



Rutgers Center for
State Health Policy

NATIONAL ACADEMY
for STATE HEALTH POLICY

August 2006

Toolbox

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS)

Money Follows the Person Toolbox

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

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This document was developed under Grant No. 11-P-92015/2-01 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal government. Please include this disclaimer whenever copying or using all or any of this document in dissemination activities.

Money Follows the Person Tool Box

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August 2006

Introduction

This tool box is intended to synthesize information that is available from multiple sources about nursing home transition and Money Follows the Person (MFP) initiatives to help states prepare for the MFP Demonstration program created by the Deficit Reduction Act. The Rutgers/NASHP technical assistance team released the Nursing Home Transition (NHT) toolbox in 2005.¹ This MFP toolbox expands that technical assistance product, with a particular focus on the upcoming MFP Demonstration. Each chapter summarizes the state of the field in a particular MFP design component, such as identifying consumers, planning and implementing transitions from an institution, financing MFP, and evaluating programs and progress. Each section also provides specific resources with links to tools that states are using. This toolbox will be continually refined and updated. This version of the toolbox concentrates on transitions from nursing facilities; future versions will add information more relevant for individuals with developmental disabilities.

Chapter 1: Overview

In many states, home and community-based services (HCBS) waiver programs began as a separate long-term supports option with dedicated funding. As these programs matured and obligated all the available funding, barriers were created that reinforced Medicaid's institutional bias. Individuals continued to have access to institutional settings while preferred community options were not available. MFP emerged as a strategy to reduce bias and allow Medicaid funds to be used to support access to services in the setting that is preferred by the consumer. Choices are not restricted based on the availability of funding.

The Centers for Medicare & Medicaid Services (CMS) describe MFP as:

A system of flexible financing for long term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. A system in which money follows the person is also one that can incorporate the philosophy of self-direction and individual control in state policies and programs.²

¹ Reinhard, S. & Gillespie, J. (2005, October). *Nursing Facility Transition Toolbox*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: http://www.cshp.rutgers.edu/cle/products/NFT_Toolbox_2006-03-06_WEB.pdf

² Centers for Medicare & Medicaid Services. (2004, August 17). State Medicaid Directors Letter, SMDL#04-005. Available at <http://www.cms.hhs.gov/smdl/downloads/smdl081704.pdf>

Over the past five years, states have gained experience helping consumers who live in nursing homes to consider a range of community options. In 2001 and 2002, the Centers for Medicare & Medicaid Services (CMS) awarded 33 grants to state agencies and Independent Living Centers to transition or divert consumers from nursing homes. Interviews with State Medicaid officials found that nursing home transition programs are a strategy to reduce Medicaid spending on nursing home care and provide beneficiaries with more options.³ A CMS State Medicaid Directors Letter⁴ review of the lessons learned from early grants identified six characteristics of successful programs:

- Dedicated staff were assigned to work with consumers to help them transition;
- Flexible funds were available to help consumers establish a community residence;
- Coordinators worked closely with home and community-based services (HCBS) programs to obtain support services;
- Coordinators worked with public housing authorities and private landlords;
- Aggressive outreach efforts were conducted to inform consumers; and
- Consumers were actively involved in planning their move to the community.

Nursing home transition initiatives were followed in 2003 by the award of Money Follows the Person grants to nine states. Money Follows the Person (MFP) was initially implemented to allow funds paid to nursing homes to “follow” the consumer to the community and pay for the home and community-based services consumers need to remain independent. The model is particularly helpful in states with waiting lists for HCBS programs.

The MFP term gained prominence in Texas as a strategy to deal with “interest” or waiting lists for home and community-based waiver services. Many states appropriate funds specifically for HCBS waiver programs. When the funds are fully obligated, new applicants are placed on a waiting list and cannot be served until a waiver participant leaves the program or new slots or additional funding is approved.

Though it is never used in this context, MFP could be interpreted to mean using funds appropriated for home and community-based services for nursing home care when a waiver participant enters a nursing home. However, the intent is to make funds available to support consumers wherever they choose to live. It describes funding arrangements that supports a person’s choice of living arrangement – community, residential or institution – regardless of where they live prior to seeking Medicaid support.

Money Follows the Person Financing Strategies

Money Follows the Person has several connotations. MFP refers to an overall strategy for appropriating funds in a way that supports the individual’s choice of settings. MFP can be viewed from two perspectives: 1) where does the funding come from and 2) where does the person come from? The first perspective encompasses so-called global budget models that pool

³ Kasper, J. & O’Malley, M. (2006, April). *Nursing Home Transition: Perspectives of State Medicaid Officials*. Washington, DC.: Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/7484.cfm>

⁴ Centers for Medicare & Medicaid Services. (2002, August 13). State Medicaid Directors Letter, SMDL#02-012. Available at: www.cms.hhs.gov/smdl/downloads/smd081302.pdf

appropriations for two or more long-term care programs and systems that allow funds appropriated for institutional care to be used for community services.⁵ The second perspective of MFP focuses on individuals who move from an institution to a community.

MFP models are also consistent with efforts to achieve better balance between nursing home care and home and community-based services. These efforts are sometimes described as “rebalancing” or “balancing.” A review of State Medicaid Director Letters and best practice reports found a range of financing strategies described below. These strategies include:

- Comprehensive financing mechanisms;
- Budget transfers; and
- Capitation arrangements.

Comprehensive financing mechanisms – global budgets, pooled funding

The most comprehensive strategy creates a financing mechanism that is setting-neutral. Money is available to support the setting and services of the consumer’s choice. Under these budget arrangements, funds for Medicaid nursing home, home and community-based services waiver programs, and sometimes state plan personal care services are appropriated in one line item rather than separate line items for each service.

Two states – Oregon and Washington – pool funding for Medicaid long-term care services in a single account. Expenditures for nursing home and home and community-based services are monitored to ensure that expenditures are kept within the amount appropriated by the legislature. This mechanism allows state agencies to allocate funds that meet consumer choices and encourages the system to divert individuals seeking admission to a nursing home and to offer relocation assistance to individuals in a nursing home. When funding for specific types of services are appropriated in separated line items, state officials must follow their process for transferring funds between accounts or seek a supplemental appropriation.

In October 2005, the Vermont Department of Disability, Aging and Independent Living implemented a §1115 waiver approved by the Centers for Medicare & Medicaid Services that equalizes access to nursing home and home and community-based services for individuals who meet criteria for the “highest needs” group. The “Choices for Care” demonstration program expands the choices available to elders and adults with physical disabilities and addresses the institutional bias created when access to a nursing home is an entitlement and home and community-based services may be limited. The demonstration creates an entitlement to home and community-based services for participants who meet specified criteria.⁶

See Chapter 7 for a more detailed discussion of this topic.

⁵ Hendrickson, L. & Reinhard, S. (2004, November). *Global Budgeting. Promoting Flexible Funding to Promote Long-Term Care Choices*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/products/ReinhardHendricksonGlobalBudget.pdf>

⁶ See <http://www.dail.state.vt.us/1115waiver/1115default.htm>.

Budget transfers

With budget transfers, states that have a waiting list for home and community-based waiver services are able to serve Medicaid beneficiaries who move to the community from nursing homes by using funds appropriated for nursing home care for waiver services instead. Under this approach, funds may be transferred to the waiver account or bills for waiver services may be paid directly from the nursing home account. This approach was first adopted in Texas for fiscal years 2002-2003 (Rider 37) and extended during fiscal years 2004-2005 (Rider 28). The riders allowed officials to transfer funds from the nursing home appropriation to the HCBS waiver appropriation on a quarterly basis for individuals who moved to the community. The program became permanent in fiscal year 2006 through creation of an account within the nursing home appropriation to pay for waiver services for individuals who move from a nursing home.⁷ Funds are available only to nursing home residents who are Medicaid beneficiaries and meet the criteria to receive Medicaid waiver services. Since its inception, over 10,000 individuals who would have been placed on an “interest” or waiting list, relocated to community settings.

In the 1990s, Vermont and Wisconsin allowed funds appropriated for nursing home care to expand home and community-based services. Act 160 directed the Vermont Department on Aging and Disabilities to reduce nursing home spending in FY 1997 through FY 2000 and transferred funds for nursing home services to home and community-based services. The law funded additional waiver slots and other community and residential services. Act 160 set priorities for expanded community services options – nursing home residents who were interested in moving to a community setting, individuals on a waiting list who were at the highest risk of admission to a nursing home, others at high risk and people with the greatest social and economic need. A trust fund was created for any funds that were transferred but not spent during the fiscal year. Normally, unspent funds revert to the treasury.

Wisconsin’s Community Integration Program II supports Medicaid beneficiaries who move from a nursing home to the community because of a closure or reduction in bed capacity. The waiver gave priority to these individuals over others already living in the community who were on a waiting list for waiver services.

A law passed by the New Jersey legislature in 2006 will create “parity” between institutional and home and community-based services.⁸ The new law has elements of global budget and budget transfer models. Appropriations for all HCBS waivers are contained in a “global” appropriation and funds to expand HCBS waivers are transferred from the savings in nursing home spending due to diversions. The bill directs state officials to:

... implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care.

⁷ Wayne Anderson, Joshua Wiener and Janet O’Keeffe. Final Report: Money Follows the Person Initiatives of Systems Change Grantees. Available at:

http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp#TopOfPage.

Rosalie Kane, Robert Kane et. al. Rebalancing Long Term Care Systems in Texas. Available at:

http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage.

⁸ See Appendix 1 of this document or http://www.njleg.state.nj.us/2006/Bills/PL06/23_.PDF.

...the expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services...⁹

Expansion of home and community-based services in New Jersey is expected to reduce the growth of expenditures for nursing home care. Reductions in expenditure growth will be transferred and pooled to pay for services under a series of Medicaid HCBS waivers. Like Vermont, unspent funds may be carried over in the HCBS budget.

Chapter 7 contains more information about budget transfers.

Capitation arrangements

Capitation is another strategy that promotes the flexible use of funds. It creates a financial incentive to deliver services in the most appropriate and cost effective settings. Capitation is typically used to combine Medicaid health and long term supports services in a single program. Fully integrated program also include Medicare services.

Stakeholders sometimes describe systems or services that support people with disabilities as either “medical” or “social” and worry that an overly medical approach will limit consumer choices and favor safety over independence and autonomy. Medical approaches tend to be associated with institutions. However, consumers have both health and support needs and separating them runs the risk that a strict “social” model will miss key events or indicators of a health condition that should be assessed and treated. Medicaid serves over 11 million people with chronic conditions, which accounts for 75 percent of state Medicaid budgets. According to some experts, the provision of a wide range of services from multiple providers in a health and long-term care delivery system that is uncoordinated, inefficient, costly and does not always improve quality of life.

State policy makers note that consumers living in community and residential settings today have far more medical needs than the consumers who received home and community-based services 20 years ago. States have implemented managed long-term care programs to try to integrate health and supportive service systems and serve the whole person.

The expected rise in the number of Medicaid beneficiaries with multiple chronic conditions and complex medical needs has budgetary and quality of life implications. Experts believe that coordinating services across health and supportive services can reduce hospital, emergency room and nursing home use. Saucier et. al. report that studies on managed long-term care programs found high levels of consumer satisfaction, lower use of institutional services and higher use of home and community-based services.¹⁰ Managed long-term care programs include

⁹ New Jersey Public Law 2006, Chapter 23, p.2, available at <http://www.njleg.state.nj.us/2006/Bills/PL06/23 .PDF> or in Appendix 1 of this document.

¹⁰ Saucier, P., Burwell, B., & Gerst, K. (2005, April). *Past, Present and Future of Medicaid Managed Long-Term Care*. US DHHS/ASPE. Available at: <http://aspe.hhs.gov/daltcp/reports/mltc.htm>

Medicaid risk-based or capitated programs and fully integrated Medicare and Medicaid programs and more recently primary care case management programs. Several states operate capitated managed long-term care programs – Arizona, Florida, Massachusetts, Minnesota, New York, Texas, Wisconsin – and programs are being developed in other states. Programs of All Inclusive Care for the Elderly (PACE) also operate in many states.

The appeal of capitated programs is the flexible financing method that allows “money to follow the person.” Managed care contractors are required to cover a list of Medicaid state plan and other services specified in the contract. They have the incentive and opportunity to pay for any service that meets the individual’s needs and substitutes for other services. However, despite their appeal, managed long-term care programs are difficult and time-consuming to design and implement. In 2004, these programs served just over 68,000 Medicaid beneficiaries.¹¹

Policies and Programs That Enhance MFP

CMS State Medicaid Director Letters describe initiatives that support access to community services and supports and the philosophy of MFP. While they may not address the broader funding mechanisms, they complement MFP strategies.

Streamlining access

Several states have designed systems to streamline access to home and community-based services, especially at points where decisions are made about available options and settings available. Comprehensive entry points (also referred to as single entry points, single points of entry, one-stops, or “no wrong door”) are evident across the country. A comprehensive entry point (CEP) is defined as a system that enables consumers to access long-term and supportive services through one agency or organization. A key function of a comprehensive entry point is to provide information to consumers, family members, professionals and provider organizations about the array of long-term care services and programs in a timely manner so that a consumer can stay in the community and receive services if that is his or her wish. CEPs help the individual choose a setting and service plan that best meets their needs and identify the funds that are available to implement this choice. Thus, in a way money “precedes” the person with CEPs. See Chapter 6 for a longer discussion on CEPs.

Aging and Disability Resource Centers (ADRCs) are an emerging strategy to provide better information and assistance to support consumer choice.¹² ADRCs offer consumers a “one-stop” process for obtaining information about a variety of community services and programs (including SSI, disability assistance, housing, employment and in-home services). ADRCs sometimes provide case management or authorization for programs or services as well. ADRCs are also working on ways to reach out to consumers and their families. See Chapter 6 for more discussion on ADRCs.

Further along the array of complementary MFP initiatives are efforts to simplify and expedite the eligibility process. See the section on expediting Medicaid financial eligibility in Chapter 5 for a discussion of “fast track” policies such as presumptive eligibility and examples

¹¹Ibid.

¹² See <http://www.adrc-tae.org> for more information on ADRCs.

of how states expedite eligibility. With presumptive eligibility, consumers can be authorized to receive services before a full eligibility determination is made. States are also scrutinizing their eligibility determination processes to expedite them by identifying and removing barriers.

Consumer direction

Individual budgets are another form of MFP. They allow individuals to develop service plans that are more responsive to an individual's needs than a traditional "menu of services." Consumers are able to purchase or receive service that support independence, including services that may not be listed under an HCBS waiver. CMS State Medicaid Directors (SMD) letter #03-008 describes consumer directed programs that use individual budget techniques that support the concept of MFP.¹³ These programs offer consumers choice, control and responsibility, which improves service quality, increases satisfaction and expands the workforce with consumers, family members, friends and neighbors. Individual budgets allow consumers to use money flexibly, an important MFP principle.

SMD letter #04-005 describes three consumer direction models that support choice and flexible funding.¹⁴

1. Traditional Model Supporting Choice
2. Agency with Choice Model
3. Fiscal/Employer Agent

Traditional Model Supporting Choice

Many traditional provider agencies honor the principles of choice, control, and the person-centered planning process. These progressive agencies allow, or even encourage, that consumers identify and refer to the agency those attendants the consumer has selected. The agencies may also offer training in the philosophy of self-direction. Many agencies provide a list of potential attendants that consumers may interview. Back-up personal attendant services are provided by the agency in situations when the consumer's selected attendants are ill or cannot come due to some unexpected reason. Attendants are expected to respect consumer preferences. States implementing this model may do so without modifying their state plan or waiver services since the provider agency continues to operate under a traditional Medicaid Provider Agreement to provide personal assistance services and is reimbursed for providing these services. The agency continues as the responsible entity over the provision of personal assistance services and over the attendants who provide this service. While the participant has the ability to select his or her attendant, the agency continues its role as the employer of the attendant and retains responsibility for the oversight of the personal attendant service. Trinity Respite Care in Lawrence, Kansas is an example of a Medicaid provider agency that gives its clients the opportunity to select their own attendants.

