quickly and community-based options for long-term care are relatively new. State officials are stressing the importance of publicizing the availability of community-based alternatives both to consumers and to the professionals who work with them.

In an effort to make information available quickly and easily, especially at a time of crisis, a number of states now offer 24-hour hotlines. For example, **Pennsylvania's** *Community Choice* program publicizes a toll free hotline number that people can call 24 hours a day, seven days a week for information on long-term care options. An *Elder Abuse Hotline*, which already was in operation, now performs an extra function. Operators route calls about long-term care services to assessors who are on call to respond to inquiries and to conduct assessments for long-term care services. **Nebraska** plans to use the state's *211 Hotline* to provide access to long-term care counselors at all times.

### **Publicity campaigns**

Publicity campaigns also are used. Early on, **Washington** conducted a community education campaign to help people become more familiar with the long-term care system and particularly with the fact that they may be able to remain in their own homes and receive services. Annually, the state participates in several statewide conferences involving stakeholders, such as seniors and caregivers, to remind the public and providers about the availability of community-based care and to get feedback about services in the state. **Vermont** mounted an *Options Education* campaign to publicize the availability of options for long-term care services. A set of outreach materials that can be used statewide and locally was developed for immediate and ongoing use. The outreach materials urge state residents to call the Senior HelpLine and talk with Information Assistance Specialists. Grant funds were used to develop the materials and mount the initial campaign. The state anticipates that maintaining the campaign should be less costly now that the materials have been developed. In the future, the campaign will be financed with funds from the long-term care budget.

## Work with professionals in the community

After market research conducted in **Nebraska** indicated that a key factor in making consumers aware of options for long-term care services is informing and motivating professional who work with them, the state developed a campaign, *Choices: Life on Your Own Terms* designed to reach the public and providers. The state also sponsored a pilot project to place *Choices* counselors in hospitals to work with discharge planners. Similarly, **Pennsylvania** held training sessions for hospital discharge planners in the ten counties where the *Community Choice* program was implemented. Officials note that the key to gaining the confidence of discharge planners is convincing them that the process of placing people in the community will not increase time spent in the hospital.

## Conclusion

Currently, states that pool long-term care funds, have well integrated administrative functions, and use waivers to cover the majority of people needing long-term care have the most flexibility with regard to building community capacity, being able to offer care in the community, and in the process, diverting consumers from nursing facilities. Home and community-based long-term care is a well known alternative to nursing home care in those states. In a number of other states, where more traditional Medicaid programs favor institutional long-term care, innovations to keep people out of nursing homes and in the community also have been tried with some success. For example, state Medicaid programs have taken steps to expedite eligibility determinations so that eligible applicants can receive community-based Medicaid long-term care services in a timelier manner. In an effort to ensure that community-based care is available immediately, some state Medicaid programs assure payment for “presumptively eligible” beneficiaries. When a single Medicaid budget covers all long-term care services, beneficiaries are less likely to have to wait for community-based care. In states that have waiting lists, some give priority to beneficiaries who wish to leave institutions or beneficiaries at immediate risk of nursing home placement. Procedures to track and manage placements also are used to ensure that individuals requesting community-based care don’t “fall through the cracks,” particularly if their course of care involves an initial short stay in a nursing facility. Challenges associated with maintaining or obtaining residences in the community are well-recognized and so some states make funds available to help finance moves or home modifications and some state Medicaid programs have more liberal financial eligibility or payment rules for individuals seeking community-based long-term care. All states recognize that there is a need to inform people about the options for long-term care services, though the techniques used to do so vary.

Although states continue to consider policy changes to promote community-based long-term care in Medicaid, the issue that overshadows all others for state Medicaid programs is the challenge posed by the growing need for services at a time when funding is limited. Most states already were considering plans to reduce the growth of Medicaid spending, but with the passage of the Congressional budget resolution for fiscal year 2006, which calls for a \$10 billion reduction in federal spending for Medicaid over the next five years, there is even more emphasis on controlling program costs.

