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**Nursing Home Transition Programs:
Perspectives of Medicaid Care Planners**

Prepared by

Judy Kasper
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Kaiser Commission on Medicaid and the Uninsured

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EXECUTIVE SUMMARY

Nursing home transition programs targeted to Medicaid-eligible nursing home residents who are candidates for returning to community settings were initiated in the late 1990's. They represent one of several strategies being undertaken by states, and supported by Congress and the Administration, to shift resources for long-term care from institutional to community settings. This report draws on interviews with care planners from five states – Florida, Louisiana, New Jersey, Ohio and Washington – who were experienced in assisting persons with significant long-term care needs in transitioning from institutional to community care settings. These care planners were presented with three hypothetical individuals in nursing homes with varying levels of care needs, and were interviewed about the issues involved in returning these people to community settings.

Overview of Study Findings

For care planners, the process of evaluating needs and arranging for provision of home and community based services to older individuals who want to transition from a nursing home, is similar to that for community-resident individuals. But interviews with care planners who work with individuals and their families in making the transition from nursing home to community, highlighted several issues of particular importance in nursing home transition:

- ***Reconnecting individuals to community supports – relatives or friends who can supplement formal services – is a critical component to transitioning.*** Care planners interviewed for this study typically paid as much attention to whether the necessary amounts and types of informal assistance were available as they did to planning formal services, because they were acutely aware that formal services alone would not be sufficient to maintain individuals in the community. As one care planner noted, “We’d be tapping every resource we’ve got.” For some individuals, nursing home entry disrupts fragile informal supports, and identifying and activating old or new ones is a challenge.
- ***The availability of group residential options, such as assisted living, adult family homes, or special supervised residences, makes transition possible for people who otherwise could not be maintained in a community residence.*** The hypothetical case of a 60 year-old man with schizophrenia and diabetes illustrates this point. Care planners felt his success in staying out of a nursing home largely hinged on finding a residential setting with supervision for his mental health and medical needs. Group residential options also provide care settings that can serve as a fall back if independent community living can not be maintained. A care planner in Washington who was concerned that the responsibilities of caring for a wheelchair-bound man would prove too much for his 70-year old wife, indicated that in talking to the wife she would let her know that if “his care got too great, it isn’t just her home or the nursing home, there are all these other alternatives in between.”

- ***Concerns related to bridging the gap in providing services upon return to community settings because individuals must re-qualify for Medicaid and be assessed to determine which programs and levels of service they can receive, are uppermost in the minds of care planners.*** When these gaps raised safety issues – returning a wheelchair-bound older man to a home without a ramp, placing a woman with mild dementia in an apartment without knowing how well she could manage with limited hours of formal assistance – care planners were reluctant to advocate for transition from the nursing home setting. As a care planner from Ohio stated, “My concern for her would be her dementia, and I would have to assess whether she could be left alone safely.” Even when service eligibility seemed to be assured upon transitioning to the community, gaps between assessment and enrollment in a program could occur (anywhere from a week to months).
- ***Finding a fit between care needs and programs can present a challenge.*** Because many home and community-based care programs are oriented toward assistance with severe physical disabilities, it can be difficult to provide sufficient assistance to individuals with mental or cognitive problems who have low levels of ADL impairment but high need for supervision or cuing. In some cases, residential options that would seem to offer such oversight specifically preclude admission of individuals with dementia, for example. As one care planner noted, “If I had an adult family home that could take mobile dementia clients, I could fill it up today out of a nursing home.” Similarly, some assisted living facilities require that residents be ambulatory. Other issues arise as well. One state-funded program in Florida is open only to persons with an in-home caregiver, so care planners noted this as an option for the older married man if he returned home but not for the older widowed woman. In Ohio, the individual with schizophrenia and diabetes could meet the criteria for unstable medical conditions, but not for serious disabilities, and as a result could not qualify for the waiver program that offered the most extensive range of services including skilled care for diabetes management.

Other studies have documented the variation in home and community-based services that exists across states. The interviews with care planners in 5 states conducted for this study shows there are multiple programs with extensive variation in eligibility criteria, services offered, and budget and spending caps, within states as well. This complexity clearly limits the ability of nursing home residents and their families to evaluate the feasibility and desirability of transition back to a community setting, and makes the role of care planners in helping people to navigate their options a critical one. The perspective of care planners also highlights issues that affect the success of programs intended to facilitate returning nursing home residents to appropriate, safe and less costly community settings.

INTRODUCTION

Nursing home transition programs targeted to Medicaid-eligible nursing home residents who are candidates for returning to community settings were initiated in the late 1990's. They represent one of several strategies being undertaken by states to shift resources for long-term care from institutional to community settings.¹ This report draws on interviews with care planners who were experienced in assisting persons with significant long-term care needs in transitioning from institutional to community care settings. A related report² based on interviews with state Medicaid program officials provides insight into the policy issues that arise in establishing programs to move individuals with significant long-term care needs from institutional to community settings.