¹³ Available at: www.cms.hhs.gov/smdl/downloads/smd091703.pdf

¹⁴ Available at: <http://www.cms.hhs.gov/smdl/downloads/smd081704.pdf>

Agency with Choice

This model was first described almost a decade ago.¹⁵ The Agency with Choice approach offers consumers an increased level of responsibility by designating the consumer as the *managing employer* without becoming the common law employer (employer of record) of his or her attendant. For Internal Revenue Services (IRS) purposes and other employment considerations, including making payment to the provider, the agency is the common law employer. The consumer recruits, interviews, and selects the attendant care provider and refers him or her to an agency for the completion of payroll responsibilities. An individual budget may or may not be used to determine the available resource allocation. The consumer generally establishes the wages and sets the working hours. Once hired, the consumer manages the attendant including the approval of timesheets. The consumer may elect to train the individual or may direct the agency to provide training on his or her behalf. The agency may offer additional services to support the consumers' ability to self-direct. These supports may include making other purchases (included in the individualized budget) on behalf of the consumer, assisting with managing the individual budget or providing training on how to hire and manage attendants. While the agency and the consumer share employer responsibilities, the agency executes a Medicaid Provider Agreement with the Medicaid agency to provide personal care services and supportive services. The agency may offer a traditional service model along with Agency with Choice services model, but clearly there is a formal distinction between the two models. The New Hampshire *Independence Plus* initiative, *In-Home Supports Waiver for Children with Developmental Disabilities*, adopts the Agency with Choice model.

Fiscal/Employer Agent Model

The Fiscal/Employer Agent model provides Medicaid program participants with the greatest level of flexibility and empowerment. In this model, the consumer or consumer's designated representative is recognized as the common-law employer of his or her individually hired attendant(s). However, the representative generally delegates the employer-related responsibilities related to payroll, and filing of employer-related payroll taxes to an organization that serves as the consumers' "employer agent." The agency may offer a broad host of services that support consumers in self-direction, including skills training, brokering other benefits such as Workers Compensation or health insurance, or other support functions including assistance with managing the individual budget. The agency may be reimbursed for financial management services as a waiver service or as an administrative function. Many states, including all but one of the "Cash and Counseling" and "Independence Plus" waiver states (for example, Arkansas, Florida, New Jersey, Louisiana, North Carolina, and South Carolina), use this model to allow Medicaid program participants and their families to self-direct.

Resources	
SMDL # 02-012	www.cms.hhs.gov/smdl/downloads/smd081302.pdf
SMDL # 03-008	www.cms.hhs.gov/smdl/downloads/smd091703.pdf
Promising Practices ¹⁶	www.cms.hhs.gov/PromisingPractices/Downloads/mfp92903.pdf

¹⁵ Flanagan, S. & Green, P. (1997, October). *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations*. US DHHS/ASPE. Available at: <http://aspe.hhs.gov/daltcp/reports/cdpases.htm>

¹⁶ Crisp, S., Eiken, S., Gerst, K. & Justice, D. (2003, September). *Money Follows the Person and Balancing Long-Term Care Systems: State Examples*. Washington, DC: Medstat. September 29, 2003.

Managed long-term care report	http://aspe.hhs.gov/daltcp/reports/mltc.htm
Integrating acute and LTC	http://www.gmu.edu/departments/chpre/research/MMIP/TApapers/TAPER1.pdf
Consumer involvement in managed LTC programs	http://www.gmu.edu/departments/chpre/research/MMIP/TApapers/TAPER3.pdf
Paper on chronic care coordination	http://aspe.hhs.gov/daltcp/reports/ccMedbenes.htm
SEP report	http://www.hcbs.org/files/19/915/SEPReport11.7.03.pdf
ADRC article	http://www.hcbs.org/files/56/2772/ADRC_article.pdf
New Jersey SEP	http://www.cshp.rutgers.edu/PDF/Easy%20Access.pdf
Statute creating SEPs	http://www.hcbs.org/files/20/996/Massachusettssepegislation.doc
MOUs (Florida)	http://www.hcbs.org/files/79/3942/State_MOA.doc http://www.hcbs.org/files/79/3938/Local_MOU.doc http://www.hcbs.org/files/79/3940/Local_MOU_Comp_Assessment.doc
Advisory board job descriptions	http://www.hcbs.org/files/82/4097/Maryland_Access_Point_Advisory_Board.doc
Navigating the LTC maze	http://www.aarp.org/research/longtermcare/resources/aresearch-import-563-2001-12.html
Point of entry case study	http://www.hcbs.org/files/58/2856/ltc_state_case_studies.pdf
Illinois simplified access	http://www.hcbs.org/files/67/3311/Illinois_-_Simplified_Access_Updated.pdf
New Jersey simplified access	http://www.hcbs.org/files/67/3317/New_Jersey_-_Single_Access_Point_updated.pdf
Wisconsin resource centers	http://www.hcbs.org/files/38/1860/WI_ResourceCenters_rev.pdf
Wisconsin Family Care	http://www.hcbs.org/files/41/2037/WI_final.doc
RTI report Redesigning Systems	http://www.hcbs.org/files/58/2861/Access_and_Services.pdf
Business planning tool	http://www.hcbs.org/files/75/3737/Planning_Tools.doc
Family Care report	http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf
Family Care website	http://dhfs.wisconsin.gov/LTCare/INDEX.HTM
ADRC resources (Lewin)	http://www.adrc-tae.org/tiki-index.php?page=PublicHomePage
Presumptive eligibility	http://www.nashp.org/Files/presumptive_eligibility.pdf
Overview of IP programs	http://www.hcbs.org/files/67/3335/ConsumerDirection_Kaiser.pdf
Balancing safety and freedom	http://www.hcbs.org/files/7/331/Strategies.rtf
Inventory of budget based programs	http://www.hcbs.org/files/91/4522/BeyondC&C.pdf
Cash and counseling web site	http://www.cashandcounseling.org/

Money Follows the Person Demonstration Program

The 2005 Deficit Reduction Act (DRA) included a major new initiative to support state efforts to help Medicaid beneficiaries move to the community. The DRA created the Money Follows the Person Demonstration to increase the use of home and community-based services (HCBS) rather than institutional services, and eliminate barriers that prevent or restrict the flexible use of Medicaid funds to allow beneficiaries to receive support in the setting of their choice. The DRA appropriates \$1.75 billion over five years – \$250 million for fiscal year (FY) 2007 (beginning January 1, 2007); \$300 million for FY 2008; \$350 for FY 2009; \$400 million

for FY 2010 and \$450 million in FY 2011. CMS plan issued a solicitation in July 2006.¹⁷ The program is authorized for five years.

The grants pay for home and community-based services, including transition services, for up to 12 months for qualified individuals who move from an inpatient facility (nursing home, hospital, or ICF-MR) to a “qualified residence.”

States will receive an enhanced Federal Medicaid Assistance Percentage (FMAP) for qualified services that is equal to one half of the difference between the regular matching rate and 100 percent. However, the matching rate can not exceed 90 percent. For instance, a state whose FMAP is 60 percent would receive 80 percent reimbursement for 12 months for services to individuals who moved to a qualified residence.¹⁸

States have to ensure continuity of services by transitioning beneficiaries into a qualified HCBS program after the end of the 12 month period for receiving the enhanced match. Individuals must continue to meet the requirements of the qualified program. A qualified program means, with respect to Medicaid, services available under 1915 (b) and (c) waivers, state plan amendment services and services that will continue after the demonstration.

Projects must serve qualified individuals, as defined by the DRA. A qualified individual is:

- A Medicaid beneficiary who has lived in an institution for not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the state;
- Is receiving Medicaid benefits for inpatient services; and
- Would continue to require the level of care provided in an inpatient facility.

Qualified individuals must move to a qualified residence to receive the enhanced matching rate for services. A qualified residence is a home that is owned or leased by the individual or family member; an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing and cooking areas over which the individual or the individual’s family has control or domain; or a residence in a community-based residential setting in which no more than four unrelated individuals reside.

MFP demonstrations may require amendments to existing 1915 (c) waivers or a new waiver. The DRA requires that applications for the demonstration include any new waivers, or amendments to existing waivers, including the maximum number of individuals served and benefits covered.

The intent of the MFP Demonstration is to help balance long-term care spending. States will be required to describe the strategies they will implement to balance spending between institutional care and HCBS. States will need to submit data on institutional and HCBS expenditures in the fiscal year prior to the demonstration and to specify the methods that will be used to increase both the actual expenditures for HCBS and the percentage of the budget used on

¹⁷ See http://www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf

¹⁸ Derived as follows: $100 - 60 = 40$; $40 * \frac{1}{2} = 20$; $20 + 60 = 80$.

HCBS services. The application will also need to describe how the state will eliminate legal, budgetary, and other barriers to supporting individuals in the setting of their choice.

States must meet the maintenance of effort requirement. This means that total HCBS expenditures during the demonstration period must be greater than the highest of what was spent in fiscal year 2005 or in any subsequent fiscal year prior to the demonstration.

The DRA states that the demonstration awards should achieve a national balance on the numbers of individuals served, the target groups that will be served and the geographic distribution among states. Preference will be given to proposals that serve individuals in multiple target groups and offer opportunities for self-direction.

The projects must operate at least two years and may operate for the full five years of the demonstration. Funding beyond the first year will depend upon meeting numerical benchmarks for increasing HCBS spending and meeting goals for the number of people who transition.

Chapter 2: Marketing, Education and Identifying Consumers Interested in Relocating

One of the first questions program planners ask is how to identify individuals who want to move from an institution and whose health and support needs can be met in the community with supportive services.

Education and Marketing

Identifying consumers who are interested in relocating is easier when there is a high level of awareness of community service options. Effective education and marketing are needed to raise awareness among consumers, family members, stakeholders and service providers about the initiative, contacts and the resources available to support consumers in the community. Strategies to increase awareness of MFP or NHT programs include activities targeted to a variety of organizations and professionals, including those serving consumers in nursing homes, community providers to whom nursing home residents may be referred (such as Area Agencies on Aging or AAAs), state agency staff who have contact with nursing home residents or staff, and local organizations that support consumer choice (such as Independent Living Centers or ILCs).

A recent report on nursing home transition projects identified Nebraska for its subcontract with an Area Agency on Aging to develop marketing materials, including newspaper advertisements, radio spots, and public presentations to increase public awareness. Maryland hired a community outreach worker and an outreach nurse to make presentations about community long-term care options at community centers, low-income housing complexes, and other sites. They also distributed pamphlets about available services and encouraged older adults

and others to tell their friends, neighbors, and relatives about community long-term care options.¹⁹

Utah’s statewide campaign

Utah developed a statewide campaign to increase awareness of home and community-based resources to help people live independently.²⁰ The state Health Department contracted with Area Agencies on Aging and Independent Living Centers to hold information sessions for nursing home residents and to provide individual counseling with consumers who were interested in receiving more specific information and assistance. The presentations address services available through Medicaid HCBS waivers and from Independent Living Centers and Area Agencies on Aging and other sources. About 20 percent of the residents attended the sessions and 15 percent of those who attended requested an individual assessment. See the complete publication here: [http://www.hcbs.org/files/67/3324/Utah - Informing NH Residents updated.pdf](http://www.hcbs.org/files/67/3324/Utah_-_Informing_NH_Residents_updated.pdf)

Flyers

Several states developed flyers to raise awareness. The flyers provide a brief summary of the state’s program and a number to call for further information and assessment. They may include additional information such as testimonial from a consumer (see Connecticut sample).

Sample Flyers	
State	Web site
Arkansas	http://www.hcbs.org/moreInfo.php/state/52/ofs/50/doc/303/Passages_Flyer
Connecticut	http://www.ct.gov/dss/LIB/dss/PDFs/MyChoices.pdf
Delaware	www.hcbs.org/files/70/3467/Passport to I dep broch NH .pdf
New Jersey	http://rilnj.org/njacil/PDF Downloads/choices_brochure.pdf or access from http://www.nursingfacilitytransition.org/

Identifying Consumers

There are several potential approaches to identifying individuals who may be interested in moving to the community. Some believe it is best to ask each resident in an institution and to work toward the resident’s goals, regardless of the resident’s level of care needs. Some suggest contacting individuals in nursing homes who gave a positive response to the Minimum Data Set (MDS) question (Q1a) about relocating. Others suggest focusing on data about health conditions and functional capacity contained in assessment tools to identify those for whom services are available in the community. The best approach for any particular program will depend on the existing infrastructure in the area. This chapter will begin with a review of recent research on nursing home discharges, and then discuss different approaches to identifying individuals interested in relocation.

¹⁹ Siebenaler, K., O’Keeffe, J., Brown, D. & O’Keeffe, C. (2005, June). *Nursing Facility Transition Initiatives of the Fiscal Year 2001 and 2002 Grantees: Progress and Challenges. Final Report*. Research Triangle Park, NC: RTI International. Available at: http://www.hcbs.org/files/74/3656/NFT_final_web.pdf.

²⁰ Tumlinson, A. (2004, December). *Promising Practices in Home and Community Based Services. Utah – Informing Nursing Home Residents about Community Long-Term Care Options*. Washington, DC: Medstat. Available at: [http://www.hcbs.org/files/67/3324/Utah - Informing NH Residents updated.pdf](http://www.hcbs.org/files/67/3324/Utah_-_Informing_NH_Residents_updated.pdf)

Research on nursing home discharges

Kasper²¹ examined data from the 1999 National Nursing Home Survey and found that 73 percent of all individuals age 65 and older discharged from a nursing home had a length of stay of less than 30 days. Kasper suggests that nursing home transition (NHT) programs target individuals who have lived in a nursing home between 30 days and one year. Individuals that need assistance with a high number of activities of daily living (ADLs), cannot rely on equipment to ambulate, and/or have dementia or mental illness are more likely to have longer stays. Kasper also notes the development of pre-admission screening and options counseling programs and short term certification for nursing facility stays.²²

This study was based on data collected before the national emphasis on helping people move and does not address younger persons with disabilities. Over time, the discharge profile may change. While NHT initiatives may not have reached sufficient scale to affect discharge patterns nationwide, data from existing NHT programs suggests that people with much longer stays can move successfully. Thus, longer stay consumers should not be excluded.

Research on Consumers Who Have Transitioned

Several states have collected data on consumers who have transitioned. Sample reports containing such data are shown in the table below.

Data on Consumers Who Have Transitioned	
State	Web Site
Connecticut	http://www.cshp.rutgers.edu/cle/Products/SustainingNHTinCTWEB.pdf
Delaware	http://www.cshp.rutgers.edu/cle/Products/6190.pdf
Indiana	http://www.cshp.rutgers.edu/cle/Products/INUnwantedNHResidenceWEB.pdf
Michigan	http://www.cshp.rutgers.edu/cle/Products/MichiganNHTfinalWEB.pdf
New Jersey	http://www.cshp.rutgers.edu/cle/products/CurrentLivingSituationNJsNHTprogramWEB.pdf
Wisconsin	http://dhfs.wisconsin.gov/ltc_cop/relocations.pdf

Independent Living Philosophy

Independent Living Centers believe that transition programs should work with anyone who expresses an interest in moving. Individuals who are highly motivated to change their living arrangement can overcome barriers that “professionals” might consider too significant or risky.

Michigan utilized this philosophy in its transition program by making a desire for relocation the only criteria for eligibility.²³ Once the consumer has been identified, the New

²¹ Kasper, J. (2005, August). *Who Stays and Who Goes Home: Using National Data on Nursing Home Discharges and Long-Stay Residents to Draw Implications for Nursing Home Transition Programs*. Washington, DC.: Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/upload/7386.pdf>

²² See also Summer, L. (2005, October). *Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Report 7402, available at: <http://www.kff.org/medicaid/7402.cfm>

²³ Reinhard, S. & Farnham, J. (2006, January, p.7). *Sustaining NHT: Meeting Summary*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at <http://www.cshp.rutgers.edu/cle/Products/NHTSummitNJSept05WEB.pdf>

Jersey Community Choice Counseling program utilizes a roundtable process involving Centers for Independent Living along with the consumer and others to help plan transitions.²⁴

Using the MDS or Similar Data

Item Q1 of the Minimum Data Set (MDS) addresses the individual's discharge potential and has three components: a). Resident expresses/indicates preference to return to the community; b). resident has a support person who is positive toward discharge; and c). stay projected to be of short duration – discharge projected within 90 days (coded as one of the following: 0=no; 1=within 30 days; 2=within 31-90 days; 3=discharge status uncertain). Beyond basic frequency breakdowns of those expressing a preference to return to the community, MDS information has to be obtained through a data use agreement with CMS.²⁵ State Medicaid agencies can use a specific CMS form.²⁶ Other agencies or users go through a more complicated process.²⁷ In all cases, users must be able to track those whose MDS information is released, to comply with Health Insurance Portability and Accountability Act (HIPAA) requirements. Medicaid agencies may share MDS data only with those organizations that are under contract with the agency.²⁸

MDS data can be used to target everyone who has expressed a preference for returning to the community, or to more finely target those with support or certain health conditions. For a recent investigation of how states are using the MDS, see the discussion paper by Reinhard and Hendrickson (2006, June) listed in the table below: States' Progress in Using the MDS to Facilitate Nursing Home Transition.

