DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-15
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

SMDL # 04-005

August 17, 2004

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) has supported states in the implementation of the principles of money follows the person (MFP) by providing resources and technical assistance. We are committed to continuing to assist states in implementing the principles of MFP under existing authorities.

A number of states have pursued strategies under existing authority that can be useful models to states interested in making immediate changes to their delivery systems. Previously, we highlighted MFP in two State Medicaid Director letters on August 13, 2002, and September 17, 2003, and provided technical assistance to states through the dissemination of "promising practices" on our Web site. In particular, we have highlighted innovative states including Arizona, Colorado, Indiana, Texas, Florida, New Jersey, Oregon, Utah, Vermont, Washington, and Wisconsin. Still other innovations are occurring under current law with the support of Real Choice Systems Change Grants for Community Living (Attachment #1).

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

We are committed to continuing to assist states in implementing the principles of MFP under existing authorities and hope to address areas of confusion that may be impeding efforts to rebalance long-term support systems. This letter intends to clarify a few issues that have been brought to our attention.

Issues Identified to Date

Home and Community-based Services (HCBS) Waiver Capacity and Cost Neutrality: Although states may implement MFP strategies without a waiver context, states that anticipate using HCBS waivers as part of their rebalancing strategy may be concerned about waiver capacity and demonstrating the cost neutrality of proposed waiver services. States may request to amend their current HCBS waiver program to include additional participants. States that do so are still required to demonstrate the continued cost-neutrality of those programs;

however, most states have found that in the aggregate waiver programs continue to demonstrate cost neutrality even with the addition of waiver participants. Any state that has concerns in this area is asked to work with CMS to assess the underlying assumptions and structural issues of its cost neutrality estimates.

Backfilling of Nursing Home Beds:
States that implement MFP strategies will begin to achieve a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional forms of service and the proportion of combined funds used for home health and personal care services under the state plan and waiver services. We anticipate that as individuals have greater choices in service delivery, a smaller proportion of individuals will choose institutional care. We encourage states to reduce nursing facility beds to assist a state in rebalancing its long-term care service system, but this is not a requirement.

Self-Directed Models:
Over the past several years, individuals and families have advocated for directly involving persons who receive Medicaid funded services and supports in the decisions that affect their lives, and providing those individuals with greater choices and control of their services and supports. For individuals to naturally select community services over institutional services, states must ensure that a broad array of quality services are provided under a long-term care system that recognizes service delivery options that are diverse and flexible. CMS is committed to supporting and further implementing models such as those contained in the *Cash and Counseling Demonstration and Evaluation Project* and the *Independence Plus* initiative. These programs not only realize MFP principles but use an individual budget to provide participants direct opportunities to make personalized decisions about the allocation of available resources. While CMS continues to encourage states to consider these system reforms, we also recognize other strategies for the provision of HCBS that expand the level of individual choice and control without making major modifications to state infrastructures. Quality community programs offer not just one model of delivering community services but rather a continuum of options in order to allow individuals to select the service delivery method that best meets their preferences, desires, and personal outcomes. The selection as to which option is best may vary depending on the level of other community supports available, or simply the inclination of the individual. Along this continuum, CMS has identified the following four basic service delivery models related to services and supports of personal attendant:

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

A description of these models and examples of state innovation is included in Attachment #2.

We will continue to help provide opportunities for people to live in the communities of their choice. We welcome your input and hope you find this information useful.

Sincerely,

/s/

Dennis G. Smith
Director

Enclosures

cc:
CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

Attachment #1

Examples of State Innovation
Under the Real Choice Systems Change Grants for Community Living:
Money Follows the Person Rebalancing Initiative

California

The California Department of Health Services (DHS) is developing models and systems that enable money to follow the person from institutional to home and community-based settings. Specifically, it is developing standardized protocols and processes, including a consumer-focused quality assurance model, a standardized consumer-oriented nursing facility transition care planning model, and a uniform assessment tool and protocol. A pilot project will test the developed tools and protocols, and inform statewide policy decisions about a Money Follows the Person Initiative in California using individual and aggregate data and fiscal analysis based on case examples.

