

**Long-Term Services and Supports Scorecard  
Promising Practices**

# State Strategies to Reduce the Risk of Long-Term Nursing Home Care after Hospitalization

Ellen O'Brien, PhD  
Independent Consultant

Wendy Fox-Grage  
AARP Public Policy Institute



[www.longtermscorecard.org](http://www.longtermscorecard.org)





## Returning to Community

After she fell and broke her hip in 2014, Dickie Voth went to a nursing home for 80 days after a hospitalization. She had previously lived alone in her own home. From the time she was admitted to St. Ben's nursing home, Dickie expressed her strong desire to return home, alone, to live as independently as possible. To put together a plan for community living, the nursing home social worker worked with Dickie, her daughter Diane, and Wendy Galanius, a community living specialist with Minnesota's Return to Community Initiative (RTCI).



Adeline “Dickie” Voth and Wendy Galanius

“RTCI is one of the resources we use to help people return home,” said Tiffany LeMieur, a nursing home social worker. “We find Return to Community . . . is especially helpful for people with complex discharge plans who need a lot of continued follow-up after they discharge or whose plan might continue to change as they go home.”

St. Ben's nursing home staff brought the community living specialist in as a team member to help Dickie move back into the community. Ultimately, Dickie and Diane, with support from the team, decided—due to her mobility limitations and other needs—that Dickie should live with Diane, who would become her full-time caregiver, with support services in place.

To complete the plan for community living, Wendy provided options for the kinds of services that might be needed. She discussed who could provide services and who would pay for them. Wendy worked with the Department of Veterans Affairs to connect Dickie to services for which she was eligible. She secured therapy services, a home health aide, and homemaker services, and connected them to accessible transportation.

“If we didn't have Wendy, I don't know where my mother and I would be right now. I seriously don't think Mother would be alive,” said Diane. “All of the beautiful things that have happened to me, Diane and Wendy have done it together. And I think that Return to Community is behind me all the way,” added Dickie.

Source: “Return to Community, Dickie,” *Minnesota Return to Community Initiative*, 8/14/2017, [http://www.mnaging.org/videos/Dickies\\_RTC.mp4](http://www.mnaging.org/videos/Dickies_RTC.mp4).

## About This Paper

In 2015, about one out of five hospitalized Medicare beneficiaries was discharged to a skilled nursing facility (SNF). Although most beneficiaries admitted for SNF care can expect to return home within a few days or weeks, some older adults who enter a nursing home following a hospitalization are at risk of a long-term nursing home stay—especially those who have dementia, who are very frail, or who lack a family caregiver and other community supports. Since some of these long stays may be preventable, the Long-Term Services and Supports State Scorecard contains the following measure: percentage of new (posthospital) nursing home stays lasting 100 days or more. Nationwide, the percentage of these long stays dropped from 20.6 percent in 2009 to 18.7 percent in 2012, reflecting the long-term decline in the use of nursing homes among older adults. However, state performance varies widely, with fewer than 15 percent of new nursing home stays lasting 100 days or more in highly ranked states including Maine, Oregon, and Minnesota, compared with 25 percent or more in the three lowest-ranked states. This Promising Practices Paper describes strategies used in four highly ranked or significantly improved states (Connecticut, Maine, Minnesota, and Oregon) that may reduce the risk of long-term nursing home care after a hospitalization. The paper also includes a toolkit of resources that can help others learn more and potentially replicate these practices, as well as contact information for experts from these four states.



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## Introduction

Most people who are admitted to a skilled nursing facility (SNF) after a hospitalization can expect to return home or to be discharged to another community setting within a few days or weeks.<sup>1</sup> Medicare covers these SNF stays for a maximum of 100 days of care, after a hospital stay of 3 days or longer. However, for many older adults, a postacute stay can lead to long-term nursing home residence.<sup>2</sup> Patients who are not discharged to the community within a few months are particularly at risk of a long-term stay. The likelihood of a nursing home resident returning to a community setting declines sharply after 90 days. Because most nursing homes provide both SNF care and long-term custodial care, transitions to long-term residence can be relatively easy.

Long-term nursing home residence can be a poor outcome from the perspective of people who enter nursing homes and their families. Most people, like Dickie Voth, do not want to live in nursing homes. Most family caregivers want to do whatever they can to ensure that their family member does not remain in the nursing home any longer than needed. People residing in nursing homes also may face much higher out-of-pocket costs than they would for community-based long-term services and supports (LTSS). Long-term nursing home stays may pose a cost problem for states as well because long-stay residents are likely to spend down their resources and become eligible for assistance from Medicaid.

Since some of these long stays may be preventable, a measure of posthospital long stays—the percentage of new nursing home stays that last 100 days or more—is included in the Scorecard as an indicator of effective care transitions. New nursing home stays

are defined as those that begin with an admission from an inpatient hospital (rather than an admission from the community or another nursing home).<sup>3</sup> In all states, most new stays are shorter than 100 days, but states vary widely in the percentage of stays that last more than 100 days. For this measure of LTSS system performance, a lower percentage is better. Since the goal of postacute care is to ensure a timely and successful community discharge, states with higher-performing LTSS systems tend to achieve a lower percentage of long stays posthospitalization. Highly ranked states include Maine, Oregon, and Minnesota, with fewer than 15 percent. By comparison, in the three states ranked lowest on this indicator, more than 25 percent of new nursing home stays extended beyond 100 days—Louisiana (35 percent), Arkansas (26.8 percent), and Texas (24.7 percent) (see exhibit 1). Across states, with only a few exceptions, the percentage of new stays that lasted 100 days or more declined between 2009 and 2012.

This paper describes how state policies in four states—Oregon, Maine, Minnesota, and Connecticut—may reduce long-term nursing home care after a hospitalization and ensure timely and effective transitions back to community living. The first three states—Oregon, Maine, and Minnesota—are among the highest performing on this indicator; they also have relatively low Medicare SNF admissions and low overall nursing home use among older adults (see exhibit 2). Connecticut had a higher percentage of long stays posthospitalization in 2012 than the other three states (16.3 percent) and a higher rate of SNF admissions in Medicare (103 admissions per 1,000 enrollees), but its percentage of long stays declined significantly from 18.2 percent in 2009 to 16.3 percent in 2012.

- 1 Among beneficiaries enrolled in fee-for-service Medicare and discharged from an acute care hospital in 2014, 46 percent went on to postacute care: 21 percent were discharged to an SNF, 16.8 percent were discharged home with organized home health care, 3.8 percent were discharged to an inpatient rehabilitation facility, and 1.2 percent were discharged to a long-term care hospital. MedPAC, *MedPAC Data Book* (Washington, DC: MedPAC, June 2016), 70. The average SNF length of stay was 26.5 days in 2015. The risk-adjusted rates of discharge to the community has increased over time, rising from 33.1 percent in 2011 to 38.8 percent in 2015. MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2017), 204, 208.
- 2 Usually, these facilities are the same institutions as those providing residential long-term care: 95 percent of SNFs provide both kinds of care.
- 3 To qualify for SNF services, a Medicare beneficiary must have had an inpatient stay in a hospital for at least 3 nights. This qualifying hospital stay typically must occur within the 30 days prior to the SNF admission. See Social Security Act § 1861(i).

### **The LTSS State Scorecard: Creating an Indicator to Measure the Risk of Long-Term Nursing Home Stays after Hospitalization**

The AARP LTSS Scorecard measures five dimensions of system performance including effective transitions. Since the transition from hospital to skilled nursing to community is common and important, the AARP Scorecard team sought to develop a measure of the risk of a long nursing home stay after a hospitalization. The indicator was based on research that documents the sharp drop in rates of community discharge after 100 days and was developed by experts at Mathematica Policy Research and the AARP Scorecard team, incorporating input from members of the Scorecard National Advisory Panel. The Scorecard indicator measures the proportion of new nursing home residents in a year whose stay lasts 100 days or more. The focus is on new nursing home residents, who are expected to return to their home or community, rather than those who were already long-term residents of nursing homes.

The best available data to measure these patterns of acute care, postacute care, and long-term nursing home use come from Medicare administrative data, in this case a “timeline” file in a Medicare database called the Chronic Conditions Warehouse (CCW). Experts at Mathematica Policy Research developed the indicator from their analysis of the timeline file.

The CCW timeline file includes a daily service use “status” for all Medicare beneficiaries; each Medicare enrollee is assigned a single status for each day of the year: (a) nursing home (including Medicare skilled nursing), (b) hospital inpatient, (c) community (including home health and assisted living), or (d) deceased.

Nursing home stays were categorized as new if they were immediately preceded by an inpatient stay, and the enrollee was not in a nursing home for at least 30 consecutive days before the beginning of the stay. Intervening events are addressed by considering inpatient stays after which the enrollee returns to a nursing home to be part of a continuous nursing home stay.

To construct the indicator, several choices must be made about how to measure nursing home length of stay and community discharge. A stay is deemed to have lasted 100 days or more if the person is either (a) in a nursing home on day 100, and was in a nursing home for at least 75 percent of the 100-day period, or (b) alive on day 100 and with no intervening days in the community. A person is assumed to have returned to the community before 100 days if they (a) spent more than 25 percent of the 100 days out of the nursing home, or (b) were alive but not in a nursing home on day 100 and had at least 1 day in the community. People who died before either 100 days or 26 community days, whichever came first, were excluded from the analysis.

