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Diversion and Transition Services in the U.S. Promising Practices and Options for the Future

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Executive Summary

The Deficit Reduction Omnibus Reconciliation Act of 2005 became law in February 2006. While it has many controversial provisions, it provides some exciting new tools that can help states to increase community opportunities for elders and people with disabilities. The act authorizes a new home care option under Medicaid that allows states to increase access to home care without linking it to current definitions of nursing home eligibility. The new state plan option will allow states to tighten nursing home eligibility while maintaining the option to serve individuals in the community. Additional provisions include: a new state plan option for self-directed personal assistance services, a new “money-follows-the-person” pilot project, and a demonstration project to provide home and community-based alternatives to psychiatric residential treatment facilities for children.

While the debate on this bill was in progress, the Center for Health Policy and Research at the University of Massachusetts Medical Center was in the process of developing a report identifying barriers that prevent or inhibit individuals from accessing supports in the community and options for expanding diversions and transitions from nursing facilities. The report describes programs in various states whose primary purpose is nursing facility diversion or transition and identifies promising practices that have helped states divert or transition individuals from nursing facilities. Drawing upon those experiences, the report provides a variety of recommendations for states to consider in addressing the barriers and strengthening efforts to divert and transition individuals from nursing facilities. In light of the new options, this report has been refined for use by a variety of states as they take their next steps toward expanding community options for people with disabilities.

Barriers to Diversion and Transition

There are several factors that increase the likelihood that individuals will use institutionally-based long-term care service rather than accessing such supports in community-based settings. The report identifies five critical factors:

- Lack of knowledge about available community-based supports
- Restrictive Medicaid eligibility rules coupled with a lengthy eligibility process for community supports
- Complex medical, psychiatric, and substance abuse issues related to individuals
- Lack of affordable, accessible housing
- Insufficient diversion/transition activities

Diversion and Transition Activities across the Country

States implement a wide variety of approaches to divert or transition individuals from nursing facilities. For this report, models are organized into seven categories and specific

state examples are included for each. The unique elements of each state's model are described in the body of the report.

1. Nursing facility screening – Washington, Massachusetts, Oregon, Maine, Wisconsin, Pennsylvania and Vermont
2. Expediting access to community supports – Washington, Vermont and Colorado
3. Education on community options – Indiana, New Hampshire, Maryland, Washington and Utah
4. Care coordination – Oregon, Washington, New Jersey, Kansas, Massachusetts, and Texas
5. Funding for transition costs – Washington, New Jersey and Michigan
6. Financing mechanisms that rebalance long-term support systems – Vermont, Wisconsin and Texas
7. Supportive housing options – Vermont, Oregon, and Massachusetts

Recommendations

Based upon the review of programs across the country, the report offers a number of recommendations for consideration. The recently passed Deficit Reduction Act will provide critical new options to help states advance to the next stage in their strategic planning process and to engage key stakeholders in the discussion and development of approaches to enhance opportunities for elders and people with disabilities to live in the community. The following recommendations include a variety of options for consideration.

Recommendation 1: Increase public awareness about available community options

Lack of knowledge about community options was identified as one of the key barriers to nursing facility diversion and transition. Although many states have addressed this through nursing facility preadmission screening programs, additional opportunities were identified to improve access to information that supports diversion:

Specific options to consider:

- a) Develop proposed legislation that articulates the philosophical commitment to a policy that promotes community options for people of all ages with disabilities
- b) Educate hospital staff and patients regarding long-term support options
- c) Replicate the successful features of the Aging and Disability Resource Center model
- d) Screen all nursing facility residents who may become eligible for Medicaid in 90 days
- e) Use the nursing facility Minimum Data Set (MDS) assessment information to identify potential candidates for transition from nursing facilities
- f) Use the Nursing Home Preadmission Screening/Resident Review (PASRR) processes for persons with mental retardation and serious mental illness to more effectively reinforce diversion/transition goals

Recommendation 2: Expedite eligibility for community-based services

The process of determining eligibility for community-based services and for receiving authorization for such services is much slower than that for eligibility and approval for nursing facility care. Consequently, individuals who need immediate access to long-term support are sometimes placed in nursing facilities when community options might be available. Moreover, individuals who are ready to transition out of nursing facilities may remain longer than needed or face delays in start-up of other medical services when they return to the community.

Specific options to consider:

- a) Amend Home and Community-based Services (HCBS) waivers to allow states to presume financial eligibility for Medicaid for up to 60 days to facilitate access to HCBS
- b) Reduce Medicaid processing time for redetermining eligibility when an individual seeks to leave a nursing facility and return to the community
- c) Expedite access to personal care assistance and durable medical equipment, key supports for individuals transitioning from nursing facilities

Recommendation 3: Increase care coordination services for targeted groups

Some individuals with disabilities also have co-occurring medical, psychiatric, and substance abuse issues. Care coordination services targeted to the needs of these individuals can often help them to remain in the community. In addition, many care coordinators in existing programs need access to additional clinical consultation services in order to address the multiple chronic conditions of the individuals they serve.

Specific options to consider:

- a) Devote additional resources to care coordination
- b) Enhance clinical support (including mental health consultation) to assist care coordinators in diversion and transition activities

Recommendation 4: Increase transitional housing options and assistance that links housing and supportive services

The lack of accessible and affordable housing and lack of coordination between housing and supportive services are among the most significant challenges to increasing community living options. Although it was beyond the scope of this report to review the variety of housing options available across the country, the report did

identify a housing initiative whose primary purpose was assisting with transition of individuals from nursing facilities to the community.

Specific option to consider:

- a) Explore implementing transitional housing models through the Congregate Housing Program or other housing programs

Recommendation 5: Increase incentives for diversion and transition

Although many states have begun to cover transition services in their Medicaid home and community-based services waivers, review of existing models revealed several additional opportunities to increase diversion/transition opportunities.

Specific options to consider:

- a) Use a combination of Medicaid and state funds to expand support for diversions and transitions
- b) Explore innovative funding mechanisms that encourage diversion and transition

In addition to the specific recommendations that address the various barriers to community living, the report identified a need for clarification of definitions in order to more effectively measure the success of diversion and transition activities. Therefore, the report also recommends that states develop and implement a consistent method for measuring diversion and transition activities.

Long-term support providers in all settings have an interest in working together to offer a wide range of choices to meet consumer preferences. This report offers a variety of strategies states can consider to increase or strengthen their diversion/transition activities to ensure that the community is indeed the first option for those seeking long-term supports.

Diversion and Transition Services in the U.S.: Promising Practices and Options for the Future

I. Background

Any individual may need assistance with personal care or other daily activities due to a developmental disability, accident, or illness. Yet, as a society, we have not prepared well for this reality. Until recently, long-term supports have been mainly provided within the family. When the family could no longer provide enough support, individuals were “placed” in institutions. Homes and communities were not designed for easy physical accessibility, and insurance rarely covered supports provided to individuals at home. However, growing awareness about nursing facility alternatives and strong advocacy from elders and people with disabilities have helped to focus increasing attention and resources on providing long-term supports at home and in the community. The growth of community supports has made it possible to divert many individuals from nursing facilities or other institutions and to help many others to return home after a temporary institutional stay.

Over the last two decades, many states have been working to transform their systems of long-term support from reliance on institutions to promotion of community living. The efforts to ensure that people can remain in the community have arisen in response to the needs of specific populations and to more far-reaching state and federal laws and policy concerns as well as in response to pressure for cost containment. In addition to broader efforts to support people in the community, such as the Home and Community-based Services (HCBS) waivers, other targeted programs that focus specifically on diverting and transitioning people from nursing facilities have been created to address the problem of institutional bias in a more focused way. Over time, a number of programs have evolved to address the needs of various groups.

In the past 20 years, public funding for home and community-based long-term supports has increased steadily across the country. Nationwide, Medicaid home and community-based services expenditures increased from less than \$1 billion in 1982 to \$13.3 billion in 2002. During the same period, Medicaid HCBS recipients increased from 1,381 to 378,566 recipients (Lakin and Prouty, 2003).

In 1999, the Supreme Court issued a ruling under the Americans with Disabilities Act (ADA) that required states to provide long-term supports in the most community-integrated setting. In *Olmstead vs. L.C.*, the Court stated that “unjustified isolation...is properly regarded as discrimination based on disability”. The ruling requires states to provide community-based supports for people with disabilities as alternatives to care in facilities when 1) the state’s treatment professionals have determined that community placement is appropriate, 2) the transfer to care in a less restrictive setting is not opposed by the affected individual, and 3) the placement can be reasonably accommodated, taking into account the resources

available to the state and needs of others. This court decision was followed by a Presidential Executive Order called the New Freedom initiative in 2001 and by a series of “systems change” grants from the Centers for Medicare and Medicaid Services. These initiatives and decisions have provided additional incentives to encourage states to increase opportunities for community living.

As part of its work for a particular state, the Center for Health Policy and Research at the University of Massachusetts Medical School (UMMS/CHPR) began work in the spring of 2005 to identify opportunities for enhancing its diversion and transition activities. However, once the report was completed, it was obvious that it could be helpful to many other states looking for similar information to identify promising diversion and transition approaches. Therefore, the report was refined to provide information in a more generic format.

While all home and community-based waiver services offered under Medicaid 1915c waivers are designed to enable states to divert or deinstitutionalize individuals from institutions, the focus of this report was not on description of the basic HCBS waiver programs. Rather, the intent of this review was to focus on practices whose **primary purpose** was to facilitate the process of diversion from nursing facility placement or transition back to a community setting.

To address this objective, UMMS/CHPR reviewed published literature and other unpublished documents about diversion and transition practices in a variety of states. UMMS/CHPR also conducted interviews with key informants and program staff engaged in nursing facility diversion and transition activities. For the purpose of this study, diversion and transition practices were defined to include any policies, programs, processes, and services whose primary purpose was to divert and transition individuals from nursing facilities.

The Deficit Reduction Omnibus Reconciliation Act of 2005 was passed by Congress on February 1, 2006. It contains many provisions that have been quite controversial. However, the Act also provides new tools that can help states to increase community opportunities for elders and people with disabilities. The new home care option under Medicaid will allow states to increase access to home care without linking it to current definitions of nursing home eligibility. For the first time, states will be able to tighten nursing home eligibility while maintaining the option to serve individuals in the community without developing complex Research and Demonstration waivers under Medicaid. This State Plan Option also allows states to offer home and community-based services to new populations who don't currently qualify for Medicaid without covering other medical expenses for them. These options can be used by states to intervene early with individuals who qualify for Medicare but who are at risk of becoming dually eligible if they enter a nursing facility. The Deficit Reduction Act also includes a new “money-follows-the-person” pilot project that will help some states to accelerate their nursing home diversion and transition activities.

Given these recent developments and the continuing interest of states in transitioning more individuals from nursing facilities to community residences, the information gathered in this report was expected to be of value to a number of states. Therefore, the state that initially commissioned the report agreed to its release to a broader audience.

After brief discussion of barriers to diversion and transition and a review of federal policy changes affecting diversion and transition, the report provides an overview of effective diversion and transition practices in a variety of states and concludes with recommendations about potentially promising program developments for state policy makers and stakeholders to consider.

This report does not assume that independent community living arrangements should be the only option for people needing long-term support. Most nursing facilities and other residential programs are mission-driven and have staffs that are committed to meeting the needs of their residents. However, many individuals in long-term care facilities would prefer alternative living arrangements that increase their level of autonomy and choice. Long-term support providers in all settings have an interest in working together to offer a wide range of such choices. The report offers a variety of strategies states can consider to increase or strengthen their diversion/transition activities to ensure that the community is indeed the first option for those seeking long-term supports.

II. Barriers to Diversion and Transition

Diversion and transition services continue to be critically needed to ensure full access to community living. Such access is hampered by factors such as limited public knowledge of home and community-based services, lengthy eligibility determination processes, and limited funding for these services. In our interviews, key informants and program staff identified the following programmatic, environmental, and individual factors that created barriers to diversion and transition:

1. Lack of knowledge about available community-based supports
 - Health providers, particularly those in hospitals, have limited knowledge of resources in the community and continue to view nursing facilities as the most expeditious and comprehensive resource for individuals needing long-term care.
 - Families and individuals rarely get information about long-term support services until they experience acute medical crises. Often their primary source of such information is the hospital's staff who has limited knowledge about options and incentives for quick discharge.

2. Restrictive Medicaid eligibility rules coupled with a lengthy eligibility process for community supports

- Financial eligibility for Medicaid-funded home and community-based services often takes weeks and sometimes months whereas admission to nursing facilities is often covered by Medicare, thus enabling individuals to access institutional services immediately.
- There is a lengthy determination process for prior approval of durable medical equipment and personal assistance services for individuals who are Medicaid enrollees.
- Individuals who are eligible for Medicaid in nursing facilities do not always qualify for Medicaid in the community because of differences in the financial eligibility criteria; this represents an institutional bias in the eligibility rules.
- Even for those nursing facility residents who do qualify for Medicaid in the community, there may be a lag in processing the change in eligibility status (from institutional to community) which delays access to prescriptions and other medical services when individuals return to the community.