Pennsylvania uses the MDS and case mix information to identify individuals. Individuals assigned to the lower case mix tiers, who do not have dementia and have housing available are contacted by local relocations teams to determine their interest in relocating. This approach supplements their work with nursing home residents who self-identify for nursing home transition. Pennsylvania will also be implementing a "front door" strategy of contacting nursing home residents soon after admission and following them to make sure they meet their discharge goals.

Massachusetts, in its NHT project, obtained a list of persons with low impairments from the state Medicaid agency (based on the Medical Minutes Questionnaire, or MMQ, which categorizes people based on the minutes of care they need).²⁹

²⁴ Reinhard and Petlick (2005, December). *Sustaining New Jersey's Evolving Community Choice Counseling Program*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/Products/NJCCCWEB.pdf>

²⁵ Frequencies by state, county and age may be obtained from: http://www4.cms.hhs.gov/apps/mds/q1a_start.asp (accessed June 7, 2006)

²⁶ Accessed June 7, 2006 from <http://www.cms.hhs.gov/cmsforms/downloads/cmsr0235m.pdf>

²⁷ Accessed June 7, 2006 from http://www.resdac.umn.edu/MDS/requesting_data.asp

²⁸ For a more detailed discussion, see Reinhard, S., Hendrickson, L. & Bemis, A. (2005, February). *Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: http://www.cshp.rutgers.edu/cle/products/MDS_Final_WEB.pdf

²⁹ Reinhard, S. & Hendrickson, L. (2006, June). *States' Progress in Using the MDS to Facilitate NHT*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/Products/MDSIIWEB.pdf>

Systems change grant program Nursing Facility Transition Initiatives for the FY 2001 and 2002 Grantees

This report by RTI International describes 18 nursing home transition programs and describes how the grantees sought to identify and work with residents and collaborate with key stakeholders to help individuals relocate. Available at:

http://www.hcbs.org/files/files/74/3656/NFT_final.htm.

Using communication boards for consumers with difficulty communicating

This guide was created as a resource to help interested individuals learn more about communication boards and how/when to use them. The boards in this kit were designed for a specific communication interaction, an intake interview to consider transition of an individual out of a nursing home. This handout provides a brief summary of the communication boards provided and some background information for you as you use the boards.

http://www.hcbs.org/files/58/2867/Communication_board.pdf

Resource Summary	
Description	Web site
Issue Brief: Using the Minimum Data Set (MDS) to Facilitate Nursing Home Transition.	http://www.cshp.rutgers.edu/cle/products/MDS_Final_WEB.pdf
States' Progress in Using the MDS to Facilitate NHT	http://www.cshp.rutgers.edu/cle/Products/MDSIIWEB.pdf
Frequencies by state, county and age to Q1a of MDS	http://www4.cms.hhs.gov/apps/mds/q1a_start.asp
Medicaid agency data use agreement	http://www.cms.hhs.gov/cmsforms/downloads/cmsr0235m.pdf
Other data use agreements	http://www.resdac.umn.edu/MDS/requesting_data.asp

Working with Nursing Home and Hospital Staff

Alabama—Discharge planning workbook

Alabama's NHT project developed a "Hospital Discharge Planners/Coordinators Workbook" that is used to train hospital discharge planners and other professionals on community-based resources available to individuals with dementia to avoid premature placement within the nursing home. The Workbook is written as a resource for all professionals involved in the ADSS Elderly and Disabled Medicaid Waiver Program. Available at:

http://www.hcbs.org/files/44/2188/NH_Transitions.DCPCWorkbook.9.20.20031.pdf

Arkansas—Work with nursing home staff from the beginning

ILCs in Arkansas strongly recommend working with nursing home staff from the beginning of the process. The majority of staff are supportive. However, not informing nursing

home staff of transition efforts or giving them the chance to participate may create opposition. The Arkansas training manual states:

“The social workers can prove to be one of your greatest assets if you can develop a good rapport with them. They can do much of the paperwork required to get things rolling. They can assist the consumer with filling out the waiver application, work with them to switch their social security back to the community, take them shopping for necessities, set the consumer up with a local doctor, and make sure they get their medicine and other items from the nursing home before leaving. They can reduce your burden significantly and will be a great referral source if they see you as a professional who cares about the best outcome for the consumer.” (pp. 6-7)

Available at: http://www.hcbs.org/files/19/930/AR_Transition_to_Freedom.pdf

North Carolina—Continuing Education Units for nursing home staff & discharge planners

The North Carolina NHT program developed a five-hour credit course for nursing home administrators, social workers and other staff and hospital staff to learn about the community resources that are available to support individuals in the community. The curriculum included a consumer panel; a description of the state’s transition initiative; and presentations from Independent Living Programs, Vocational Rehabilitation services and Assistive Technology programs. Representatives from other community organizations and programs, behavioral health programs and development disability programs were also included. The ability to approve Continuing Education Units (CEUs) created interest in attending the “course.”

Resource Summary	
State	Web site
Alabama	www.hcbs.org/files/44/2188/NH_Transitions.DCPCWorkbook.9.20.20031.pdf
Arkansas	http://www.hcbs.org/files/19/930/AR_Transition_to_Freedom.pdf
North Carolina	Hard copy brochure provided by Linda Kendall-Fields at Nursing Home Transition Summit, summarized in the following document: http://www.cshp.rutgers.edu/cle/Products/NHTSummitNJSept05WEB.pdf

Chapter 3: The assessment, planning and transition process

Beneficiaries in several states are identified during an options counseling or assessment process. Options counseling educates consumers about the services available to them. Assessment determines what services the consumer needs.

Sample Assessment Processes

Massachusetts—Proactive assessment

The Massachusetts Executive Office of Elder Affairs (EOEA) contracts with 27 Aging Services Access Points (ASAPs), community-based non-profit organizations most of which are Area Agencies on Aging, to screen and assess nursing home residents who are dually eligible or whose stay is paid by Medicaid. Nursing home stays may be approved for different periods of

time, e.g., 30 days, 60 days or a longer period. Nurses and case managers develop discharge and community support plans for individuals who are interested in moving or who will be able to move by the expiration of their approved length of stay.

Nursing homes are required to send the names of all new admissions who are Medicaid beneficiaries or who have applied for Medicaid to the ASAP in their area. Some report them daily or weekly, others less frequently or not at all. ASAPs deal with the irregular reporting by visiting each nursing home at a regular, pre-arranged time. Registered nurses (RNs) visit anyone who is a Medicaid beneficiary, even if the stay is covered by Medicare, or who is applying for Medicaid coverage is visited. RNs can visit other residents when they are invited to do so by the nursing home social worker.

Pennsylvania—Collaboration and rapid assessment

The Pennsylvania Department of Aging and the Department of Public Welfare provide funding to their 30 local partnerships to provide transition coordination. The funding was made available only after local agencies submitted a plan that described how they collaborate with all partners. Funding was awarded for outreach, identification, and initial transition coordination with the consumer.

Pennsylvania also has a pilot program called “Community Choice” in ten counties to provide rapid assessment for services. Consumers call a toll-free number at any hour and can get an assessment within 24 hours if they are at immediate risk of nursing home placement.

See: Mollica, R. & Reinhard, S. (2005, May). *Money Follows the Person Site Visit: Pennsylvania Community Choice Initiative*

<http://www.cshp.rutgers.edu/cle/products/PAsitevisitsummary1WEB.pdf> ;

State web site: <http://www.dpw.state.pa.us/Disable/HomeCommServices/003670971.htm>

Washington—Dedicated case managers

In Washington the Aging and Disability Services Administration (ADSA) assigns nurses or case managers to each nursing home to work with residents. Each case manager is responsible for working with residents in 2-3 nursing homes. Case managers had been assigned to hospitals to work with discharge planners but ADSA found that people being discharged from hospitals frequently needed rehabilitation services before they could return home. ADSA shifted staff from hospitals to nursing homes to work with residents as their potential to move home improves.

Case managers, who may be social workers or registered nurses, contact residents within seven days of admission from a hospital to a nursing facility to inform them of their right to decide where they will live, discuss their preferences, likely care needs and the supports that are available in the community, and other service options. A full comprehensive assessment is completed when the consumer indicates their readiness to work with the social worker to relocate and the nurse/social worker develops a transition plan with the consumer.

See: Mollica, R. (2005, August). *Building Nursing Home Transition into a Balanced Long-Term Care Solution: The Washington Model*.

<http://www.cshp.rutgers.edu/cle/products/WAsitevisitsummaryfinalLPWEB.pdf>;

Gillespie, J. & Mollica, R. (2005, June). *Streamlining Access to Home and Community-Based Services: Lessons from Washington*.

<http://www.cshp.rutgers.edu/cle/products/WashingtonStatePolicyinPractice080305WEB.pdf>

Texas – Relocation specialists

Texas issued a request for proposals (RFP) to select organizations to provide relocation services and to increase community awareness of community options. The Department of Aging and Disability Services selected four Independent Living Centers to be responsible for outreach to nursing home residents, assessment of residents interested in relocating, assist with the relocation process and follow individuals who transition to make sure they are receiving appropriate services. The specialists develop transition plans, help with referrals and application for Medicaid waiver services, and coordinate services and resources needed to support the transition. The ILCs are also responsible for administering one-time transition assistance services.

See: http://www.nashp.org/Files/TX_RFP_for_rel_spec.doc

New Jersey—Screening and tracking

New Jersey implemented its Community Choice Counseling Program in 1998 to offer nursing home residents information about community options. Assessment and options counseling is provided by nurses and social workers who are state employees. Every nursing home applicant who is a Medicaid beneficiary or will become a Medicaid beneficiary within six months of admission must be screened.

Track I status is assigned to individuals with a poor clinical prognosis, where the assessment finds that a short term stay is not feasible or predictable. Track I consumers may be contacted periodically to determine whether their potential for discharge has improved. Track II individuals receive approval for a short term stay to stabilize medical conditions, complete a rehabilitation program or to restore maximum functional capacity. Track III identifies individuals who can be supported immediately in the community (otherwise known as “diversion”).

See: Reinhard, S. & Petlick, N.H. (2005, December). *Sustaining New Jersey’s Evolving Community Choice Counseling Program*.

<http://www.cshp.rutgers.edu/cle/Products/NJCCCWEB.pdf>

Minnesota—Long-term care consultation

In 2001, Minnesota changed the name “preadmission screening” to “long-term care consultation” to better reflect its philosophy of providing choice to consumers. Still mandated for those under 65 within 40 days of admission to a nursing facility, consultation is now available at no charge to anyone requesting it. Trends since the program’s implementation show a shift toward utilization of home and community-based services as compared with nursing facilities.

See: Auerbach, R. and Reinhard, S. (2005, September). *Minnesota's Long-Term Care Consultations (LTCC) Services*.

<http://www.cshp.rutgers.edu/cle/products/MinnesotaLTCC100705WEB.pdf>

Resource Summary	
State	Web site
Minnesota	http://www.cshp.rutgers.edu/cle/products/MinnesotaLTCC100705WEB.pdf Assessment instrument: http://edocs.dhs.state.mn.us/lfsrver/Legacy/DHS-3428-ENG
New Jersey	http://www.cshp.rutgers.edu/cle/Products/NJCCCWEB.pdf
Pennsylvania	http://www.cshp.rutgers.edu/cle/products/PAsitevisitsummary1WEB.pdf , http://www.dpw.state.pa.us/Disable/HomeCommServices/003670971.htm
Washington	http://www.cshp.rutgers.edu/cle/products/WAsitevisitsummaryfinalLPWEB.pdf ; http://www.cshp.rutgers.edu/cle/products/WashingtonStatePolicyinPractice080305WEB.pdf
Texas	http://www.nashp.org/Files/TX_RFP_for_rel_spec.doc
Job descriptions	http://www.nashp.org/Files/Transition_coord_job_desc.doc

Assessment Tools

States and Independent Living Centers use a range of assessment tools to identify health and functional issues, preferences and support needs. An overview of assessment instruments is available from two recent efforts:

- Aging and Disability Resource Center Toolbox: <http://www.adrc-tae.org/tiki-index.php?page=AssessmentToolsMatrixPublic>
- Gillespie, J. (2004, December). *Assessment Instruments in 12 States*.
<http://www.cshp.rutgers.edu/cle/Products/GillespieAssesmentWEB.pdf>

Colorado: Single entry point assessment

Colorado has a long history of HCBS provision and the use of single entry point agencies. These agencies conduct several types of assessments; the forms for each can be found at the link in the table below.

Delaware Passport to Independence: Inventory of Community Service and Support Needs

This 21-page inventory of community services and support needs (see link in the table below) is based on a Texas Independent Living Partnership tool.

Kansas: Client Assessment and Referral Evaluation (CARE)

Kansas uses CARE for nursing home preadmission screening and follow-up, and uses data from CARE in its transition efforts. There is a question about whether the anticipated stay is less than three months, and if so, case managers follow up with residents. Kansas also plans to

use MDS data in addition to the CARE assessment to more broadly identify those who wish to leave.³⁰

Maine: Universal preadmission assessment

Since deciding in 1993 to reduce reliance on institutional care, Maine has taken steps on many levels to encourage care in the community. With respect to assessments, Maine requires a preadmission assessment for everyone going into a facility, with a conditional length of stay of only 90 days initially, after which another assessment is done.³¹

Michigan: Web-based level-of-care determination

Michigan has developed a web-based level of care determination that is required for those entering a nursing facility, a Medicaid waiver program or the Program of All-Inclusive Care for The Elderly (PACE). When Michigan tightened its level of care requirements in 2004, it created a category called service dependency for those who had spent more than a year in a facility and were dependent on the services there, even if they did not meet medical criteria.

Washington: Comprehensive Assessment, Reporting and Evaluation (CARE)

Washington has developed a comprehensive system that does all of the above (assessment, reporting, evaluation) and also serves as a methodology for authorizing payments. The assessments draw from previously developed assessments already proven reliable across different assessors, such as the MDS and cognitive performance scores.

Wisconsin: Automated level-of-care assessment using MDS data

In July of 2006, Wisconsin is moving to an automated assessment system based on applying an algorithm to MDS assessment data. They hope that this will decrease the workload for employees involved, while still permitting face-to-face assessments in cases that are unique.

Assessment Tools	
State	Web site
ADRC Toolbox	http://www.adrc-tae.org/tiki-index.php?page=AssessmentToolsMatrixPublic
Overview of 12 states (2004 publication)	http://www.cshp.rutgers.edu/cle/Products/GillespieAssesmentWEB.pdf
Colorado	Forms: http://www.chcpf.state.co.us/HCPF/LTC/sepindex.asp History: http://www.hcbs.org/files/44/2163/CO_final.pdf
Delaware	http://www.hcbs.org/files/72/3559/ASSESSMENT_TOOL.pdf

³⁰ Source: Reinhard, S. & Hendrickson, L. (2006, June). *States' Progress in Using the MDS to Facilitate NHT*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/Products/MDSIIWEB.pdf>

³¹ For more discussion of Maine, see Summer, L. (2005, October). *Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Report 7402, available at: <http://www.kff.org/medicaid/7402.cfm> .

Kansas	http://www.srskansas.org/hcp/css/pdf/forms/HI-UAI.pdf
Maine	http://www.maine.gov/dhhs/beas/medxx_me.htm
Michigan	General info for Medicaid providers on Department of Community Health site: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-103102--,00.html Assessment form: http://www.michigan.gov/documents/AttachA_NF_LOC_Criteria_Form-WEB-BLANK_107510_7.pdf Manual for web-based system: http://www.michigan.gov/documents/User_Manual_Final-jkc_107422_7.pdf
Minnesota	http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-3428-ENG (see program discussion in previous section on Sample Assessment Processes)
Washington	http://www.adsa.dshs.wa.gov/professional/care/ Screen prints of system: http://www.adrc-tae.org/documents/washcare.pdf
Wisconsin	Memo explaining change: http://dhfs.wisconsin.gov/rl_dsl/NHs/NH06014.htm Handout with logic: http://dhfs.wisconsin.gov/rl_DSL/Training/MDSLOCLogicExpl.pdf Functional screening info: http://www.dhfs.state.wi.us/LTCare/FunctionalScreen/Index.htm

The Transition Process

Relocation preparation includes addressing where the consumer wants to live, determining what supports the consumer has and what he or she will need, and moving out. In order to move out, rent and security deposits, basic furnishings, household items, food, and access to needed services must all be purchased or established. States have developed assessment tools or guides for relocation preparation that generally include a transition timeline beginning at least two to three months prior to the move (including the day of the move), and ending a few months following the move. They address seven key areas: health, housing, transportation, daily living, personal finance, social and recreational, and employment. These tools or guides are addressed to consumers who want to move and staff who will help with the move. Staff may include designated transition case managers, waiver case managers and/or nursing facility discharge planners.