EXHIBIT 1

Percentage of New Nursing Home Stays Lasting 100 Days or More, by State

| Rank (2012) | State                | 2012         | 2009         | Rank (2012) | State                | 2012  | 2009  |
|-------------|----------------------|--------------|--------------|-------------|----------------------|-------|-------|
|             | <b>United States</b> | <b>18.7%</b> | <b>20.6%</b> | <b>26</b>   | California           | 18.3% | 19.0% |
| <b>1</b>    | Arizona              | 8.9%         | 11.4%        | <b>27</b>   | North Carolina       | 18.4% | 22.3% |
| <b>2</b>    | Oregon               | 9.2%         | 10.3%        | <b>28</b>   | South Carolina       | 18.4% | 21.8% |
| <b>3</b>    | Utah                 | 10.5%        | 12.2%        | <b>29</b>   | Kansas               | 18.4% | 20.6% |
| <b>4</b>    | Idaho                | 13.5%        | 16.7%        | <b>30</b>   | Iowa                 | 18.4% | 19.2% |
| <b>5</b>    | Maine                | 13.8%        | 14.3%        | <b>31</b>   | Illinois             | 18.5% | 20.4% |
| <b>6</b>    | Minnesota            | 14.0%        | 16.2%        | <b>32</b>   | Nevada               | 19.2% | 21.3% |
| <b>7</b>    | Alaska               | 14.2%        | 17.6%        | <b>33</b>   | New Hampshire        | 19.4% | 17.1% |
| <b>8</b>    | Colorado             | 14.8%        | 16.4%        | <b>34</b>   | Missouri             | 19.7% | 22.7% |
| <b>9</b>    | New Jersey           | 15.1%        | 16.4%        | <b>35</b>   | Kentucky             | 19.9% | 22.6% |
| <b>10</b>   | Washington           | 15.2%        | 16.9%        | <b>36</b>   | Wyoming              | 20.0% | 19.8% |
| <b>11</b>   | Hawaii               | 15.3%        | 19.1%        | <b>37</b>   | South Dakota         | 20.2% | 19.5% |
| <b>12</b>   | Montana              | 15.4%        | 17.5%        | <b>38</b>   | District of Columbia | 20.6% | 22.2% |
| <b>13</b>   | Delaware             | 15.5%        | 18.9%        | <b>39</b>   | Tennessee            | 20.8% | 24.0% |
| <b>14</b>   | Florida              | 15.7%        | 16.5%        | <b>40</b>   | Georgia              | 21.1% | 24.5% |
| <b>15</b>   | Virginia             | 16.0%        | 18.7%        | <b>41</b>   | West Virginia        | 21.5% | 23.6% |
| <b>16</b>   | Vermont              | 16.1%        | 16.3%        | <b>42</b>   | Pennsylvania         | 21.6% | 23.1% |
| <b>17</b>   | Connecticut          | 16.3%        | 18.2%        | <b>43</b>   | Mississippi          | 21.7% | 24.6% |
| <b>18</b>   | Maryland             | 16.5%        | 18.8%        | <b>44</b>   | Rhode Island         | 21.7% | 21.3% |
| <b>19</b>   | Nebraska             | 16.5%        | 18.8%        | <b>45</b>   | Oklahoma             | 22.3% | 24.2% |
| <b>20</b>   | Wisconsin            | 17.1%        | 20.1%        | <b>46</b>   | New York             | 22.9% | 25.9% |
| <b>21</b>   | Massachusetts        | 17.1%        | 19.1%        | <b>47</b>   | North Dakota         | 23.1% | 23.4% |
| <b>22</b>   | Alabama              | 17.4%        | 19.3%        | <b>48</b>   | Indiana              | 23.5% | 24.4% |
| <b>23</b>   | Michigan             | 17.6%        | 20.8%        | <b>49</b>   | Texas                | 24.7% | 26.9% |
| <b>24</b>   | New Mexico           | 17.8%        | 20.7%        | <b>50</b>   | Arkansas             | 26.8% | 27.2% |
| <b>25</b>   | Ohio                 | 18.3%        | 20.2%        | <b>51</b>   | Louisiana            | 35.0% | 35.0% |

Source: Susan Reinhard et al. Picking Up the Pace of Change, Long-Term Services and Supports State Scorecard 2017 Edition (Washington, DC: AARP Public Policy Institute, June 2017). Accessed at: <http://www.longtermscorecard.org>.

EXHIBIT 2

Indicators of Nursing Home Use, Selected States

| State                | Percentage of New Nursing Home Stays Lasting 100 Days or More (2012) <sup>a</sup> | Percentage of New Nursing Home Stays Lasting 100 Days or More (2009) <sup>b</sup> | Percentage of State Residents Ages 85+ in a Nursing Home (2014) <sup>c</sup> | Number of SNF Admissions per 1,000 Medicare Enrollees <sup>d</sup> |
|----------------------|---|---|--|--|
| <b>Oregon</b>        | 9.2%  | 10.3%   | 3.3%   | 40   |
| <b>Maine</b>         | 13.8%   | 14.3%   | 9.8%   | 67   |
| <b>Minnesota</b>     | 14.0%   | 16.2%   | 12.0%  | 68   |
| <b>Connecticut</b>   | 16.3%   | 18.2%   | 13.5%  | 103  |
| <b>United States</b> | <b>18.7%</b>  | <b>20.6%</b>  | <b>9.5%</b>  | <b>66</b>  |

Sources: <sup>a</sup> Carol V. Irvin, Noelle Denny-Brown, Eric Morris, and Claire Postman, *Pathways to Independence: Transitioning Adults Under Age 65 from Nursing Homes to Community Living*, The National Evaluation of the Money Follows the Person Demonstration, Cambridge, MA: Mathematica Policy Research, December 12, 2016, 30; <sup>b</sup> *LTSS Scorecard, 2014*, 189; <sup>c</sup> Centers for Medicare and Medicaid Services, *Nursing Home Data Compendium, 2015 Edition*, 174; <sup>d</sup> Kaiser Family Foundation, *StateHealthFacts, Medicare Service Use: Skilled Nursing Facilities, 2014*.



## Promising Practices

New nursing home residents who are at risk of staying long term in nursing homes are those who are ages 85 and older, have dementia, lack a family caregiver, and have low income. Dually eligible beneficiaries with both Medicare and Medicaid coverage tend to have longer Medicare SNF stays than Medicare-only beneficiaries.<sup>4</sup>

Timely and successful transitions back home depend on whether:

- Individuals' goals and preferences are respected;
- Nursing homes provide effective care and discharge planning;
- Family caregivers are available and supportive of returns to the community; and
- Affordable housing, services, and supports are readily available in the community.

Although Medicare requires all SNFs to plan for each beneficiary's discharge,<sup>5</sup> the capacity of facilities to achieve successful community transition varies widely.<sup>6</sup> The ease with which nursing homes can facilitate successful transitions also depends on the availability of community services and supports—most especially the support of family caregivers. Some states and communities have robust home- and community-based services (HCBS) systems that enable people with LTSS needs to live independently and avoid nursing home placement. In one recent study of nursing home use in Medicaid, nursing home stays were shorter in states with higher HCBS spending and use.<sup>7</sup>

### Promising Practices to Divert New Residents from Long Nursing Home Stays

1. Identify at-risk residents and provide support for community transitions and family caregivers.
2. Improve nursing home quality, and downsize and diversify the nursing home industry.
3. Implement enhanced preadmission screening, assessment, and community care planning.
4. Expand access to affordable HCBS and residential alternatives to nursing homes.

State strategies for diverting new nursing home residents from long-term stays address these patient, facility, and HCBS system factors. States are tackling incentives for long stays and barriers to community discharge through:

- Targeted efforts to identify and transition new nursing home residents back to community living (Minnesota);
- Initiatives to divert hospitalized patients to home with supportive services—rather than an SNF—at the point of hospital discharge (Connecticut);
- Improvement of nursing home quality (e.g., payment incentives for quality improvement in Minnesota);
- Payments to downsize and diversify the nursing home industry (Oregon, Connecticut);

4 M. Rahman et al., "Higher Medicare SNF Care Utilization by Dual-Eligible Beneficiaries: Can Medicaid Long-Term Care Policies Be the Answer?," *Health Services Research* 50, no. 1 (2015):161–79.

5 Office of Inspector General, US Department of Health and Human Services, *Skilled Nursing Facilities Often Fail to Meet Care Planning and Discharge Planning Requirements*, February 2013.

6 The Medicare Payment Advisory Commission (MedPAC) reports that the risk-adjusted rate of community discharge varied widely across skilled nursing facilities in 2015: the bottom 25 percent of facilities had a community discharge rate of 28.8 percent compared with 47.7 percent for the top 25 percent of facilities. MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, DC: MedPAC, March 2017), 209.

7 Robert Schmitz, Victoria Peebles, Rosemary Borck, and Dean Miller, *Medicaid-Financed Institutional Services: Patterns of Care for Residents of Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities in 2008 and 2009*, US Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, May 7, 2014. ("[T]hese associations were 'not especially large.' The small associations are not surprising, given the many variables that determine both length of stay and HCBS use that were not considered here"), 28–29.