It is worth noting, however, that many of the innovations to rebalance long-term care services and provide more care in the community were initiated at times when budgets were tight precisely because policy makers were willing to consider plans presented as lower cost alternatives.

## Appendix 1

### Efforts to Promote Diversion in Eight States

#### Indiana

Indiana has developed a *Priority Diversion Initiative*. The focus of the state's efforts is on people who already have Medicaid coverage and are in need of long-term care services. There is a system in place now so that hospitals notify Area Agencies on Aging immediately when they have a patient who will need long-term care services. The Area Agencies provide case management for all consumers receiving long-term care services, regardless of the setting. Because it may be difficult to make all the necessary arrangements for community-based care in the three or four day period, which is the typical hospital stay, some people move to nursing facilities, but the approval notice for nursing home care indicates that they are being admitted as "short-term residents" who are expected to leave within 45 days and case managers continue to facilitate community-based care for those who request it. The state has also changed its waiting list policy to give priority for community-based care to people in hospitals at risk of direct admission to nursing facilities and people living in the community who are certified by physicians to be at risk of an emergency admission to a facility.

#### Maine

In 1993, Maine adopted a policy to reduce reliance on institutional long-term care. Shortly after that the state mandated universal pre-admission assessment for all consumers requesting care in a nursing home, regardless of payment source. The state recognized that a substantial number of individuals entering nursing homes as private payers become Medicaid eligible. The intention was to ensure that everyone would have the opportunity to learn about all available options when they first request long-term care services. Individuals are asked to sign a form confirming their intentions regardless of whether they choose institutional or community-based care. State policies such as limiting the initial certification periods for nursing homes and allowing nursing home residents to keep some of their income to fund a move also contribute to goal of serving people in the community. And, the state's Nurse Practice Act has allowed more services to be delivered by community-based service providers.

#### Nebraska

Nebraska's *Waiver While Waiting* initiative ensures that people who are determined likely to qualify for waiver services for the aged and adults with disabilities can receive care in the community even before their applications are completely processed. After state-sponsored research indicated that lack of awareness was one of the barriers to choosing community-based long-term care, a campaign to publicize options for long-term care among consumers and professionals was instituted. The state also distinguishes between short and longer term stays when individuals are admitted to nursing homes. Efforts to provide more appropriate housing in the community, including a program to convert nursing homes to assisted living facilities, have occurred and the state has passed the Nurse Practice Act, designed to address the shortage of providers in the state.

## **New Jersey**

New Jersey's *Community Choice Program* counsels people in nursing homes about community-based options for care. The program began as a pilot program to work with people in nursing homes, particularly those who are newly admitted. During the Medicaid pre-admission screening process, beneficiaries are designated as likely to remain in the facility for a short or long-term period. They also have the option of retaining some income, which ordinarily would be paid to the nursing facility, so that they can pay to maintain homes or make the transition back to the community. And, some state funds are available to pay for transition needs.

## **Oregon**

Since 1981, when Oregon received the first home and community-based services waiver, the philosophy and standard practice in the state has been to provide as much long-term care as possible in community-based settings. Thus, all program operations are essentially geared to promoting diversion from nursing homes and relocation for nursing home residents who request care in the community. Oregon's aggressive efforts to build community capacity have included activities to ensure that community-based facilities are regulated in a manner that allows for the provision of long-term care services to consumers with all types of impairments. The state's Nurse Practice Act responds to staffing shortages in the state. A policy that requires all prospective nursing home residents to be screened before entering the facility provides an opportunity to discuss options for care with all consumers. Locally, the staff that manages Medicaid eligibility and placement for people needing long-term care services has developed good working relationships with hospital personnel so that people who potentially need long-term care services can be identified.

## **Pennsylvania**

*Community Choice* is a pilot program operating in ten counties in Pennsylvania. "Fast track" enrollment is an important feature of the program. Applicants can call a 24-hour hotline. A new short assessment form provides space for applicants to make self-declarations regarding income and resources. Assessors, who are always on call and can see applicants within 24 hours if necessary, can make immediate eligibility determinations, develop temporary plans of care, and authorize services for an initial period while financial information is verified and a more comprehensive plan of care is developed. The state also has trained hospital discharge planners about the new program. Companion efforts focus on nursing home admission. Physician certification of the need for a nursing facility level of care is required for both nursing home admission and home and community-based services. Pennsylvania is revising the process used to determine the initial certification period and location of services, after which a reassessment must occur.