The initiation of formal nursing home transition programs began in the late 1990's. Prior to this point, only a few states had procedures for identifying and assisting individuals in nursing homes in moving back to the community. The five states that participated in this study -- Florida, Louisiana, New Jersey, Ohio and Washington -- each received federal grants for nursing home transition activities and varied in their experience with transition programs.² Louisiana, New Jersey and Ohio received Nursing Facility Transition Grants in 2002 under the Federal System Change Grants for Community Living; Washington received its grant in 2001. Both New Jersey and Florida received grants under the Nursing Home Transition Demonstration Program (New Jersey in 1998, Florida in 2000). In addition, Washington and New Jersey had nursing home transition programs in place prior to the initiation of federal grant support for these activities.

STUDY APPROACH

The states selected for this study varied in how active and experienced they were in nursing home transition activities. In each of the states selected, interviews were conducted with state Medicaid officials who were knowledgeable about, and often responsible for, nursing home transition and related Medicaid long-term care services programs. Following each of these interviews, officials were asked to recommend two care planners -- one in a rural and one in an urban setting -- who were familiar with nursing home transition efforts and could be interviewed about the issues involved. All interviews lasted between 45 minutes and 1 hour and were conducted between July and December, 2004. These interviews focused on 3 hypothetical individuals in nursing homes. Briefly, these individuals were:

- Harry, a 70 year-old married man admitted following hospitalization for a spinal cord injury who has ADL needs, uses a wheelchair, and requires care for an indwelling catheter;
- Mildred, an 80 year-old widow admitted following hospitalization for a stroke, who has mild dementia, uses a walker, and needs assistance with bathing, dressing, and meal preparation;
- George, a 60 year-old man with schizophrenia who has experienced repeated hospitalizations due to poor management of diabetes and was admitted for post-acute care following his most recent hospitalization.

Care planners were sent materials prior to the interview which described these 3 individuals in more detail and provided the questions to be covered. In general, care planners viewed these individuals as good representations of the kinds of people and situations they dealt with frequently. More than once a care planner commented that Harry, Mildred or George reminded her (or him) of someone they had recently worked with. Care planners also frequently wanted more detailed information about care needs or social situations than the scenarios provided – was there a son who could help or was an individual able to transfer independently? Nonetheless, they had little difficulty discussing options for meeting care needs under different sets of assumptions.

As Table 1 below shows, the 3 individuals that were the focus of the care planner interviews were described as having varying care needs and community resources.

Table 1. Care Needs and Characteristics of Persons Used As Case Studies			
Characteristic	Harry	Mildred	George
Care Needs:			
Physical Disability	Walking, severe	Walking, moderate	None
Mental Disability	None	Moderate	Severe
ADL Needs	Bathing Dressing Transferring Eating Toileting	Bathing Dressing Transferring	None
IADL needs	Meals Shopping	Meals Shopping Money management Household chores	Meals Shopping Money management Household chores
Equipment use	Wheelchair	Walkers or aide escort	None
Supervision or cueing needs	No	Perhaps	Yes
Medical	Catheter	Medications	Diabetes Management
Resources:			
Spouse	Yes	No	No
Community housing	Owens home	No	No
Income sources	Social Security	Social Security	SSI
Medicaid eligibility	Became eligible in nursing home	Became eligible in nursing home	SSI recipient prior to nursing home admission

Harry had severe mobility impairment and extensive ADL needs. Mildred’s mobility and ADL limitations were moderate, but in combination with her mild dementia, resulted in greater IADL needs. George had no physical disabilities, but his severe mental illness compounded his need for help in managing his diabetes and resulted in limitations in independent living skills (IADLs). Harry and Mildred both became eligible for Medicaid while in the nursing home.³

George was categorically eligible prior to entering the nursing home based on receipt of Supplemental Security Income.

Care planners were asked to draw on their experience to consider several issues related to transitioning these individuals out of a nursing home and back to a community setting. The interview covered:

- The role of informal support
- Community housing options
- Amounts and types of care that would be needed in the community
- Obstacles to obtaining needed services in home and community-based settings
- The role of Medicaid and other programs in providing services

Care planners also were asked to rank each individual on ease of return to the community with appropriate levels of care on a scale from 1 to 10, with 1 being very easy and 10 being very difficult.

In the course of these interviews care planners described programs in their states that they would turn to in making care arrangements. *Appendix A* provides a description of home and community based care programs in each state.