Community Living Brief: Going Home: Taking Charge of Your Transition Services

This Community Living Brief explores the transition to an independent, integrated living situation. This article serves as a guide to assist the individual when considering moving back into the community, and contains a detailed checklist and timeline for activities. The article provides information on finding an advocate and also provides a transition checklist to help facilitate the moving process.

See: http://www.hcbs.org/files/40/1987/Volume_1.pdf

Arkansas Transition to Freedom Best Practices Manual

This manual was prepared as a collaborative project of four Independent Living Centers for transition staff. It includes narrative success stories in addition to an operations manual

containing all necessary state forms. It stresses the importance of involving the nursing home staff:

The manual gives guidance for obtaining a self-reported assessment of Activities of Daily Living (ADLs) – bathing, dressing, eating, toileting, transferring), Instrumental Activities of Daily Living (IADLs) – housework, meal preparation, medication management, shopping, transportation, finances), diagnosis, medical history or conditions, mental and emotional status, ability to follow instructions, participation in social activities, confusion or disorientation, and attitude.

The personal history form addresses issues that may become barriers to establishing a community residence such as: the consumer’s reputation, unpaid utilities, credit problems, and problems with police, family relationships or substance abuse. The transition plan identifies what is needed, who will provide it and the costs for housing, supports for ADLs and IADLs, environmental adaptations, counseling, medical, transportation, and other services.

See: www.hcbs.org/files/19/930/AR_Transition_to_Freedom.pdf

Colorado Handbook for Transition Navigators

This handbook was prepared by the Colorado Department of Health Care Policy and Financing and Independent Living Centers to help advocates and agencies inform nursing home residents about their right to live in the community, and to assist those who want to move. The report defines transition, offers the nuts and bolts of the program and covers tips for moving day and beyond.

See: www.hcbs.org/files/58/2869/Transitions_Manual.pdf

Connecticut Transition Guide

Created by the Connecticut Association of Centers for Independent Living, this booklet helps individuals who want to leave a nursing facility and move to the community. The booklet provides information on: self assessment; personal finances and resources; funding and benefit programs; housing; daily supports; health services; social, faith and recreation needs; work, school and other pursuits.

See: <http://www.ct.gov/dss/LIB/dss/PDFs/TransGuide.pdf>

Maryland Moving Home Resource Guide

This guide was prepared by Making Choices for Independent Living, an ILC in Baltimore, Maryland. It covers the resources available to help people moving to the community, including programs and entities that assist with housing, medical and personal care, access to Medicaid home and community-based services waivers, and civil rights. Issues to consider during transition planning considerations are described such as credit and criminal history, money management, housing, furnishings, security deposits, transportation, health care and assistive technology.

See: www.hcbs.org/files/17/823/MDMoving_HomeResourceGuide.doc

Michigan Planning Tools for Assisting Individuals to Transition from Nursing Homes to Community Living

This tool was developed by the Michigan Centers for Independent Living for transition coordinators. The tool includes a series of person-centered materials – a description of the transition process, timelines and worksheets for tasks that need to be completed in the following areas:

Planning	Daily living
Health	Personal finance
Housing	Social/recreational
Transportation	Employment

The tool lists topics that should be covered during interviews with consumers as well as questions to ask consumers who do not wish to move to understand barriers and preferences. A key feature of the tool is the section on person-centered planning – what it means, essential elements, preparation, an outline for the planning meeting and special issues. The planning tool also includes sections on person-centered planning and special issues such as credit history, community reputation, law enforcement, family, and substance abuse issues.

See: www.hcbs.org/files/17/845/MINFT_planning.htm

New Jersey Nursing Facility Transition Resources

The New Jersey Association of Centers for Independent Living has developed a workbook for transitioning consumers, which is also available on the internet. The workbook contains many tools to help consumers set goals and identify needed services and information needed in order transition from a facility to the community.

See: <http://www.nursingfacilitytransition.org/>

Transition guides	
Source	Web address
Community Living Brief: Going Home: Taking Charge of Your Transition Services	http://www.hcbs.org/files/40/1987/Volume_1.pdf
Arkansas Transition to Freedom Best Practices Manual	www.hcbs.org/files/19/930/AR_Transition_to_Freedom.pdf
Connecticut Transition Guide	http://www.ct.gov/dss/LIB/dss/PDFs/TransGuide.pdf
Colorado Handbook for Transition Navigators	www.hcbs.org/files/58/2869/Transitions_Manual.pdf
Maryland Moving Home Resource Guide	www.hcbs.org/files/17/823/MDMovingHomeResourceGuide.doc
Michigan Planning Tools for Assisting Individuals to Transition from Nursing Homes to Community Living	www.hcbs.org/files/17/845/MINFT_planning.htm
New Jersey Nursing Facility Transition Resources	http://www.nursingfacilitytransition.org/

Self-Assessment Tools

Tools that help consumers identify their own needs are useful in the transition process. Several states have developed these aids.

Connecticut Self-Assessment

A self-assessment form helps consumers determine what supports they would need to transition out of a nursing home and into the community. The “Self-Reflection/Assessment” section of the guide asks consumers to consider:

- What is my disability, or what are the things that led to my being here or keep me here?
- How does my disability affect my ability to live independently?
- What is my ideal situation (geographic; living with others)?
- Are there others in my life (family, friends, etc.) I could ask to assist me in moving to the community?
- What strengths, resources, and qualities do I have that will be part of my success?
- What are my fears, concerns, or other things I believe may be a problem?
- What can be done to remove or reduce them?
- What strengths and resources exist in my family, friends, and communities that will help me succeed?
- What else is important to me?

Delaware Passport to Independence: Individual Guide

The Delaware Passport to Independence goals are to: identify residents of nursing homes who may want to move to a new home; interview and assess residents for possible community living; explore if it’s feasible for residents to transition; and create an Individualized Service Plan for those choosing to be considered.

Minnesota Take the Road to Independence: The Options Initiative

The Minnesota Association of Centers for Independent Living (MACIL) prepared “A Consumer Guide for Planning Your Move from a Nursing Home.” This comprehensive guidebook assists with relocation decisions as consumers transition from nursing homes into the community.

Texas Texoma Real Choice Program demonstration project

The program’s goal is to connect persons with disabilities to real service options with the help of system navigators available to assist people through systems and support groups. The web site has links to the following tools used to implement the program: an introduction to Texoma; a program overview; a sample job description; referral form; presurvey form; intake form; information release; client needs assessment questionnaire; referral/authorization form; care plan; withdrawal of permission form; and a customer survey.

Self-Assessment tools	
Tool	Web address
Connecticut Self-Assessment	www.hcbs.org/files/29/1430/Self_assessmentCT- FINAL.doc
Delaware Passport to Independence: Individual Guide	www.hcbs.org/files/70/3468/Passport_to_Ind_Guide.pdf
Minnesota A Consumer Guide for Planning Your Move from	www.hcbs.org/files/73/3638/take_the_road.doc

a Nursing Home	
Texoma Real Choice demonstration	www.hcbs.org/moreInfo.php/nb/doc/287/Texoma Real Choice Program: System Navigators-Over

Tasks and Checklists

Moving to a new home is a complex, time-consuming and somewhat frustrating process even for people without a disability. Moving from a nursing home and establishing a residence is far more complex. Lists of the many tasks that need to be completed can expedite the transition process. A review of several checklists found the following tasks listed:

- Organize papers and documentation (birth certificate, social security card, proof of citizenship) that will be needed;
- Applying for Medicaid in the community;
- Change the address for SSI, Social Security, Veterans Administration;
- Establish a checking account or change the address;
- Apply for food stamps;
- Obtain photo identification if necessary;
- Deal with poor credit report or criminal history with the landlord;
- Obtain medical supplies, adaptive equipment;
- Ensure access to prescription medications, arrange for 30 day supply from the nursing home;
- Obtain furniture, bed and linens, dishes, utensils, pots and pans;
- Arrange and complete home modifications;
- Phone and utility hook ups;
- Make keys for service providers if necessary;
- Arrange a “trial” stay;
- Arrange transportation on moving day;
- Connect with support groups;
- Practice using transportation to grocery store, doctor’s appointments.

Chapter 4: Nursing Home Transition Services

Moving to the community requires coordination and timing to make sure all the varied pieces are in place at the same time. Services are designed primarily to serve consumers in the community or in a nursing home. Programs were not originally designed to help consumers leave a nursing home after a long-term stay. Services must be in place on the day a consumer moves from a nursing home to a community setting in order to meet their health and support needs. Much of the preparation happens prior to the move. The important pieces include establishing Medicaid financial eligibility in the community; establishing functional eligibility for an HCBS waiver, state plan or other services; coordinating the array of services and providers that will be needed on or shortly after the move; and arranging the time sensitive transition services that are needed in order for the consumer to move (see previous chapter for a checklist and other transition planning tools).

This chapter is designed to answer several questions:

- What types of activities can be reimbursed?
- How can transition services be paid for?
- What about consumers who need to move back and forth between a nursing home and a community residence?
- What can be done to help consumers maintain their housing in the community?
- What about expenses that Medicaid won't cover?

What is Reimbursable?

CMS recognized the importance of covering transition expenses and issued a State Medicaid Directors Letter on May 9, 2002 that explains how states can cover Community Transition Services under HCBS waivers.³² The letter allows states to pay the reasonable costs of community transition services for such things as:

- Security deposits that are required to obtain a lease on an apartment or home;
- Essential furnishings (beds, chairs, tables, kitchen items) and moving expenses required to occupy and use a community domicile;
- Set-up fees or deposits for utility or services access (e.g. telephone, electricity, heating);
- Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy.

Items that are diversional or recreational are not routinely covered – televisions, cable TV access or VCRs/DVDs – but may be approved by CMS if they are justified by the State.

Another letter dated July 14, 2003 recognizes that the purchase of medical equipment may be necessary for the success of a transition, and offers several strategies to pay for such equipment prior to the consumer's transition.³³

What are states doing?

A review of state programs that support transition services in 2005³⁴ found 13 states that cover transition services. Limits on the amount of support for transition services ranged from \$350 in Oregon to \$4,000 in Pennsylvania.

Transition assistance services in Indiana are arranged by Area Agencies on Aging. AAA case managers develop a plan of care and estimated cost which is submitted to and approved by the Office of Medicaid Policy and Planning. Once approved, the AAA contacts the vendor, and purchases and pays for the approved services. Invoices and receipts are submitted to Medicaid for payment. AAAs pay for the approved items with operating funds available to the AAA and are reimbursement by the state agency.

³² Centers for Medicare & Medicaid Services. (2002, May 9). State Medicaid Directors Letter, SMDL#02-008. Available at: <http://www.cms.hhs.gov/smdl/downloads/smd050902a.pdf>

³³ Centers for Medicare & Medicaid Services. (2003, July 14). State Medicaid Directors Letter, SMDL#03-006. Available at: <http://www.cms.hhs.gov/smdl/downloads/smd071403.pdf>

³⁴ Eiken, S., Holtz, D. & Steigman, D. (2005, January). *Medicaid HCBS Waiver Payment for Community Transition Services: State Examples*. Washington, DC: Medstat. Available at: http://www.hcbs.org/files/67/3306/HCBS_Transition_Services.pdf

Case managers in the Texas Department of Aging and Disability Services authorize transition assistance services that are purchased by providers (home health agencies, ILCs). Providers receive \$152 to cover the administrative cost of arranging services. Services are paid for by the provider. Businesses that sell the item or provide the actual service are paid by the waiver provider. The waiver provider submits an invoice and receipts (or is just the receipts) to DADS with a signed statement from the consumer that they have received the services. The case manager compares the receipts against the authorized plan of care and approves payment. It takes 30-60 days for the payment to be processed. Some Independent Living Centers do not have sufficient cash flow to pay for the services and are not able to arrange them.

Reimbursement Options for Transition Activities

The key component of a successful MFP program is the availability of staff to work with consumers to plan and implement the move. Programs use different titles to describe the function – transition coordinator, transition navigator, relocation specialist, care coordinator, case management, supports coordinator and others. These activities are typically covered by grant funds. When the grant is completed, there are three primary options for states to cover nursing home transition care coordination under Medicaid.³⁵

- §1915 (c) home and community-based waivers;
- §1915 (g) optional targeted case management services;
- Administrative activity.

§1915 (c) home and community-based services waivers

The Medicaid manual describes case management as an “activity which assists individuals in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other appropriate services, regardless of the funding source for the services to which access is gained.” Case management services may be used to locate, coordinate, and monitor necessary and appropriate services and may be used to encourage the use of cost effective medical care by referrals to appropriate providers and to discourage over-utilization of costly services such as emergency room care for routine procedures. Case management services may also serve to provide necessary coordination with providers of non-medical services, such as local education agencies or department of vocational rehabilitation, when the services provided by these entities are needed to enable the individual to function at the highest attainable level or to benefit from programs for which he or she might be eligible.

Case management services can be delivered to residents up to 180 consecutive days prior to discharge from a nursing home. The assessment, functional determination and preliminary plan of care can be completed while the person is still in the nursing home. This flexibility avoids creating a gap between the person’s move to the community and the initiation of services. Federal financial participation (FFP) may only be claimed by the state Medicaid agency on the date the person leaves the institution and is enrolled in the waiver. Further details are included in

³⁵ Mollica, R. (2003, December). *Sustaining Nursing Home Transition Programs: Covering Case Management Services*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/Products/MollicaSustainingNHTCCM.pdf>

the Olmstead III letter to all State Medicaid Directors, dated July 25, 2000.³⁶ Costs incurred prior to the date of waiver enrollment are claimed as a special single unit of transitional case management.

Limitations on waiver enrollment effect how many people may receive case management. States with waiting lists would be limited in helping people move unless supports are available from another source. However, case management may only be claimed when the individual is enrolled in the waiver after discharge and is receiving at least one waiver service.

§1915 (g) Optional targeted case management services

Targeted case management (TCM) is defined as “services which will assist individuals, eligible under the plan, in gaining access to needed medical, social, educational and other services.” TCM may be furnished to nursing home residents who are preparing to move to the community. Like the §1915 (c) waiver, TCM may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay. States may specify a shorter time period or other conditions under which targeted case management may be provided.

States must identify a target group to receive services such as nursing home residents planning to move to the community. States may include limitations in comparability (TCM will not be available in the same amount, scope and duration to all eligible recipients) and statewideness (TCM may be limited to specific geographic areas of a state). Medicaid recipients must be given a choice of TCM providers who meet the state's qualifications. However, with regard to target groups that consist entirely of persons with developmental disabilities, or individuals with chronic mental illness, the state may limit the providers of TCM to ensure that case managers are capable of ensuring that needed services are actually delivered to these vulnerable populations.

States interested in using TCM should be aware that the President's budget proposed changing the federal matching rate from the service matching rate to the administrative rate of 50 percent.

Administrative activity

Case management may be reimbursed “as a function necessary for the proper and efficient operation of the Medicaid State plan.” The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, who are employed in State or local agencies other than the Medicaid agency and who perform duties that directly relate to the administration of the Medicaid program. As an administrative activity, case management must be related to covered Medicaid services and do not cover gaining access to other services such as housing, food stamps or other non-Medicaid services.

In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State's claims for Federal funds under the appropriate authorities. Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

³⁶ Centers for Medicare & Medicaid Services. (2000, July 25). State Medicaid Directors Letter. Available at: <http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf>

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by the CMS regional office.