Maine

The Maine Department of Behavioral and Developmental Services is adopting a standardized assessment and budgeting process for mental retardation waiver services that results in consistent, predictable, and truly portable budgets. The State is directing resources toward more person-centered, consumer-driven services offered in the most integrated and appropriate setting and identifying cross-system performance measures that enable Maine to comprehensively and coherently assess its success at achieving a balance of services across systems. Maine is piloting an individual budget tool and assessing its impact on consumer satisfaction, providers, budget neutrality, staffing requirements, and Medicaid management information systems.

Nevada

The Nevada Department of Human Resources is rebalancing the State's long-term services programs so that community services and supports are the primary source of support for people with disabilities. It is identifying individuals for community integration, implementing their transitions, and using peer advocates to assist in the transition process. In addition, Nevada is establishing a Housing Specialist at the Nevada Developmental Disabilities Council to help individuals locate affordable housing and access State and local housing assistance programs. The State is also revitalizing the Nevada Home of Your Own program, an initiative to help people with disabilities secure housing, and developing and maintaining a registry of affordable, accessible housing in Nevada.

Additional examples can be found on the CMS Web site at www.cms.gov/newfreedom.

Attachment # 2

Service Delivery Models for Attendant Care

Service delivery models have been evolving over the last decade and continue to be refined and clarified. The following are four basic models that CMS has identified based on state experiences. Each of these design approaches can be used by states to enable them to employ money follows the person principles. States are not limited in the various strategies they may employ.

Traditional Agency Model

Under a traditional agency model, an agency assumes responsibility for recruiting, hiring, managing, training, and dismissing employees who are hired to provide, at a minimum, basic assistance with activities of daily living to individuals living in the community. The agency sets the wages and hours, and directs the actions of the employee while in the participant's home and provides necessary back-up as needed. Services are provided based on a standardized assessment of needs typically performed by a medical professional. A Medicaid agreement executed with the Medicaid agency, and the provider agency, clearly articulates the scope of the services and identifies allowable tasks that may be performed. The agency is paid by the Medicaid agency to provide personal assistance services.

Traditional Model Supporting Choice

Many traditional provider agencies honor the principles of choice, control, and the person-centered planning process. These progressive agencies allow, or even encourage, participants to identify and refer to the agency, attendants they have selected and offer training in the philosophy of self-direction. Many agencies also provide a list of potential attendants that participants may interview. Back-up is provided by the agency. Attendants are expected to respect participant preferences. States implementing this model may do so without modifying their state plan or waiver services since the provider agency continues to operate under a traditional Medicaid Provider Agreement to provide personal assistance services and is reimbursed for providing these services. The agency continues as the responsible entity over the provision of personal assistance services and over the attendants who provide this service. While the participant has the ability to select his or her attendant, the agency continues its role as the employer of the attendant and retains responsibility for the oversight of the personal attendant service. The Trinity Respite Care in Lawrence, Kansas is an example of a Medicaid provider agency that gives its clients the opportunity to select their own attendants.

Agency with Choice

This model, first described in a research document entitled *Consumer-Directed Personal Assistance Services: Key Operational Issues for State CD-PAS Programs Using Intermediary Service Organizations* (1997) by Susan Flanagan and Pamela Green, provides an increased level of responsibility by designating the participant as the ***managing employer*** without becoming the common law employer (employer of record) of his or her attendant. For IRS purposes and other employment considerations, including making payment to the provider, the agency is the common law employer. The participant recruits, interviews, and selects the attendant care provider and refers him or her to an agency for the completion of payroll responsibilities. An individual budget may or may not be used to determine the available resource allocation. The

participant generally establishes the wages and sets the working hours. Once hired, the participant manages the attendant including the approval of timesheets. The participant may elect to train the individual or may direct the agency to provide training on his or her behalf. The agency may offer additional services to support the participants' ability to self-direct. These supports may include making other purchases (included in the individualized budget) on behalf of the participant, assisting with managing the individual budget or providing training on how to hire and manager attendants. While the agency and the participant share employer responsibilities, the agency executes a Medicaid Provider Agreement with the Medicaid agency to provide the personal care services and any supportive services. The agency may offer a traditional service model along with Agency with Choice services model, but clearly there is a formal distinction between the two models. The New Hampshire *Independence Plus* initiative, *In-Home Supports Wavier for Children with Developmental Disabilities,* adopts the Agency with Choice model.