STUDY FINDINGS

Harry, a 70 year-old married man in a nursing home

Description: Harry was admitted to a nursing home following hospitalization for a severe spinal cord injury suffered in a car accident. Harry uses a motorized wheelchair but needs help bathing, dressing, and feeding himself. His 70 year-old wife, Mary, visits each day for either the noon or evening meal and does his laundry weekly. Harry has an indwelling catheter that must be cared for. Mary lives in the home the couple owns. Half of Harry's Social Security retirement income goes to Mary under federal spousal impoverishment protections, but Harry still qualified for Medicaid coverage of his nursing home care (under the 300% special income rule). The couple did not qualify for Medicaid prior to Harry's accident.

Overview from Care Planners: A spouse and a home to return to were important elements in planning for Harry's care needs. While all care planners looked first at returning Harry to his own home, uncertainties about both his wife Mary's capabilities as a caregiver, and aspects of his home's physical environment, affected views on how easily Harry could be returned home and whether that was the best option. Care planners who assumed Mary was a reasonably healthy 70-year old, saw the need for two types of formal assistance at a minimum -- help from aides in the morning to help Harry get up and get dressed, and again at night to go to bed (activities seen as beyond Mary's physical capabilities) and skilled nursing care for his catheter. No Medicaid home and community-based care option would provide 24-hour care to Harry in his own home. The challenge for care planners was to determine how much care Harry could qualify for -- which varied considerably across states -- and whether Mary could reasonably be expected to fill in the gaps. Harry's dependence on a wheelchair created concerns about the safety of his home environment unless accommodations could be made, but in some areas created obstacles to other housing options such as assisted living.

Ratings of Difficulty in Transitioning (1=easiest; 10=most difficult):

Care planners who were concerned that Harry might qualify for limited services in the community, that Mary could not provide additional assistance by herself, and that she and Harry might not have supportive family or friends to step in, regarded Harry as more difficult to transition (scores of 6,7,8). Ratings were fairly consistent within states, with Florida and Louisiana care planners viewing Harry as easier to transition than those in New Jersey or Washington.

	Florida	Louisiana	New Jersey	Ohio	Washington
Care Planner A	5	3	7	6	6
Care Planner B	3	4	8	4	7

Issues in transitioning Harry to a community care setting:

Informal support

Harry's wife, Mary, was seen as playing a critical role in his care and his ability to return home, but most care planners also were concerned about her health and how well she would be able to care for her husband.

“My main concern is how well can Mary care for him – how well is she able to be a caregiver for those many hours that outside help's not going to be available?” (New Jersey)

Care planners who assumed Mary was a reasonably healthy 70-year old, saw the need for two types of formal assistance at a minimum: help from aides twice a day – in the morning to help Harry get up and get dressed, and again at night to go to bed, because these activities were beyond Mary's physical capabilities – and skilled nursing care for his catheter. Hours of assistance beyond what these tasks required might be provided based on needs assessment and eligibility for various waiver programs but no Medicaid home and community-based care option would provide 24-hour care to Harry in his own home.

The challenge for care planners was to determine how much care Harry could qualify for and whether Mary could reasonably be expected to fill in the gaps. Concern was expressed about whether Mary would be able to monitor Harry at night, get him out of the house if needed (several care planners noted that whether Harry could assist in transferring in and out of his wheelchair would be an important consideration), and leave him unsupervised for trips to the grocery store. Most felt Mary and Harry would need other sources of support to draw upon, including children, friends or neighbors. Care planners emphasized the need to look for additional supports wherever possible.

“We would try to pick their brain so to speak. Did Harry serve at least one day in a war? If so we're on the phone to the VA, saying what can you do to help this man? Was he in the Masons? We'd be tapping every resource we've got.”(Florida)

“Is there a volunteer from the church who would come in on Saturday and relieve Mary? Is there a son who will transport him to his medical appointments? We want to find out what services exist for him and would be available and then we identify his unmet needs and what services we need to add to make it a safe plan for him at home.” (Washington)

Housing

Another major consideration in Harry's return home, was the physical environment. While Harry had the advantage of a home to return to, all care planners recognized the need for a wheelchair ramp and potential home modifications such as widening doors to accommodate a wheelchair. It is often difficult to access resources for home modifications prior to an individual's return to

“I would sit down and tell her all the options she has under the waiver program so that she knows that if his care got too great, it isn't just her home or the nursing home, there are all these other alternatives in between that. So if something changes or she gets terminally ill or something, you just don't go from your home straight into the nursing home, there are other more independent settings.” (Washington)

the community. Several care planners were concerned about moving a wheelchair-bound individual into a home without making accommodations beforehand.