## **Vermont**

Vermont's *Act 160*, passed in 1996, mandated a shift from institutional to home and community-based long-term care. Under the Act, funds generated from reducing the projected growth of institutional spending have been used to build community capacity. Community coalitions were established across the state and charged with planning and coordinating local long-term care services. A new waiting list policy was developed for home and community-based waiver services, which gives priority to individuals in institutions who wish to return to the community and need waivers services to do so and individuals at greatest risk of entering nursing homes

without waiver services. Currently, CMS is evaluating an 1115 research and demonstration waiver proposal submitted by Vermont to operate the long-term care Medicaid program combining funds for both nursing homes and the home and community-based waivers under a global budget. Under the proposal, people who meet the state's "highest need" criteria would be equally entitled to home and community-based or nursing home services. Recognizing that people who stay in the community will likely have ongoing expenses related to maintaining a home, the 1115 waiver also would grant larger deductions in calculating the value of assets, for individuals who are single, own their homes, and wish to stay in them. The state has also mounted an *Options Education* campaign to publicize the fact that people have choices about how long-term care services are delivered.

### **Washington**

Diversion efforts are part of a well integrated system in Washington, which has a strong commitment to providing care in the community. The state uses a "fast track" eligibility process, which allows some applicants whose financial circumstances are not complex to make initial self-declarations about their finances. The state also guarantees payment for community-based providers who deliver services on a "presumptive" basis while more complete Medicaid applications are being processed. To facilitate community placement, Washington requires that patients leaving the hospital and nursing home patients receive assessment and service information in a timely manner. Some case managers work exclusively in nursing homes to help patients develop relocation plans. State funds, in addition to funds available through the Medicaid program, are used to help with the cost of maintaining or modifying residences or moving back to the community. Washington has implemented a nurse delegation program in in-home and community residential settings. This has enabled non-licensed caregivers to perform nursing tasks, thus alleviating difficulties related to the nursing shortage in the state.