3. Complex medical, psychiatric and substance abuse issues related to individuals

- Publicly-funded care coordination services are not readily available for many individuals with physical disabilities. For those who have co-existing medical, psychiatric or substance abuse issues, such support may be particularly critical to enabling them to remain in the community.
- Care coordinators for other populations may have insufficient knowledge of complex medical, psychiatric, or substance abuse issues and thus may benefit from access to clinical consultation services.

4. Lack of affordable, accessible housing with supports

- There is a general lack of affordable accessible housing which makes it difficult for individuals with disabilities to find suitable residences.
- For individuals leaving institutions, lack of access to housing is a critical barrier and can often delay a discharge for an extended period of time.
- Individuals leaving institutions often need their services to be well coordinated in their homes, particularly through a transition period. Yet, there are few transitional living options.

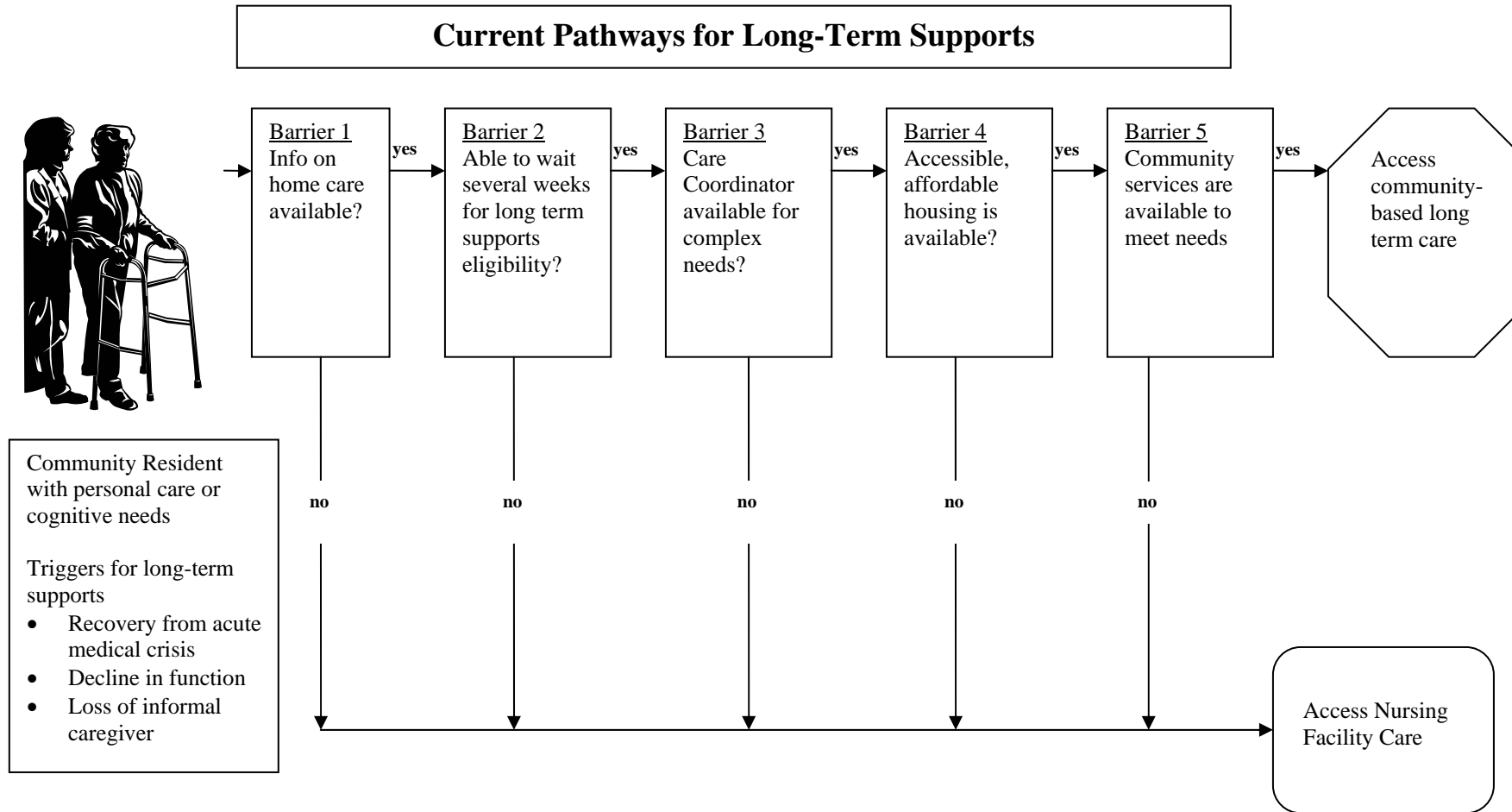
5. Insufficient diversion/transition activities

- Financial incentives for high occupancy often discourage nursing facilities from identifying potential candidates for discharge.
- Even though the Minimum Data Set (MDS) used for conducting assessments of nursing facility residents includes questions about individuals' interest in returning to the community, that data is rarely used by states to systematically target individuals for transition to the community.

Diversion and Transition Services in the U.S.

- While states have begun to cover transition services under the HCBS waivers, there are still many groups who have no access to such services to assist with transition, and the funds available in some state-funded programs (e.g. elder home care) are so limited that there are disincentives for using them for transition.
- Lack of consistency in reporting on diversions and transitions makes it difficult to measure progress.

The current barriers to the system continue to limit the number of individuals who can access home and community-based services. The flow chart on the next page provides a visual depiction of how the current system works and how the various barriers continue to draw individuals off the path of community services and toward nursing facilities.



III. Federal Policy Changes Supporting Diversion and Transition

As noted earlier, the Deficit Reduction Omnibus Reconciliation Act offers new opportunities to enable states to enhance their options for community-based long-term support. These initiatives will become effective on January 1, 2007. There have also been many earlier initiatives that have paved the way for states to implement diversion and transition initiatives. The Olmstead decision and related initiatives at the federal level, for example, have encouraged a stronger emphasis on diversion and transition efforts. In this section, we briefly describe how current federal policy permits states to implement important components of their diversion/transition programs.

New Initiatives under the Deficit Reduction Act

a. Expanded Access to Home and Community-Based Services

A new home care benefit under the Deficit Reduction Act provides a Medicaid State Plan Option for home and community-based services that addresses many concerns previously raised by state long-term care policy makers. Authorized under section 6086 of the Act, the option allows states to enroll individuals for Medicaid-funded home and community-based services without requiring that they meet the restrictive requirements for nursing home eligibility. This provision enables states to tighten nursing home entry requirements without also tightening access to HCBS. Under this option, states are allowed to offer HCBS services to individuals who qualify for Medicaid as long as their incomes not exceed up to 150% of the federal poverty level. Because states are also able to ignore some income and assets in determining eligibility for Medicaid (a process known as income and asset “disregards”), it is likely that states may be able to make their programs even more generous by disregarding some income before determining whether an individual meets the 150% threshold. Expanding Medicaid eligibility for HCBS may allow states to use Medicaid funds (thus capturing federal matching funds) for home and community-based services that were previously state-funded.

Although this provision frees states from the complex waiver application and approval processes, it allows states to retain components that allow control over program growth through waiting lists, limitations based on functional eligibility criteria, and geographic limitations which were previously only allowed under Medicaid waivers.

b. Optional Choice of Self-directed Personal Assistance Services

Section 6087 of the Deficit Reduction Act authorizes states to establish self-directed personal assistance services as a State Plan Option under Medicaid. This option allows consumers to hire, fire, supervise, and manage individuals who provide assistance with personal care and daily living activities. The new state plan options is modeled after the national Cash and Counseling Demonstration program and allows states to develop programs in which people with disabilities can not only hire their own workers, including legally liable relatives, but also can use their individual budgets to purchase items that increase their independence or substitute for direct human assistance.

c. Money Follows the Person Rebalancing--Demonstration Project

Section 6071 of the Deficit Reduction Act authorizes funding for a pilot project that provides enhanced matching funds for states that are selected to develop a money-follows-the-person initiative with the pilot funding. Under the pilot, states receive up to a 50% increase in their matching funds for individuals who transition from facility-based settings to approved residences in the community.

This new pilot complements earlier initiatives encouraged by the Centers for Medicare and Medicaid Services (CMS) to enable states to rebalance their long-term care systems. CMS had issued three letters related to “money follows the person” and other federal “rebalancing” initiatives.¹ These letters defined the concept of money follows the person 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.”

These letters also explain that concepts such as self-direction and individual control are related to the money follows the person concept. They clarify questions such as how states can address issues such as budget neutrality by amending their HCBS waivers to increase the number of HCBS slots in order and reduce the number of nursing facility beds. The letters also give examples of various initiatives across the nation. (CMS Letters to the State Medicaid Directors, August 17, 2004, September 17, 2003, and August 13, 2002).

d. Home and Community-based Alternatives to Psychiatric Residential Treatment Facilities for Children—Demonstration Project

Section 6063 of the Deficit Reduction Act authorizes a demonstration project for up to ten states that apply to develop home and community-based alternatives for children who, in the absence of such services, would require psychiatric residential treatment. The demonstration project is established under the 1915c Medicaid authority for home and community-based services waivers, and is subject to other terms and conditions related to those waivers. The demonstration project is authorized for five years.

2. Previous initiatives with continued relevance:

a. Case management

As noted previously, the Centers for Medicare and Medicaid Services (CMS) use the traditional term, “case management” to describe care coordination activities. These activities are a central component of any diversion/transition effort. On July 25, 2000, CMS announced a change to federal policy regarding case management that permitted federal reimbursement for case management prior to an individual’s departure from a nursing facility and clarified the

¹ “Rebalancing” means “adjusting the state’s publicly funded long-term supports – to increase the availability of community options and reduce reliance on institutions – so the supply of available services reflects the preferences of older people and people with disabilities.” (Crisp et al, 2003).

use of three different forms of reimbursable case management for transition purposes. (CMS Letter to State Medicaid Directors 7/25/00).

Two recent reports, one issued in January, 2005 by Eiken, Holtz, and Steigman and another by Robert Mollica in December, 2003 outline the benefits and drawbacks of each approach. These three case management approaches and their respective pros and cons are outlined in Table 2 below.

Section 6052 of the new Deficit Reduction Act makes some modifications to the definitions of case management and targeted case management, specifically identifying some excluded activities particularly related to the direct delivery of foster care services. Activities such as assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, and home investigations, among other activities, are now clearly excluded from reimbursement under the Medicaid case management/targeted case management service.

b. Environmental modifications

The July 25, 2000 CMS letter also set out the standards for using HCBS waiver funds for “environmental modifications,” i.e. home modifications. Home modifications made up to 180 days prior to discharge are eligible for federal financial participation (FFP), when they are included in the waiver and are initiated “before the individual leaves the institution and enrolls in the HCBS waiver.” Home modifications permitted are those that must be made to ensure the individual’s health and welfare in the home under most circumstances, (e.g. a ramp to get into the house, but not painting the house). In addition, assessments and even reassessments to determine the need for such modifications can be reimbursed under specific circumstances (CMS Letter to State Medicaid Directors 7/25/00; Eiken, Holtz, and Steigman 2005).

c. Home-health services

The July 25, 2000 CMS letter also clarified the standards for eligibility for home health services. Many states had followed the Medicare practice of only providing home health services to “homebound” beneficiaries. The July 25th letter stated that applying the same standard to eligibility for Medicaid services was a violation of federal regulations. This change increased access to Medicaid home health services (CMS Letter to State Medicaid Directors 7/25/00).

d. One-time transition costs

In addition, on May 9, 2002, CMS issued a letter to state Medicaid directors clarifying the use of HCBS funds for one-time transition costs. HCBS funds can be used for expenses such as security deposits (but not rent), moving expenses, essential furnishings (e.g. a bed, not a VCR), set-up fees or deposits for utility or service access (e.g. telephone, electricity, heating, but not cable access), and expenses necessary to ensure health and welfare, such as pest eradication, allergen control, or one-time cleaning before occupancy (CMS Letter to State Medicaid Directors 5/9/02; Eiken, Holtz and Steigman 2005).

e. Medical equipment

In another letter issued on July 14, 2003, CMS clarified its policies on medically necessary medical equipment, e.g. wheelchairs. It noted that HCBS waiver funds could be utilized to purchase medical equipment for nursing facility residents in the process of transitioning to the community under specific conditions including:

- 1) the equipment is covered as a service or service component in an approved HCBS waiver;
- 2) The equipment “is obtained no sooner than 60 days prior to the scheduled date of transition to a community living arrangement”;
- 3) The claim is not submitted until the person is discharged and enrolled in the HCBS waiver.