Because of these concerns, in some states with more residential alternatives, care planners suggested licensed community care settings such as adult family homes and assisted living (these options were constrained in rural settings). A planner in Washington suggested two options for Harry – returning home with his spouse with in-home care services, or one of several residential care options (e.g. licensed adult family home). She also emphasized that she would make clear to Mary that if circumstances changed, alternatives to nursing home care existed. Harry could not qualify for assisted living in one rural area of Washington, however, because he was not ambulatory. In other states, alternative residential options were very limited. In Ohio, for example, care planners reported that Section 8 housing for low-income individuals has a waiting list and has been closed to new occupants for two years. In Florida there also are waiting lists for Section 8 housing and limited slots for assisted living under the Medicaid waiver that is used to transition individuals from nursing homes. Care planners also suggested contacting church groups that sponsor homes that are low-income and wheelchair-accessible or seeking VA assistance with housing if Harry were a veteran. In New Jersey, it was suggested that if Mary and Harry did not own their home they might be considered for subsidized disabled senior housing (again in limited supply).

Evaluating care needs

Personal Care

The care available to Harry if he returned home would be determined by his long-term care needs and his eligibility (based on income and assets) for the various home and community-based programs states offer through Medicaid (and in some cases state-funded programs for those not eligible for Medicaid). Care planners typically looked to place Harry in a waiver program, even in states with the personal care option. Most felt his income might not be low enough to qualify for Medicaid personal care, and although more hours of personal care would be available, waiver programs offered a broader array of services. These included services such as respite – seen as important for Mary – and personal emergency response systems which would allow Harry to be left alone while Mary went shopping. While there was agreement among care planners that some assistance would be needed each morning and evening because Mary would be unable on her own to get Harry up and dressed or put him to bed, the range of hours of care that could be provided was wide.

A Florida care planner felt Harry would probably need assistance at least 5 days a week, and could qualify for an hour and a half of ADL assistance each day and homemaking or chore services twice a week for a couple of hours. Mary would be expected to do laundry, meal preparation, and handle other tasks. She noted that Harry would not be eligible for adult day care programs, which might provide additional help and relieve Mary, because these programs require that clients be able to get to the bathroom and toilet on their own. In Louisiana, while Harry could qualify for waiver services that provide care from 12 to 15 hours a day, there are daily caps (\$60) on waiver services that limit hours. One care planner was concerned that a 24-hour schedule showing that somebody would be with Harry at all times would need to be developed (drawing on natural supports such as family and church members) to assure his health

and safety in the community because of his dependence on a wheelchair (“he can’t self-evacuate”).

In Washington, Harry seemed most likely to qualify for the Community Options Program, a waiver program which covers in-home and other residential settings (the Medically Needy Waiver covers individuals with incomes higher than Harry’s, and Medicaid Personal Care would require a much lower income to qualify). Like waiver programs in other states, in addition to ADL assistance, if Harry returned home he would receive a daily home-delivered meal, some resources for home modifications, and a personal emergency response system which could be used to notify both informal caregivers and 911. Since costs could not exceed \$135 a day (90% of the average nursing home rate), one care planner felt Harry could receive 5 to 6 hours of assistance 5 days a week, or 2 to 4 hours daily.

New Jersey’s two waiver programs were seen by care planners there as the most likely options for Harry (as in Washington, his income was too high to qualify for the Medicaid personal care benefit). One would provide care at home including home health services, prescriptions, therapy, medical transportation, medical or social day care and respite care. The other provides additional services but not home health or prescribed drugs, and requires cost-sharing. In Ohio, neither care planner felt Harry was likely to be assessed as needing care at the level which is required for the Home Care Waiver program that offers the most extensive services. Were he able to qualify for Medicaid -- in his case spending down to meet Medicaid income eligibility of \$560 a month-- he could then be considered for two other programs designed to meet basic home care needs for nursing and daily living services. Otherwise, another waiver program could provide a range of services (excluding skilled care) on a more limited basis. In all states, however, substantial assistance from Mary and other community supports were seen as essential in meeting the totality of Harry’s care needs.

Skilled Care

Harry’s need for maintenance of his catheter required a skilled nursing visit to his home, or a trip to a site (e.g. adult day care facility) where this care could be provided. For the most part care planners looked to home health services under Medicare or Medicaid. A care planner in Washington indicated that a nurse could do maintenance of his catheter if he attended adult day care. While an in-home personal care provider could clean the bag, this individual would not be authorized to change the catheter. A nurse through Medicare home health would have to visit and provide this service. In Louisiana, a care planner indicated that home health services, through Medicare or Medicaid, would have to be in place to provide catheter care before Harry left the nursing home.

Determining eligibility for home and community-based services

Despite being a Medicaid-eligible nursing home resident, Harry would be reassessed on both financial and needs criteria once he returned to the community. Uncertainty about what he would qualify for might influence whether he and Mary were willing to undertake moving him out of nursing home care.