Medicaid coverage options		
Option	Advantages	Disadvantages
1915 (c) waiver service	<p>The Federal Medicaid Assistance Percentage (FMAP) may be higher than the administrative rate.</p> <p>Eligible activities include arranging, coordination and helping to arrange access to services that are not covered by Medicaid such as housing and food stamps.</p> <p>Activities may be provided (reimbursed) up to 180 days prior to the date the person becomes a waiver participant.</p> <p>States may establish qualifications for providers of case management services to people in nursing homes that includes prior experience serving this population.</p>	<p>States may not limit providers of case management to a single individual or entity. Consumers must have a choice of providers of case management services.</p> <p>Reimbursement may be claimed³⁷ only when the person becomes a recipient of waiver services.</p> <p>Case management services provided to nursing home residents who do not leave the nursing home cannot be reimbursed.</p> <p>States with a waiting list for waiver services would not be able to claim FFP for waiver case management services provided to individuals who do not use Medicaid waiver services.</p>
Targeted case management	<p>States may define nursing home residents as a target population. Case management activities may be paid by the state to the provider prior to the date the individual becomes a waiver participant.</p> <p>States may claim FFP for case management activities prior to the individual leaving the nursing home and becoming a waiver participant.</p> <p>The individual need not be enrolled in a waiver for the state to claim FFP.</p> <p>States may also choose to provide targeted case management to individuals who are enrolled in HCBS</p>	<p>States may not limit access to providers of case management services, except as specified above, for individuals with developmental disabilities or chronic mental illness.</p> <p>The President's budget would reduce the federal matching rate to 50%.</p>

³⁷ Case management services may be delivered prior to enrollment in the waiver but FFP may not be claimed until enrollment.

Medicaid coverage options		
Option	Advantages	Disadvantages
	waivers.	
Administrative activity	<p>States may limit providers of case management activities which may be important in states that use single entry point agencies to facilitate access to services.</p> <p>Services may be claimed and reimbursed prior to the individual leaving a nursing home and becoming a waiver participant.</p> <p>Case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community (e.g., due to death, the individual's choice not to receive waiver services, loss of Medicaid eligibility, etc.). This is because the service is performed in support of the proper and efficient administration of the State plan.</p>	<p>Only case management activities related to assisting an individual to gain access to services covered by the Medicaid state plan or home and community-based services waiver may be reimbursed.</p> <p>Services are reimbursed at the administrative rate (50% of case managers, or 75% for services provided by registered nurses) which may be lower than the FMAP for services depending on the provider of case management activities and the state's FMAP.</p>

Moving Back to the Nursing Home Briefly

Moving between settings for brief periods can be accommodated by keeping an HCBS waiver slot available when the consumer plans to return to the community after a short term stay in a nursing facility.

Helping Consumers Maintain Housing in the Community

Consumers who are able to maintain their housing during their nursing home stay have an easier transition than those who need to find new housing. *Federal Medicaid rules governing the treatment of income for individuals in institutions, 42 CFR 435.832, permit states to disregard income that is needed to maintain a home.* This exemption, coupled with transition coordination, allows consumers who may need to stay longer than a short-term post-acute period to maintain their housing.

The rule provides:

For single individuals and couples, an amount (in addition to the personal needs allowance) for maintenance of the individual's or couple's home if— (1) The amount is deducted for not more than a 6-month period; and (2) A physician has certified that either of the individuals is likely to return to the home within that period.

Exempting sufficient income to maintain the home or apartment will increase Medicaid payments during the nursing home stay but will prevent longer stays.

The discussion of Washington state in State Medicaid Directors Letter 02-012 discusses strategies to help consumers maintain a home in the community.³⁸

Helping Consumers Re-establish Housing

Consumers who have lost their housing often need assistance establishing a household in order to move to the community. Several states have used state funds or grant funds to support one-time transition needs.

Transition Funding not Covered by Medicaid

At least one state set up separate funds to more expeditiously meet transition expenses. Connecticut found that participants sometimes had difficulty acquiring funds, either because their needs did not fit into existing programs or because of barriers in accessing funds due to complicated applications or lengthy waiting periods. To be able to fund these expenses quickly and with a minimum of red tape, the program developed a “Common Sense Fund” for participants. The use of these funds was generally limited to \$500 per individual, but could be increased to \$1000 without committee approval. A “Common Sense Workgroup” oversaw the management of the funds. Applications were done with a short form filled out by the transition coordinator and the consumer, and disbursements were generally made within 24 hours of application. Among other things, the funds paid for security deposits, furniture, utility deposits and community-appropriate clothing. Private donations have helped to sustain these funds beyond the grant.

Transition and Other Services Resource Documents	
Document	Web site
State Medicaid Director’s Letter, #02-008 (May 9, 2002)—clarifies how to pay for transition expenses under 1915(c) waivers	http://www.cms.hhs.gov/smdl/downloads/smd050902a.pdf
State Medicaid Directors Letter, #03-006 (July 14, 2003)—suggests how to pay for medical equipment for transition	http://www.cms.hhs.gov/smdl/downloads/smd071403.pdf
Medicaid HCBS Waiver Payment for Community Transition Services: State Examples	http://www.hcbs.org/files/67/3306/HCBS_Transition_Services.pdf
Covering Case Management Services	http://www.cshp.rutgers.edu/cle/Products/MollicaSustainingNHTCCM.pdf
State Medicaid Directors Letter, (July 25, 2000)—earliest date for which payment may be claimed	http://www.cms.hhs.gov/smdl/downloads/smd072500b.pdf
State Medicaid Directors Letter #02-012 (August 13, 2002); describes promising practices in MFP	http://www.cms.hhs.gov/smdl/downloads/smd081302.pdf

³⁸Centers for Medicare & Medicaid Services. (2002, August 13). State Medicaid Directors Letter #02-012. Available at: <http://www.cms.hhs.gov/smdl/downloads/smd081302.pdf>

Chapter 5: Barriers to Transitions

Grantees describe several factors that create barriers to transition. These factors include delays in establishing Medicaid eligibility, the process for enrolling individuals in HCBS waivers and, the barrier frequently cited as most severe, a lack of accessible, affordable housing.

Establishing Services in the Community

Expediting Medicaid financial eligibility

Although the federal government will not reimburse states for errors in presuming eligibility, several states allow workers to presume eligibility in order to initiate home and community-based services. *Delays in making a decision about whether an applicant is eligible for Medicaid may affect decisions about where a person will receive services.* A report to CMS from the Medstat Group, Inc. on presumptive eligibility reported that almost half of all nursing home residents are admitted from hospitals and another 11 percent are admitted from other nursing homes. Just under 30 percent come from private or semi-private residences.³⁹ Nursing homes are more willing to admit individuals while the Medicaid application is being processed. Nursing homes are generally larger organizations than HCBS providers, and get more revenue from privately-paying clients. Thus, they are more accustomed to charging patients or their families for services and in many cases are more able to bear the risk of waiting for an eligibility determination. In addition, they are generally experienced with assessing residents' income and resources with respect to whether the resident will become a Medicaid beneficiary or remain private pay.

Several states have implemented processes that range from expediting the time it takes to process the application up to the actual presumption of eligibility. Both processes are sometimes referred to as "fast track."

Presumptive eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible and to initiate services *before* the official determination has been made by the eligibility staff.

Expedited processes address the factors that are most likely to cause delays – fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing home and community-based services, help the individual or family member complete the application and attach sufficient documentation of income, bank accounts, and other assets to allow the financial eligibility worker to make a decision. Expedited processes reduce the time it

³⁹ Stevenson, D., McDonald, J. & Burwell, B. (2002, August). *Presumptive Eligibility for Individuals with Long-Term Care Needs: An Analysis of a Potential Medicaid State Option*. Washington, DC: Prepared for CMS, CMSO, DEHPG by the Medstat Group, Inc.

takes to complete a financial application using the normal channels. Services do not begin until eligibility is established.

A review of selected fast track practices found several variations. Applicants may be presumed eligible by the care coordinator staff responsible for conducting an assessment, determining level of care and authorizing home and community-based waiver services. In other programs, care coordinators are familiar with Medicaid eligibility criteria and assist the applicant but do not presume eligibility. The presumption is made by the staff responsible for financial eligibility. Programs that allow care coordinators to presume eligibility require additional training.

Expediting Eligibility Resources	
Resource	Web site
Expediting eligibility paper	http://www.hcbs.org/files/41/2045/Presumptivepolicypaperfinal.doc
Fact Sheet	http://www.hcbs.org/files/74/3687/PresumptiveonepagesummaryWEB.pdf

Housing Barriers—Finding a Place to Receive HCBS

Organizations with experience helping people move to the community almost always identify the lack of accessible, affordable housing as the primary barrier to relocation. Many communities lack a sufficient supply of subsidized housing to meet the demand. Others have difficulty matching available units to people with disabilities who are searching for them. *Two strategies are needed: one to expand the supply and another to help property managers market their accessible units and consumers to find available units.*

An RTI report on Nursing Facility Transition documented these challenges:

“Grantees confirmed that obtaining affordable, accessible housing has been one of the most challenging aspects of their transition initiatives. They cited a variety of factors contributing to the housing problem including long waiting lists for subsidized housing, a general shortage of housing that includes modifications and/or adaptive equipment, difficulty in obtaining rental assistance vouchers, lack of cooperation from local public housing authorities (PHAs), lack of success in forming housing coalitions at the local and the state levels, and unaffordable rents for persons receiving Supplemental Security Income even with vouchers. Despite these obstacles, Grantees stated that they eventually found housing for those they sought to transition.

“Grantees described major difficulties securing housing vouchers, citing insufficient funding for vouchers and unsuccessful efforts to formalize agreements with local housing authorities to prioritize vouchers for transitioning individuals. Some Grantees also reported that local PHAs reduced the number of vouchers available due to funding constraints. Other Grantees reported that because rents are so high in some areas, some people return the vouchers because they can not find affordable housing even with the voucher. The returned vouchers are given to the next person on the waiting list, leading to

a paradoxical situation where underutilization within a given time period coexists with long waiting lists for vouchers.”⁴⁰

General housing resources

A wide range of housing resources are available to support production of new housing and access to existing affordable housing. A Resource Guide prepared for the Rutgers/NASHP Technical Assistance Collaborative by the Technical Assistance Collaborative, Inc. in March 2003 provides an overview of the housing needs of people with disabilities as well as some of the challenges in meeting these needs; provides information about the design, principles, and critical components of housing for people with disabilities; describes the various agencies that may be involved in addressing the housing needs of people with disabilities and the programs these agencies administer; describes the HUD-mandated strategic planning processes that control access to federal affordable housing resources; identifies some of the numerous housing strategies that have been shown to be effective in meeting the housing needs of people with disabilities; and provides detailed information about the various housing programs and resources that are available to address the housing needs of people with disabilities.

Technical Assistance Guide for Housing Resources and Strategies: Discussed above.
Available at: http://www.hcbs.org/files/51/2539/Final_Regional_Forum_guide.pdf

Access to housing for persons with disabilities. A report by the Muskie School of Public Service on lessons learned from three demonstration projects.
Available at: <http://www.hcbs.org/files/79/3929/HousFinalReport.pdf>

Advocating for reasonable accommodations is a presentation by Ann O’Hara of the Technical Assistance Collaborative, Inc.
Available at: <http://www.hcbs.org/files/41/2031/ReasonableAccommodationAnnOhara.pdf>

Executive Order issued by Texas Governor Rick Perry addressing barriers to helping people transition from institutions to community settings.
Available at: http://www.hcbs.org/files/30/1472/Perry_Order_EO-RP-13.doc

Action list: steps toward systems change

The following actions can build support for improving access to accessible, affordable housing units:

Gather information

- Develop a resource list (directory) of local Public Housing Authorities and timetable for review of local plans for use of HOME, Community Development Block Grant, and Housing Choice Vouchers. Disseminate the list to disability-related organizations to encourage their participation in needs statement and priorities for allocation of resources in local plans.

⁴⁰ Siebenaler, K., O’Keeffe, J., Brown, D. & O’Keeffe, C. (2005, June). *Nursing Facility Transition Initiatives of the Fiscal Year 2001 and 2002 Grantees: Progress and Challenges. Final Report*. Research Triangle Park, NC: RTI International. Available at: http://www.hcbs.org/files/74/3656/NFT_final_web.pdf.

- Develop a resource list of disability-related organizations, service providers, and area service offices (aging, mental health, MR/DD) and distribute to the area PHAs and State Housing Finance Agency to encourage collaboration and coordination of supports with developers and public housing managers.
- Create a Housing Registry that is updated regularly to identify affordable and accessible housing units available to be leased by individuals with disabilities statewide.
- Explore opportunities to secure additional resources from the State’s Housing Trust Fund to support affordable integrated multifamily development that meets the needs of individuals with disabilities.
- Explore licensed and unlicensed facility options to bring a more intensive level of supportive services into public housing for seniors—services that promote aging in place and nursing home diversion.

Build collaborative relationships and train leaders

- Establish a state level work group on Services Coordinated with Housing that includes leaders from:
 - a. State Housing Finance agency
 - b. State Medicaid Agency
 - c. Department on Mental Health
 - d. Department on Developmental Disabilities
 - e. Department on Elder Affairs (Aging)
 - f. State Independent Living Council
 - g. Association of Public Housing Authorities (local PHAs)
 - h. State Developmental Disabilities Council
- Create and implement a Housing and Services Leadership Program that trains self-advocates and family members to: 1) become actively involved in local public housing authority resource allocation, 2) team up with developers to expand affordable and accessible multifamily development, and 3) educate policymakers at the county and state level about the Olmstead decision and the urgent need to expand resources for services coordinated with housing.
- Explore joint project opportunities between state housing and service agencies.
- Provide assistance to local area Continuum of Care applications that brings together service and housing agencies to leverage and coordinate resources.

Commit resources

- Create an annual action plan that commits the State Agency Work Group members to collaborate in needed policy development, capacity building, and improved coordination of resources.
- Create a Bridge Subsidy program that provides rental assistance for individuals with disabilities who are on waiting lists for housing choice vouchers.
- Evaluate and modify your state’s qualified allocation plan (QAP) to provide a competitive advantage to developers seeking low income housing tax credits who dedicate at least 10 percent of their units in a proposed multifamily development to meet the affordability and accessibility needs of persons with disabilities.

- From local and balance of state Community Development Block Grant funds, dedicate resources to support an aging in place home modification program to expand opportunity for individuals with disabilities to live independently.
- Establish a first-time home ownership program that offers below market rate financing, with less emphasis on credit scoring and assistance with a down payment.
- Adopt universal design standards for multifamily projects financed by the state housing agency.
- Set a priority for housing choice vouchers for individuals returning to community living from nursing facilities or other institutions.

Document and publicize progress to keep the cycle going

- Conduct an annual conference that brings together lenders, developers, public housing authorities, service agencies, and persons with disabilities to learn about best practices, model projects, and build stronger cooperative relationships.
- Publish an annual report at the Governor's level that documents progress made in expanding community choices that link services with affordable and accessible housing for seniors and persons with disabilities.

Increasing the supply of accessible and/or affordable housing

Universal design for accessibility

The concept of universal design means products and layouts that make the space usable by the greatest number of people, and a space that can be adapted to the changing needs of residents.

EasyLiving Home Program

The EasyLiving Home program is the nation's first voluntary certification program that specifies criteria in everyday construction to add convenience for residents and to allow residents to welcome all visitors regardless of age, size or physical ability. The program was developed by a coalition of public and private organizations to encourage the inclusion of features that make homes cost effective, accessible and convenient without sacrificing style or adding substantial costs. The program began in Georgia and expanded in 2005 to include West Virginia, New Hampshire and Texas. 2006 will offer other states the opportunity to affiliate. Builders pay a fee to join and get help with building plans and marketing support. As of July, 2006, the web site lists 32 builders in Georgia (23 active) and three builders in West Virginia.

To be certified, homes must include the following features: 1) a step-free entrance into the main floor; 2) a bedroom, kitchen, wheelchair-friendly bathroom and entertaining area all on the main floor; 3) every interior door on the main floor provides a minimum of 32 inches of clear passage. These are features that can be easily planned for new construction, but can be costly to retrofit later.

For more information, see: <http://www.easylivinghome.org>

Kentucky Housing Corporation

Kentucky Housing Corporation is the Housing Finance Authority for the State of Kentucky. To address the needs of individuals with disabilities and the elderly, the authority implemented a Universal Design Policy. Approximately five years ago, the organization explored the concept of Universal Design in an effort to address the need to allow families to age in place. Any project receiving financing for the development of residential housing must build to universal design requirements. A grant from CMS played critical role in developing the policy, which applies to single-family projects and multifamily projects with more than four units. Requirements include minimum doorway openings of 32 inches, light switches no more than 48 inches from the ground, appropriate blocking in bathroom around walls and tubs to be adapted for grab bars and a bedroom on the ground floor. Developers must provide a paved parking area with paved walkway into the house as well as cable high-speed internet access to the unit. Since the program's inception in January 2003, 3,850 units have met the requirements. For more information, see: <http://www.kyhousing.org/page.asp?sec=72&id=468>

Low income housing tax credits (LIHTC)

The low income housing tax credit was created by the federal government in 1986 to create an incentive for investors to put funds into affordable housing. Each state receives an allotment of credits based on population. States allocate these credits on a competitive basis. States develop "Qualified Action Plans" (QAPs) to document their priorities for allocating credits. Advocates seeking the development of housing that is accessible to those with disabilities, in addition to being affordable, have sought to make accessibility a priority in the QAP. This has become a reality in several states.