- Statewide information, outreach, and education for people who need supportive services to live independently (Connecticut, Maine);
- Nursing home preadmission screening to counsel patients and families about community care options (Maine); and
- Expansion of HCBS and a continuum of residential care options (Maine, Connecticut).

### 1. TARGETED SUPPORT FOR COMMUNITY TRANSITIONS

*As part of a strategy to reduce reliance on nursing homes and Medicaid expenditures for LTSS, most states have developed programs to transition long-term nursing home residents to community settings. Some states, including **Minnesota, Maine, and Connecticut**, have developed approaches that target residents early in their nursing home stays or at the point of hospital discharge, when it may be possible to stem the flow of admissions to SNFs.*



#### Minnesota's Return to Community Initiative

Minnesota's Return to Community Initiative (RTCI) helps Dickie Voth (see story above) and others transition from a nursing home to the community to avoid long-term stays. Unlike many diversion and transition programs that focus on people who are enrolled in Medicaid, the state-funded RTCI focuses on those who are on Medicare and paying privately for long-term nursing home care (when they no longer qualify for Medicare's skilled nursing facility benefit) and who may be at risk of spending down to Medicaid. Launched in 2010, RTCI is a program of the Senior LinkAge Line, the Minnesota Board on Aging's information and assistance service. The program operates statewide with service areas defined by local Area Agencies on Aging (AAAs). The RTCI program uses clinical and other information collected on all nursing home residents at the time of admission to identify people *who fit*

*a community discharge profile, but who remain in the nursing home after 60 days.* Community living specialists—who are nurses or social workers employed by local AAAs—contact the residents whose names appear on a list (produced weekly) to inform them about assistance that can help them plan for a successful transition home. In addition to those who are on the target list, specialists also assist people who have been referred to RTCI by nursing home staff, their Senior LinkAge Line colleagues, or a Minimum Data Set (MDS) section Q referral. Section Q improves the ability of nursing homes, states, and other qualified entities to identify institutionalized individuals who are interested in returning to the community. Residents (or their designees) are asked if they wish to speak to someone about the possibility of returning to the community. When a resident expresses a desire to learn about HCBS options, the facility staff is required to make referrals to a state-designated local contact agency. The agency works with the residents to assess available HCBS options and plan their transition back to the community.<sup>8</sup>

#### RTCI: Community Discharge Profile

Nursing home residents are scored at admission using items on the Minimum Data Set that are predictive of community discharge within 90 days, including:

- Preference for community discharge,
- Receipt of rehabilitative services,
- Admission from acute care,
- Only moderate dependence on assistance with activities of daily living,
- Not moderate or severe cognitive impairment,
- Not incontinent, and
- No daily behavior problems.

People targeted for outreach are those (a) who prefer to live in the community, (b) who are not Medicaid eligible, and (c) whose stay in the nursing home is between 60 and 90 days.

8 See the Centers for Medicare and Medicaid Services webpage on the MDS section Q: <https://www.medicare.gov/medicaid/ltss/community-living/index.html>.

## PROMISING PRACTICES

Nursing home social workers remain responsible for discharge planning, but community living specialists collaborate with nursing home staff to help residents and their family caregivers identify goals and needs, and plan for care in the community. Some people on the list may no longer be candidates for transition to the community when a specialist reaches out—due to a change in health or function, for example. Others may have a discharge plan in place and may not need or want any additional assistance. However, for those who do need assistance, the role of the community living specialist is to enhance residents' and family caregivers' capacity to coordinate and continue care at home. The community living specialist uses a planning tool to assess needs and help residents and families understand the community resources that are available to them. Specialists, residents, and family caregivers develop a community living support plan that all agree can enable successful transition to the community that aligns with residents' goals and preferences.

A community living specialist follows up with clients who have left the nursing home for their own home, an assisted living facility, or another community setting. The program includes check-ins at specified intervals (a phone call or in-person visit within 72 hours, an in-person visit within 10 days, a 30-day and 60-day check-in, a 90-day check-in, and subsequent check-ins every 90 days for up to 5 years). This schedule can be modified to fit individual and family needs and preferences. During these follow-up calls or visits, the specialist can assess how well the plan is working and make needed changes to enable people to live successfully in the community, and avoid rehospitalization or readmission to the nursing home.

Since RTCI's launch in April 2010, RTCI-assisted discharges have steadily increased—roughly 390 transitions per year and a total of

4,551 transitions as of May 2017.<sup>9</sup> Most of the roughly 400 nursing homes in Minnesota have some RTCI-assisted discharges, although most facilities had 5 or fewer. Most of the people who returned to the community with support from the program fit the community discharge profile—they preferred to reside in the community, had entered the nursing home as a postacute admission, were relatively independent, and were not cognitively impaired or had only mild cognitive impairment. A year after discharge, half of the RTCI-assisted individuals lived in the community, 36 percent had been readmitted to a nursing home, and 14 percent had died. Only a small percentage (11 percent) had converted to Medicaid.<sup>10</sup>

Based on its record of success, an expansion of RTCI was included in the Minnesota governor's 2018–19 budget proposal and recently enacted. RTCI will be expanded to several new targeted groups at risk of spend down to Medicaid including older adults who are discharged from a hospital to the community who are at risk of readmission, and older adults whose Medicare-certified home care has come to an end and as a result are at risk of readmission to a hospital or nursing home. The expansion also adds a new self-directed caregiver supports grant for family caregivers. The program will provide small grants that caregivers can use to purchase services that can help them maintain their caregiver role while also maintaining their own health.



**Maine's Long-Term  
Care Ombudsman's  
Advocacy and  
Assistance**

Maine's Homeward Bound program helps nursing home residents transition to community living through a collaborative approach that relies heavily on the state's private, nonprofit Long-Term Care

9 Krista Boston, Director, Consumer Assistance Services, Minnesota Department of Human Services, personal communication to Ellen O'Brien, May 25, 2017.

10 Krista Boston et al., "Symposium: A Statewide Model for Transitioning Nursing Home Residents to the Community," Presentation to the Gerontological Society of America Conference, 2016, slides 70–71. (Document included in Toolkit below.)

Ombudsman.<sup>11</sup> The Ombudsman serves residents of nursing facilities and assisted housing programs, including residential care facilities and assisted living facilities, as well as people receiving services at home or in the community, such as adult day service settings. Because of the strong presence of its staff and volunteers in both facility and community settings, the Ombudsman has been instrumental in increasing the awareness of the Homeward Bound program and in providing support for care planning and community transitions for nursing home residents, including people eligible for Medicaid and Homeward Bound and those who are not.

The Maine Department of Human Services contracts with the Long-Term Care Ombudsman to serve as outreach provider and referral manager for Homeward Bound. The Ombudsman is responsible for conducting outreach, initial eligibility screening, and completion of the Homeward Bound application form. Referrals come from institutional and community providers, as well as family members and residents. Potential participants may also be identified by nurses and others who work with nursing facility and hospital staff to address the needs of people with behavioral health needs.

Specifically, an advocate from the Ombudsman Program provides information about transition coordination, so an individual who is seeking services can choose one of the three agencies providing this service. Throughout the transition, Homeward Bound participants receive advocacy support from the Ombudsman.

The Ombudsman Program also makes MDS section Q referrals. Within a matter of days of receiving a referral, the Ombudsman makes in-person contact and provides general information about community living services and supports. The Ombudsman then makes referrals to the Center for Independent Living (Alpha One) and/or the local Aging and Disability Resource Center.

### The Maine Long-Term Care Ombudsman's Role in Homeward Bound

- Receive referrals of potential Homeward Bound demonstration participants from a variety of referral sources.
- Provide information and educational resources to potential demonstration participants, family members, and other interested parties.
- Ensure the informed choice and consent of all potential and enrolled demonstration participants.
- Conduct the preliminary assessment process.
- Refer the participant to the appropriate type of transition coordinator given his or her needs.

The Ombudsman makes a referral to Homeward Bound for individuals who are currently or likely to become eligible for Medicaid, and are currently meeting or likely to meet the 90-day residency requirement for community transition assistance.

The Ombudsman has developed targeted materials and trainings on section Q, Homeward Bound, and other community transition resources that are designed to help familiarize nursing home administrators and staff with community options and support facilities in their community discharge planning roles. Through its collaboration with the state agency reviewing MDS and section Q data, the Ombudsman uses data insights to monitor compliance with section Q and to target its outreach activities to nursing homes in the state with relatively few section Q referrals.

By the end of 2016, the Homeward Bound program had a total of 92 transitions, in line with the projected number of transitions from the program's launch. The program had made a total of 406 outreach contacts, exceeding its goal of 308 contacts from the beginning of the program, in 2013.

11 Homeward Bound is Maine's Money Follows the Person program. The [Money Follows the Person \(MFP\) Rebalancing Demonstration Grant](#) helps states rebalance their Medicaid long-term care systems. The goals are to increase the use of HCBS and reduce the use of institutional services, strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions, and put procedures in place to provide quality assurance and improvement of HCBS.