“Nursing home Medicaid is what he’s under at this point, and then once he’s discharged back to the community, we have to apply for community Medicaid, they’re two different, separate Medicaid programs.” (Florida)

In Florida, while Harry could transition from a nursing home to assisted living under the Elderly Assisted Living Waiver, and be assured of continuing coverage for services through Medicaid, a return to his own home would not offer the same guarantee. Individuals who are candidates for transitioning to the community are evaluated in the nursing home by a social work team and then referred to community-based agencies (the primary responsibility of these teams is to evaluate individuals for purposes of nursing home diversion; prior to 2003 they also were responsible for reviewing 10% of nursing home residents for transition, but that requirement was lifted by legislation). Although the evaluation team could help with Harry's discharge planning, and refer him for Medicaid waiver services, whether he would qualify could not be determined until he was discharged and had re-applied for Medicaid. As one care planner explained, Harry would be enrolled on an interim basis in a state-funded program that provides personal care and other services based on a sliding-scale co-pay that is tied to monthly income (this program also requires that a caregiver be present in the home). Assuming he qualified for the Medicaid waiver program, there would be a 3-month wait from the assessment to program enrollment even though Harry would have priority for waiver services over other eligible community residents. If he failed to qualify for services under the waiver program, the care planner felt that Harry could not be maintained at home, and would likely return to a nursing home.

In Louisiana, Harry could be put on the Request for Services Registry while in the nursing home (a state-wide registry for individuals seeking home and community-based services). If his name came up for a slot, he would be assigned a care planner, and at the same time a Medicaid application would be submitted to the local Medicaid office to determine his eligibility for the waiver program or Long Term Personal Care Services (Medicaid personal care option). If Harry qualified for the personal care benefit he could return home immediately as long as his health and safety could be assured. There remains a waiting list for the waiver program, however, even though Harry would have priority as a nursing home resident.

In Ohio, once Harry left the nursing home, the first step would be to see if he qualified for Medicaid in the community. A needs assessment would determine which program he qualified for. The turnaround for determining eligibility after assessment was reported as short, from 3 to 5 days.

In New Jersey and Washington, care planners who are state employees would counsel Harry in the nursing home about his options for community-based care and would assess his care needs and the programs he could qualify for. In both of these states, this process provides greater certainty for individuals who are considering transitioning about what services they would qualify for upon return to the community.

Implications of nursing home transition for spousal income protection

Federal legislation requires that community-residing spouses of individuals who receive nursing home care covered by Medicaid, be able to retain income and assets.⁴ States have the option of extending these protections to spouses of individuals receiving home and community-based services under waiver programs, but not all do. In Florida, spousal impoverishment protections

have not been extended to the waiver program that transitions nursing home residents to assisted living. Medicaid would cover Harry's long-term care in assisted living, but room and board would be taken from Harry and Mary's Social Security income, leaving Mary with less to live on than were Harry to remain in a nursing home. In Ohio, spousal income protections would remain the same if Harry qualified for the Ohio Home Care waiver, but neither care planner felt he would meet the level of care eligibility criteria. To qualify for nursing and ADL assistance under Medicaid, the couple would have to spend-down to Medicaid eligibility.

In Washington, Mary's protected income is the same regardless of whether Harry receives services at home under the Medicaid waiver program or in a nursing home; her protected income is substantially less if he is cared for in alternative community housing, such as an adult family home however. Individuals with incomes over a certain level pay a "participation fee" for care under the waiver which varies by setting. If Harry and Mary rely on a single income stream, there is essentially no spousal impoverishment protection if Harry is in a community residential care setting.

In states that would reassess Harry's eligibility for Medicaid-covered home and community-based services after his return to the community, Harry and Mary's joint income and assets would be considered in determining his eligibility for services. States often have multiple options for which Harry might qualify with varying income and asset criteria, but in general these do not provide as much financial protection for Mary as the nursing home spousal protection legislation. In New Jersey for example, Harry might first be considered for the Medicaid personal care option (New Jersey Care Program) which requires joint income of no more than \$1,041 per month and assets not to exceed \$6,000. Then for two waiver programs with higher monthly income (\$1,692 for Harry alone) and asset eligibility criteria (\$2,000 in assets for Harry only; no more than \$18,000 for Mary). Finally, for a state-funded program (Jersey Assistance for Community Caregivers) that requires cost-sharing on a sliding scale (eligibility based on assets only) and is limited to 14 services.