Fiscal/Employer Agent Model:

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

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SEP 17 2003 SMDL #03-008

Dear State Medicaid Director:

Last year, I sent a letter highlighting promising practices and strategies available under current law to help states promote the principle of "Money Follows the Person." Since that time, this concept has been widely discussed in "Open Door" forums and I have received several requests for additional examples and clarification on this topic. This letter responds to those requests and sets forth a common understanding of the principle of Money Follows the Person.

Money Follows the Person refers to a system of flexible financing for long term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. It is a market-based approach that gives individuals more choice over the location and type of services they receive. As illustrated by the enclosure to this letter, a system in which Money Follows the Person is also one that incorporates the philosophy of self-direction and individual control in state policies and programs. It includes, but is not limited to, key systems to ensure: 1) the delivery of comprehensive information to individuals on long term supports and services through single access points; 2) the availability of responsive supports across settings and providers; 3) the existence of systems to ensure quality of life and services; and 4) the ability of separate funding streams to appear seamless on the part of the individual.

The Department of Health and Human Services has taken a number of actions to expand opportunities and assist states in the appropriate "rebalancing" of state long term service and support systems that embody the principle of Money Follows the Person:

- On July 28, 2003, Secretary Thompson transmitted legislation to Congress to authorize the *Medicaid New Freedom Initiative Demonstration Act of 2003.* Included in this package is a proposed $1.75 billion 5-year demonstration, entitled the *Money Follows the Individual Rebalancing Demonstration,* that would provide individuals with disabilities who reside in nursing homes with more choices to live in their own communities and will include provisions to ensure quality assurance. This legislation is awaiting Congressional action.

- The CMS is in the process of awarding almost $7 million to states under the 2003 *Real Choice Systems Change Grants* to assist them in implementing Money Follows the Person strategies.

- Four states have received approval of *Independence Plus* waivers that further empower families and individuals in exercising greater choice, control and responsibility for their services.

- The CMS has posted a series of *Promising Practices* reports on its Web site designed to assist states in identifying activities underway in other states that assist individuals to live better in the community, including activities in which funds move with individuals and their choices (see http://www.cms.hhs.gov/promisingpractices).

Money Follows the Person is a principle most evident in a system in which there is an equitable array of institutional and community-based options to respond to individual needs and preferences. Currently states vary in the degree to which community-based options are offered, with some states spending less than 10 percent and others more than 70 percent of their long term support expenditures on community-based options.[1] State "rebalancing efforts" that seek to reduce reliance on institutional care options and increase home and community-based supports set the context for strategies such as Money Follows the Person.

A number of states have pursued different strategies under existing law that can be useful models to states interested in making immediate changes to their delivery system. We highlight a few examples in the paragraphs below:

Arizona – Managed Care to Rebalance Systems and Promote Money Follows the Person

The Arizona Long Term Care System (ALTCS) uses a managed care model to provide long term support for older people and people with physical and developmental disabilities at risk of institutionalization. In Arizona's largest county, Maricopa County, three managed long term care plans compete with one another to provide a complete array of all Medicaid-covered services for their members, including acute care services, behavioral health services, long term supports, and the provision of prescription drugs. The state's capitation methodology serves as a policy tool for rebalancing the system. The ALTCS pays a blended capitation rate to the health plans, such that the plan is paid the same amount regardless of whether a person lives in a nursing home or in a home or community residential setting. In setting the capitation rate, the state assumes that a certain percentage of each plan's enrollees will be served in the community. Each year, the state adjusts the target rate of people to be served in community-based settings. With this system, plans are provided with a natural incentive to serve more people in the community.

[1] CMS/CMSO, CMS Form 64, *Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program,* FY 2002.