## PROMISING PRACTICES



### Connecticut's Transition and Diversion Continuum

Connecticut's Money Follows the Person (MFP) demonstration program has been “a leading force in efforts to rebalance the system of LTSS to reflect consumer needs and choice.”<sup>12</sup> With state and federal funding, Connecticut has implemented a diversion and transition continuum that both (a) helps Medicaid beneficiaries living in nursing homes make a successful transition to community living, and (b) helps divert other individuals from long-term institutional care by enhancing information and awareness, and raising expectations for home- and community-based care.

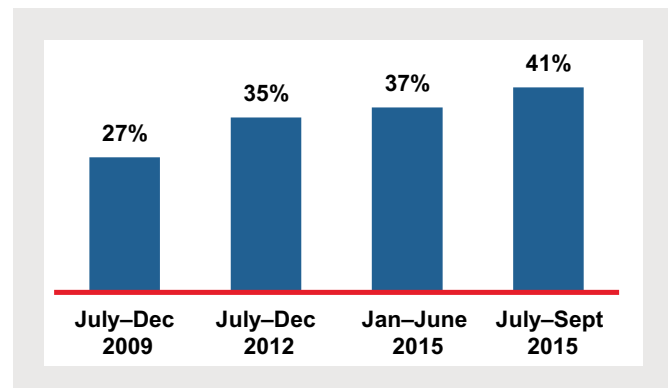
Since 2008, more than 3,900 people have transitioned from nursing homes to community living through MFP.<sup>13</sup> The state's MFP program engages with people who need assistance with housing and services to achieve successful and sustained community living. Many MFP program participants have been long-term residents of nursing homes—having lived in a nursing home for three years on average.

Increasingly, MFP has built in processes to meet with new residents sooner and reduce lengths of stay for Medicaid beneficiaries newly admitted to SNFs. Beginning in 2015, nursing homes are required to notify the Connecticut Department of Social Services when a resident is expected to qualify for Medicaid within a 180-day period. MFP program staff may then assess the resident to determine if he or she prefers, and is able, to live in the community; develop a care plan; and

help the resident transition to the community.<sup>14</sup> Connecticut's transition and diversion continuum also includes efforts to reduce the percentage of postacute care discharges to SNF.<sup>15</sup> The state's balancing plan calls for efforts to better inform and train hospital discharge planners about home- and community-based options for postacute care.<sup>16</sup>

Effective outreach and a robust referral system have been fundamental components of the program's success. There is a high degree of awareness of the diversion and transition programs across the state, especially among hospitals and physicians. To build on the successes of MFP, the state launched My Place CT ([myplacect.org](http://myplacect.org)) in 2013 to reach consumers with LTSS needs and to build a more streamlined means for accessing information and services.<sup>17</sup> The state's balancing plan emphasizes the need to help consumers, family caregivers, and providers access timely and accurate information with which to make decisions and help them plan and manage in-home care and support. My Place CT

#### EXHIBIT 3 Percent of SNF Admissions Returning to the Community within Six Months



12 Long-Term Care Planning Committee, Report to the General Assembly, *Balancing the System: Working Toward Real Choice in Long-Term Services and Supports in Connecticut*, Report Highlights (Hartford, CT: Long-Term Care Planning Committee, January 2016), 3.

13 UConn Health, Center on Aging, *CT Money Follows the Person Quarterly Report*, Quarter 4, 2016, October 1–December 31, 2016.

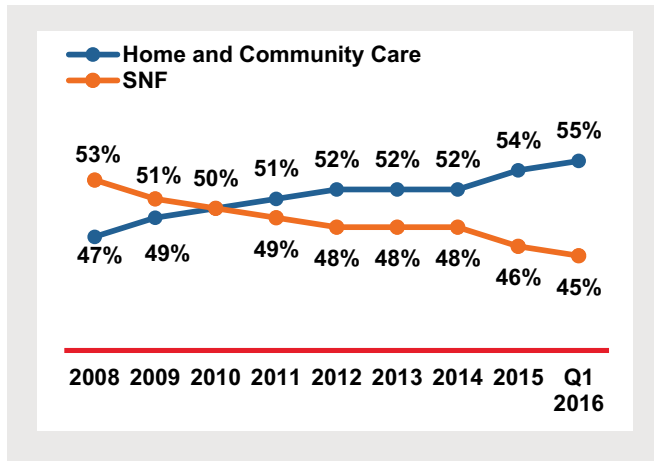
14 Nicole Dube, “Acts Affecting Seniors,” Office of Legislative Research, Connecticut General Assembly, Hartford, CT, July 9, 2015, 13. This requirement is an extension of the Medicaid level-of-care determination process.

15 State of Connecticut, Department of Social Services, *Strategic Rebalancing Plan: A Plan to Rebalance Long-Term Services and Supports*, January 2013.

16 Ibid.

17 In addition to its consumer education function, the site seeks to promote workforce development—helping people who are entering or reentering the workforce understand what types of caregiving jobs are available, to list positions, and to provide contacts.

**EXHIBIT 4**  
**Percentage of Hospital Discharges to Home and Community Care versus SNF**



helps consumers assess support needs, find services, access state benefits, and find affordable housing and transportation. A link to a new prescreening tool lets consumers answer some assessment questions and receive information on services and supports that they may be eligible to receive.<sup>18</sup>

In 2016, to realize the My Place CT vision of in-person help at various community entry points, the Department initiated the Care through Community Partner network of trusted places where consumers can access online resources and receive help finding information and referral. Planning also continues for a web-based system that will support electronic referrals to LTSS, which will be especially helpful to hospital and SNF discharge planners.

To assess the state’s progress on diverting long-term stays, several benchmark measures are monitored, including all-payer discharges from hospital to home (for people who need LTSS) and Medicaid discharges from SNF to home within six months. The percentage of Medicaid beneficiaries admitted to SNFs who were

discharged to a community setting within six months increased from 27 percent in 2009 to 41 percent in 2015 (see exhibit 3).<sup>19</sup> And, across all payers, the percentage of people needing supportive services discharged from the hospital to home increased from 47 percent in 2008 to 55 percent in 2016, while hospital discharges to SNFs declined from 53 percent in 2008 to 45 percent in 2016 (see exhibit 4).<sup>20</sup>

**2. NURSING HOME QUALITY, DOWNSIZING, AND DIVERSIFICATION**

*Some highly ranked states, including Oregon, Connecticut, and Minnesota, have incentivized quality improvement in nursing homes (including the quality improvement for discharge planning and transitional care services) and have worked with the nursing home industry to close, downsize, and diversify into community care.*



**Oregon’s Nursing Home Downsizing and Diversification**

Oregon has been a national leader in LTSS for over 30 years, pioneering innovative approaches to providing services in the community to people who would otherwise live in an institutional setting.<sup>21</sup> Oregon has among the lowest rates of nursing home use (3.3 percent of people ages 85+ reside in a nursing home) and low use of SNF care in Medicare compared with the national average (see exhibit 2). Nonetheless, the state continues to “explore ways in which it can build upon areas in which it is a model for the nation, as well as improve in areas to make the system better.”<sup>22</sup> A recent initiative focuses on downsizing and diversifying the nursing home industry.

As Oregon has expanded its Medicaid HCBS programs, notably most recently with the

18 *Department of Social Services Annual Report*, State Fiscal Year 2016.

19 UConn Health, Center on Aging, *CT Money Follows the Person Quarterly Report*.

20 Ibid.

21 The Lewin Group, Inc., *Bending the Curve: Opportunities to Promote Sustainability in Oregon’s Long-Term Services and Supports System*, Prepared for the Oregon Department of Human Services, February 10, 2016.

22 Oregon Department of Human Services, Aging and People with Disabilities Program, *Senate Bill 21 Final Report* (February 21, 2015).

implementation of its 1915(k) Community First Choice waiver program,<sup>23</sup> nursing home caseloads have declined, falling from roughly 5,000 per year on average in 2005–07 to just over 4,000 per year in 2013–15. The resulting drop in nursing home spending offsets some of the increased spending on HCBS. But, unless some nursing homes close, the fixed costs associated with nursing facilities will reduce the savings associated with fewer nursing home residents.<sup>24</sup>

Oregon has pushed for reductions in nursing home bed capacity and opportunities to expand residential and supported housing alternatives to nursing home care. A 2013 law (Oregon House Bill 2216) provided incentives to the nursing home industry to reduce nursing facility bed capacity by 1,500 beds by June 30, 2016—changing the nursing facility rate calculation if the 1,500-bed reduction target is not met. The basic payment rate for nursing homes is tied to allowable costs. The basic rate is determined by ranking the allowable costs per Medicaid day by facility and identifying the allowable cost per day at the applicable percentage (the 63rd percentile for the period beginning July 1, 2013). Nursing homes’ basic payment rate is reduced to a lower percentile (as low as the 53rd percentile) depending on the extent of progress made toward the target. (See the details in the regulations cited in the toolkit below.)