Resources for home modifications

Care planners felt a ramp and possibly other modifications, such as widening doorways, to accommodate Harry's wheelchair, would be necessary for Harry to return home. Medicaid personal care programs do not cover home modifications, but in some states Medicaid waiver programs do. In addition, one-time relocation funds for individuals who are transitioning from a nursing home are available in many states (either as part of a Medicaid waiver or through state funds as in New Jersey and Washington), but these funds while flexible – they can be used to cover

“To make changes to a home to make it accessible, we can draw on Senior Minor Home Repair (a service of Senior Services, a nonprofit agency) but that has a cap of \$150. The Residential Care Discharge Allowance (a state-funded program available once per person per nursing home discharge) could be used toward a ramp for Harry but that is \$816 maximum. I talk to families to see if a person is a member of a church or fraternal organization that might take on home modification as a project, sometimes I can get the Boy Scouts to do something. You have to be pretty creative.” (Washington)

moving expenses, first month's rent, damage deposits, telephone services, home modifications – are limited.

In Louisiana, \$3,000 is available for accessibility modifications under the Medicaid waiver program, but these funds do not cover general repairs. As one care planner pointed out these are often needed for homes that have been unoccupied during a nursing home stay. For that, she looks for volunteers – church members or other family members. One of New Jersey's waiver programs would cover “environmental access adaptations.” In some circumstances, funds can be tapped through the New Jersey Protection and Advocacy Program (a state umbrella organization that operates programs for people with disabilities including one focused on assistive technology). In Ohio, a care planner knew of a city and state-funded program that could provide a ramp, but indicated a 3 to 6 month wait for installation would be likely.

In Florida, care planners also looked to options outside of the Medicaid program. If Harry qualified for the Medicaid waiver program “environmental access adaptations” are a covered service, but there were concerns about Harry returning home before a ramp was in place (and waiver eligibility could not be determined until he was discharged from the nursing home). Care planners suggested programs funded by the Older Americans Act, a community development block grant program that might be used to install a ramp at no cost, a local program that picks a number of houses a year to modernize for low income people, and small volunteer groups that would install ramps.

Rural areas

Persons who wish to transition from nursing homes often face additional constraints in gaining access to needed home and community-based services. In Washington, for example, a care planner indicated she had few resources to draw upon in placing Harry if he did not return to his own home. The 3 adult family homes in her area had 6 beds each, which were almost always full. In one, clients had to be completely ambulatory and able to exit using stairs; one of the others designated only 2 of 6 beds for Medicaid clients. One assisted living facility in the area would not accept Harry unless he was able to transfer in and out of his wheelchair on his own and operate it independently; he would also have to toilet independently. Even if Harry moved home, in this rural county, he would not be eligible for meals on wheels because he has a spouse available to prepare meals.

“With the waiver, you get a worker to come in your home. Well, when it's out in a little town, you have to depend on the family to help the agencies find somebody.” (Louisiana)

“A lot of my people wind up staying in the nursing home because there are just no options.” (Washington)

Mildred, an 80-year old widow in a nursing home

Description: Mildred was admitted following hospitalization for a stroke. She has difficulty walking and uses a walker in her room, although she often needs help to pull herself out of her chair to reach her walker. Her stroke also left her with mild dementia. An aide assists her when she leaves her room for meals or to sit in the common room. Mildred also needs assistance with dressing and bathing. Although she cannot prepare meals, she can feed herself and make her way to the toilet in her room on her own. Prior to entering the nursing home, Mildred rented a small apartment and lived alone. She had to give up the apartment and put her belongings in storage during her nursing home stay. She qualifies for Medicaid coverage of her nursing home care because her income from Social Security is below 300% of the SSI benefit; her current income is 185% of the federal poverty line (\$1,435 a month).

Overview from Care Planners: Mildred had no home to return to. In considering both living arrangements and care needs, care planners looked for ways to strengthen and make use of Mildred’s “natural supports,” including family, church groups, Council on Aging programs, and housing and service arrangements that would provide opportunities for added informal support. Since Mildred’s care needs would not warrant substantial levels of assistance from home and community-based programs, identifying additional support and supervision was essential. Assisted living and other residential facilities provided one solution, as long as Mildred was ambulatory and “independent enough” for these settings. Other care planners felt Mildred could successfully transition to low-income housing, but availability was limited. Mildred’s mild dementia was an important factor in considering her care needs and safety, including issues such as whether she could be left alone for periods of time, and contingencies for further decline. Care planners were also concerned, however, that Mildred go to a setting that would provide social interaction and stimulation.

Ratings of Difficulty in Transitioning (1=easiest; 10=most difficult):

Care planners who viewed Mildred as more difficult to transition (scores of 6, 7, 8) were concerned about the severity of her dementia and whether she could be left alone. Those who felt Mildred could be relocated to assisted living or an adult family home viewed her as relatively easy to transition. Sometimes there were differences within states. The care planner in a rural area of Washington viewed Mildred as difficult because her dementia would prevent her from qualifying for assisted living in that area; this was also a concern for one care planner in New Jersey.