Table 2: Medicaid Case Management Reimbursement Mechanisms

Type of Case Management	Pros	Cons
Case Management as Administrative Expenditure	<ol style="list-style-type: none"> 1) No time limits on how long case management services can be reimbursed <u>before</u> an individual leaves the facility (in contrast to the 180 –day limits below.) 2) States that use community organizations to provide this service can pick and choose among providers (rather than accepting any willing provider as usually required for Medicaid.) 3) Medical services administered by a state agency, such as nursing services, are reimbursed at a 75% rate. 	<ol style="list-style-type: none"> 1) Case managers can only be reimbursed for assistance in obtaining Medicaid services, but not for other supports, such as housing. 2) Expenditures must be consistent with the state’s Medicaid cost allocation plan, requiring a lengthy and time-consuming amendment if not already covered.²
Targeted Case Management	<ol style="list-style-type: none"> 1) Can be used to obtain non-Medicaid supports, such as housing but not foster care services. 2) Targeted case management services are reimbursable for up to 180 consecutive days before the individual moves to the community. 3) Allows states to target specific populations for this service. 	<ol style="list-style-type: none"> 1) Although 180 consecutive days may help transition some individuals, it may not be enough time for others. 2) The state must offer recipients a choice among qualified case management providers. States can decide who is “qualified,” and there may be exceptions for those with psychiatric and developmental disabilities. 3) Cannot be used for individuals between the ages of 21 and 64 in “Institutions for Mental Diseases (IMDs).”
HCBS Waiver Case Management	<ol style="list-style-type: none"> 1) Can be used to obtain both Medicaid and non-Medicaid supports (excluding foster care services) 2) Costs are reimbursable even if the person dies during the transition. 	<ol style="list-style-type: none"> 1) Subject to the 180-day pre-transition time limit. 2) The option in which states have the least discretion in choice of providers. 3) Not reimbursable <u>unless</u> and <u>until</u> the individual moves to the community and is waiver-eligible. Payment is retroactive to 180 days prior to discharge.

Sources: Eiken, Holtz and Steigman 2005, Mollica 2003 and Deficit Reduction Act of 2005.

² To claim reimbursement for administrative case management, the state must calculate how much case management time, and therefore, how much cost, can be allocated to Medicaid recipients. If the cost of transition case management is not currently covered, then the state may need to amend its calculations.

In addition, CMS clarified that states could permit medical equipment vendors to provide the equipment to a nursing facility resident for a trial period before transition and that states could purchase medical equipment tailored to the individual before transition, followed by arrangements for the equipment to move with the nursing facility (NF) resident to the community. (CMS Letter to State Medicaid Directors 7/14/03; Eiken, Holtz and Steigman 2005).

f. Minimum Data Set

The most recent letter, dated February 18, 2005, gives states information on the requirements for Medicaid Data Use Agreements that states must complete in order to access Minimum Data Set (MDS) data. This data could prove useful in identifying nursing facility residents who may be potential candidates for transition.

g. Assistive Technology

The 2004 amendments to the Assistive Technology (AT) Act require states to set aside some of the AT funds they receive for assistance with NF transition. In this context, the term “transition” includes transitions from school to community, as in Turning 22, and also transitions from nursing facilities and other institutional settings to the community. This funding can be used to support public and private programs that provide assistive technology, but cannot be used to provide direct support to individuals. P.L. 108–364. Section 4(e)(3)(B)

h. Systems Change Grants

Federal policy has fostered diversion and transition activities through the Nursing Facility Transition grants and other grants funded under the New Freedom Initiative. These grants have permitted states to test a wide variety of diversion and transition strategies. The most recent round of grants, awarded in September 2005, awarded individual grants of approximately \$3 million each to ten states for a five-year effort to transform their long-term support systems to address specific goals tailored to the needs of each state.

IV. Diversion and Transition Approaches across the Country

The history and nature of diversion and transition activities among the states varies widely. A few states, such as Oregon and Washington, have been working to shift the balance between institutional and community care for many years. Their efforts to divert people include both broader approaches, such as a single budget item for all long-term support services, and specific programs explicitly designed to divert and transition individuals. At the other end of the spectrum are states that have only recently focused on diversion and transition after receiving federal grant funding, such as that made available through the nursing facility transition (NFT), Real Choice Systems Change, and Aging and Disability Resource Center (ADRC) grants. These funds have often served as a catalyst for other state efforts.

The Kaiser Commission on Medicaid and the Uninsured recently completed a report entitled “Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities.” The report documents many of the initiatives covered in this report with a

somewhat different organizational focus and level of detail. The Executive Summary of the Kaiser report notes that a key factor for many of the states with successful diversion/transition activities is a strong “philosophical commitment and legislative direction.” (Summer, 2005).

States with such commitment and direction have an overarching mandate that helps reinforce and connect the various specific initiatives within the state. Oregon established such a legislative mandate in 1981 and subsequently became the first state to shift a majority of its long-term care spending to community services. Other states that have achieved such a commitment include New Jersey, Pennsylvania, Texas, Vermont, Washington, and Wisconsin, and their success is evident in dramatic shifts in expenditures from nursing facilities to community-based long-term supports. In many cases, the specific effects of individual initiatives cannot be determined because they are part of a broader strategy based on this public commitment. The individual initiatives support one another to achieve results that are greater than the effect that individual initiatives could have achieved. As states consider their potential to enhance opportunities for community living and look at the experiences of other states, this need for broad consensus and legislative support will be important in achieving success.

Many specific approaches to divert and transition individuals from nursing facilities have emerged across the country. While all these approaches concentrate on diverting individuals from nursing facility admission or transitioning nursing facility residents back into the community—often with the support of community services-- they are implemented differently across states. In our literature review, we examined the approaches used by various states and identified those programs that would be most helpful in diversion and transition efforts. The approaches are grouped into the following seven categories:

1. Nursing facility screening
2. Expediting community supports
3. Education on community options
4. Care coordination
5. Funding for transition costs
6. Financing mechanisms
7. Supportive housing options

Table 3 identifies examples of states using these diversion and transition approaches and the different ways these strategies are implemented. The following section describes these models in greater detail.

Many other state activities complement these diversion/transition activities. For example, several states have amended their Nurse Practice Acts to expand the potential pool of workers who can provide specific services at home. Other states have expanded their financial eligibility for HCBS or disregarded certain assets to enable more individuals to

qualify for home care. In general, states have increased the number of available openings on their HCBS programs to reduce or eliminate waiting lists. These activities clearly support the work of diversion and transition, but since their *primary purpose* is not necessarily diversion, we have not provided detailed discussion in this report. Nevertheless, these activities are important options that should be considered as part of a broad strategy to enhance options for community living.

1. Nursing facility screening

Experience shows that the earlier diversion programs intervene before and after nursing facility admission, the more likely they are to successfully prevent a long-term stay (Kasper 2005). Programs commonly referred to as “pre-admission screening programs” are the primary means by which such intervention takes place.

In general, NF screening entails assessing a person’s needs, the appropriateness of nursing facility admission, and the services necessary to support an individual in the community when such admission is not appropriate. When such screening fails to confirm the need for nursing facility care, a discharge or care plan is generally developed.

Many states have pre-admission screening requirements for individuals seeking nursing facility admission (Pepe, et al. 1997). However, “pre-admission” screening often takes place after nursing facility admission and primarily serves to prevent long-term stays rather than just to prevent an initial admission. Therefore, we will use the term “screening” for such activities whether they occur before or after an individual is admitted to a nursing facility.

a. Oregon – Mandatory screening for all nursing facility applicants

Oregon requires face-to-face screening for all nursing facility applicants, including individuals who seek Medicaid-funded nursing facility services, individuals who are likely to be eligible for Medicaid coverage within 90 days of nursing facility admission, and private-pay applicants for nursing home admission (Justice and Heestand, 2003). Individuals can be exempt from this pre-admission screening if they meet certain criteria, such as admission for a rehabilitative stay under 30 days’ duration or urgent medical need. However, if exempted at the time of admission, they still must receive the face-to-face admission assessment within seven days from the date of admission or within seven days after the 30th day of admission post-hospitalization.

This system is broader than screening programs in many states which require screening only for individuals who are currently Medicaid-eligible or who are seeking Medicaid coverage for a nursing facility placement after having spent down their assets. In Oregon, private pay applicants seeking entry to a Medicaid-certified nursing facility receive a less detailed “private admission assessment” by a hospital or state contractor.

Private pay applicants may have an optional review of their income and asset information. The private assessment also provides optional information regarding appropriate care settings and services, including nursing facilities and community-based options such as adult foster care, assisted living, residential care, in-home services, and other community-based services. Recommendations made during the pre-admission screening are not binding and the private pay consumer may choose from any of the long-term care options available.

The private admission assessments are conducted either by hospitals, that do them free of charge, or by “certified programs” that have agreed to comply with Oregon’s regulations regarding such activities and that have paid an annual fee of \$200. Occasionally, a hospital will also be a certified program. The maximum fee that certified programs may charge the state for assessments is \$140. Certified programs must make a good faith effort to determine whether the individual receiving the assessment may be Medicaid eligible. If the individual appears to be Medicaid eligible or may become Medicaid eligible within 60 days, the certified program must contact and coordinate with the local Area Agency on Aging/Seniors and People with Disabilities unit to provide further assessment services (ORS 411.071, et. seq.,2004).

Table 3: Other States' Diversion and Transition Approaches

Types of Approaches	Implementation methods	States
1. Nursing facility screening	<ul style="list-style-type: none"> • Private pay admissions screening by certified programs • ADRC role in screening NF admissions to NFs • Screening within 7-14 days of admission • PASARR review and follow-up • MDS data use 	<ul style="list-style-type: none"> • Oregon/Maine • Wisconsin • Washington, Massachusetts • Massachusetts • Pennsylvania and Vermont
2. Expediting access to community supports	<ul style="list-style-type: none"> • Presumptive financial eligibility for Medicaid HCBS waiver services • Prioritization of NF residents for access to HCBS waiver slots • Fast Track –A model in which a care coordinator, financial eligibility worker, and “runner” are placed in a hospital to expedite HCBS waiver eligibility. 	<ul style="list-style-type: none"> • Washington • Vermont • Colorado
3. Education on community options	<ul style="list-style-type: none"> • Education of hospital staff and patients • Education of nursing facility staff and Residents 	<ul style="list-style-type: none"> • Indiana and New Hampshire • Maryland, Washington, Utah
4. Care coordination	<ul style="list-style-type: none"> • State hires dedicated transition workers • Contracting with ILCs specifically for transition using state funds. • Independent Living transition coordinators • Coordination of care for medically fragile children 	<ul style="list-style-type: none"> • Oregon, Washington, and New Jersey • Texas • Kansas • Massachusetts
5. Funding for transition costs	<ul style="list-style-type: none"> • NFT grant-funded assistive technology (AT) fund • State allocated \$10,000 per CIL to pay for transition expenses. • Residential discharge allowance funded by the state to cover one-time expenses like rent, security deposits, furniture purchases, cleaning, etc.. • Assistive technology fund financed by state. • Civil Penalties Money Fund financed with NF deficiency penalties. • Home maintenance allowance through Medicaid program 	<ul style="list-style-type: none"> • New Jersey • Wisconsin • Washington • Washington • Washington • Washington
6. Financing mechanisms that rebalance long term support systems	<ul style="list-style-type: none"> • Shifting funding from nursing facility budget to community services budget • Single long-term support budget for nursing facilities and community long-term services. 	<ul style="list-style-type: none"> • Texas, Vermont, and Wisconsin • Oregon and Washington
7. Supportive housing options	<ul style="list-style-type: none"> • 24-hour enhanced residential care HCBS waiver for elders at risk of NF placement • Transitional housing in congregate units • Increased supportive housing options 	<ul style="list-style-type: none"> • Vermont • Massachusetts • Oregon

Although the private pay assessment is less detailed than a Medicaid assessment and recommendations are not binding, screening for both Medicaid-eligible and private-pay NF applicants is one of the factors that enabled Oregon to achieve “culture change,” according to a state official.³ This approach helps create a uniform system, encourages the development of community options and sends the message that the community is everyone’s first option. The Oregon official also believed that this approach reduced Medicaid costs by diverting people who would inevitably spend down their assets in a nursing facility and apply for Medicaid. She stated that according to the Oregon Health Care Association, only about 7% of individuals admitted to nursing facilities have a length of stay greater than one year.

b. Maine – Mandatory screening for all nursing facility applicants

Maine requires face-to-face screening for all nursing facility residents, regardless of the source of payment. The state hires a private contractor, Goold Health Systems, to conduct medical eligibility determination (MED) assessments for an NF applicant’s level of care. This mandated assessment is deferred when accessing skilled nursing facility benefits for consumers who do not need Medicaid to pay for their SNF stay. When conducting the medical eligibility determination assessment, the assessors use laptops that can receive client’s financial information electronically. The assessor then knows the financial status of the person being assessed and can offer the appropriate option based on both the financial and medical information gathered. For private pay individuals, the assessor advises them on their long-term care options based on the assessment.