- 
- <sup>1</sup> Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Long Term Care*, July 2004.
- <sup>2</sup> Calculations based on data from: “Table 1: Medicaid Expenditures for Long-Term Care Services: 1992-2004” from Burwell, Brian; Kate Sredl, Steve Eiken, *Medicaid Long Term Care Expenditures - FY 2004*, available at <http://www.hcbs.org>.
- <sup>3</sup> *Distribution of Medicaid Long-term Care Expenditures, Institutional vs. Community-Based Services, FY2004*, from Burwell, Brian; Kate Sredl, Steve Eiken, *Medicaid Long Term Care Expenditures - FY 2003*, available at <http://www.hcbs.org>.
- <sup>4</sup> Ibid
- <sup>5</sup> Smith, Gary, et al., *Understanding Medicaid Home and Community Services: a Primer*, Washington, DC: U.S. Department of Health and Human Services, 2000.
- <sup>6</sup> Smith, Gary, et al.
- <sup>7</sup> See for example: Centers for Medicare and Medicaid Services (2000). *Olmstead Update No. 3*, available at <http://www.cms.hhs.gov/states/letters/>; Rutgers Center for State Health Policy/National Academy for State Health Policy, Community Living Exchange Technical Assistance Collaborative (2002). *Nursing Home Transition Programs Summary Brief*, available at <http://www.hcbs.org>.
- <sup>8</sup> Centers for Medicare and Medicaid Services (2000). *Olmstead Update No. 3*.
- <sup>9</sup> See for example: Mollica, Robert and Jennifer Gillespie (2003). *Single Entry Point Systems: State Survey Results*. Community Living Exchange Collaborative: A National Technical Assistance Program. New Brunswick, NJ, Rutgers Center for State Health Policy; O’Shaughnessy, Carol, Rob Weissert, Julie Stone, Sidath Panangala, Meridith Walters. (2003). *A CRS Review of 10 States: Home and Community-Based Services--States Seek to Change the Face of Long-Term Care: Pennsylvania*, Congressional Research Service.
- <sup>10</sup> See for example: Indiana Family and Social Services Administration (2003). *Report of the Governor’s Commission on Home and Community-Based Services*; Pennsylvania Intra-Governmental Council on Long Term Care (2002). *Home and Community-Based Services Barriers Elimination Work Group Report*; Reinhard, Susan and Marissa Scala (2001). *Navigating the long-term care maze: new approaches to information and assistance in three states*. Washington, DC, AARP;
- <sup>11</sup> Centers for Medicare and Medicaid Services (2000). *Olmstead Update No. 3*.
- <sup>12</sup> Bruen, Brian, Joshua Wiener, Seema Thomas (2003). *Medicaid Eligibility Policy for Aged, Blind, and Disabled Beneficiaries*, AARP, Public Policy Institute.
- <sup>13</sup> Centers for Medicare and Medicaid Services, *The New Freedom Initiative: President’s 2005 Budget and CMS Accomplishments*, available at: <http://www.cms.hhs.gov/newfreedom/2005budgetsum.pdf>.
- <sup>14</sup> Lauerman, Bailey (2001). *Nursing Home Transition Pilot Project Research Report*, Nebraska Department of Health & Human Services.
- <sup>15</sup> Pennsylvania Intra-Governmental Council on Long Term Care (2002).
- <sup>16</sup> See for example: Reinhard, Susan and Charles Fahey (2003). *Rebalancing long-term care in New Jersey: From institutional toward home and community care*, Milbank Memorial Fund.
- <sup>17</sup> See for example: Mollica, Robert. (2001). *State Assisted Living Practices and Options: A Guide for State Policy Makers*, National Academy for State Health Policy.
- <sup>18</sup> Ryan, Jennifer and Nora Super (2003). *Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?* Washington, DC, National Health Policy Forum.
- <sup>19</sup> Mollica, Robert and Jennifer Gillespie (2003).
- <sup>20</sup> See for example: Stevenson, D., C. Murtaugh, P. Feldman, M. Oberlink (2000). *Expanding Publicly Financed Managed Long-Term Care Programs to Provide Greater Access to Home and Community-Based Care*, Center for Home Care Policy and Research, The Visiting Nurse Service of New York.
- <sup>21</sup> Rutgers Center for State Health Policy/National Academy for State Health Policy, Community Living Exchange Technical Assistance Collaborative (2002).
- <sup>22</sup> Centers for Medicare and Medicaid Services (2000). *Olmstead Update No. 3*.
- <sup>23</sup> Ibid.
- <sup>24</sup> Summer, Laura and Emily Ihara (2004). *State Funded Home and Community-Based Service Programs for Older People*, AARP Public Policy Institute.
- <sup>25</sup> Medicaid post-eligibility treatment of income rules (CFR435.832)435.725,.733,.832
- <sup>26</sup> Bruen, Brian, et al. (2003).



---

<sup>27</sup> Mollica, Robert (2001).

<sup>28</sup> See for example: Stevenson, D., C. Murtaugh, P. Feldman, M. Oberlink (2000). *Expanding Publicly Financed Assisted Living and Other Residential alternatives for disabled Older Persons: Issues and Options*, Center for Home Care Policy and Research, The Visiting Nurse Service of New York. Wiener, Joshua, Jennifer Tilly, Lisa Alecxih. (2002). *Home and Community-Based Services in Seven States*, Health Care Financing Review.

The Kaiser Family Foundation is a non-profit, private operating foundation dedicated to providing information and analysis on health care issues to policymakers, the media, the health care community, and the general public. The Foundation is not associated with Kaiser Permanente or Kaiser Industries.

1330 G STREET NW, WASHINGTON, DC 20005  
PHONE: (202) 347-5270, FAX: (202) 347-5274  
WEBSITE: WWW.KFF.ORG / KCMU

Additional copies of this report (#7402) are available  
on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).