Iowa

The Iowa Finance Authority (IFA) serves as the housing consultant to the Real Choice grantee and serves on the State's consumer taskforce. IFA has supported Real Choice activities by establishing a 30 percent LIHTC set aside for housing with services for persons with disabilities. This means that 30 percent of all the LIHTC issued by IFA are used as equity investments in accessible, affordable and integrated housing development. For more information, see: <http://www.ifahome.com>

North Carolina

North Carolina's Housing Finance Agency offers bonus points through its Low Income Housing Tax Credit program for developers that elect to build fully accessible units in 25 percent of the total number of apartment units, compared with the 5 percent required by state law. In addition, NCHFA offers additional bonus points through the Qualified Allocation Plan for developers that install roll-in showers in 5 percent of the units being developed. The agency employs a Development Cost Analyst to oversee construction activities including building plan review and site inspections. Plan reviews are conducted prior to construction to ensure that the plans and specifications meet federal, state, and local building codes, especially those involving accessibility, and to ensure that the agency's mandatory design and quality standards are met. For more information, see: www.nchfa.com

Funds for modification/repair

In many cases, existing housing owned or occupied by the consumer and/or the consumer's family can be modified so that the consumer can safely live there. However, the

upfront cost of modifications may be prohibitive. States have recognized the potential long-term savings in their long-term care budgets that can be realized by helping consumers with the cost of home modifications, if it avoids institutional placement.

Oregon

Developed by the State Department of Treasury separate from the General Fund, Oregon's Community Mental Health Housing Fund was developed to provide housing for chronically mentally ill persons. Funds can be used for acquisition, maintenance, repair, furnishings and equipment. The State seeded the fund through the proceeds received by the Department of Human Services from the sale of F. H. Dammasch State Hospital property. At least 95 percent of the sale proceeds shall remain in the account in perpetuity. For more information, see: <http://www.leg.state.or.us/ors/426.html> (Section 426.506)

Nebraska – Making Homes Accessible Program

The Nebraska Assistive Technology Partnership provides interest free, deferred loans for persons with disabilities and the family they live with to make their homes accessible for independent living. These loans range from \$1,000 to \$14,999. The funding for these loans comes from the Nebraska Affordable Housing Trust Fund. This loan program supplements the home modifications made through the Medicaid Home and Community-based Waiver program. Nebraska's HCB Waiver Program has a cap and the Trust fund loans provide the gap financing. For more information, see: <http://www.nde.state.ne.us/ATP/>

Minnesota Housing Finance Agency - Home Accessibility Remodeling Program

Minnesota Housing Finance Agency (MHFA) has developed two programs to assist with home modifications. It established a state-funded home accessibility remodeling program, and formed, trained, and supported a statewide delivery network of local housing and community action agencies. MHFA staff members have directly counseled, trained, or provided continuing education about home accessibility remodeling design and financing to an extensive array of parties. The State developed a "Home Accessibility Remodeling Funding Resources" guide to foster community-based living options, which is available to all on the Agency's Web site. As of July 2004, there have been 17,100 Web hits on the design series and 4,700 Web hits on the funding guide.

For more information, see: http://www.mhfa.state.mn.us/homes/Access_Remodeling.htm

Ensuring housing affordability

Iowa – HCBS rent subsidy and other programs

The Iowa Finance Authority offers a rent subsidy program for persons who receive services under a federal Medicaid HCBS waiver program and who are at risk of nursing facility placement. The program provides a monthly rent assistance payment to help consumers live successfully in their own home and community. IFA utilizes Housing Choice Voucher set-asides to provide the program

IFA has assisted in the development of a statewide housing plan focusing on homeownership, consumer advocacy for housing with services, rent subsidies to move persons

out of institutions and a revolving loan fund to provide low interest-first mortgages for properties to be used in conjunction with LIHTC for accessible and affordable housing in the community.

For more information, see: http://www.ifahome.com/hcbs_rent_subsidy.asp

Texas – Rental Assistance

The Texas Department of Housing and Community Affairs (TDHCA) received 35 Project Access Vouchers and combined these with HOME Investment Partnership Program funds, creating a \$4 million pilot program. Through these two rental assistance options, persons affected by the Olmstead Decision may apply for rental assistance so they may transition from nursing homes or other institutions into the community. HOME Tenant-Based Rental Assistance (TBRA) provides rent subsidies, security deposits, and utility deposits to qualified consumers. Persons assisted with TBRA cannot exceed 80 percent of the area median family income (AMFI) and 90 percent of the persons assisted must be under 60 percent AMFI. However, TDHCA scoring criteria awards extra points for organizations helping persons below 30% AMFI.

For more information, see: www.tdhca.state.tx.us

Help locating housing

Housing Search Guide

This guide was developed to assist professionals who have a role in “relocation” of people with disabilities from nursing facilities to community living arrangements with appropriate services and supports. The Guide was developed by staff of the Texas Independent Living Partnership, a program of ARCIL, Inc. funded by CMS under the “Real Choice Systems Change” program.

Available at: http://www.hcbs.org/files/59/2949/Housing_Search_Guide.pdf

Housing registries

Housing registries have emerged in recent years as a way to match people with disabilities with accessible, affordable units. A review of housing locator web sites by Ray and Battista⁴¹ found 24 web sites that were operational in 2004 (see table). The review looked at site features, accessibility characteristics, vacancy information, rental housing inventory, site development and hosting options, and marketing mechanisms.

Massachusetts

Massachusetts supported the development of an affordable, accessible housing registry that is operated by a non-profit housing association. The data base collects and maintains information about vacant accessible housing units in both subsidized and market rate developments.

Property managers with an accessible or affordable unit for rent list their vacancies at no cost on **Mass Access** including state or federally assisted units, public housing, and private

⁴¹ Ray, A.L. & Battista, V. (2004, December). *A Comparison of State Housing Locator Web Sites*. Gainesville, FL: Shimberg Center for Affordable Housing. Available at: <http://www.hcbs.org/files/59/2946/comparison.pdf>

market developments. All units are listed on the data base to allow people who may have a disability but do not need the features of an accessible unit to conduct a housing search.

The data base includes the region and community of the development; the number and type of units/bedrooms; access status; features of the development (proximity to hospitals, supermarkets, pharmacies, transportation); owner information; contact; public or private assistance available; and information on the accessible/adaptable/affordable units. Other information is also available help consumers locate appropriate housing.

North Carolina

North Carolina’s Housing Finance Agency has an Accessible Apartment Locator on its web site. Properties are listed with fully accessible or adaptable units for the mobility impaired that are under construction or have been completed. The Locator is organized by county, and provides the apartment community’s name, address, city, whether the community is designed for families or the elderly, number of apartments, number of fully accessible and adaptable units, a contact person and a telephone number.

Housing Locator Web Sites	
State/Agency	Web address
Kentucky	http://www.kyrents.org
Maine	http://www.adaptedhome.org
Massachusetts	http://www.massaccesshousingregistry.org
Minnesota (Minneapolis/St. Paul Metro)	http://www.housinglink.org
National Accessible Apartment Clearinghouse	http://www.accessibleapartments.org/custom/basicsearch.asp?id=19
Nebraska	http://www.nifa.org/customers/project_listings.html
New Mexico	http://www.housingnm.org/Secured/AffordableRentals/Search/HomePagePublic.htm
New York State	http://www.dhcr.state.ny.us/ahd
North Carolina	http://www.nchfa.com/Applications/Apt_Afford_Locator/AAL_Search.aspx
Oregon (Portland Metro)	http://www.housingconnections.org
Socialserve.com	http://www.socialserve.com . Covers housing in Arizona, Colorado, Georgia, Indiana, Kansas, Missouri, Nebraska, New Jersey, North Carolina, Ohio and South Dakota.
South Dakota	http://www.sdhda.org/rent/index.html
Texas	http://hrc-ic.tdhca.state.tx.us/hrc/VacancyClearinghouseSearch.m
Utah	http://webapps.dced.state.ut.us/shod/
Vermont	http://www.housingdata.org/doarh/index.php
Washington	http://aptfinder.org/cgi-bin/index.pl

Helpful organizations

Information about public agencies and private organizations that can help your state with policy development, technical assistance, and finding funding to expand accessible and affordable housing are described below (see web links in table at end):

The Arc of the United States

The Arc of the United States is a national organization of and for people with mental retardation and related developmental disabilities and their families. It works to include all children and adults with cognitive, intellectual, and developmental disabilities in every community. It is devoted to promoting and improving supports and services for people with mental retardation and their families. The Arc works to ensure that the estimated 7.2 million Americans with mental retardation and related developmental disabilities have the services and supports they need to grow, develop, and live in communities across the nation.

The Center for Housing and New Community Economics (CHANCE) Institute on Disability/UCE University of New Hampshire

The Center for Housing and New Community Economics (CHANCE) works to improve and increase access to integrated, affordable, and accessible housing coordinated with, but separate from, personal assistance and supportive services. CHANCE's purpose is to offer alternatives to approaches that segregate, congregate, and control people with disabilities. CHANCE's preliminary efforts are focused on three major initiatives:

Project Access is a national initiative designed to assist people with disabilities to move from nursing homes into the community.

Strategies, Barriers, and Outcomes of Home Ownership for People with Severe Disabilities is a research project that is systematically investigating the quality of life outcomes of home ownership for people with severe disabilities. The research will focus on the personal service, financial, and support network variables associated with achieving and maintaining successful home ownership.

The National Home of Your Own Alliance Clearinghouse is a project that promotes home ownership based on the belief that non-traditional income streams and federal, state, and local subsidies could be structured and blended to support homeownership for people historically excluded from the housing market.

Consortium for People with Disabilities Housing Task Force (CCD Housing Task Force)

The CCD Housing Task Force works with the Congress and the Department of Housing and Urban Development to increase access to decent, safe, and affordable housing for all people with disabilities and to protect the rights guaranteed under the Fair Housing Act. The CCD Housing Task Force also works collaboratively with TAC to produce Opening Doors, a housing initiative for the disability community.

The Corporation for Supportive Housing (CSH)

The Corporation for Supportive Housing (CSH) supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance abuse, and other chronic health challenges and are at risk of homelessness, so that they are able to live with stability, autonomy, dignity, and reach for their full potential. CSH works through collaborations with private, nonprofit and government partners, and strives to

address the needs of, and hold themselves accountable to, the tenants of supportive housing. With nonprofits and government, CSH strives to help local organizations gain the financial and technical assistance they need to build more and better housing with services. They try to facilitate sharing of successful techniques and strategies throughout the industry. Finally, CSH works to streamline and improve development and funding systems.

Fannie Mae HomeChoice Mortgage Loans

HomeChoice mortgage loans are designed to meet the special underwriting needs of low- and moderate-income borrowers who have disabilities, or who have family members with disabilities living with them. The mortgage offers a down payment as low as \$500; greater flexibility in qualifying and underwriting standards; and acceptance of nontraditional credit histories. HomeChoice mortgage loans are available through Fannie Mae-approved lenders working in partnership with coalitions of organizations that combine efforts to create homeownership opportunities for people with disabilities. HomeChoice loans are also available through single agencies that have been approved by Fannie Mae and offer home-buying support similar to that offered by coalitions.

U.S. Department of Housing and Urban Development (HUD)

The U.S. Department of Housing and Urban Development (HUD) seeks to provide a decent, safe, and suitable living environment for every American. HUD strives to create opportunities for homeownership, provide housing assistance for low-income persons, create, rehabilitate, and maintain the nation's affordable housing, enforce the nation's fair housing laws, help the homeless, spur economic growth in distressed neighborhoods, and help local communities meet their development needs. HUD programs that may benefit persons with disabilities are found at <http://www.hud.gov/groups/disabilities.cfm>

The Judge David L. Bazelon Center for Mental Health Law

The Judge David L. Bazelon Center for Mental Health Law is a nonprofit legal advocacy center based in Washington DC. Their advocacy is based on the principal that every individual is entitled to choice and dignity. For many people with mental disabilities, this means something as basic as having a decent place to live, supportive services, and equality of opportunity. The Center has four goals:

Community membership – increasing access to Medicaid and private insurance coverage of mental health, enforcing fair housing laws and creating systems of care for children at risk of institutional or foster placement.

Self-determination and choice – calling for access to recovery-oriented mental health services, expanding use and recognition of advance directives for psychiatric care and encouraging the development of self-help networks.

Preserving protections and entitlements – the Americans with Disabilities Act, and in the shift to managed care, Medicaid-covered rehabilitation services.

National Association of Housing and Redevelopment Officials (NAHRO)

The National Association of Housing and Redevelopment Officials (NAHRO) is the leading housing and community development advocate for the provision of adequate and affordable housing and strong, viable communities for all Americans, particularly those with low and moderate incomes. It strives to strengthen the capacities of member Public Housing Agencies (PHAs) and helps to develop and deliver the highest quality products and services for housing and community development practitioners. NAHRO works to ensure that housing and community development officials have the leadership skills, education, information, and tools to serve communities in a rapidly changing environment. It advocates for the appropriate laws and policies, which are sensitive to the needs of the people served, are financially and programmatically viable for the industry, are flexible, and promote deregulation and local decision-making.

The Nation's Disability Rights Network

National Association of Protection and Advocacy Systems

The Protection and Advocacy (P&A) System and Client Assistance Program (CAP) comprise the nationwide network of congressionally mandated, legally based disability rights agencies. P&A agencies have the authority to provide legal representation and other advocacy services, under all federal and state laws, to all people with disabilities (based on a system of priorities for services). All P&As maintain a presence in facilities that care for people with disabilities, where they monitor, investigate and attempt to remedy adverse conditions. These agencies also devote considerable resources to ensuring full access to inclusive educational programs, financial entitlements, health care, accessible housing and productive employment opportunities.

National Disability Institute

National Disability Institute (NDI) is a national nonprofit based in Washington, DC dedicated to advancement of the social and economic freedom of Americans with disabilities. Affiliated with the National Cooperative Bank and NCB Development Corporation, NDI has provided expert advice, training, and technical assistance to the federal, local, and state government and related diverse stakeholders (public housing authorities, developers, disability-related organizations, lenders, families, and adults with disabilities) on varied strategies to expand affordable and accessible housing choices linked to services. Strategies include impacting federally required state and local housing plans, policy development, and demonstration activities.

National Low Income Housing Coalition (NLIHC)

The National Low Income Housing Coalition (NLIHC) is dedicated to ending America's affordable housing crisis. The NLIHC has five main goals. It seeks to increase public knowledge of low-income housing issues in order to increase public support for progressive low-income housing policy. It strives to make low income housing a priority issue on the federal political agenda. The NLIHC wants to create an increase in federally assisted housing as well as spur an increase in federal investment in low-income housing. Lastly, the NLIHC wants to see more low-income people engaged in self-advocacy on housing issues.

Opening Doors

Opening Doors is a joint effort by TAC and the Consortium for Citizens with Disabilities Housing Task Force (CCD Housing Task Force). The major part of this initiative is producing publications that are helpful to the entire disability community. This free newsletter is designed to provide important information on affordable housing issues to people with disabilities, their families, advocates, and service providers across the United States. Publication topics include understanding Section 8, rural housing development, accessibility, and responding to Olmstead.

Technical Assistance Collaborative (TAC)

TAC is a national organization that works to achieve positive outcomes on behalf of people with disabilities by providing state-of-the-art information, capacity building, and technical expertise to organizations and policymakers in the areas of mental health, substance abuse, human services, and affordable housing. TAC's multidisciplinary professional staff has worked extensively in the fields of affordable and supported housing. Their expertise spans the full range of federal and mainstream housing programs and policies that can expand affordable housing for people with disabilities and people who are homeless. Their website has an extensive downloadable set of publications that will help you understand strategies that will improve access to federal housing resources at state and local levels.