The law calls for collaboration between state agencies and private health care providers “to align financial incentives with the goals of achieving better patient care and improved health status while restraining growth in the per capita cost of health care.”<sup>25</sup> The law establishes an augmented rate for

any facility that purchases another facility’s entire bed capacity and phases out its excess capacity—otherwise known as *buy and close*. The Oregon Department of Human Services works with local nursing facility providers that are considering taking advantage of the capacity-reduction initiatives to assess opportunities for more residential and supported housing capacity development.<sup>26</sup>

As of May 2017, the number of nursing home beds had been reduced by 1,210, 80 percent of the 1,500-bed target.<sup>27</sup> As a result, facilities are being paid a lower rate than they would be paid had the target been met; they are paid the 61st percentile of allowable costs rather than at the 63rd percentile. The reductions in bed supply resulted from a variety of factors, including one nursing facility that used the buy and close incentives established in the law. The number of licensed beds per 1,000 population 75 years and older steadily declined from 60 in 2000 to 46 in 2015 (see exhibit 5), reflecting both the reduction in licensed capacity and growth in the state’s older population.<sup>28</sup> SNF operators have diversified into home health, assisted living, hospice, and independent living.



**Connecticut’s Nursing Home Diversification and Rightsizing Strategy**

Connecticut’s *Strategic Plan to Rebalance Long-Term Services and Supports* describes a broad agenda to support older adults, people with disabilities, and family caregivers in choosing how and where to receive services and supports. Nursing home diversification is an important part of the plan. The state’s diversification program encourages

23 The [Community First Choice Option](#) allows states to provide home- and community-based attendant services and supports to eligible Medicaid enrollees under their state plan. This state plan option was established under the Affordable Care Act of 2010.

24 Lewin, [Bending the Curve](#), 16. HCBS spending on aged and physically disabled populations increased 70 percent from state FY 2009 to FY 2015 and participants increased from roughly 27,000 to 35,000 (pp. 14–15).

25 77th Oregon Legislative Assembly—2013 Regular Session, [House Bill 2216, Enrolled](#), 4

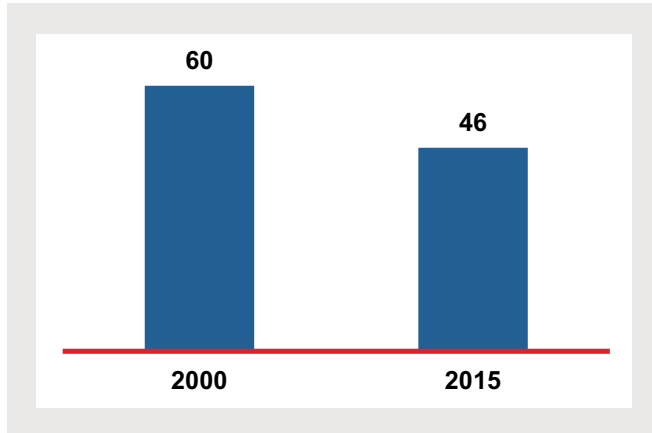
26 “[Update on Nursing Facility Capacity Reduction Activities](#),” October 2014.

27 Bed capacity reduction count provided by Mike McCormick, Deputy Director, Aging and Disabilities Program, Oregon Department of Human Services, personal communication with Ellen O’Brien, May 25, 2017.

28 Carolyn A. Mendez-Luck, Jeff Luck, Annie E. Larson, and Carla S. Alvarado, [The State of Nursing Facilities in Oregon, 2015](#) (Oregon State University College of Public Health and Human Services, 2016), 9.

EXHIBIT 5

**Oregon Licensed Nursing Facility Beds per 1,000 Adults Ages 75+**



nursing homes to establish new business models to support HCBS options for Medicaid beneficiaries. Several other policies limit the expansion of nursing home beds, including a moratorium on adding nursing home beds and flat Medicaid funding.

To help nursing home operators diversify, the state created a grant program to help facilities fund new investments: to redesign their business models to accommodate the shift to community living, reduce the number of beds in the state, and reduce the percentage of discharges from hospitals to nursing facilities.

Proposals must strengthen LTSS choices for Medicaid beneficiaries, build capacity for LTSS, decrease the number of nursing facility beds in an orderly fashion in locations that currently have or are projected to have a surplus of beds, or directly decrease the percentage of SNF admissions from hospitals in a geographic area.

The Connecticut Department of Social Services, in conjunction with the Connecticut Departments of Housing and Public Health, solicited proposals from nursing facilities and awarded \$12 million in grants over a two-year period (2014–15). Federal and state Medicaid funds as well as state bond funds financed the grants. The nursing facilities receiving grant funds have invested in building an infrastructure for community services, including navigators, transition coordinators, affordable adult family living, and adult day services.

**Nursing Home Diversification Grants**

- **Mary Wade Home Inc. (New Haven)** – up to \$2,001,730 to develop and establish a homemaker companion agency to increase supply of direct-care workers in New Haven, expand person-centered educational opportunities, and establish community navigators to assist people with connecting to local community supports.
- **Miller Memorial Community Inc. (Meriden)** – up to \$1,338,110 to introduce a new service delivery model that will improve continuity of care and help community members avoid nursing home placement, reduce length of stay in the nursing home, and reduce hospitalizations post discharge.
- **Hebrew Home and Hospital Inc. (West Hartford)** – up to \$1,072,220 to diversify a wing of the nursing home to a transitional living wing, which provides additional services and supports to transition people back to the community.
- **Jewish Home for the Elderly of Fairfield County Inc. (Fairfield)** – up to \$81,260 to develop a protocol for affordable, community-based living in an adult family living home as an option, so seniors can remain in or return to the community from a nursing home.
- **Leeway Inc. (New Haven)** – up to \$2,250,010 to develop the Community Transformation Treatment Program, a model of community care that includes a robust community case management program with an integrated adult day health center. The program emphasizes personal empowerment through health literacy and coaching, to prepare individuals to return successfully to the community by extending physician-directed chronic care management services.

Connecticut’s program also established the first state–federal partnership with the US Department of Housing and Urban Development (HUD) to support nursing home diversification. Nursing facilities wishing to diversify business models must get support from underwriters to use the building for a purpose other than the traditional nursing home model. HUD underwrites mortgages for 59 of the approximately 230 nursing facilities in the state.





*Minnesota's Nursing Facility Performance-Based Incentive Payment Program*

Minnesota is a national leader in setting policy standards for nursing home quality of life and quality of care. The nursing facility Performance-based Incentive Payment Program (PIPP) is one of many strategies designed to improve quality for people who need LTSS. The program has funded projects designed to improve care transitions, including efforts to reduce hospitalizations and increase successful transitions to the community.

PIPP expands opportunities for facilities to invest in quality improvement, allowing facilities to apply for a time-limited payment rate increase. Unlike standard pay-for-performance quality improvement programs that tie incentive payments to performance benchmarks set by the payer, PIPP invites facilities to develop projects based on their own assessments of needs and opportunities for improvement.<sup>29</sup> Individual nursing facilities or a collaboration of multiple facilities are eligible to apply for PIPP funding.

The Minnesota Department of Human Services uses a competitive application process to select which projects will be funded. A facility may request a performance-based incentive payment of up to 5 percent of their operating payment rate, but facilities must achieve measurable program outcomes to retain full funding. The rate add-on amount, duration, and outcomes are negotiated with the department.<sup>30</sup> Since 2007, 261 facilities (of the roughly 400 in Minnesota) have participated in the program. SNFs have focused on a wide variety of topics, including clinical quality (87 projects), psychosocial aspects of care (46 projects), organizational change (39 projects), technology (22 projects), and care transitions (20 projects).<sup>31</sup>

**Examples from Minnesota's PIPP: Improving Care Transitions**

- **Benedictine Health Systems – *Seamless Transitions*.** A nurse transition coordinator was placed at each of 15 facilities to work with residents, families, and an interdisciplinary team to assess residents' needs for a successful return home and provide telephone follow-up.
- **Sholom Home East – *Community Living Skills*.** A program to improve residents' successful return to community housing (with or without services) through one-on-one community skills training for residents and their families.
- **CareChoice – *Resident-Centered Care Connections*.** A three-year project to reduce avoidable hospital readmissions and enable effective transitions across care settings in 17 nursing homes.
- **Ecumen – *Medication Management*.** A project in 12 facilities to improve medication management using a consulting pharmacist to assess patients' needs prior to admission to the nursing home, provide medication education to residents and families during the nursing home stay, and provide follow-up after discharge.