Indiana – Money Follows the Person/Rebalancing Efforts by Reducing Excess Capacity

In 2002, Indiana began an initiative to reduce excess utilization of its nursing facility industry by providing home and community-based services to people at imminent risk of nursing facility admission and to people in nursing facilities that are closing. Indiana funds this initiative using the dollars that would have been spent serving individuals in nursing facilities. To divert people from nursing facility admissions, Area Agency on Aging case managers work with hospital discharge planners to identify and offer home and community-based service options to hospital patients who may be admitted to a nursing facility from the hospital. In 2002, this effort provided home and community-based services for 316 people. In order to assist people in nursing facilities that are closing, Indiana developed a formal process to ensure people have an option to select home and community-based services. Teams comprised of local Area Agency on Aging and state agency staff were established to inform residents of facilities that were closing of their rights and service options, and to assist them in obtaining housing and supports in the community or in another institution.

Oregon – Money Follows the Person through Equal Access Points and Integrated Programs

Oregon's success in achieving an equitable balance between community-based and institutional supports is attributed to several related initiatives over the past two decades. We highlight two methods below:

- *Equal Access Through the Level of Care Determination Process*—Oregon bases its eligibility for long term support services on the level of care determination for each participant, irrespective of the setting in which they seek services. Each individual receives an identical comprehensive assessment conducted by a case manager employed by a single entry point. The assessment information is then electronically entered into a database that calculates whether a person meets the state's nursing facility level of care criteria. The state then decides whether sufficient funds are available to provide home and community-based or nursing facility services to all people who meet these criteria.

- *Merging Administrative and Regulatory Responsibilities at the State and Local Level*—A single state agency is responsible for managing all Medicaid community and institutional long term support programs. This integration of long term support programs is achieved not only at the state level but also at the local level. Oregon's single entry points throughout the state allow for an effective exchange of information about the full range of available options and combine responsibilities for assessing, determining eligibility, and case coordination. This approach permits Oregon to coordinate polices and procedures that promote common goals across all programs on many levels and has resulted in achieving greater success in negotiating a balance among competing programs.

Several States: Self-Directed Services and the Use of Individual Budgets to Promote Individual Choices

Evaluations of programs that utilize self-direction and individual budget techniques have found that offering participants a high degree of choice, control, and responsibility improves service quality, enhances participant satisfaction, and expands the workforce providing home and community-based services. These programs also provide flexible supports and services that better meet participants' needs. Since 1996, states have gained experience with self-direction and using individual budgets through the National Cash and Counseling Demonstration and Evaluation Project (Arkansas, New Jersey and Florida), the Developmental Disability Self-Determination Projects (29 states), and other national and state initiatives. Based on the experiences and successes of these programs, CMS developed the *Independence Plus* Initiative in May 2002 to assist states that want to offer self-direction. To date, New Hampshire, South Carolina, Florida, and Louisiana have received *Independence Plus* waivers.

The above examples are practical solutions states have already taken to further balance their systems and promote the principle of Money Follows the Person. By incorporating Money Follows the Person principles into their Medicaid programs, states advance the concept of consumer control and self-direction in service delivery, and address the objectives of the President's *New Freedom Initiative*, and other important Federal, state and local efforts directed at community living.

I hope you find the clarification and examples useful as you continue in your efforts to meet the needs and preferences of all persons in your state who are elderly or have a disability. Any questions concerning this letter may be referred to Glenn Stanton, Acting Director, Disabled and Elderly Health Programs Group at (410) 786-6041.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Kathryn Kotula
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