In 2002, Maine’s contractor assessed 15,849 individuals at an average cost of \$157.59 per assessment.⁴ Financial eligibility was determined separately by state agency staff. Of the number of individuals who underwent the MED, six percent were determined not to require a NF level of care. Of those individuals assessed at the end of their NF stay, ten percent were determined not to require an NF level of care. These individual are informed of alternative options (such as home care, residential care) that could meet their needs. Maine has simultaneously pursued other approaches, with the overall result that the number of Medicaid nursing facility residents in Maine dropped by 18 percent between 1995 and 2002, while Medicaid HCBS increased 78 percent during the same period. Although it is not possible to attribute these changes solely to Maine’s nursing facility screening program, this effort has certainly been a central component of Maine’s approach to reducing NF utilization (Crisp et al, 2003).

c. Wisconsin – Voluntary information and options counseling

In Wisconsin, all nursing facilities, residential care facilities and adult family homes must inform potential Medicaid residents of community options. These facilities are also required to refer individuals whose long-term support needs are expected to last more than 90 days to an Aging and Disability Resource Center (ADRC) for a consultation regarding their long-term care options. This ADRC consultation is completely voluntary to the consumer and consists of long-term care “options” counseling, and functional and financial screening. Should an individual agree to the consultation, it must be provided (Justice, 2003). The consultation may

³ Conversation with Senior and Disabled Services Division, July, 2005.

⁴ Maine Bureau of Elder and Adult Services 2005.

be conducted in person or, if the individual prefers, by telephone, mail, or e-mail. Wisconsin's ADRCs are supported largely through state funds; although ADRCs in counties that were implementing a new managed care initiative called Family Care had the option of obtaining Medicaid reimbursement for the screenings they performed. In addition, in theory, "ADRCs could collect federal funds for the information and assistance (I&A) function during CY 2000 based on a county-specific formula estimating the percentage of MA eligibles per population for whom they provided I & A" (Lewin, 2003).

The ADRC model was developed in Wisconsin, but with the support of the Administration on Aging (AOA) and the Centers for Medicare and Medicaid Services (CMS), the model is in the process of being replicated in 43 states that have received ADRC grants since 2003. The ADRC Grant Program is designed "to assist states in their efforts to create a single, coordinated system of information and access for all persons seeking long-term support to minimize confusion, enhance individual choice, and support informed decision-making." (http://www.aoa.gov/prof/aging_dis/aging_dis.asp). A technical assistance exchange contractor supports grantees in their development activities (www.adrc-tae.org).

d. Washington and Massachusetts – Post-admission screening

A number of states utilize post-admission screening to identify individuals who may be candidates for transition to the community. Washington nursing facility case managers must contact individuals admitted to a nursing facility within 7 days. They must conduct a functional assessment and present and discuss information regarding transition with the individual and the family. For individuals who want to return to the community, the case manager will assess eligibility for community services and assist in the development and implementation of a transition plan. The case manager also monitors the individual after transition (Mollica, 2003a).

Similarly, in 2004 Massachusetts revised its nursing home screening process and developed a timelier, comprehensive needs assessment that helps individuals identify an array of service options. The desired outcomes were to: reduce MassHealth nursing facility lengths of stay; reduce conversions to MassHealth and the number of MassHealth nursing facility days; increase discharges of MassHealth members from nursing facilities; improve collection of data on clinical characteristics of the NF eligible population and the community service options; enhance knowledge of community service options; and promote greater family and informal caregiver participation in service planning.

Under the new Comprehensive Service and Screening Model (CSSM), nurses and case managers from the local Aging Services Access Point agencies (ASAPs) conduct face-to-face evaluations of all MassHealth applicants and dually eligible individuals in nursing facilities. These evaluations focus on determining the clinical needs of individuals including their functional and psychosocial capabilities and limitations, the need for continued stay in the nursing facility, and/or the potential for community placement. In cases where it is determined that the individual requires an additional stay in the nursing facility, the ASAP is authorized to "prescribe" a time period for which Medicaid payment is approved. The new process has enabled the ASAPs to be more proactive in identifying and assisting individuals who wish to transition from nursing facilities to the community.

e. Massachusetts Pre-admission Screening and Annual Resident Review (PASARR) for persons with mental retardation

In the Omnibus Budget Reconciliation Act of 1987, Congress required that all individuals with mental retardation or serious mental illness be screened prior to nursing facility admission to assure that the nursing facility admission is appropriate and to determine whether individuals who are admitted to nursing facilities need specialized services related to their disabilities. Each state designs its own systems and procedures for implementing this nursing home Pre-admission Screening/Resident Review process known as PASRR or PASARR.⁵

In Massachusetts, nursing facilities must report the admission of anyone who may have mental retardation or developmental disabilities to the state Department of Mental Retardation (DMR). The NF completes and faxes to DMR a “Level I” form indicating the likelihood that the applicant has mental retardation or a developmental disability. Prior to or shortly after the admission, the Aging Services Access Point (ASAP) agency conducts a face-to-face interview to determine whether or not the individual meets the medical criteria for admission to the nursing facility.⁶ Those individuals with mental retardation or related conditions seeking Medicaid payment for nursing facility services, who meet the admission criteria, must undergo a second review, called a “Level II PASARR.”

The “Level II PASARR” screen is performed by the DMR and its purpose is to determine whether the individual needs nursing facility admission or has needs that can be met in the community or another setting. The Level II PASARR is also used to determine whether the individual requires “specialized services” while in the nursing facility.⁷ For individuals identified as needing short-term convalescent care (not to exceed 30 days) the Level II review may be delayed until the individual has been in the facility for one month.

Many states administer similar processes and stop at this point. In Massachusetts, if the individual is still institutionalized 30 days later, the nursing facility must once again notify DMR, and diversion activities including a PASARR Level II screen, must begin. In this model, care coordination is referred to as “service coordination” and those who perform these activities are “service coordinators.” Depending upon the DMR area office, service coordinators may be focused solely on diversion activities or they may have additional duties. Service coordinators meet with the individual and any family/guardian to develop a diversion plan. They then continue working with them to obtain housing, personal care assistance, financial support, and any other necessary services to move to the community. To assist in addressing any medical comorbidities, nurses and psychologists are available for consultation at the DMR area and regional office levels.

⁵ DMR in Massachusetts conducts these reviews annually for all nursing facility residents with mental retardation and for that reason refers to the process as PASARR (the second “A” referring to “Annual”).

⁶ The review and approval of admission by the ASAP is distinct from the Level I PASRR form completed by the nursing facility.

⁷ For an individual with MR or related conditions, “specialized services” may include a variety of activities such as day habilitation and assistive technology.

f. Pennsylvania and Vermont – Using MDS data to identify transition candidate

Pennsylvania used Minimum Data Set (MDS) data to identify potential consumers who wanted to return home. The MDS has two questions on this topic. Q1a indicates whether the “resident expresses/indicates preference to return to the community.” Q1b inquires whether a resident has “a support person who is positive toward discharge.” Either of these questions can be used as a tool to identify individuals willing and capable of transitioning. Similarly, Vermont’s MDS approach was to combine (Q1(a)) with the following criteria, which are also based on the nursing facility resident characteristics identified in the MDS: a) the Resource Utilization Group Special Rehabilitation or Clinically Complex; b) bowel and bladder incontinence, and c) a Cognitive Performance Score indicating whether the person was cognitively intact or borderline intact (Reinhard, Hendrickson and Bemis, 2005).

Pennsylvania and Vermont’s use of the MDS data, however, encountered a major barrier. The data they received was between a few months and a year old and, when contacted, many residents who had indicated this desire had either died, deteriorated in health, or no longer indicated a desire to return home. These two cases suggest that the use of MDS data as a tool in transitioning nursing facility residents will depend on its timeliness.

2. Expediting Community Supports

Due to the ready availability of nursing facility care, individuals can usually find NF beds quickly when they are seeking admission. Also, because of the high cost of nursing facility care, it is often easy for individuals to demonstrate that they will qualify for Medicaid. Therefore, nursing facilities often use a process called “presumptive eligibility” to expedite admissions. The effect is that it is often easier for an individual to get access to a nursing facility than to home or community-based care. For that reason, some states have focused on presumptive financial eligibility for home and community-based waiver services and other strategies for expediting community supports.

a. Washington – Presumptive eligibility

In Washington, the Aging and Disability Services Administration (ADSA) allows social workers or nurses to authorize delivery of essential services before the full financial eligibility process for HCBS waiver services is completed for functionally eligible clients. Presumptive financial eligibility is available to applicants for HCBS waiver programs, including hospital discharges.

The Care Coordinator (known as “case manager”) obtains sufficient financial information from the individual including a statement or declaration from the individual that lead staff to the reasonable conclusion that the applicant is eligible for Medicaid under the waiver rules. After consultation with financial eligibility staff, the Care Coordinator can authorize services for up to 90 days. The client signs an agreement that specifies that services are temporary pending Medicaid financial eligibility and must submit application within 10 days or services will be terminated;

In general, Care Coordinators are trained to be conservative when presuming financial eligibility. Individuals ineligible for presumptive financial eligibility are those with information

that requires further review (trusts, real estate holdings) or that raises questions about the final decision. The state pays for all services when an applicant is found ineligible. The state limits its liability by establishing a maximum period of 90 days within which the individual must have completed the financial eligibility process.

About 5 percent of applications or 100 clients a month used this process. The error rate for presumptive eligibility clients was 3%, from Jan 2004 through June 2005. For this period, approximately \$8,332 of state funds paid for individuals who did not meet the financial eligibility criteria.

The process has reduced the average time required to make decisions from 37 days to 25 days. State officials estimate that presumptive eligibility saves Medicaid an average of \$1,964 a month per person, assuming that these clients would have entered an institution if services were delayed (Mollica, 2004): This represents annual savings of over \$2 million even after accounting for the small percentage of clients whose eligibility determination was in error.

b. Vermont – Priority access to HCBS

Another common strategy is found in Vermont, which expedites HCBS waiver eligibility by requiring waiver staff to assess applicants and designate a high priority to four groups of individuals:

- 1) Nursing facility residents who could not go home without HCBS waiver services;
- 2) Hospital patients requiring home and community based services to avoid nursing facility admission;
- 3) Community applicants at significant risk of harm without waiver services; and
- 4) Applicants at significant risk of moving to a more restrictive setting without waiver services.

Waiting times for individuals on the list have been reduced to 60 days and even less, in some instances (Medstat 2004a).

c. Colorado – Fast Track

Another approach to expedite HCBS is funded by one of the Nursing Facility Transition grants. Colorado's "Fast Track" program expedites HCBS waiver services by placing staff on-site at the Denver Hospital to facilitate home and community based services eligibility determinations. The program consists of a team of three persons-- a financial eligibility technician, a case manager, and a "runner," who contacts necessary parties and literally "runs" documents back and forth between them. Hospital discharge social workers inform the Fast Track team about patients who are likely to be discharged to a nursing facility. The case manager then assesses the patient for community services while the financial eligibility staff and runner gather necessary information to determine financial eligibility. The evaluation for the NFT grant showed that approximately 71% of individual referrals were successfully diverted to the community in the program's second year (Kennedy, 2003).

3. Education on community support options

Hospitals are responsible for almost 50 percent of nursing facility admissions nationwide (Mollica, 2004). This volume of admissions from hospitals provides for a strong rationale for efforts to educate hospital staff and patients about available options for diversion.

Another essential component of efforts to transition individuals from nursing facilities has been outreach and educational efforts aimed at nursing facility staff and residents. Some states place greater emphasis on one group rather than the other, with a majority of states first educating the NF staff and then enlisting their support in identifying and conducting outreach to residents. Most of these outreach efforts consist either of mailings to nursing facility administrators and staff and/or personal meetings with them.

a. Indiana and New Hampshire-Educating hospital staff and patients on community options

Indiana and New Hampshire reach out and educate hospital staff and patients on the availability of community options. In FY 2002, Indiana established a program in which Area Agencies on Aging case managers worked with hospital discharge planners, among others, to identify patients who needed nursing facility level of care but were potential candidates for community based services. This approach resulted in 316 people discharged from hospitals who were receiving home or community-based supports in FY 2002. By the end of 2004, the available data showed that 1,500 patients had been diverted from nursing facility settings. (Crisp et al, 2003). According to one estimate, 65 percent of these individuals were still receiving community services after one year. The average monthly cost per diverted recipient was \$2,232 as compared to \$2,800 in the nursing facility (ADRC-TAE Issue Brief, 2004).

Through its Aging and Disability Resource Center (ADRC) grant, New Hampshire developed several tools to promote diversion in hospital settings. Hospitals in New Hampshire are required by law to inform the state of discharges to NFs. To implement this requirement more effectively, New Hampshire developed criteria for hospital discharge planners to use to determine whether individuals discharged to skilled nursing facilities and rehabilitation hospitals were potential candidates for referral to an ADRC. In addition, protocols were also drafted to assure that hospital referrals to agencies coordinating long term care services included referrals to the ADRCs.