The PIPP projects focused on care transitions reflect the growing consensus that transitional care interventions can improve transfers from nursing homes to home for older adults.<sup>32</sup> Improving care transitions, however, may require significant improvements in nursing home resources including the availability of nursing and medical staff, diagnostic and pharmacological services, and adequate social services for resident and family engagement and follow-up. Although there are no formal evaluations specifically focused on the PIPP

29 Greg Arling et al., "Minnesota's Provider-Initiated Approach Yields Care Quality Gains at Participating Nursing Homes," *Health Affairs* 32, no.9 (2013): 1631–38.  
 30 Minnesota House of Representatives, "Nursing Facility Regulation and Reimbursement," Information Brief, Minnesota House of Representatives, St. Paul, MN, November 2016, 11.  
 31 Valerie Cooke, Manager, Quality and Research Nursing Facility Rates & Policy, Department of Human Services, personal communication with Ellen O'Brien, May 18, 2017.  
 32 Mark Toles, Heather M. Young, and Joseph Ouslander, "Improving Care Transitions in Nursing Homes," *American Society on Aging* (blog), January 1, 2013.

care transition projects, researchers reported that facilities participating in PIPP (2007–10) overall exhibited significantly greater gains than did nonparticipating facilities, in both targeted areas and overall quality, and maintained their quality advantage after project completion.<sup>33</sup>

### 3. NURSING HOME PREADMISSION SCREENING AND COMMUNITY CARE PLANNING

*Many states use their nursing home screening processes to develop timely, comprehensive needs assessments that help educate individuals and families about service options available in the community. **Maine** requires face-to-face screening for all nursing home residents, regardless of source of payment, and finds candidates for transition to the community.*



#### **Maine's Uniform Assessment and Care Planning**

Beginning in the mid-1990s, Maine initiated several reforms to target nursing facility admissions to those most in need by establishing stricter medical eligibility criteria and requiring that anyone seeking admission to a nursing facility, regardless of payment source, be assessed for medical eligibility and provided a community plan of care (this is an advisory plan that helps inform people's decisions about nursing home and community-based care). Maine instituted a mandatory statewide preadmission screening program with one agency and a uniform assessment process. The organization that performs the assessment was, until very recently, Goold Health Systems, and the assessment was commonly referred to as the Goold assessment. (Goold is now called Change HealthCare.) The statewide, uniform assessment determines medical eligibility for a range of Medicaid and state-funded services, including SNF care, specialized adult family care homes, and home- and community-care services. By contacting individuals with LTSS needs before they access

services, the state can share information about HCBS as an alternative to nursing facility care.

The process for conducting LTSS medical eligibility determinations for older adults and adults with physical disabilities begins with a referral from a health care provider, family member, or individual consumer. The assessment—called the Medical Eligibility Determination (MED)—is completed face to face and takes place at the person's residence; it measures individual needs and results in a list of options for services. The medical eligibility determination process results in a calculation of the amount of assistance a person needs with daily nursing care, therapies, and activities of daily living (e.g., bathing, dressing, toilet use, transferring, moving between locations, and eating). The assessment also considers eligibility based on cognitive impairment and behavioral problems and the amount of assistance needed with instrumental activities of daily living, which include preparing meals, shopping, managing money, using the telephone, performing housework, and taking medication. The goals of the assessment process are to provide timely, consistent, and objective (functional/medical) eligibility decisions; educate individuals and their families about in-home and community support services, as well as residential or facility options; and support equitable allocation of resources based on functional and financial needs, consistent with available resources. (See the toolkit below for a copy of the MED.)

A critical component of this process is the development of service plans that provide consumers with estimates of available public support for home care services and estimates of their out-of-pocket costs. For eligible consumers who choose to receive their care at home, this service plan functions as the authorization for payment by Medicaid or the state-funded HCBS program. The use of a standardized assessment instrument with uniform definitions and the use of a single point of entry into Maine's LTSS system provide a comprehensive system for determining service needs and resource requirements.

33 Arling et al., "Minnesota's Provider-Initiated Approach."

## PROMISING PRACTICES

### 4. HOME- AND COMMUNITY-BASED SERVICES AND RESIDENTIAL ALTERNATIVES TO NURSING HOMES

States with low overall nursing home use (including long nursing home stays after a hospitalization) have invested in HCBS and residential alternatives to nursing homes—often with state-funded programs that reach beyond the Medicaid-eligible population. In **Maine** and **Connecticut**, state-funded programs provide financial assistance with the cost of home-based services and supports to people who are not eligible for Medicaid. The expansion of residential, community-based care (**Maine**) also contributes to the relatively low use of nursing home care in those states.



#### Connecticut's Home Care Program for Elders

Connecticut's Home Care Program for Elders (CHCPE) provides an array of services that can delay or prevent nursing home admission for older adults who are eligible for a nursing home level of care or who are at risk of nursing home placement without preventive home care services; it also assists families who are struggling to maintain the care of older relatives at home.<sup>34</sup> Importantly, people who are financially eligible for Medicaid as well as people with LTSS needs who have resources above Medicaid's eligibility limits are eligible for assistance.

Participants are eligible for different levels of service depending on their functional status and financial resources. People in category 1 are at risk of nursing home placement and have resources (countable assets) that exceed Medicaid's eligibility thresholds.

They may qualify for assistance with a range of services, with expenditures capped at 25 percent of the average Medicaid cost in a nursing facility (see exhibit 6). People in category 2 meet the nursing home level of care, but have assets above the Medicaid eligibility level. They are eligible for a higher level of service, with care plan costs capped at 50 percent of the average monthly cost of care in a nursing home. Participants in category 3 and category 5 are Medicaid-eligible and have similar assistance needs to those in categories 2 and 1, respectively. Their care plan expenditures are capped at 50 percent and 100 percent of nursing home costs, respectively.<sup>35</sup>

Care plan services include a wide range of services such as homemaker services, companion services, a personal emergency response system, home-delivered meals, adult day services, mental health counseling, assisted living, personal care attendant services, assistive technology, care management, minor home modifications, and adult family living. (Adult family living includes personal care and supportive services—e.g., homemaking, chores,

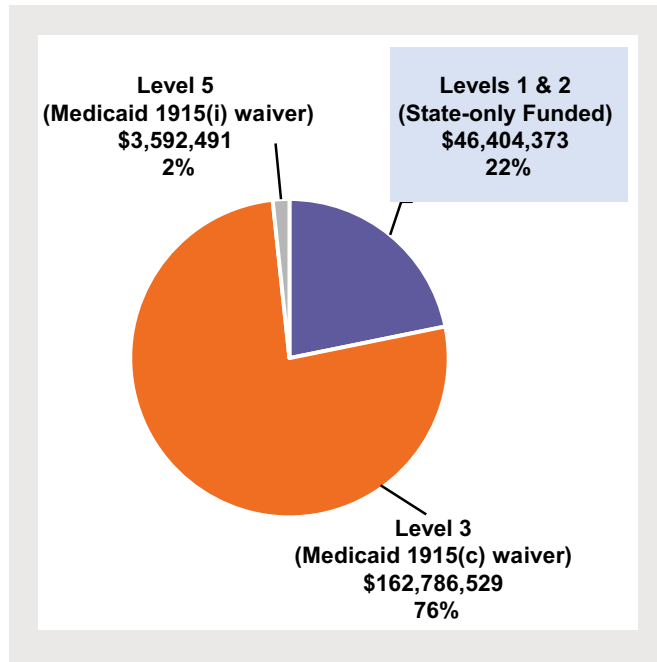
**EXHIBIT 6**  
**CHCPE, Limit on Care Plan Expenditures by Category of Enrollment (Spending limit as a percentage of the average Medicaid monthly cost for nursing home care [\$5,945 in 2017])**

| Financial Status        | Functional Status   |                                      |
|-------------------------|---|--------------------------------------|
|                         | At Risk of Nursing Home Admission without Preventive Services | Meets Criteria for Nursing Home Care |
| Ineligible for Medicaid | <b>Category 1</b><br>25%                                      | <b>Category 2</b><br>50%             |
| Eligible for Medicaid   | <b>Category 5</b><br>50%                                      | <b>Category 3</b><br>100%            |

34 State of Connecticut, Department of Social Services, *Annual Report for the Connecticut Home Care Program for Elders, State Fiscal Year 2015* (Hartford, CT, November 15, 2016).

35 Category 4 covers a small number of nonelderly adults with degenerative neurological conditions. Although there are no income limits in the state-funded portion of CHCPE, income limits apply in Medicaid. The Medicaid waiver program (category 3) has an income limit of 300 percent of the Supplemental Security Income limit (\$2,205 per month for an individual in 2017). The 1915(i) home care program (category 5) has an income limit (\$1,508 for an individual in 2017). This program is meant for individuals who are at risk of hospitalization or short-term nursing home placement but have less critical needs than an individual in the Medicaid waiver home care program.

**EXHIBIT 7**  
**Connecticut Health Care Program for Older Adults, State Cost by Program Category, State Fiscal Year 2015**



attendant services, meal preparation—provided to people in CHCPE who reside in a private home.) Family caregivers are eligible for payments of between \$42.58 and \$107.06 per day.<sup>36</sup> Three agencies provide independent, comprehensive assessments, a plan of care, and ongoing care management services when needed to monitor and coordinate home care services. Program participants also may self-direct, working directly with service providers if they do not need or want ongoing care management.

A significant share of CHCPE participants are in the state-funded component for people who are not eligible for Medicaid. In 2015, 20,301 people received services through CHCPE, including 5,026 who were in a state-funded component.<sup>37</sup> These non-Medicaid-eligible (categories 1 and 2) participants had average expenditures of \$768 in

2015, compared with \$1,854 in the Medicaid-funded waiver portion (category 3). Unfortunately, due to state budget challenges, enrollment in category 1 currently is closed, and cost-sharing requirements were increased (a 9 percent cost-sharing requirement for participants in category 2). Nonetheless, the state-funded categories (1 and 2) account for a significant share—nearly a quarter—of all state funding in CHCPE (\$46.4 million of the \$212.8 million in state spending). State expenditure on these categories has remained relatively flat over the past several years, but CHCPE represents a significant state investment in the delivery of home care services to people who, despite being at risk for nursing home admission, do not qualify for Medicaid.