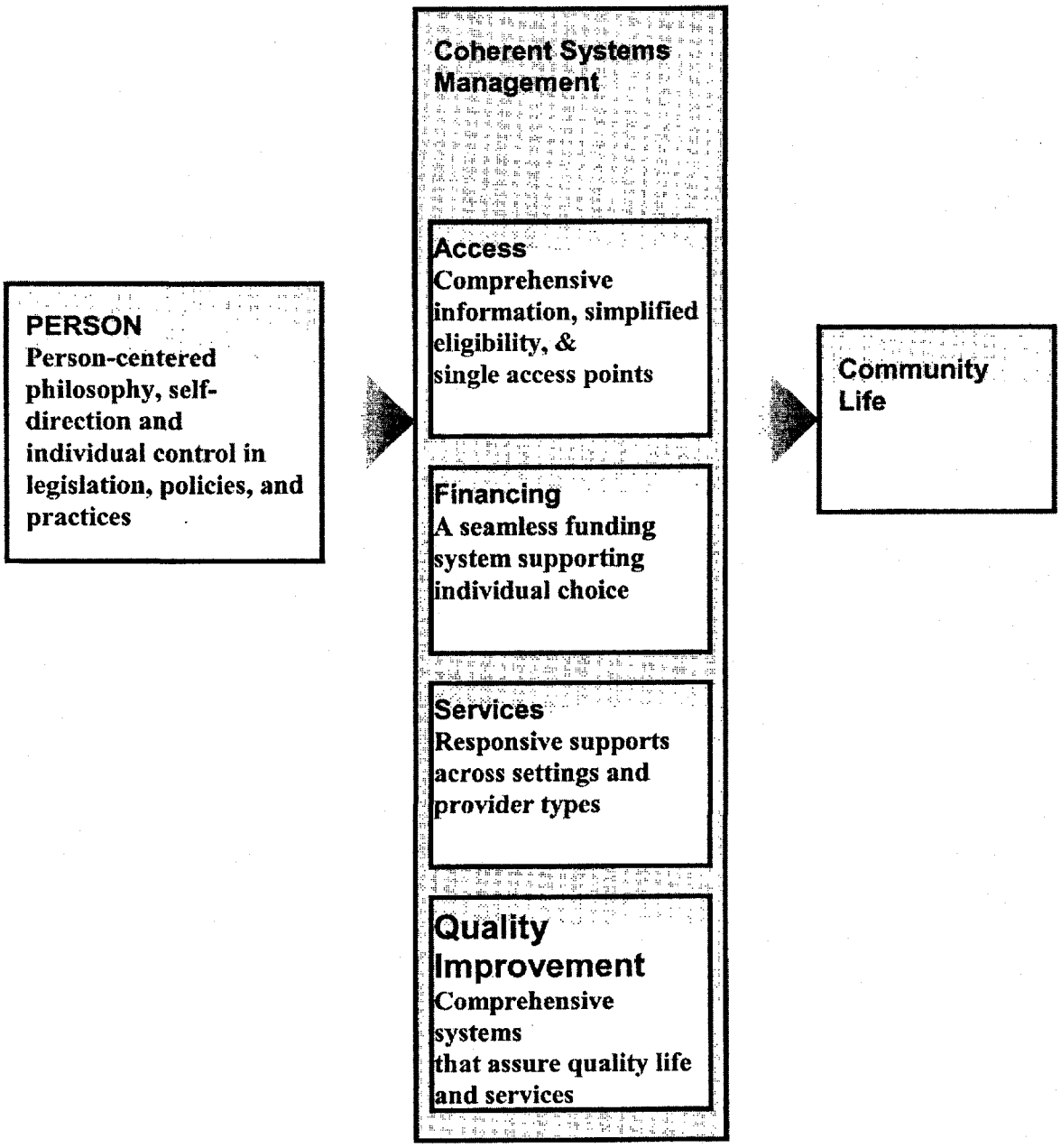
Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments

Enclosure

Key Building Blocks of a System in Which Money Can Follow the Person



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations

August 13, 2002 SMDL# 02-012

Letter Summary

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

Dear State Medicaid Director:

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

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

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

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

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

State Innovation Under Existing Authority

Colorado

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

Texas

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

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

Florida

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

New Jersey

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

Utah

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

Vermont

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

Washington

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

Wisconsin

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

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

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

Lessons Learned from early Nursing Facility Transition grants

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

/s/

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Lee Partridge
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Brent Ewig
Senior Director, Access Policy
Association of State and Territorial Health Officials

Jim Frogue
Acting Director, Health and Human Services Task Force
American Legislative Exchange Council

Trudi Matthews
Senior Health Policy Analyst
Council of State Governments