The ADRC grant is being piloted in two counties in New Hampshire with a total of four hospitals. ADRC staff have met with hospital discharge planners and social workers to inform them of the ADRC services and to refine the protocol for referrals to the ADRCs. In addition, at one hospital, an ADRC staff member regularly accompanies hospital staff on rounds with patients. This provides an opportunity to talk directly to patients and their families. The project also has a more recent nursing facility component where staff work with nursing facility staff, residents and their families. According to the Department of Health and Human Services⁸, early results from the project indicate that it has succeeded in decreasing the length of time needed to obtain eligibility for New Hampshire's HCBS waiver by at least one-third.

⁸ Interview with Bureau of Elderly and Adult Services, Department of Health and Human Services, 2005.

For those states that conduct post-admission screening, educating nursing facility staff and residents is an integral part of the process. The most successful outreach efforts are those that permit one-on-one, person-to-person contact.⁹ This outcome is true regardless of whether the contact is first initiated through nursing facility staff or by the consumer directly. This personal approach gives the transition coordinators the opportunity to allay any concerns regarding the intent of their efforts and to establish themselves as someone who can be helpful to those involved, both, residents and nursing facility discharge planners and staff alike.

Some states have made additional outreach efforts to facilitate transition. Engaging the facility staff directly in transmitting information to residents is one way to assure that the staff also learns about options. In 2002, Maryland adopted a prescriptive approach that required nursing facility social workers to give residents a one-page fact sheet explaining the HCBS waiver and other community services and ask them to sign a written acknowledgment of receipt. This fact sheet must be given to residents upon admission or discharge or “at least one time annually at the request of the resident” (Nursing Home Transmittal No. 176, 2002).

b. Maryland and Washington – Placing Outreach Staff in Nursing Facilities

A number of states, including Maryland and Washington, are placing their educational and outreach resources in nursing facility settings rather than hospitals. For example, Maryland state staff works with residents, particularly short-stay residents, soon after the resident has been admitted to the rehabilitation center or nursing facility. In Washington, this contact must be made within seven days of admission. These states believe that this approach has several advantages over conducting outreach to hospital patients. First, the approach allows more time to provide necessary information to individuals, given that the average length of a hospital stay is less than 5 days (CDC, 2005). Second, transition staff found it premature to discuss transition options pre-rehabilitation if a hospital patient is awaiting discharge to a rehabilitation setting. Third, staff found it very difficult to assess whether an individual is a good candidate for community services before that individual has completed the rehabilitation (Burgess Memo, 2004).

c. Utah – Educational sessions for nursing facility residents

In 2001, Utah conducted a statewide campaign to educate nursing facility residents about HCBS options using group and one-on-one education sessions. Representatives from the local AAA and ILC conducted the group sessions together, using materials developed by the state HCBS staff to ensure comprehensiveness and impartiality. Presenters were trained by state staff to provide information to nursing facility residents. Residents who expressed interest in transitioning to the community were interviewed separately and given needs assessments. Between February and August 2001, 30 residents moved to the community, with 15 people using Medicaid community programs. The campaign reached 85 percent of all Utah’s nursing facilities, where 20 percent of these residents attended the group sessions (Medstat, 2004b).

⁹ Interview with Steve Eiken, Medstat, 2005.

4. Care Coordination to Assist with Transition

The federal Medicaid program covers a service called “case management.” Case management consists of “services which will assist an individual eligible under the state plan in gaining access to needed medical, social, educational, and other services.” Because some individuals who use these services object to being described as “cases” to be “managed,” other terms have arisen to describe these activities. These terms, include “care management,” “care coordination,” “service coordination,” and “transition coordination,” among others. Different programs discussed in this report use various of these terms to describe these activities. Sometimes, the terms are intended to imply different philosophical approaches or different degrees of control or authority. However, often the terms can be used interchangeably to refer to a set of activities that include assessment, service coordination, and follow-up monitoring. We will use the term “care coordination” whenever possible in discussing these activities and make it clear when a particular program uses a different term.

Those who have already been residing in nursing facilities for longer periods have frequently lost many of their connections to the community, including housing and family support. Assisting these individuals to return to the community includes working closely with them to construct or reconstruct the building blocks of community living. Nursing facilities have specific obligations in planning a resident’s discharge.¹⁰ However, neither screening activities, nor the activities of NF discharge planners are sufficient to ensure that a person leaves a nursing facility and returns to the community. Care coordination entails helping consumers implement their care plan, thereby facilitating the transition.

Care coordination is the primary approach used by states to transition individuals from nursing facilities to the community and is often integrated with efforts to educate nursing facility residents. As noted above, this service is called by many other names including “case management,” “service coordination,” “transition coordination,” “transition facilitation,” or even “counseling.” The services provided included helping residents obtain HCBS and other Medicaid services and often other supports such as housing and medical services.

a. Oregon – Relocation workers

Oregon began hiring state “relocation workers” in 1982 with state funding to assist individuals who wanted to transition from nursing facilities. These workers contacted NF residents who have been flagged, usually upon admission, as potentially eligible for transition. The workers then followed up with residents on at least a monthly basis for the first 90 days to investigate transition possibilities. These workers helped the residents devise and implement a transition plan. Most of the individuals were transitioned to adult foster homes, although some transitioned to assisted living. Between 1982 and 1996, approximately 10,000 individuals

¹⁰ Nursing facilities are obligated to designate a permanent member of their staff to be responsible for discharge planning. 105 C.M.R. 150.003 (6)(2). Authorization by a physician, nurse practitioner, or physician’s assistant is required. 105 C.M.R. 150.003 (6)(6). The intention to discharge must be discussed with the resident and/or the resident’s guardian or next of kin. The residents and their guardians are also entitled to written notice. 940 C.M.R. 4.09(1) The discharge plan is required to “consider the patient’s or resident’s home situation, financial resources, social needs, and community resources as well as his medical and nursing requirements,” but there is little guidance as to what specific steps discharge planners must take to address these factors in the discharge plan. 105 C.M.R. 150.011(G) (7).

were transitioned from Oregon’s nursing facilities (National Long-Term Care Mentoring Program, 1996). Because Oregon policymakers believe that most people who could transition have done so, the program has been scaled back.

b. Washington – Assessment and transition assistance

In Washington, state-employed case managers contact new Medicaid nursing facility residents within 7 days of admission. They must conduct a face-to-face functional assessment, and present and discuss information regarding transition with the individual and the family. For individuals who want to return to the community, the case manager will assess eligibility for community services as described above, assist in the development and implementation of a transition plan and then help plan for ongoing community services. The case manager also monitors the individual after transition. In addition to new Medicaid residents, case managers can also work with long-term Medicaid residents and with private-pay residents who are likely to become Medicaid eligible within 180 days. There are several sources of funding for transition costs, which are discussed elsewhere in this report. The fact that case managers are assigned to specific nursing facilities helps them to identify residents eligible for transition, as well as develop ongoing relationships with nursing facility staff. To monitor progress, each of Washington’s six regional long-term support offices has nursing facility caseload reduction targets with monthly statistics tracking caseload trends (Mollica, 2003).

c. Several States—Nursing facility transition counselors

Evaluations of states that received federal nursing facility transition grants show that these states used at least some portion of their funding for care coordination activities. However, implementation of these programs varied widely. For example, care coordination staffing was by state and county employees or contractors as in Florida, New Jersey and Pennsylvania, or by private non-profit organizations that contracted with the state in Arkansas and Michigan. In Wisconsin, both county employees and independent living centers (ILCs) played this role. In addition, some states such as Colorado and New Jersey had staff that were exclusively dedicated to the mission of transitioning people from nursing facilities, while Arkansas and Texas added this role to existing duties. Based on the evaluation of the NFT grants, the approach of dedicated transition coordinators appeared to be the more effective of the two.¹¹

New Jersey, one of the early NFT grant states, modeled itself after Washington and created a program called “Community Choice.” Community Choice hired approximately 30 to 40 “counselors” who were assigned to specific nursing facilities with the purpose of identifying and then working with residents who were potential candidates for transition. These counselors focused initially on individuals who entered as “short-stay” residents. This effort resulted in approximately 1,500 individuals being transitioned from nursing facilities over a period of 2 to 3 years. Given that the initial focus was on these “short-stay” residents, it is possible that individuals who may have left on their own are included in this number. Nevertheless, the fact that New Jersey hired a substantial number of staff solely dedicated to transition, also likely contributed to the success of this program. New Jersey has continued to expand its efforts with a current staff of approximately 70 Community Choice counselors who

¹¹ Conversation with Steve Eiken, Medstat, June 20, 2005.

transition several hundred people each year on an ongoing basis. According to New Jersey's Department of Aging and Human Services, Community Choice has helped more than 4,735 individuals make the transition from nursing facilities back into the community since the program's inception in 1998 (Community Choice Web Site, 2005).

d. Texas – Nursing facility transition assistance

As part of its plan to comply with the 1999 *Olmstead* decision, Texas created the “Promoting Independence Initiative.” As one of the activities under this initiative, the Texas Department of Human Services (now the Texas Department of Aging and Disability Services) sent a letter to nursing facility residents and their authorized representatives informing them about their community options and giving them the phone number for their local Community Care office. If a Medicaid-funded resident indicates a desire to transition to the community, then either a state-employed care coordinator or a transition coordinator from an independent living center assesses the person to determine medical and/or functional eligibility for community services. After establishing eligibility, the care coordinator works with the person to develop and implement a care plan for the community, using any service for which they are eligible. To help facilitate the transition process, \$2,500 per person was available for transition costs. This care coordination effort was implemented along with a new “Money Follows the Person” financing system, which is discussed below. The combined result of the care coordination and new financing mechanism is that 3,181 individuals transitioned between mid-2001 and early 2004 (Eaton, Kafka and Klein, 2004).

e. Kansas—Independent Living Center Relocation & Diversion Initiatives

“Since the beginning of the disability rights movement, a major thrust of independent living centers (ILCs) has been to enable individuals with significant disabilities to leave nursing facilities and to live independently in the community” (O’Day 1998). Although many ILCs across the country were always involved in such transition efforts, this is still an optional service. However, if ILCs offer such transition services, federal law requires them to report on their activities.¹²

The nature and extent to which such activities are implemented varies among the ILCs. In most cases, their efforts include visiting the individual in the nursing facility after they have been referred to the ILC and completing a common intake form containing a uniform goal index to determine a consumer’s aspirations.

Peer counseling and peer modeling are intrinsic components of the work that the ILC staff does with the consumer to teach independent living skills and encourage the individual to have the confidence to make the transition. These peer activities take place on a face-to-face basis whenever possible, but staff may at times interact with consumers in other ways, e.g. by telephone or e-mail when that approach is more efficient. The amount of time the process takes varies according to a number of factors including the nature of the individual’s needs,

¹² Federal law defines a center for independent living as “a consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that . . . is designed and operated within a local community by individuals with disabilities; and . . . provides an array of independent living services”¹² 29 U.S.C. 796a. There are four core independent living services that these entities are required to provide, which include: 1) information and referral; 2) independent living skills training; 3) peer counseling; and 4) individual and systems advocacy 29 U.S.C. 705(17).

the natural supports available, the availability of housing (particularly accessible housing in a given community) and other factors. The length of time that an individual is followed after the transition also varies.

The Topeka Independent Living Resource Center (TILRC) has been a national leader in nursing home transition activities. One of 13 independent living centers in the state, TILRC assists from 10 to 40 individuals in leaving nursing facilities each year. Under the Center's Director of Advocacy Services, a staff of 13-15 independent living advocates provides outreach, advocacy, counseling, and skills training to individuals in the community and in nursing facilities. The staff also provides intensive transition assistance to individuals who are attempting to leave facilities. TILRC uses a variety of creative outreach strategies to get information to nursing facility residents including delivering special holiday gift packages (at Halloween, Valentine's Day, and other occasions.) The packages include information materials on home and community-based services and contact information for IL advocates.

TILRC advocates go to nursing facilities regularly, whether by invitation or as a community service. Their staff has identification badges, and they identify themselves upon entry at the main reception desk. "The openness" of facilities to these visits has been reinforced by state regulators who sent letters notifying the facilities of the role of these workers in helping to advise residents of their rights under the Olmstead decision.

TILRC has developed a transition checklist and a variety of informational materials. In addition to its outreach activities, TILRC operates a Transitional Living program in which individuals whose housing is not ready when they are ready for discharge may move into a furnished two-bedroom single family residence. The average stay in this unit is about two weeks with a maximum stay of 8 weeks. The transitional living house is used for short-term transitions, emergencies, and temporary homelessness.

f. Massachusetts--Community Case Management services for medically fragile children

Community Case Management (CCM) is a Medicaid-funded program in Massachusetts that provides community long-term care case management services to medically fragile children age 22 and under in Massachusetts. Children are eligible if they require more than two hours of continuous nursing services per day to remain safely at home. Members are assessed in their homes by CCM Nurse Case Managers who use a qualitative, comprehensive medical needs assessment tool to determine medical necessity. The case managers authorize and coordinate the most medically appropriate cost-effective package of long-term care services for these children. The CCM clinical team is comprised of a pediatrician, pediatric nurse case managers, physical therapists, respiratory therapists, a social worker, and a speech pathologist. The program is administered by the University of Massachusetts Medical School Commonwealth Medicine.