**Maine’s Residential Care Facilities and Home and Community Supports**

When Maine significantly tightened its eligibility for Medicaid-funded nursing home care in the mid-1990s, the state developed alternative, community-based services. The state’s residential care facilities provide more independent living for people who do not meet Medicaid nursing home level of care or financial eligibility. In addition, Maine’s state-funded programs provide a range of home and community LTSS, including in-home personal care, nursing, therapies, homemaker services, adult day services, assisted living, and respite services.

Residential care facilities were designed to serve people with low care needs who, under the new, more restrictive level of care guidelines, would no longer qualify for nursing home care. The new benefit reduced state expenditures, with the state spending roughly half of the monthly cost of nursing home care for residential care.<sup>38</sup> Maine also expanded HCBS through Medicaid waivers and state-funded programs. Maine’s state-funded home care programs include Home-

36 See the Connecticut Department of Social Services *Provider Bulletin, 2013-50*, December 2013.

37 State of Connecticut, Department of Social Services, *Annual Report for the Connecticut Home Care Program for Elders, State Fiscal Year 2015* (Hartford, CT, November 15, 2016).

38 Brett Seekins, “Personal Care Service Homes – A Replacement for Residential Care Facilities in Maine?,” October 2012.

**Functional Eligibility in Maine’s State-Funded Home Care Programs**

- **Home-Based Care:** Needs assistance with one activity of daily living (ADL) plus two other ADLs, instrumental activities of daily living (IADLs), or nursing.
- **Consumer-Directed Personal Assistance Services:** Needs assistance with one ADL plus two other ADLs, IADLs, and ability to self-direct.
- **Homemaker Services:** Needs help with housekeeping, laundry, groceries.
- **Adult Day Services:** Needs assistance with one ADL or cueing with four ADLs.
- **Alzheimer’s Respite:** Dementia diagnosis.

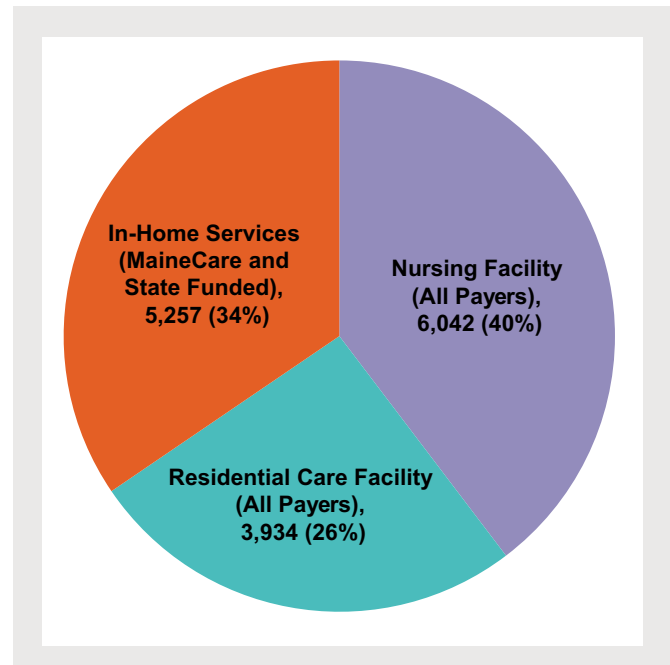
Based Care, Consumer-Directed Personal Care Assistance Services, Homemaker Services, Adult Day Services, and Respite Care for People with Alzheimer’s or Related Disorders.

The Home-Based Care program provides LTSS to assist eligible consumers to avoid or delay inappropriate institutionalization. There is a required financial assessment, and enrollees pay a share of the cost based on their income and assets (4 percent of income, 3 percent of assets). Elder Independence of Maine develops and implements the service plan, contracting with individual home health agencies to provide in-home supports. Individuals are eligible for one of four levels of services depending on their assessment. At the highest level, IV, expenditures on care are capped at 80 percent of the average monthly cost of nursing home care.

Between 2000 and 2010, the number of people residing in nursing homes in Maine declined by 15 percent, with most of the decline occurring among people most at risk of nursing home admission—those ages 85 and older. The percentage of people ages 85 and older residing in nursing homes declined from 16.5 percent in 2000 to 11.5 percent in 2010.<sup>39</sup> Over the same period, the number of people living in residential care increased by almost 1,000, rising from roughly 3,087 in 2010

to 4,005 in 2010. In 2014, among older adults and adults with disabilities, 40 percent of all LTSS users were in nursing homes, 26 percent were in residential care, and 34 percent were in MaineCare-funded (Medicaid) or state-funded services at home (see exhibit 8).<sup>40</sup>

**EXHIBIT 8  
Maine LTSS Users by Setting, Older Adults and Adults with Disabilities, 2014**



39 Julie Fralich, “Shaping the Health and Long-Term Care Infrastructure Serving Older Adults: Historical Trends and Future Directions,” *Maine Policy Review* 24, no. 2 (2015): 99–110.

40 K. Snow et al., *Adults Using Long-Term Services and Supports, Population and Service Use Trends in Maine*, State Fiscal Year 2014, (Chartbook) (Portland, ME: University of Southern Maine, Muskie School of Public Service, 2016).

## Discussion

Today, older adults have a lower risk of long-term institutionalization after hospitalization than they did a decade ago. They are more likely to receive supportive services at home or in community settings due to changing expectations about the role of nursing homes, the growing contributions of family caregivers, and the expansion of residential alternatives, such as assisted living.<sup>41</sup>

State policies also matter. The ability of low-income older adults to make a successful transition to community living depends on the availability of personal care assistance services and other home-based supports. States, however, vary widely in how they use Medicaid state plan benefits and waiver programs—as well as state-funded programs—to meet the needs of older adults who are at risk of long-term nursing home admission.

In addition to changes in Medicaid and LTSS policy, changes in the postacute care landscape—largely driven by changes in Medicare—may be influencing the trends in long-term nursing home use. In some states and communities, hospitals are giving greater consideration to discharge destinations and outcomes. Accountable care, value-based, purchasing, and bundled payment programs are bringing increased attention to posthospital care and the role of postacute care in helping people smoothly transition back into a community setting.<sup>42</sup> Because nursing facility quality varies widely,<sup>43</sup> hospitals are creating preferred provider networks as a strategy for improving transitions and avoiding preventable readmissions.

Despite the increased focus on quality and outcomes, nonclinical factors—such as the availability of high-quality home care and SNF providers in a community, as well as patient and family preferences—often determine postacute care placement after a hospital stay. The likelihood of receiving care in a high-quality facility varies across the Medicare population. The individuals who face the greatest challenges when making a transition home or to another community setting may end up in the nursing facilities with the least resources to help manage care and ensure a smooth transition home. Some research suggests that dually eligible beneficiaries with Medicare and Medicaid coverage are at risk of extended posthospital nursing home stays because they are less likely than non-dually eligible beneficiaries to be admitted to high-quality SNFs that achieve the highest rates of community discharge.<sup>44</sup>

Social factors are an important determinant of who stays in a nursing home after a hospitalization and who returns to a community setting. People at risk of long stays are those who have more limited financial resources, who may not have adequate housing or accessible transportation, and who may not have the ability to make home modifications. Perhaps the most important factor influencing community discharge is having a family caregiver who is willing and able to provide needed support. In the study of community discharge that underlies the Return to Community Initiative in Minnesota, the researchers found that preferring or having support to return to the community

41 The Scorecard indicators for the percentage of long stays and assisted living supply, for example, are correlated: states with more assisted living options tend to have fewer long-term nursing home stays.

42 “The Role of Post-Acute Care in New Delivery Models,” Trend Watch, American Hospital Association, December 2015.

43 MedPAC reports that the risk-adjusted rate of community discharge varied widely across skilled nursing facilities in 2015: the bottom 25 percent of facilities had a community discharge rate of 28.8 percent compared with 47.7 percent for the top 25 percent of facilities. MedPAC, *Report to the Congress*, 209.

44 Momotazur Rahman et al., “Dual Eligibility, Selection of Skilled Nursing Facility, and Length of Medicare Paid Postacute Stay,” *Medical Care Research Review*, 71, no. 4 (August 2014): 384–401.

was a significant predictor of actual community discharge, even after controlling for other factors.<sup>45</sup>

Health care systems in many states and communities have an inadequate infrastructure in place to address these social factors. Unfortunately, families often have little understanding of how to plan for the care and support needs of a newly frail older adult with increasing needs for assistance. To address these gaps, many states have created robust partnerships between hospitals and nursing homes and the community-based organizations—such as Area Agencies on Aging and Aging and Disability Resource Centers—that are most knowledgeable about the services and supports available in the community.

## Conclusion

In nearly every state, the percentage of older adults who remain in long-term nursing home care after a hospitalization has declined. States that are highly ranked on this indicator have undertaken a variety of strategies to reduce the risk of long-term institutional stays. These strategies include targeted efforts to identify and transition new nursing home residents back to community living and more broad-based initiatives to expand access to HCBS and create a continuum of residential care options. As states continue to improve community services and supports for frail older adults and younger adults with physical disabilities, better information is needed about what works to ensure

Connecting people to available services, however, is just part of the challenge in a system that does not do enough to manage the health and social needs of people who need LTSS. Some programs, including the Program of All-Inclusive Care for the Elderly and home-based primary care programs, including those being piloted under Medicare's Independence at Home demonstration program, can help bring medical and social services together to meet the needs of these older adults who are otherwise at risk of long-term institutionalization. States' efforts to support older adults and people with physical disabilities in the community would be substantially facilitated by increased efforts in Medicare to integrate medical and social services for these complex patients.

timely and effective care transitions from SNFs to community settings and sustain independent community living over the long term. The promising practices described in this paper can inform program and policy development in states seeking to improve community transitions for new nursing home residents and prevent long-term institutional residence. Lower-performing states should assess the barriers to community discharge in their communities and evaluate whether the strategies outlined here and compiled in the following toolkits can help improve their state's performance on this measure.