	Florida	Louisiana	New Jersey	Ohio	Washington
Care Planner A	3	6	3	7	3
Care Planner B	5	8	8	5	8

Issues in transitioning Mildred to a community care setting:

Informal support

In considering both living arrangements and care needs, care planners looked for ways to strengthen and make use of Mildred's "natural supports." These included family, church groups, Council on Aging programs, and housing and service arrangements that would provide opportunities for added informal support.

These types of supports were a means of making the services available to Mildred go further ("We try to look for sources of help from her natural supports first before drawing on the waiver, because it is limited and if we can find assistance in other places we can use the money in the waiver for other things." Louisiana). Equally important, however, was the desire to see Mildred engaged in social interaction.

"I would definitely see the need to put in some companionship hours. I would use every hour available for her just to give her companionship – and the transportation to go places. What I'm looking at for her is that I want her to have as much interaction with other people as possible."
(Louisiana)

Housing

Housing options for Mildred ranged from various subsidized housing options (e.g. Section 8, church-sponsored housing) to assisted living and other residential care facilities. In Louisiana, care planners felt Section 8 housing was the best option, but were concerned about her mild dementia ("she's going to have to have someone there who can direct her care if she can't -- at a later point, if not now."). One Ohio care planner also indicated Mildred would likely qualify for senior citizen housing and for Section 8 low-income housing, but there were waiting lists for both (no new Section 8 housing slots in two years and a 6 to 9 month waiting list for senior housing). A second care planner in Ohio indicated she would investigate assisted living for Mildred but there would be no financial assistance from Medicaid at present (Ohio is implementing an Assisted Living waiver program in 2007 targeted to transitioning Medicaid recipients from nursing homes). In Florida, the Medicaid waiver program for elderly people who transition from nursing homes to assisted living was viewed as the best option for Mildred. Section 8 housing in Florida is limited.

In New Jersey and Washington, residential care settings that would provide services in addition to a place to live were suggested for Mildred. In New Jersey, Mildred's Social Security check would pay room and board in assisted living (except for a monthly personal allowance of \$83) and Medicaid would pay for services, including medications and meals. One care planner suggested using the \$600 available for individuals relocating from a nursing home to purchase additional furniture she might need. A residential health care facility which would provide a structured environment and ADL assistance was another alternative.

Care planners in Washington also suggested assisted living and adult family homes for Mildred. If she had been eligible for Medicaid on admission to the nursing home, the Medical Institution Income Exemption program in Washington could have been used to continue paying her rent so

she wouldn't lose her apartment (a doctor's validation that Mildred should be able to return home within 6 months would be needed to qualify). Mildred's dementia was an issue in finding community placements however. One New Jersey care planner stated there was a reluctance to place severely demented people in assisted living. Another in Washington said Mildred would have to be "independent enough" for assisted living.

"If I had an adult family home that could take mobile dementia clients, I could fill it up today out of a nursing home."
(Washington)

Evaluating care needs

Safety concerns were expressed by care planners in considering Mildred's needs for services and supervision. Her care needs were not great enough to warrant substantial levels of assistance from home and community-based programs, so the issue facing care planners was how to provide additional support and supervision. Assisted living and other residential care facilities provided one solution, as long as Mildred was ambulatory and "independent enough" for these care settings.

"She won't get 24 hour care and the issue is can she be left alone or not?" (Louisiana)

"My concern for her would be her dementia, and I would have to assess whether she could be left alone safely." (Ohio)

In Louisiana, care planners thought Mildred could probably get up to 16 hours a week of assistance, and receive Meals on Wheels, but would not qualify for the personal care benefit which could provide up to 56 hours a week. Likewise in Ohio, Mildred's needs for assistance would not qualify her for programs that provided the maximum hours of care, and care planners expressed concerns about the adequacy of the programs she would qualify for in terms of supervision. One planner thought Mildred could manage if she had a daughter or a friend still in good health that she could move in with ("We might be able to find an adult day center for her to attend during the daytime. Some of those offer bathing, and she could be monitored as well as get breakfast and lunch.")

In Florida, Mildred could transition to assisted living. If she chose to return to the community, she would face a waiting list for waiver services even if she qualified. If Mildred qualified for waiver services she would receive a score (from 1 to 5 with dollar caps at each level) that would determine the amount of services she would receive. If an individual needs more than the cap, care planners can appeal, but as one noted "it is a problem if the score isn't high enough to access enough resources." Gaining more resources for one individual still requires that overall guidelines be met: "We know that if someone's going to day care 5 days a week, they're already exceeding the guidelines (monthly care plan costs at the high end). To stay within the guidelines, we look at whether someone else who is getting 5 hours of personal care can manage with three. Are they incontinent and do they need 5 baths a week? If they're not, and they don't have a skin breakdown, can they manage with 3 baths a week? That's how we're trying to reduce costs so it doesn't affect the care of the client and their basic needs are being met, but we're not doing any extras." Unless Mildred had a community caregiver, she would not qualify

for some programs, for example the state-funded Florida program that was suggested as an interim for Harry until waiver services began.