The program served 400 children in its first year of operations (FY 2004) and by the end of FY 2005 was serving 528 members. A survey of family members conducted by MassHealth in the fall of 2005 found a high level of satisfaction with the program. In addition, the program was able to demonstrate financial savings by maximizing third-party liability claims that far exceeded the cost of administering the program. In FY 2004 the program realized \$4 million

in cost-avoidance due to third-party liability claims and \$5 million in FY 2005. Although the program has not yet been subjected to a formal evaluation, the Office of Medicaid has been so satisfied with the initial results that the program was shifted from a pilot project to a permanent program in July 2005.

e. New option not yet tested—funding personal assistants for transition

As noted above, CMS has provided specific guidance about coverage for case management to assist with transition as well as funding for one-time expenses. In exploring this idea further, a new option was informally proposed to CMS and received a positive reception—to allow coverage for personal assistants to help residents with the transition. Such activities could include taking the resident on visits to assess the appropriateness of specific housing options. CMS indicated that this was a new idea that had not been officially proposed by a state but that it would likely be a coverable service.¹³

5. Funding for Transition Costs

State approaches for funding transition costs ranged from giving lump sums to agencies to disburse as they saw fit to providing a capped amount for each eligible transitioning individual to be disbursed by a state case manager or service coordinator.

a. Wisconsin, New Jersey, and Pennsylvania – transition funds

In Wisconsin, the state allocated \$10,000 per ILC to pay for transition expenses.¹⁴ In New Jersey, state transition funding was capped at \$600 per person, although approval could be granted for more. An interesting addition to the New Jersey approach was an NFT grant-funded assistive technology (AT) fund of \$172,077 to pay for AT that exceeds the state limit.¹⁵ Pennsylvania allocated the largest sum of money, approximately \$290,000 (58% of \$500,000 grant), for transition costs. Expenditures from this fund were approved by a central program manager on a case-by-case basis (Eiken and Heestand, 2003).

b. Washington – Multiple funding pools for transition costs

Washington has had several notable means of funding transition costs. The state permits new nursing facility residents to avail themselves of the home maintenance allowance, which Washington calls the “Medical Institution Income Exemption,” that is permitted under federal regulations at 42 C.F.R. 435.832(d). This exemption allows new nursing facility residents to keep up their income, up to the federal poverty level, for the first 6 months after admission, if the funds are used to maintain a home and a physician certifies that they do not need more than a six-month NF stay.

¹³ Idea proposed through communication with CMS officials 9/05. Their initial response was positive.

¹⁴ Wisconsin’s NFT grant was discontinued after 15 months, but a new program was put in place that incorporated some of its practices. Under the new program, ILCs were given a lump sum from which they could pay for both staff and transition costs, instead of separate fund allocations for each purpose (Eiken, Stevenson and Burwell, 2002).

¹⁵ Massachusetts also has a limited amount of funds that are allocated for “transition,” in accordance with recent changes in federal law. However, the definition of “transition” in this case is quite broad and includes transition from childhood to adulthood.

Washington also has some fully state-funded initiatives such as the Residential Care Discharge Allowance, which allows up to \$816 for transition costs per individual. This amount can be accessed quickly and easily by transition care coordinators by inputting the necessary information in Washington's automated payment system and receiving a check. If the individual needs more than \$816, the additional amount can be approved at the local level. This fund is flexible and can be used for expenses for which federal Medicaid funds cannot be used, such as paying rent. (During fiscal year 2005, the average monthly cost was \$47,000. This annual amount served about 114 clients, with an average of \$443 per allowance (Medstat 2004c).

In addition, Washington has a state-financed Assistive Technology (AT) Fund that pays for AT equipment, services and evaluation, durable medical equipment, and minor home modifications. The AT Fund average request is about \$2,000 and the limit on payments is \$10,000 per person per year. Expenditures that exceed \$10,000 are reviewed by the Office of the Chief of the State Unit on Aging, which makes decisions on a case-by-case basis. The fund is financed by an appropriation of \$95,000 per fiscal year in state general revenues (Mollica, 2003a). This fund is used only if there is a Medicare or Medicaid denial or the service/device is not covered under the Medicaid State Plan draft. The researchers received conflicting information regarding whether this fund will also pay for the expenses of individuals already living in the community.

Finally, Washington used Civil Monetary Penalties (CMP), i.e. NF deficiency fines, to move individuals from deficient nursing facilities to another setting, including community settings. Amounts up to \$800 were automatically allowed, with larger sums permitted with additional approval. According to a senior Washington state official, approximately \$700,000 was spent over a three-year period.¹⁶ This application was only one of a few uses that Washington made of this resource, so it was depleted over a period of several years as a result of multiple demands. Nevertheless, it provided a meaningful source of funding for a substantial period of time.

6. Financing mechanisms that support diversion and transition

The philosophical commitment and legislative direction to shift incentives away from nursing home utilization and toward community-based services is perhaps most evident in those states that have structured their budgets to facilitate shifts in resources that will enable individuals to remain in or move to the community. These initiatives have been called "shifting the balance" or letting the "money follow the person."

a. Texas – Money follows the person

As part of its "Promoting Independence Initiative," described above, Texas created a new financing mechanism that enabled nursing facility residents to receive HCBS waiver services and bypass the waiver "interest list." To make this possible, in its 2001 Appropriations Act, the Texas legislature enacted Rider 37, which states that "(i) it is the intent of the legislature that as clients relocate from nursing facilities to community care services, funds will be

¹⁶ Conversation with Aging and Adult Services Administration, Washington, July, 2005.

transferred from the nursing facility to community care services to cover the cost of shift in services” (Reinhard and Hendrickson, 2004). Texas reissued this same language in Rider 28 in 2003 along with several other riders, one of which required that funds be returned to the nursing facility budget if the individual stopped receiving services.

The shifting of funds for those who transition into the community makes it possible for individuals to “jump” the waiver interest list. Individuals are also allowed to use up to \$2,500 of their waiver budgets on transition services for items such as paying utilities, first month’s rent, and related one-time expenses. This approach is often referred to as “money follows the person” in Texas. However, the state does not transfer the amount being spent in the nursing facility to the community at the time the individual moves to the community. Rather, the state periodically determines the average amount spent on HCBS waiver services and then transfers that amount from the NF budget to the community services budget retrospectively to cover expenditures for those waiver participants who had transitioned from the nursing facilities. As noted, in 2003, the Texas legislature passed a provision stating that if an individual who has transitioned stops receiving HCBS waiver services, then money is no longer transferred from the nursing facility budget for their care. Thus, the base number of HCBS waiver slots is not expanded. This language was codified in 2005 with the passage of House Bill 1867 in the 79th Regular Legislative Session.

The initial Rider 37 took effect on September 1, 2001. By early 2004, 3,181 individuals had transitioned from nursing facilities.¹⁷ As of the end of December 2005, Texas estimates that 10,000 individuals have been transitioned as a result of these initiatives.¹⁸

b. Vermont – Shifting the balance legislation

Like Texas, Vermont passed legislation, Act 160 in 1996, to rebalance the state’s long-term care system by shifting the emphasis from institutional care to home and community-based care. Specifically, the statute had the following overarching purposes:

- Enhance the state’s independent living options for elders and younger people with disabilities
- Slow nursing facility budget growth
- Redirect dollars saved from slower nursing facility budget growth to home and community based care, with substantial consumer participation and oversight as part of the planning process.

Act 160 established a formula for determining a target amount by which NF expenditures should be decreased by multiplying a certain number of nursing home beds by the cost of a bed over the subsequent four-year period. It further required that any savings realized from cost reductions for NF spending be reallocated to home and community-based services. Two provisions in the legislation accomplished this task. The precise legislative language for reducing the amount allocated for nursing facility expenditures was as follows:

¹⁷ Web cast and Teleconference: Money Follows the Person: The Texas Experience. Presented by: Marilyn Eaton, Bob Kafka, Judy Telge, and Jay Klein. March 31, 2004

¹⁸ Conversation with Texas Department of Aging and Disability Services, February 2006.

By the end of fiscal year 1997, the agency shall reduce Medicaid nursing home expenditures by an amount computed by multiplying 46 beds by the average annual expenditure for a nursing home bed in fiscal year 1997, as determined by the division of rate setting. For fiscal years 1998 through 2000, the agency, in cooperation with the nursing home industry and other affected parties, may reduce Medicaid nursing home expenditures in each fiscal year by an amount computed by multiplying the number of beds for that fiscal year, as indicated in the following schedule, by the average annual expenditure for a nursing home bed for that fiscal year, as determined by the division of rate setting, provided that, at the end of fiscal year 2000, the agency shall have reduced the Medicaid nursing home expenditures by the total amount of the reductions scheduled for each fiscal year, 1997 through 2000.

--Vermont Act 160, Section 2(a)

In FY 1998, the formula used 68 beds as the multiplier. In FY 1999, the figure used was 59 beds and in FY 2000, the figure stated was 61 beds. The number of nursing home beds used as the multiplier was based upon two separate calculations, each of which yielded similar results. The first set of calculations was performed in response to a 1991 report written by the Vermont Department of Aging and Disabilities, now called the Department of Disabilities, Aging and Independent Living (DAIL), which determined that the existing allocation of public long term care expenditures was 80% for nursing homes and 20% for home-based care (DAIL, 1991). The report recommended that Vermont move toward a 70%/30% split between these two types of care. Therefore, Vermont DAIL staff calculated the amount of money that would need to be reallocated to achieve this split and then converted that figure to nursing facility beds equivalents.

The second set of calculations was based upon projections of demand for "nursing home level of care" or Medicaid recipients in both nursing facilities and the community. These projections were found in Vermont's annual Health Resource Management Plan (HRMP), which is produced as part of its Certificate of Need process. For Act 160, the DAIL took the HRMP's numbers for the "nursing home level of care demand" that were unmet by Medicaid-paid nursing facility beds and calculated the cost of meeting that demand through its HCBS and Residential Care Medicaid waivers, both of which served individuals who needed a "nursing home level of care" in the community. Once calculated, this amount was converted to the cost equivalent of a specific number of nursing facility beds, with an eye on reaching the 30% target for home-based spending. (Personal communication with Julie Wasserman, 11/14/05).

The second provision, which reallocated the savings created by the previous provisions to home and community based services stated:

The reductions required in subsection (a) of this section shall be redirected in fiscal year 1997 to fund home and community-based services. For fiscal year 1998 and thereafter, the reductions required in subsection (a) of this section shall be redirected in that fiscal year to fund both home and community-based services and any programs designed to reduce the number of nursing home beds. Any general funds that are redirected but not spent during any fiscal year shall be transferred to the long-term care special administration fund which is

hereby created. Notwithstanding the provisions of 33 V.S.A. § 588(3), interest earned on the fund shall be retained in the fund. All monies received from or generated to the fund shall be expended only for home and community-based services or for mechanisms that reduce the number of nursing home beds. The fund shall be managed and disbursements made in accordance with the provisions of subchapter 5 of chapter 7 of Title 32.

--Vermont Act 160, Section 2(d)

In practice, Vermont did not rely on these figures to determine the amount that it was going to reallocate to community services. Nor did Vermont reallocate whatever funds were not spent from the nursing facility budget to community services, particularly HCBS waiver slots. This reallocation occurred during a period when a large number of nursing facility beds were closing as a result of market forces. Nursing home expenditures as a percent of the total long-term care budget dropped from 88% in 1996 to 70% in 2004 (Reinhard and Hendrickson, 2004). The new budgetary mechanism also allowed local communities to receive \$50,000 to provide services and make purchases that consumers could not afford and typical government funding sources would not support. Decisions about how to allocate these local funds were made in collaboration with local long-term care coalitions, which are comprised of local providers and consumer advocates. Although, these provisions of Act 160 have expired, the state has continued expanding its support of home and community-based services.

c. Wisconsin – Reallocating funds for community options

Wisconsin also reallocated funds from nursing facilities to the community. The Wisconsin Community Options Program Waiver (COP-W) serves older people and people with physical disabilities. This waiver is separated into two waiver programs: Community Options Program Waiver (COP-W) and the Community Integration Program II (CIP II)¹⁹. The source of state funding for these two waiver program budgets differs. The target groups and eligibility criteria for both programs include elders and individuals under 65 who have physical disabilities and who require a nursing facilities level of care. COP-W pays for ongoing home and community-based services *and* transition costs²⁰ while CIP II pays for ongoing home and community services.

In Wisconsin, counties manage the COP-W with allocations based on the Community Aids formula (base allocation or for special needs, such as nursing facility relocations or to address waiting lists). They provide HCBS assessment and care coordination. Counties serve people on a first-come first-served basis and many counties have waiting lists for their services. People living in nursing facilities must wait until they are at the top of the waiting list before moving.

To address the waiting list, the state increases the county's allocation by the amount necessary to meet the community needs of each person who leaves the NF while using COP-W. Once this person no longer needs waiver services, the funds will remain available

¹⁹ In addition to the COP-W waiver, Community Options Program (COP) is a flexible state program that provides services not available under the COP-W or through other programs.