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45 Greg Arling, Robert L. Kane, and Julie Bershadsky, *Targeting Criteria and Quality Indicators for Promoting Resident Transitions from Nursing Home to Community* (Report to the Minnesota Department of Human Services, University of Minnesota School of Public Health, January 2009). Community discharge within 90 days was least likely for people who were least likely to have a supportive family caregiver in the community, including older adults who were unmarried; living alone prior to admission; on Medicaid per diem; cognitively impaired or had an Alzheimer's or other dementia diagnosis; dependent on assistance with activities of daily living; or incontinent; or had a mental illness, diabetes, cancer, or end-stage disease diagnosis.



Toolkits

| Promising Practices                          | States      | Toolkits  |
|--|-------------|---|
| 1 Targeted Support for Community Transitions | Minnesota   | <p><b>Return to Community Initiative</b></p> <ul style="list-style-type: none"> <li>• <a href="#">DHS Bulletin 16-25-01</a>. Assistance for Private Pay Nursing Facility Consumers Who Want to Return to the Community.</li> <li>• <a href="#">Policy brief</a>. Promising Practice: Nursing Home Transition and Diversion.</li> <li>• <a href="#">Slide presentation</a> - program overview.</li> <li>• <a href="#">Research paper</a>. Targeting Criteria and Quality Indicators for Promoting Resident Transitions from Nursing Home to Community (ASPE, 2009).</li> <li>• <a href="#">Research paper</a>. Targeting Criteria (<i>Health Services Research</i>, 2010).</li> <li>• <a href="#">Client stories</a> - video clips.</li> <li>• RTCI Protocols: 72-hour, 10-day, 30-, 60-, and 90-day check-ins; Community Living Specialist Protocols, Community Planning Tool, Return to Community Protocol.</li> <li>• Dashboard Report (June 2016).</li> <li>• Evaluation Findings. Presentation slides from research conference (November 2016).</li> <li>• Statute. <a href="#">Expansion of RTCI</a> in Governor’s 2018–2019 budget proposal; <a href="#">revised statute (256.975 subd. 7</a> has been amended by <a href="#">Chapter 6, Article 3, Section 6 256.975 subd. 12</a> has been added by <a href="#">Chapter 6, Article 3, Section 7</a>).</li> </ul> |
|  | Connecticut | <p><b>Transition/Diversion Continuum</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Connecticut Strategic Rebalancing Plan</a>, 2013.</li> <li>• MFP <a href="#">Operational Protocol</a>.</li> <li>• MFP <a href="#">Quarterly Reports</a>.</li> <li>• <a href="#">MyPlaceCT</a> website.</li> </ul>   |
|  | Maine       | <p><b>Long-Term Care Ombudsman’s Outreach and Advocacy</b></p> <ul style="list-style-type: none"> <li>• Maine statute, <a href="#">§5107-A</a>: Long-term care ombudsman program.</li> <li>• Homeward Bound <a href="#">operational protocol</a>.</li> <li>• Homeward Bound <a href="#">video</a>.</li> <li>• Homeward Bound consumer outreach <a href="#">brochure</a>.</li> </ul>   |



## PROMISING PRACTICES

|   | Promising Practices   | States      | Toolkits   |
|---|---|-------------|--|
| 2 | Nursing Home Quality, Downsizing, and Diversification           | Oregon      | <p><b>Nursing Home Downsizing and Diversification</b></p> <ul style="list-style-type: none"> <li>• <a href="#">House Bill 2216</a> on downsizing.</li> <li>• <a href="#">Nursing Facility Capacity Reduction Report</a>, December 2014.</li> <li>• Department of Human Services, Aging and People with Disabilities, <a href="#">Oregon Administrative Rules, Chapter 411, Division 70, Nursing Facilities/Medicaid – Generally and Reimbursement</a>. (On penalties for failing to meet bed reduction goals, see p. 88.)</li> <li>• <a href="#">The State of Nursing Homes in Oregon, 2015</a>, April 2016 report.</li> </ul>   |
|   |   | Connecticut | <p><b>Nursing Home Diversification and Rightsizing</b></p> <ul style="list-style-type: none"> <li>• <a href="#">Connecticut Strategic Rebalancing Plan</a>, 2013.</li> <li>• Nursing Facility Diversification <a href="#">webpage</a>.</li> <li>• Nursing Facility Diversification <a href="#">Request for Proposals, 2014</a>.</li> <li>• <a href="#">State of Connecticut Medicaid Long-Term Care Demand Projections</a>.</li> </ul>   |
|   |   | Minnesota   | <p><b>Nursing Facility Performance-Based Incentive-Based Payment Program (PIPP)</b></p> <ul style="list-style-type: none"> <li>• <a href="#">PIPP webpage</a> with latest (2017–2019) project summaries.</li> <li>• “<a href="#">Nursing Facility Reimbursement and Regulation</a>,” brief, Research Department, Minnesota House of Representatives, 2016.</li> <li>• Greg Arling et al., “<a href="#">Minnesota’s Provider-Initiated Approach Yields Care Quality Gains at Participating Nursing Homes</a>,” <i>Health Affairs</i> 32, no. 9 (2013): 1631–38.</li> <li>• Valerie Cooke et al., “<a href="#">Minnesota’s Nursing Facility Performance-Based Incentive Payment Program: An Innovative Model for Promoting Care Quality</a>,” <i>Gerontologist</i> 50, no. 4 (August 2010): 556–63.</li> </ul> |
| 3 | Nursing Home Preadmission Screening and Community Care Planning | Maine       | <ul style="list-style-type: none"> <li>• Maine <a href="#">Medical Eligibility Determination (MED)</a> form</li> <li>• Christine Gianopoulos, “<a href="#">What Works? Maine’s Statewide Uniform Assessment and Home Care Planning System Tells All</a>,” <i>Gerontologist</i> 41, no. 3 (2001): 309–11.</li> </ul>  |
| 4 | Expanding HCBS and Residential Alternatives to Nursing Homes    | Maine       | <ul style="list-style-type: none"> <li>• Home-Based Care program, <a href="#">Policy Manual</a></li> <li>• Maine <a href="#">Medical Eligibility Determination (MED)</a> form</li> </ul>   |
|   |   | Connecticut | <ul style="list-style-type: none"> <li>• Connecticut Home Care Program for Elders (CHCPE) <a href="#">Regulations</a>.</li> <li>• CHCPE <a href="#">Annual Report, 2015</a>.</li> <li>• CHCPE <a href="#">Categorical Eligibility Chart, 2017</a>.</li> <li>• CHCPE <a href="#">Request for Referral</a> form.</li> <li>• <a href="#">Unmet Needs in the Connecticut Home Care Program for Elders, 2010 report</a>.</li> </ul>   |

**State Experts****CONNECTICUT****Dawn Lambert**

Director, Money Follows the Person Demonstration  
 Connecticut Department of Social Services  
 860-424-4897  
[dawn.lambert@ct.gov](mailto:dawn.lambert@ct.gov)

**Julie Robison, PhD**

Associate Professor  
 Center on Aging  
 University of Connecticut Health Center  
 860-679-4278  
[jrobison@uchc.edu](mailto:jrobison@uchc.edu)

**MINNESOTA****Krista Boston**

Director, Consumer Assistance Programs  
 Minnesota Department of Human Services  
 651-431-2605  
[krista.boston@state.mn.us](mailto:krista.boston@state.mn.us)

**Valerie Cooke**

Manager, Quality and Research  
 Nursing Facility Rates & Policy  
 Minnesota Department of Human Services  
 651-431-2263  
[valerie.cooke@state.mn.us](mailto:valerie.cooke@state.mn.us)

**MAINE****Kathryn Temple**

Aging Services Program Manager  
 Office of Aging and Disability Services  
 Maine Department of Human Services  
 207-287-4211  
[kathryn.temple@maine.gov](mailto:kathryn.temple@maine.gov)

**Brenda Gallant**

State Long-Term Care Ombudsman  
 Executive Director  
 Maine Long-Term Care Ombudsman Program  
 207-621-1079  
[bgallant@maineombudsman.org](mailto:bgallant@maineombudsman.org)

**Larry Gross**

CEO  
 Southern Maine Area Agency on Aging  
 207-396-6501  
[lgross@smaaa.org](mailto:lgross@smaaa.org)

**OREGON****Michael McCormick**

Deputy Director, Aging and People with  
 Disabilities Program  
 Oregon Department of Human Services  
 503-945-6229  
[mike.r.mccormick@state.or.us](mailto:mike.r.mccormick@state.or.us)

**Jim Carlson**

President & CEO  
 Oregon Health Care Association  
 503-726-5255  
[jcarlson@ohca.com](mailto:jcarlson@ohca.com)

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