Helpful Organizations—Quick Links	
Resource	Web site
The ARC of the US	www.thearc.com
CHANCE	http://chance.unh.edu
Consortium for People with Disabilities	www.c-c-d.org/tf-housing.htm
The Corporation for Supportive Housing	www.csh.org
Fannie Mae	www.fanniemae.com
HUD	www.hud.gov
The Judge David L. Bazelon Center for Mental Health Law	www.bazelon.org
NAHRO	www.nahro.org
Nation's Disability Rights Network	www.protectionandadvocacy.com
National Disability Institute	www.ncbdc.org/pi_ndi.apx
NLIHC	www.nlihc.org
Opening Doors	www.tacinc.org/openingdoors.htm
Technical Assistance Collaborative Inc.	www.tacinc.org

Chapter 6: Local Delivery Systems and Accessing Services

Comprehensive Entry Points Make For a Seamless Transition

Systems for helping consumers access community services vary with the organization and structure of each state's HCBS system. Ideally, organizations that manage access to HCBS waiver programs offer a seamless transition from institutional to community services. States with

comprehensive entry point systems (CEPs) – also called single entry points, single point of entry, or one-stops – are more likely to facilitate transition from an institution to a community seamlessly. One of the key functions of a comprehensive entry point is to provide information to consumers, family members, professionals and provider organizations about the array of long-term care services and programs in a timely manner. Often consumers enter an institution because they are not aware of all of their community options or cannot access services in a timely manner. CEPs typically complete an assessment and determine functional (and sometimes financial) eligibility for long-term care services.⁴²

The assessment may be completed for consumers living in a community setting who need home and community-based services or are seeking admission to a nursing facility, or for consumers who recently entered a nursing home to determine their eligibility for Medicaid reimbursement and to prepare a plan to support the individual’s discharge to the community. In a Money Follows the Person context, CEPs help the individual choose a setting and service plan that best meets their needs and identify the funds that are available to implement their choice. In a sense, Money “Precedes” the Person in this context.

Registered nurses or social workers are able to determine functional eligibility, coordinate the determination of financial eligibility in the community and authorize HCBS for those who require them, minimizing the referrals and coordination that is needed when other organizations manage these functions. Depending on the structure of the CEP, nurses and social workers may be assigned to work only on transition activities. After a period in the community, the consumer is generally transferred to a community case manager for ongoing support.

Comprehensive entry point functions may be combined in a single agency or split among agencies. In most cases, a particular agency or organization is the CEP. In other cases, functions are split between agencies. For example, in Washington, the state agency performs the assessment, eligibility determination and service authorization while area agencies on aging implement the consumer’s care plan and provide ongoing case management. Other states may separate the information and screening functions from the authorization and care management activities. CEPs in a particular state may facilitate access to one or more, but not necessarily all, funding sources or programs.

In 2003, the Rutgers Center for State Health Policy/NASHP Community Living Exchange Collaborative conducted a survey of states to identify CEPs. The survey found 43 single entry points operating in thirty-two states and the District of Columbia. A CEP was defined as a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest forms, these organizations manage access to one or more funding sources and perform a range of activities that may include information and assistance, preliminary screening or triage, nursing facility preadmission screening, assessment of functional capacity and service needs, eligibility determination, care planning, service authorization, monitoring, and reassessment. The report is available at: <http://www.nashp.org/Files/SEPReport11.7.03.pdf>

⁴² “Functional” eligibility refers to health problems and the extent of help the consumer needs to manage basic activities (bathing, eating, toileting). Each state defines its own functional eligibility criteria or level of care criteria for admission to a nursing facility and participation in an HCBS waiver program.

The survey found that:

- 24 serve older adults, the population most commonly served by CEPs.
- 11 of the eighteen CEPs that serve a single population serve people with MR/DD only.
- 25 CEPs serve two or more populations.
- State agency field offices are the type of organization that most frequently acts as the CEP, followed by community-based nonprofits and Area Agencies on Aging.
- CEPs perform a range of functions. All CEPs develop care or individual service plans and monitor service delivery. Most also complete assessments, authorize services, and complete periodic reassessments. 17 CEPs determine financial and functional eligibility. 24 conduct nursing facility preadmission screening.
- 42 CEPs provide access to Medicaid home and community-based services funded programs, 35 provide access to programs funded by state general revenues, and 26 manage Medicaid state plan services. Most of the CEPs that serve older adults provide access to Older Americans Act funded services.

ADRCs

Beginning in 2003 with 12 states and adding more in 2004 and 2005, Aging and Disability Resource Centers (ADRCs) were funded in nearly every state by the Centers for Medicare & Medicaid Services and the Administration on Aging. ADRCs were designed to provide a recognizable point of contact for information and assistance about long-term support options. This includes programs such as SSI, disability assistance, housing, employment, and in-home services. ADRCs use a variety of strategies to increase awareness about service and program choices. They also refer and assist consumers to find the supports of their choice and help individuals determine whether they meet the functional and financial eligibility. ADRCs may also perform additional functions typically associated with a CEP system such as service authorization for specific programs and services, care management or care coordination and others. For more information about ADRCs, see: <http://www.adrc-tae.org>

Resources

Promising Practices in Long-Term Care Systems Reform: Colorado's Single Entry Point System. This 2003 report by Medstat describes Colorado's single entry point system. SEP agencies may be county departments of social service, county health departments, or private non-profit organizations. SEPs assess functional eligibility for Medicaid nursing home care, home health benefits provided for more than 60 days, five HCBS waivers, a Medicaid Research and Demonstration waiver providing self-directed services, and two state-funded programs.

Available at: <http://www.cms.hhs.gov/PromisingPractices/Downloads/coseps.pdf>

Colorado SEP regulations. Regulations governing single entry points. Available at: http://www.chcpf.state.co.us/HCPF/Pdf_Bin/390_sep.pdf

New Jersey Community Choice Initiative. Describes New Jersey's system for providing information and assistance to people in nursing homes. Available at:
http://www.hcbs.org/files/67/3317/New_Jersey_-_Single_Access_Point_updated.pdf

Rebalancing long-term care. This paper by Reinhard and Fahey describes New Jersey's approach to balancing institutional and community services. Available at:
<http://www.hcbs.org/files/19/947/rebalancingnewjersey.htm>

Review of IT Systems for Single Point of Entry. This Rutgers Center for State Health Policy/NASHP Community Living Exchange Brief describes results from a survey of selected state information technology systems that support the provision of information and assistance to individuals seeking long-term supports. Available at:
http://www.hcbs.org/files/47/2307/ITSSPE_060104.pdf

Aging Services Access Points. This statute formalized the Massachusetts' single entry point structure. Available at: <http://www.hcbs.org/files/20/996/Massachusettssepegislation.doc>

Illinois promising practice. This brief summarizes the state's Care Coordination Unit model for providing simplified access to HCBS waiver and Older Americans Act services. Available at:
http://www.hcbs.org/files/67/3311/Illinois_-_Simplified_Access_Updated.pdf

Wisconsin family care report. This Medstat case study describes the development and operation of the state's family care program. Available at:
http://www.hcbs.org/files/41/2037/WI_final.doc

Redesigning Long-Term Care Systems through Integrated Access and Services. This RTI report describes roles of the aging services network in home and community-based service programs in California, Maine, Massachusetts and Ohio. Available at:
http://www.hcbs.org/files/58/2861/Access_and_Services.pdf

Family Care Evaluation. This evaluation of Wisconsin's Family Care Program was prepared by the Lewin Group in 2003 for the Wisconsin Legislative Audit Bureau. Available at:
<http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf>

Wisconsin ADRCs. This promising practice describes Wisconsin's Aging and Disability Resource Center model for providing comprehensive information about long-term services and programs. Available at: http://www.hcbs.org/files/38/1859/WI_ResourceCenters_rev.rtf

Oregon's HCBS System. This promising practices report by Medstat describes the state of Oregon's HCBS system. Available at:
<http://www.cms.hhs.gov/PromisingPractices/Downloads/orhcbss.pdf>

South Carolina's HCBS System. This promising practices report by Medstat describes the state of South Carolina's HCBS system. Available at:
<http://www.cms.hhs.gov/PromisingPractices/Downloads/scsop.pdf>

Vermont’s HCBS System. This promising practices report by Medstat describes the state of Vermont’s HCBS system. Available at:

<http://www.cms.hhs.gov/PromisingPractices/Downloads/vthcbss.pdf>

Common Factors of Systems Change. This 2004 promising practices report by Medstat describe common factors in systems change efforts across a number of states. Available at:

<http://www.cms.hhs.gov/PromisingPractices/Downloads/commonfactors.pdf>

Washington report. The States in Action brief describes how Washington included nursing home transition as an important component of their comprehensive long-term care system.

Available at: <http://www.hcbs.org/files/80/3967/WAsitevisitsummaryfinalLPWEB.pdf>

Streamlining Access. This Rutgers Center for State Health Policy/NASHP Community Living Exchange Issue Brief describes Washington’s approach to streamlining access to home and community-based services. Available at: <http://www.hcbs.org/files/76/3769/Wash.pdf>

Home and Community-based Services in Seven States. A report of the major features of the home and community-based services system for older people and younger adults with physical disabilities in Alabama, Indiana, Kentucky, Maryland, Michigan, Washington, and Wisconsin. The report covers financing of services; administrative systems; eligibility, assessment, and case management structures; the services provided; and quality assurance. Available at:

http://www.hcbs.org/files/7/335/7states_wiener.pdf

Point of Entry Systems for Long-Term Care: State Case Studies. This report from the New York City Department of Aging describes models for constructing SEPs and their strengths and challenges. Available at: http://www.hcbs.org/files/58/2856/ltc_state_case_studies.pdf

Memorandum of Agreement. This document was developed by the Florida Department of Elder Affairs to describe the roles and responsibilities of the state agency and local ADRCs.

Available at: http://www.hcbs.org/files/79/3942/State_MOA.doc

Long-Term Care: A Single Entry Point for Three Populations. A paper prepared by the Legislative Reference Bureau in Hawaii which was directed by the legislature to determine the merits of establishing a single entry point for long-term care services used by elderly adults and families of disabled children and disabled younger adults in Hawaii. Available at:

<http://www.hawaii.gov/lrb/rpts95/ltc/ltdoc.html>

Ohio timely access. Promising practice paper on electronic communication between case managers and providers. Available at:

<http://www.cms.hhs.gov/PromisingPractices/Downloads/ohita.pdf>

Delivery System Resources—Quick reference	
Resource	Web site
Rutgers/NASHP CEP study	http://www.nashp.org/Files/SEPReport11.7.03.pdf
ADRC information	http://www.adrc-tae.org
Colorado promising practice	http://www.cms.hhs.gov/PromisingPractices/Downloads/coseps.pdf
Colorado CEP regulations	http://www.chcpf.state.co.us/HCPF/Pdf_Bin/390_sep.pdf

New Jersey Community Choice	http://www.hcbs.org/files/67/3317/New_Jersey_-_Single_Access_Point_updated.pdf
Rebalancing LTC: New Jersey	http://www.hcbs.org/files/19/947/rebalancingnewjersey.htm
CEP IT systems report	http://www.hcbs.org/files/47/2307/ITSSPE_060104.pdf
Massachusetts CEP Statute	http://www.hcbs.org/files/20/996/Massachusettssepegislation.doc
Illinois promising practice	http://www.hcbs.org/files/67/3311/Illinois_-_Simplified_Access_Updated.pdf
Wisconsin family care report	http://www.hcbs.org/files/41/2037/WI_final.doc
Redesigning LTC systems report	http://www.hcbs.org/files/58/2861/Access_and_Services.pdf
Wisconsin ADRCs	http://www.hcbs.org/files/38/1859/WI_ResourceCenters_rev.rtf
Family Care Evaluation	http://www.legis.state.wi.us/lab/reports/03-0FamilyCare.pdf
Oregon HCBS system	http://www.cms.hhs.gov/PromisingPractices/Downloads/orhcbss.pdf
South Carolina HCBS	http://www.cms.hhs.gov/PromisingPractices/Downloads/scsop.pdf
Vermont HCBS	http://www.cms.hhs.gov/PromisingPractices/Downloads/vthcbss.pdf
Common factors in systems change	http://www.cms.hhs.gov/PromisingPractices/Downloads/commonfactors.pdf
Washington report	http://www.hcbs.org/files/80/3967/WAsitevisitsummaryfinalLPWEB.pdf
Streamlining Access: Washington	http://www.hcbs.org/files/76/3769/Wash.pdf
HCBS in seven states report	http://www.hcbs.org/files/7/335/7states_wiener.pdf
CEP case studies (NY)	http://www.hcbs.org/files/58/2856/ltc_state_case_studies.pdf
Memorandum of Agreement	http://www.hcbs.org/files/79/3942/State_MOA.doc
Hawaii Single entry point paper	http://www.hawaii.gov/lrb/rpts95/ltc/lctdoc.html
Ohio timely access	http://www.cms.hhs.gov/PromisingPractices/Downloads/ohita.pdf

Chapter 7: Financing and Budget Issues

Funding an MFP strategy depends on the state’s overall budget structure and process and the features of the state’s Medicaid eligibility criteria and service coverage.

Budgeting strategies

Global budgets and program transfers are the primary approaches. A few states combine funding for nursing homes and HCBS in a single “global” budget.

Washington

Budgets for long-term care services in Washington are based on caseload forecasts prepared by an independent Caseload Forecasting Council. The Council projects and adjusts the expected caseloads for nursing home and home and community-based service programs for elders and adults with physical disabilities. The council consists of two individuals appointed by the governor and four individuals who are appointed by the House and Senate leadership. A member of the legislature chairs the Council. The forecast is submitted to the legislature and becomes the basis for determining the Governor’s budget for nursing home spending, home and community services programs and case managers and is used by the legislature to develop the budget.

Projections are based on historical trends and changes in policy that affect eligibility or the amount of services that may be authorized. Caseloads are projected for each month of the biennium. The home care caseload is expected to grow 3.0% from June 2005 to June 2006 and 2.9% from June 2006 to June 2007. The Medicaid nursing home caseload will decline 2.9% each year and the Medicaid personal care state plan caseload will rise 4.2% and 4.4% respectively. See Table 1.

Month	HCBS		Nursing home		State plan personal care	
	Caseload	Percent	Caseload	Percent	Caseload	Percent
July 1997	24,524	--	14,815	--		
June 1998	26,748	9.1%	14,363	-3.1%		
June 1999	28,296	5.8%	13,853	-3.5%		
June 2000	30,201	6.7%	13,685	-1.3%	3,404	--
June 2001	31,307	3.3%	13,290	-2.9%	4,045	18.8%
June 2002	32,979	5.7%	13,002	-2.2%	4,866	20.3%
June 2003	34,404	4.3%	12,726	-2.1%	5,466	12.3%
June 2004	34,993	1.7%	12,273	-3.6%	5,710	4.5%
June 2005	35,844	2.4%	11,979	-2.4%	5,995	5.0%
June 2006	36,919	3.0%	11,637	-2.9%	6,264	4.2%
June 2007	37,987	2.9%	11,295	-2.9%	6,516	4.4%

Oregon

Oregon uses a similar approach. The Governor’s Office and the Legislature set the total amount that will be spent on long-term care based on caseload projections for the programs covered.⁴⁴ Lower spending for nursing home services means that savings can be used to serve more people in community settings. The Department of Human Services is responsible for projecting caseloads, setting provider rates and managing expenditures. Spending is monitored by the Governor’s budget office.

Budget Transfer Strategy

Texas

Texas uses a budget transfer approach to fund the “promoting independence initiative.” Passed by the legislature in 2001, funds are transferred from the nursing home account to the HCBS account as consumers move from nursing homes to the community. The budget process groups budgets into “strategies.” Nursing home and hospice comprise one strategy; HCBS

⁴³ Data obtained by the author from Washington’s Aging and Disability Services Administration. Caseload data are available via the internet at: <http://www.cfc.wa.gov/Data.htm>

⁴⁴ Information on state budget practices is based on Hendrickson, L. & Reinhard, S. (2004, November). *Global Budgeting. Promoting Flexible Funding to Promote Long-Term Care Choices*. New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. Available at: <http://www.cshp.rutgers.edu/cle/products/ReinhardHendricksonGlobalBudget.pdf>

programs are a separate strategy. Funds may be transferred between accounts or strategies but the process is cumbersome. Rider 28 authorized the transfer of funds without going through the normal process to request transfers.

Funds are transferred quarterly based on the number of beneficiaries who relocate and the cost of their services during the quarter. Consumers served through the initiative are tracked separately from other HCBS participants. The transfer does not permanently increase the number of HCBS waiver slots. Individuals are dropped from the transfer calculation when they no longer receive home and community-based services.

Vermont

In Vermont, stakeholders and the Department of Disability, Aging and Independent Living (DAIL) worked with the legislature to increase choice, shift the policy emphasis and obtain funding to expand home and community-based services in order to slow the growth of nursing home spending. Act 160 directed the Department on Aging and Disabilities to reduce nursing home spending in FY 1997 through FY 2000. The reductions required a drop in the Medicaid census of 46 beds in FY 1997; 68 beds in FY 1998; 59 beds in FY 1999; and 61 beds in FY 2000. The Act gave the Secretary of Human Services the authority to reduce the supply of nursing homes:

...if it develops a plan to assure that the supply and distribution of beds do not diminish or reduce the quality of services available to nursing home residents; force any nursing home resident to involuntarily accept home and community-based services in lieu of nursing home services; or cause any nursing home resident to be involuntarily transferred or discharged as the result of a change in the resident's method of payment for nursing home services or exhaustion of the resident's personal financial resources.