²⁰ On January 1, 2003, WI added community transition services to its COP-W (the waiver can pay for many transition services.) Prior to that, WI set aside \$1.0 million in 2001 and \$1.3 in 2002.

for other people in that county who need HCBS services. This earmarked relocation funding is an incentive for counties to seek out people in nursing facilities wishing to transition to community settings.

The state increases the CIP II budget every time an NF closes a bed and a Medicaid participant transitions to the community. The CIP II budget increases by the CIP II rate. If that person does not use the CIP II services, then the funds will be available for another person leaving an NF. At the same time, the state budget for Medicaid NF residents is reduced, so the result is a transfer of funds from NFs to HCBS services. Participants can receive CIP II funds as soon as they move out of the NF. If the participant moves to a new county, the funding will transfer with them.

Wisconsin staff report that 153 people left Wisconsin NFs in 2001 due to targeted funding from CIP II, COP-W, and the state-funded community supports program, COP. In calendar year 2002, the average daily cost of CIP II and COP-W participants was \$74.76, whereas the average daily cost for equivalent care in a NF was \$100.45 (Medstat, 2005). In calendar year 2003, 266 people were relocated from nursing facilities to community-based settings using COP-W and CIP II. The average daily cost was \$77.03 for waiver participants versus \$99.14 for nursing facility residents for equivalent care. In 2003, a portion of nursing facility bed closures resulted in an additional 226 CIP II slots (Community Options program Waiver ' Report, 2003).

d. Oregon and Washington – Consolidated budget for long-term care

Pioneers in rebalancing their systems, Oregon and Washington eliminated the need to take money from one budget and transfer it to another by creating a single long-term care budget for both institutional and community services. In both states, the nursing facility and home and community care budgets are in the same administrative entity, thereby making it relatively simple to allocate funds between programs. Oregon and Washington state statutes place a clear priority on community care and cost-savings. Funds have been allocated in a manner consistent with those priorities, with the result that the majority of resources have shifted to the community.

7. Supportive Housing Options

The lack of housing, particularly housing with supportive services, was cited by a substantial majority of individuals interviewed as a major barrier to transitioning individuals from nursing facilities. One of the primary advantages of nursing facilities is that they combine housing with long-term supports in one package. An effective home and community-based system needs to include options that offer a similar service package without simply creating a new form of facility-based care. It was beyond the scope of this report to identify housing models except those whose primary purpose was diversion or transition. The transitional housing program offered by Elder Services of the Merrimack Valley (ESMV) offers such an alternative. It provides its occupants with the opportunity to adjust to community living and take the steps necessary to obtain appropriate community supports over time. This model could be implemented statewide.

People who leave nursing facilities need some place to go. Unfortunately, by the time that someone has been in a nursing facility for a period of even six months, many connections to the community have been lost due to a loss of housing, informal or family support, and other resources. For transitioning individuals, community housing with on-site supports could ease the transition. Therefore, non-institutional housing options that include some capacity to address an individual's long-term support needs represent an important part of any state's rebalancing efforts. Those states that have been most successful in rebalancing their long-term care systems are those that have addressed the issue of supportive housing.

a. Vermont and New Jersey – Services linked with housing

Some states have addressed the issue of housing through the use of Medicaid waivers. For example, Vermont created the Enhanced Residential Care waiver, which provides 24-hour care at a licensed residential care home to delay and prevent nursing facility admission. The creation of the waiver was part of the statewide effort to reduce nursing facility usage. Services in this waiver include care coordination, nursing services, and personal care assistance. Similarly, New Jersey created a waiver to provide assisted living, adult family care (Crisp, et al. 2003), and self-directed services. New Jersey has also state funded congregate housing.

b. Oregon – Services linked with housing

Perhaps the state with the longest history of success in providing supportive housing is Oregon. Oregon has put a great deal of effort into developing its system of community supports for elders and younger persons with disabilities. Oregon was at the forefront of the development of housing alternatives, with supports, such as adult foster care and assisted living by providing low-interest loans and similar incentives to developers who were willing to set aside a certain number of units for Medicaid recipients. In this way, an array of options evolved that were shared by both Medicaid-eligible and private-pay individuals.

c. Transitional Housing linked with Congregate Housing

Elder Services of the Merrimack Valley (ESMV), one of the Massachusetts Aging Services Access Point (ASAP) agencies, has an agreement with the local housing authority to maintain four units in the Congregate Housing program specifically targeted to help nursing facility residents transition back to a community setting. Most of the referrals come from the ASAP network. Residents receive services depending on their individual needs and circumstances such as family and informal support.

ESMV guarantees the rent if any of the units is not occupied. The four units have been filled since the beginning of the initiative (approximately 2 years) with 3 of the 4 initial residents. ESMV recently helped one resident move to an apartment in subsidized elder housing. This individual was the first resident to move from the transitional setting to the community. The transitional unit was re-filled immediately. ESMV staff report that they could use additional units, and the agency is exploring options for expansion.

The Congregate Housing program was nationally developed by the Department of Housing and Urban Development and the Administration on Aging in the 1980s, and these developments exist across the country. Congregate housing provides housing arrangements

that offer a shared living environment in a home-like setting that integrates shelter and supportive services. Many units are physically accessible. In some ways, the congregate housing movement has been overshadowed by the more upscale “assisted living” movement, and in some states this has led to large numbers of vacancies in congregate housing. Therefore, the use of some units for transitional housing, to enable individuals to make the transition from a nursing facility to the community, may have promise in many states.

V. Lessons Learned

What lessons have states learned from their transition efforts? In an August 13, 2002 letter to state Medicaid directors, CMS identified the following lessons that states with NFT grants had identified as key:

- 1) It is best to hire staff dedicated specifically to facilitating transitions;
- 2) Adequate and flexible funding of items such as security deposits, utility set-up, moving expenses, furnishings, and other related expense must be available to set up a residence in the community;
- 3) Transition staff must work closely with both public and private housing vendors and landlords to ensure that housing is available;
- 4) Close coordination with other community services is necessary to ensure that services are available as soon as the individual moves into the community;
- 5) Aggressive outreach to nursing facility residents is necessary;
- 6) Nursing facility residents should take an active role in planning their own transition;
- 7) A high level of dedication among transition staff is critical and can often be found among people who have, themselves, transitioned to the community.

Another important lesson learned from the states’ experience is the importance of timing (Kasper 2005). Expediting enrollment into HCBS and other community services is essential both for diversion and transition purposes and was a component of nearly every state’s strategy. Similarly, being able to expedite payments to community vendors is an important step in smoothing a transition to the community.

Helping NF residents to maintain their community ties as is done in Washington is another helpful transition strategy, e.g. allowing residents to keep their income to maintain their community housing for up to six months after admission to a nursing facility. This is a good example of a concrete strategy for maximizing an individual’s chances of remaining connected to the community and preventing a long-term nursing facility stay.

As noted above, the most effective outreach strategies appear to be those in which there is significant and ongoing person-to-person contact between transition staff and hospital or nursing facility staff and residents. As with many things, the strength of relationships is a

central component of effective outreach (Ginsberg, 2002). A willingness on the part of transition staff to approach hospital and nursing staff with an attitude of “We’re here to help you” appeared to be the most effective strategy.

Finally, although many states share the common goal of diverting and transitioning elders and younger people from nursing facilities, they do not share a common definition of what constitutes a diversion or transition. While this does not necessarily affect actual diversion/transition activities, this inconsistency makes it a challenge to evaluate the effectiveness of their diversion and transition activities. For example, one state reported that information on home and community based supports is provided to hospital patients or individuals in the community. This state’s diversion statistics were based on the number of individuals to whom information was provided. However, it is not valid to attribute diversions solely to the presence or absence of such information. Some individuals may not enter a nursing facility even without such information, and some nursing facility residents receiving state assistance to return to the community may have done so on their own, particularly those admitted for short-term stays. Clarity of definitions will help states better evaluate the success of diversion or transition activities.

VI. Recommendations to Increase Diversion and Transition

The present review of diversion and transition activities across the country has revealed a number of gaps that continue to restrict opportunities for individuals to live in the community. This section provides specific recommendations to enhance opportunities for nursing home diversion and transition and thus address the barriers identified in Section II of the report. In making our recommendations, we relied on the reported success of measures in specific states and the information obtained from interviews about relative merits of each approach. No cost analysis or independent evaluation of the programs was conducted. Whether the approaches identified below should be replicated by any particular state should be assessed not only on available information on their effectiveness but also on other factors including ease of implementation, stakeholder buy-in, and the presence of similar local conditions.

The flow chart at the end of this section provides a visual depiction of how the proposed interventions would assist individuals and states in addressing the barriers to diversion or transition from nursing facilities.

Recommendation 1. Increase public awareness about available community options

The public is not sufficiently aware of the wide range of community options that can address the needs of persons with disabilities or chronic conditions. Pressures on hospitals to discharge patients are substantial and aggressive efforts are required to effectively divert individuals from nursing facility care. A multi-pronged effort to educate hospital staff, physicians, patients, and the general public about availability of community options and dispelling the myths about their relative risks are important steps to consider. Enhancement of nursing facility screening activities is another key activity that would help to assure that all options are explored prior to an admission or at least before a short-term admission becomes a long-term stay. Experiences of New Jersey, Oregon, and Pennsylvania provide examples of options for consideration, and potential refinements or expansions suggested by interviewees in Massachusetts provide additional avenues for addressing this recommendation.

Specific options to consider:

a. Develop proposed legislation that articulates the commitment to community options

Passage of legislation articulating a state's commitment to enhanced community choices would further reinforce diversion and transition options. Most of the states that have made the greatest strides in expanding access to home and community-based services have operated under broad legislature mandates that expressed the public commitment to encourage community living options for people needing long term supports. Public consensus on community choices appears to be growing slower across the country, and the experience of many states reinforces the financial as well as personal advantages of such expanded choices.

b. Educate hospital staff, patients and their families

Given the large volume of nursing facility admissions that follow discharge from a hospital, states should consider piloting hospital-based initiatives to educate hospital staff, patients, and families. These initiatives could include development of written materials to be given to all persons needing long-term care following a hospital discharge as is done in New Hampshire. If materials are developed out of a campaign to educate hospital staff and patients, such materials should also be made available to staff and residents in nursing facilities.

c. Replicate the successful features of the Aging and Disability Resource Center (ADRC) Model

CMS and the Administration on Aging have provided specific funding to encourage replication of the ADRC model for providing information and referral services across age and disability. This model brings together lead agencies in aging and disability with a state in order to improve the information provided to any caller through a, “no wrong door” approach to providing information and access to services. Additional features of the collaboration between the two partner organizations include the cross-training of each agency’s staff on their respective philosophies and service options, and the ADRC’s tracking systems. The ADRC approach has significant potential for replication across the country.

d. Screen for nursing facility residents who may become eligible for Medicaid in 90 days

Some states, like Oregon, screen all nursing facility applicants. This approach has the benefit of ensuring that the state’s entire system is working in the same direction. However, it is very resource intensive. One approach would be for states to increase their screening to include individuals who are likely to convert to Medicaid within 90 days to determine whether they can be transitioned back to the community. In this way, the state can identify individuals who are potentially Medicaid-eligible and work with these individuals to begin the process of transitioning to the community before they spend all their resources and qualify for Medicaid. Oregon increased its screening to persons likely to convert to Medicaid before expanding its screening activities to all NF applicants. Using this approach in Massachusetts could similarly serve as a cost-effective step toward screening a broader group of nursing facility applicants.

e. Use the MDS to identify potential transition candidates

Of the data-based approaches used by states thus far, Pennsylvania’s approach appears to be the most promising. If MDS data can be obtained in a timely manner, then states could identify individuals for potential transition based on their responses to these MDS questions: Q1a, (which indicates that the “resident expresses/indicates preference to return to the community”) and Q1b, (which inquires whether a resident

has “a support person who is positive toward discharge.”) Follow-up contacts could be made by care coordinators or transition staff at independent living centers.

f. Strengthen the PASRR processes to reinforce diversion/transition

In many states, the existing PASRR processes have been developed to meet the minimum requirements of federal law. However, enhancements to these processes could assist states in meeting their diversion/transition goals. Wherever possible, these screening activities should be conducted prior to admission or as soon as possible after admission. Even for individuals for whom the federal law permits a 30-day stay prior to screening, earlier review would enable care coordinators to better assess the opportunities for diversion/discharge and to begin planning the supports that will be needed upon discharge. Moreover, states could strengthen the information collected in the PASRR reviews to more effectively “rule out” community options and to explore community service options more fully with the individual in an attempt to encourage discharge. Refinements of data collection tools could also provide the opportunity to analyze patterns of need among persons with developmental disabilities and serious mental illness. Such analysis could be used in planning system-wide interventions to increase the number of individuals diverted.