At the end of the fiscal year, unspent funds in the nursing home appropriation were placed into a trust fund that could be used to expand home and community-based services or to support other efforts to reduce the number of nursing home beds. The law gave priority to nursing home residents who wanted to relocate to a community setting, anyone on a waiting list who was at the highest risk of admission to a nursing home, others at high risk, and people with the greatest social and economic need.

Act 160 enabled DAIL to create 685 additional HCBS Waiver slots; increase rates to Adult Day Centers, facilitating the development of increased capacity; increase the rates to personal care attendants; develop and support ten community Long-Term Care Coalitions; reduce the waiting list for the Attendant Services Program; raise case management rates; develop and support the Housing and Supportive Services program in congregate housing settings; raise rates in the Enhanced Residential Care Waiver; provide flexible funds to fill critical service gaps not covered by other programs; and increase the funding for home modifications by \$100,000.

Wisconsin

A budget transfer approach was used for just a few years in Wisconsin. At the end of each fiscal year, the Medicaid office calculated the number of nursing home days that were paid by Medicaid compared to the previous fiscal year. If the days for the most recent year were less

than the previous year, the difference was multiplied by the average nursing home payment and a request was submitted to the legislature to transfer the resulting amount to HCBS waiver programs. The process resulted in transfers for two years but eventually “savings” were used to offset declining revenues and the transfer process did not continue.

Maryland

In 2003, the Maryland legislature passed what was considered to be a “money follows the person” bill. The legislation allows nursing home residents paid by Medicaid for 30 days to receive waiver services even if there is a waiting list for applicants from the community. The bill provides:

(A) The Department may not deny an individual access to a home and community-based-services waiver due to a lack of funding for waiver services if:

- (1) The individual is living in a nursing home at the time of the application for waiver services;
- (2) The nursing home services for the individual were paid by the program for at least 30 consecutive days immediately prior to the application
- (3) The individual meets all the eligibility criteria for participation in the home and community-based services waiver; and
- (4) The home and community-based services provided to the individual would qualify for federal matching funds.

SECTION 2. AND BE IT FURTHER ENACTED, That on or before September 1, 2003, the Department of Health and Mental Hygiene shall notify all nursing home residents whose nursing home services were paid for by the Maryland Medical Assistance Program for at least 30 consecutive days prior to the application for home-and community-based services about the opportunity to apply for participation in a home- and community-based services waiver.

Resources	
Resource	Web Site
Global Budget paper (Hendrickson/Reinhard)	http://www.cshp.rutgers.edu/cle/products/ReinhardHendricksonGlobalBudget.pdf
Texas Promoting Independence	http://www.dads.state.tx.us/business/pi/mfp_grant/Promoting_Independence_overview.pdf
Vermont Choices for Care	http://www.dad.state.vt.us/1115waiver/1115default.htm
Vermont Act 160 report	http://www.dad.state.vt.us/Reports/Act160pages/Legisl_RptJan00.html
Wisconsin waiver manual	http://dhfs.wisconsin.gov/ltc_cop/waivermanual/TOC%20COP%2011%202005.pdf
Wisconsin NFT summary	http://www.cms.hhs.gov/PromisingPractices/Downloads/wi-hcbsav.pdf
Maryland MFP bill	http://mlis.state.md.us/2003rs/billfile/hb0478.htm

Chapter 8: Evaluating, Sustaining and Expanding Programs

Planning for Evaluation

The beginning phase of any project is consumed by hiring and training staff, building the infrastructure to carry out the activities, and working with stakeholders on program design and operations. The project will generally operate for several years. In the beginning, there is little time to think about what happens when the project ends, who will decide whether to sustain it, how the decision will be made and what information will be needed to support the decision. States need to develop a plan to evaluate or monitor the program at the beginning of the project. Evaluation and continuation are a critical component to include in the initial design and implementation.

Discuss data to be collected and analyzed before the project begins

Nursing home transition project staff strongly recommend that program staff meet with the people who will be collecting and analyzing the data before the project begins. There should be extensive discussion about the expected achievements of the program and the questions that will be asked by policy makers, governor's office staff and legislators to consider whether and how the program will be continued after the demonstration period.

Anticipate questions from decision makers

Anticipating the questions that will be asked by decision makers helps project managers, operations and field staff and data management staff consider the data that should be collected, the availability of the information from existing reporting systems and consequent modifications or new data collection methods that may be needed. Discussing the expected or anticipated outcomes with decision makers is important to shape the design of the project, identify differences in expectations among state officials, stakeholders and consumers and to make sure that project staff understand what information will be useful to determine the future of the initiative. Among the possible expectations are:

- A reduction in nursing home spending;
- Reduced growth of nursing home spending;
- Reduction in nursing home occupancy rates;
- Reduction in Medicaid paid bed days;
- Fewer conversions from Medicare or private pay to Medicaid;
- Reduced lengths of stay for Medicaid beneficiaries;
- Reduced nursing home capacity due to reduced occupancy.

Once the expectations of decision makers are clear, they should be related to the data that is available to monitor and document the project's impact and, if necessary, there should be a commitment to devote sufficient time and resources to obtaining the data.

Give careful consideration to measuring outcomes

Potential problems with measuring trends

The scope of the project will affect the ability to achieve these outcomes, especially if the project operates in a limited geographic area. Tracking statewide trends to determine the impact of a project that operates in a small number of counties or geographic areas limits the ability to measure the impact. Outcome measures and trends should be tracked in the areas affected by the project and compared with areas that are not affected by the project.

Defining “transition”

One early question to address is the definition of a “transition.” A significant percentage of the people who enter a nursing home have only a short term rehabilitative stay. Nursing home social workers often arrange the discharge plan and the consumer is not at risk for a lengthy Medicaid stay. Other consumers enter a nursing home, lose their community residence, convert to Medicaid and languish in a nursing home when other options are available. In the middle are consumers who might enter the nursing home for a temporary stay but face barriers to returning to the community. Nursing home discharge planning staff may not be aware of the array of service options available, especially for consumers who are dually eligible. Intervention by staff who are familiar with community resources can help the consumer and the nursing home social service staff arrange community services for someone who, without the intervention, was likely to convert to Medicaid.

Policy staff seek to count consumers whose nursing home stay is paid by Medicaid, or will be paid by Medicaid within a specified period if assistance is not provided to help the consumer develop and implement a plan to move to the community.

The MFP demonstration recognizes, for purposes of the enhanced match, Medicaid beneficiaries who have resided in a nursing home for at least six months, or up to 2 years as determined by the state. The six month to two years is the minimum length of stay threshold. States may receive the enhanced match for people who lived in a nursing home for longer periods of time.

Other data elements that might be collected include:

- Number of people receiving assistance to transition;
- Number of people transitioned each month;
- Age of consumers who move;
- Living arrangement in the community;
- Length of stay in the nursing home and community-based services;
- Length of time the person remains in the community (active and closed case);
- Number of consumers that do not use Medicaid services after relocation;
- Barriers to relocation;
- Length of time to complete the relocation; and
- Utilization of HCBS, state plan and other services.

Consumer satisfaction

States may also want to conduct consumer satisfaction surveys to obtain participant feedback on the transition process and their satisfaction with the quality of service and the quality of life in the community compared to what it was in the nursing home. Connecticut used this approach in their evaluation of their transition program.

Potential problems with cost data

Policy makers and budget officials will be interested in the number of people transitioned, the impact on Medicaid nursing home occupancy and the impact on Medicaid spending. Some staff are interested in collecting and comparing all Medicaid spending for nursing home residents and consumers who move to the community. The Washington Aging and Disability Services Administration and the New Jersey Department of Health and Senior Services collected total Medicaid spending for people who moved to the community and received HCB waiver services and found that the difference was so minimal that it was not worth the effort to extract and analyze the data.

Medicaid community and nursing home spending trends may be affected by factors that are unrelated to the relocation of beneficiaries to the community. Nursing home rates may receive a larger increase than HCBS providers. Provider taxes raise the amount that is claimed for nursing home expenditures but may not increase what is actually spent. Another barometer of the impact of relocation initiatives is the number of Medicaid nursing home bed days and the number of HCBS waiver participant days. This comparison is also limited. A significant number of people transitioned in Massachusetts, Michigan and New Jersey did not receive any Medicaid services after they moved. Others received state plan personal care or other services which are not reflected in number of HCBS participant days.

Communicating Results

The power of individual stories and experiences

Staff project staff and policy makers with experience with nursing home transition noted the importance of collecting individual stories and experiences from people who have made the transition successfully.

Target to audience

Project staff will need differential communication strategies depending on the audience – governor's staff, budget staff, legislators and staff, policy makers and stakeholders. One state held a series of meetings with the editorial boards of local newspaper to market the program and describe the impact it has on the lives of real people. Legislators may respond better to fact sheets that briefly describe the program, explain who is served, what it costs and the impact on consumers and Medicaid spending. Budget officials may want more detailed reports on the number of people served, the cost and spending trends. Policy makers may prefer brief 1-2 summaries that describe what the program is, who is served, how it is managed and operated, and where it fits with the organizations overall mission and strategic plan.

Resources

Systems change grant program Nursing Facility Transition Initiatives for the FY 2001 and 2002 Grantees

This report by RTI International describes 18 NFT programs and includes information on administrative and legal barriers; identifying and working with residents; collaborating with key stakeholders; developing and implementing pre- and post-transition service coordination; identifying and addressing housing needs and payment sources; and funding mechanisms.

Available at: http://www.hcbs.org/files/74/3655NFT_final.htm

Nursing Facility Transition Grantee Annual Report Data

This report provides analysis of NFT grantees annual reports (2002-2003). It includes aggregate data on the number of people who left or where diverted from a nursing facility, transition costs, length of nursing facility stay prior to transition, type of housing after transition, and age at time of transition.

Available at: <http://www.hcbs.org/files/73/3612/NFTannualreportdata062005.pdf>

States in Action: Building Nursing Home Transition into a Balanced Long-Term Care System: The Washington Model

This technical assistance document is a summary of a site visit to the state of Washington in April 2003 organized by the Rutgers/NASHP Community Living Exchange. Thirteen representatives from Nursing Home Transition Grantees from Alaska, California, Delaware, Indiana, Maryland, Massachusetts and New Jersey participated in the site visit.

Available at: <http://www.hcbs.org/files/20/967/WAsitevisitsummaryfinal.doc>

Promising Practices in HCBS

Eight reports in the Promising Practices in HCBS series developed by The MEDSTAT Group for CMS highlight promising practices in moving to the community.

Available at: <http://www.cms.hhs.gov/promisingpractices/moving.asp>

Case Studies of Nursing Facility Transition Programs

Nine reports describing the experiences and lessons learned from NFT grantees were prepared by The MEDSTAT Group for the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy.

Available at: <http://www.aspe.hhs.gov/daltcp/projects2.shtml#MEDSTAT15>

Sustaining New Jersey's Evolving Community Choice Counseling Program

This report by the Rutgers/NASHP Community Living Exchange describes the statutory foundations and current operations of New Jersey's nursing home transition program.

Available at: <http://www.cshp.rutgers.edu/cle/Products/NJCCCWEB.pdf>

Meeting Summary: Sustaining Nursing Home Transition

This report by Rutgers Center for State Health Policy summarizes a summit of Nursing Home Transition grantees convened in September 2005 in New Jersey to discuss strategies for sustaining the programs.

Available at: <http://www.cshp.rutgers.edu/cle/Products/NHTSummitNJSept05WEB.pdf>

Evaluating Nursing Home Transition in Michigan

This brief, by the Rutgers/NASHP Community Living Exchange, describes how Michigan evaluated its Nursing Home Transition Initiative.

Available at: <http://www.cshp.rutgers.edu/cle/Products/MichiganNHTfinalWEB.pdf>

Sustaining Nursing Home Transition in Connecticut

This brief, by the Rutgers/NASHP Community Living Exchange, describes how Connecticut stakeholders worked collaboratively to secure ongoing state funding for nursing home transition.

Available at: <http://www.cshp.rutgers.edu/cle/Products/SustainingNHTinCTWEB.pdf>

Delaware Passport to Independence: An Analysis of Programs and Services Provided (2003-2005)

This evaluation of Delaware's Nursing Home Transition Program was done by Rutgers Center for State Health Policy.

Available at: <http://www.cshp.rutgers.edu/Downloads/6190.pdf>

Current Living Situation and Service Needs of Former Nursing Home Residents: An Evaluation of New Jersey's Nursing Home Transition Program

This evaluation was done by Rutgers Center for State Health Policy.

Available at:

<http://www.cshp.rutgers.edu/cle/products/CurrentLivingSituationNJsNHTprogramWEB.pdf>

Resources	
Resource	Web site
RTI NFT grant report	http://www.hcbs.org/files/74/3655NFT_final.htm
NFT grantee annual reports	http://www.hcbs.org/files/73/3612/NFTannualreportdata062005.pdf
Washington site visit report	http://www.hcbs.org/files/20/967/WAsitevisitsummaryfinal.doc
Promising practices	http://www.cms.hhs.gov/promisingpractices/moving.asp
NFT Case studies	http://www.aspe.hhs.gov/daltcp/projects2.shtml#MEDSTAT15
Sustaining New Jersey's CCC program	http://www.cshp.rutgers.edu/cle/Products/NJCCCWEB.pdf
Meeting Summary: Sustaining NHT	http://www.cshp.rutgers.edu/cle/Products/NHTSummitNJSept05WEB.pdf
Evaluating NHT in Michigan	http://www.cshp.rutgers.edu/cle/Products/MichiganNHTfinalWEB.pdf
Sustaining	http://www.cshp.rutgers.edu/cle/Products/SustainingNHTinCTWEB.pdf

NHT in Connecticut	
Delaware Passport to Independence: Analysis	http://www.cshp.rutgers.edu/Downloads/6190.pdf
Evaluation of New Jersey's NHT program	http://www.cshp.rutgers.edu/cle/products/CurrentLivingSituationNJsNHTprogramWEB.pdf

Appendix 1:

New Jersey's Independence, Dignity and Choice in Long-Term Care Act

Accessed August 28, 2006 from: http://www.njleg.state.nj.us/2006/Bills/PL06/23_.PDF

CHAPTER 23

AN ACT concerning long-term care for Medicaid recipients and supplementing Title 30 of the Revised Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.30:4D-17.23 Short title.

1. This act shall be known and may be cited as the "Independence, Dignity and Choice in Long-Term Care Act."

C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.

2. The Legislature finds and declares that:

a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;

b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;

c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;

d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;

e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in *Olmstead v. L.C.* and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;

f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health and Senior Services, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global long-term care budgeting process designed to provide the Department of Health and Senior Services with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;

g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;

h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and

i. The enactment of this bill will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.

3. As used in this act:

"Commissioner" means the Commissioner of Health and Senior Services.

"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.

"Home and community-based care" means Medicaid home and community-based long-term care options available in this State, including, but not limited to, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid

expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner, in consultation with the Commissioner of Human Services, shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) the provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and

(b) the use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and

(2) commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. no later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and

b. no later than January 1, 2008, present a report to the Governor, and to the Legislature

pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community based long-term care options available to Medicaid recipients; and annual percentage changes in both long-term care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;

b. Commence the following no later than January 1, 2008:

(1) implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;

(2) identify home and community based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;

(3) develop and implement with the Commissioner of Human Services a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and

(4) develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and

c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.

7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Health and Senior Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the

Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health and Senior Services, Human Services and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.

b. The advisory council shall:

(1) monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and

(2) develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.

c. The advisory council shall comprise 15 members as follows:

(1) the commissioner, the Commissioner of Human Services and the State Treasurer, or their designees, as ex officio members; and

(2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.

d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.

e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

C.30:4D-17.30 Waiver of federal requirements.

8. The Commissioner of Human Services, with the approval of the Commissioner of Health and Senior Services, shall apply to the federal Centers for Medicare and Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

C.30:4D-17.31 Tracking of expenditures.

9. The commissioner, in consultation with the Commissioner of Human Services, shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.

10. There shall be included a unique global budget appropriation line item for Medicaid

long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.

11. This act shall take effect immediately.

Approved June 21, 2006.