Recommendation 2. Expedite eligibility for community supports

Since individuals who need long-term supports may be at risk in the community if such services are not provided in a timely fashion, it is critical to assure timely access to services. Otherwise, there will continue to be an inherent bias in favor of receiving support in a nursing facility. Information gathered in Washington and Massachusetts suggested potential program refinements in this area.

Specific options to consider:

a. Amend HCBS waivers to presume financial eligibility for up to 60 days to facilitate access to HCBS

Following the example of Washington, states should consider authorizing HCBS waiver services based on a self-declaration of income and assets and allow the individual to receive HCBS waiver services for up to 60 days while their Medicaid application is in process. This would decrease the amount of time it takes to obtain HCBS, thus increasing the incentives for diversion/transition. The new home care provision in the Deficit Reduction Act provides federal matching funds to assist states that want to implement such “presumptive eligibility.”

b. Reduce processing time for conversion from nursing facility to community Medicaid eligibility

States should review internal processes to assure that there is no lag in converting the individual’s Medicaid eligibility from the long-term care (nursing facility) category of eligibility to the community category when an individual is transitioning from a nursing

facility to the community. Expediting this process could help consumers to obtain prescription drugs, medical transportation and other essential Medicaid services immediately upon their return to the community from a nursing facility.

c. Expedite access to personal care assistance and medical equipment

For individuals transitioning from nursing facilities, states may want to consider establishing a minimum number of hours of service that could be approved in advance to assure that individuals can have HCBS services in place immediately upon their return home. States should also seek ways to expedite the review and approval process for personal care assistants and durable medical equipment prior approval requests made on behalf of individuals who are in need of diversion or transition from a nursing facility. A follow-up assessment could be conducted once the person has settled in the community and a more stable picture of the number of necessary hours could then be determined. States should also consider encouraging access to other assistive technology to support individuals leaving nursing facilities.

Recommendation 3: Increase care coordination services for targeted groups

Given that care coordination services are essentially the linchpin of any diversion/transition effort, they are a good investment of state dollars. The expansion in the options for obtaining federal reimbursement for transitioning individuals from nursing facilities enhances the state's ability to devote additional resources to this critical service.

Those states that have had the most success with transitioning individuals to the community are those that hired care coordinators specifically devoted to this purpose. To the extent that future diversion/transition efforts can support full-time transition care coordinators, this practice should be encouraged. Leaving the question of whether there should be full-time employees devoted exclusively to this work up to local implementers may be a reasonable way to allocate scarce resources which may vary significantly from locality to locality and organization to organization.

Specific options to consider:

a. Devote additional resources to care coordination

Devoting more resources to care coordination through a variety of programs provides opportunities to develop approaches that are tailored to the needs of discrete populations. For example, some nursing facility residents may benefit from a peer counseling model, while others may prefer another approach. Deaf individuals often have difficulty in obtaining diversion and transition services from some programs because of the language barrier and a lack of understanding of their needs. Some groups of consumers may need more intensive services than others. Additional resources targeted to care coordination would help to ensure that transition efforts were more effective in meeting these types of specific consumer needs.

b. Enhance clinical support (including mental health) to assist care coordinators in diversion and transition activities

Not all care coordinators have opportunities for input and support from clinical staff, such as nurses. Given the complex clinical profiles of many individuals who need diversion or transition services, such clinical consultation services, including mental health consultation, should be strengthened in existing programs and should be available to care coordinators involved in other transition efforts, such as that implemented by the independent living centers. In addition, as a strategy to prevent re-admission to nursing facilities, clinical support should be available on an ongoing basis after the transition is complete.

Given the critical need to address these mental health comorbidities, engaging expertise from the mental health system could be of great value for a substantial number of consumers. States should seek ways to reinforce access to mental health supports in some diversion/transition programs, such as involving their community-based mental health providers more actively on an ongoing basis.

Recommendation 4: Increase transition housing opportunities including those that link housing and supportive services

Even though housing departments may collaborate with the various human services agencies to make accessible public housing units available to elders and people with disabilities, there continue to be individuals who are institutionalized primarily due to a lack of affordable, accessible housing and individualized services. The lack of accessible and affordable housing and lack of coordination between housing and supportive services are among the most significant barriers to transforming long-term supports to increasing community living options. Putting a priority on development of accessible housing is an important goal that would assist diversion and transition efforts even though its primary purpose is clearly broader than diversion/transition. In addition, focusing specific attention on developing transitional housing options for persons seeking to leave nursing facilities could help expedite transition efforts. States with underutilized congregate housing units may want to look at the Massachusetts pilot project as a potentially replicable option to help individuals in their first year of transition. The initiative developed by the Topeka Independent Living Resource Center offers a similar model for establishing such transitional housing.

Specific option to consider:

a. Expand transitional housing through the Congregate Housing program

The pilot transitional housing program in Massachusetts addresses one aspect of the housing barrier identified by nearly every key informant and program staff person interviewed. Housing, with supports, needs to be obtained quickly. The Congregate Housing program is available across the country. While it is not an option for all, states may find that the program has additional capacity that could help individuals to transition more quickly from a nursing facility to the community.

Recommendation 5: Increase incentives for diversion and transition

As noted previously, Washington state has several funds that it uses to finance different types of transition costs. States could either replicate these different financing sources or simply create a single larger fund for such transition expenses. The experience of states that have funded transition costs is that a broad, flexible definition of transition costs is the most effective way to fund such expenses. This permits care coordinators to use the money in a variety of circumstances, which are not always foreseeable. This approach would maximize care coordinators' abilities to address issues which they currently express as frustrations such as the lack of accessible housing and the difficulty and time lag in obtaining durable medical equipment and personal assistance. Options from Washington, Vermont, and Wisconsin provide the basis for the specific suggestions related to this recommendation.

Specific options to consider:

a. Use a combination of Medicaid and State funds to support transitions

Many states have begun to cover transition costs under their HCBS waivers and may find it helpful to increase the range of services that can be covered to support transitions under the HCBS waivers. For example, it appears possible to fund personal assistance to help assist nursing home residents in making visits into the community to arrange for needed services and supports such as evaluating housing options; such assistance could meet an important need for individuals who are unable to find housing without assistance. States may want to explore this option to assist nursing facility residents to have true choice and involvement in the transition process.

To the extent possible, state funds should be used to complement the federal funds available, i.e. to cover expenses that are not allowable under Medicaid law or which exceed the amounts that federal law may permit. Following the example of other states like Washington, if a state obtains Medicaid waivers that cover some of the expenses for transition services, it may still be beneficial for them to use state funds to fill gaps and cover those who do not qualify for the waiver. States should also investigate the possibility of emulating Washington and using some of its Civil Monetary Penalty funds to finance transition from nursing facilities.

In setting up the structures for administering these funds, states should assure that individuals and their care coordinators can quickly and easily access the funds since rapid access to transition funds is critical to consumers' ability to obtain housing and other critical supports.

b. Explore innovative financing mechanisms that encourage diversion and transition

Given the federal emphasis on rebalancing and "Money Follows the Person" initiatives, along with the state's emphasis on cost-containment, the time may be ripe for the states to implement some innovative funding mechanisms that will help to align long-term care financing with overarching policy goals in order to reduce the existing institutional bias while saving costs. States such as Vermont and Wisconsin have

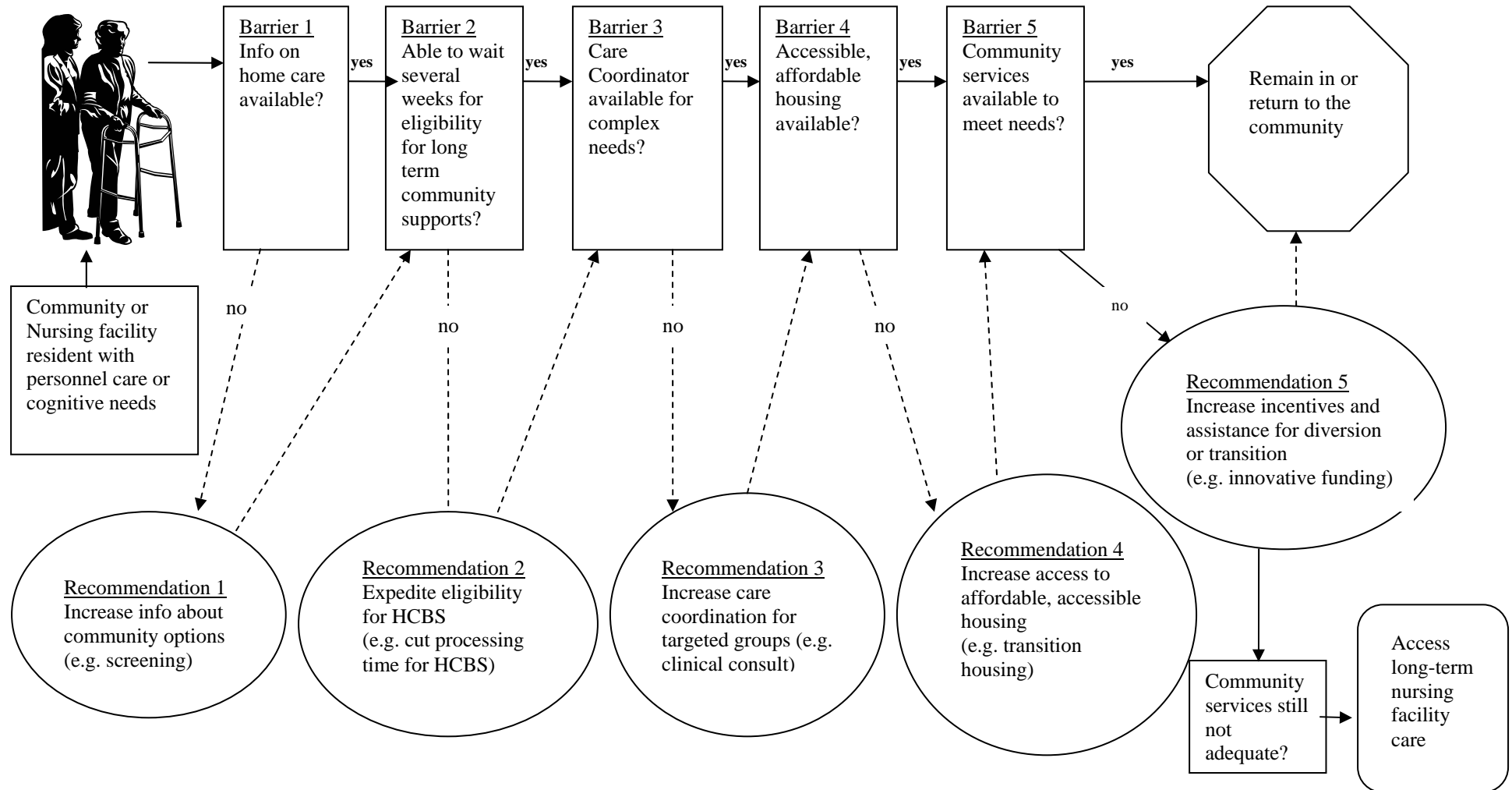
succeeded on a long-term basis in shifting their resources to the community by modifying their financing mechanisms to make it easier to fund community services in order to reduce institutional costs. Further study may be helpful in determining what modifications to financing mechanisms would be most effective and feasible in the current political and economic climate.

Data Consistency

As states move forward to implement diversion and transition activities, it will be important to establish benchmarks and measure progress. One challenge to this is the need to establish a set of consistent definitions for measuring diversion/transition activities. Although educational activities are important, they cannot on their own be assumed to result in a diversion or transition. Therefore, counts of informational activities should be maintained, but should be tracked as educational activities. The following definitions are proposed for consideration by state policy makers and their respective program directors:

- Educational activities to support diversion/transition:
Number of individuals who received information or education about community options either in written or oral form. This number could be reported separately for individuals in the community, hospitals, and nursing facilities;
- Diversion from nursing facility stay:
Number of individuals who received active intervention that enabled them to avoid admission to a nursing facility;
- Discharge following short-term stay:
Number of individuals who relocated to the community from a long-term stay less than or equal to 90 days (Note: The Rolland settlement defines this category of diversion while most other programs consider it to be transition);
- Discharge following a medium-term stay:
Number of individuals who relocated to the community after a nursing facility stay that exceeds 90 days but is less than one year;
- Discharge following a long-term stay:
Number of individuals who relocated to the community after a nursing facility stay of one year or more.

Proposed Interventions to Increase Community Living Opportunities



VII. Conclusion

Over the last few years, many states have made important strides toward rebalancing their system of long-term supports. The states that have been most successful on a long-term basis are those that combine three elements – aggressive outreach and care coordination, financing mechanisms that reallocate resources to the community and an investment in community alternatives, such as supportive housing, adult foster care, and other models. States can learn much from the accumulated wisdom of other states, allowing them to build on successes and create innovative new programs for elders and people with disabilities who want to live in the community.

The recommendations in this report address many of the existing barriers that continue to limit the number of individuals who can access home and community-based services. While states may not be able to pursue all proposed options, a combination of interventions would clearly increase opportunities for elders and people with disabilities to live in non-institutional settings.

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