Care planners in Washington and New Jersey favored assisted living or other group home arrangements for Mildred. As one care planner put it, “If she wanted to go back to her apartment we could look at that. With her needs, her hours probably wouldn’t be very high so I would be a little bit concerned about safety there.”

Determining eligibility for home and community-based services

In Florida, New Jersey and Washington, Mildred’s transition to assisted living or a residential group home setting would ensure continued services under Medicaid waiver programs in these states. If she relocated from the nursing home to an apartment or to live with a daughter or friend, Mildred’s experience applying and qualifying for home and community-based services would be much like Harry’s. Uncertainties about how much assistance she would qualify for would likely be a disincentive in trying to move Mildred out of a nursing home to these kinds of settings.

Whether care planners can communicate across nursing home and community settings is one factor that can contribute to these uncertainties and affect whether someone like Mildred is able to transition from a nursing home. Washington is unusual in having state-employed (and funded) care planners who discuss community-based options with all Medicaid (or likely eligible) nursing home residents who are newly admitted. New Jersey also assesses individuals in nursing homes but does not evaluate every newly admitted patient.

In Florida, community-based care planners could not assess Mildred until she returned to a community setting. As one care planner explained, if Mildred wanted to apply to housing programs while she was in the nursing home, a family member or social services in the nursing home would have to help her. A referral from the social work team, which has responsibility for both nursing home diversion and nursing home transition, would require that Mildred be assessed for waiver services more quickly once she was discharged than someone who calls from the community and wants to be assessed. However, the inability to plan for services prior to discharge would be an obstacle, and unless Mildred were strongly motivated it is unlikely she would be identified as a candidate for transition.

George, a 60-year old nursing home resident with serious mental illness and diabetes

Description: George was diagnosed with schizophrenia as a young man. He has received SSI cash assistance for many years. George has lived in a small board-and-care home for the past 10 years, but poor management of his diabetes has resulted in repeated hospitalizations. During his last hospitalization the board-and-care home ceased operating and George was admitted to a nursing home for post-hospital care. George is cognitively impaired as result of his life-long mental illness. His diabetes is now well-controlled and George is a candidate for moving back to a community setting to receive long-term care services.

Overview from Care Planners: At age 60, George’s serious mental illness and medical needs related to his diabetes combine to present significant challenges in transitioning out of a nursing home. He was unlikely to qualify for home and community-based programs that require ADL impairments and need for assistance with personal care tasks. As a care planner in Louisiana stated, “we don’t offer 24-hour services, and I guarantee you, with a diagnosis of schizophrenia they would be looking really hard at whether or not he can be okay without 24-hour coverage.” In Florida another planner observed “If there was no room and board home that he could go to, I don’t think he would be a candidate for the community with his health conditions and mental health problems. Most of our assisted living facilities require that a client be able to manage their own medications.” Care planners were not optimistic that the type of supervision that George needed could be obtained in most of the housing options available to him. Even in states with appropriate supervised housing (mental health providers and nurses to monitor his diabetes), slots were in scarce supply.

Ratings of Difficulty in Transitioning (1=easiest; 10=most difficult):

Although George had the lowest needs for functional assistance, his mental health and diabetes care needs, combined with his lack of informal support in the community, made him the most difficult to transition. All but one care planner ranked George between a 7 and a 10 (most difficult).

	Florida	Louisiana	New Jersey	Ohio	Washington
Care Planner A	8	7	5	8	9
Care Planner B	7	9	10	8	10

Issues in transitioning George to a community care setting:

Informal support

Care planners wanted to know whether George still had contact with his family but assumed that his natural supports were few. The availability of a caregiver to supervise George’s handling of his medications for his mental health problems, and his ongoing diabetes care, came up in every care planner’s list of concerns. While Medicare would send a nurse to teach George or a caregiver, such as a willing board and care home operator, how to manage his insulin, if he were unable to do that and did not have a primary caregiver helping him with his mental health and medical needs, in the words of a care planner “the nurse would probably be calling adult protective services and saying he needs to be in a nursing home.” Without ongoing informal support or a housing environment that provided intensive supervision, George’s opportunities to leave the nursing home and remain a community resident were judged to be slim.

“I would have to think long and hard about trying to move George out because the natural supports, the community support is just not there. It’s doable but it’s going to take a lot of teamwork.”
(Louisiana)

Housing

Appropriate housing for George was difficult to identify and in limited supply. In Louisiana, supervised housing in group homes was viewed as the best option, but there are waiting lists of several years. One care planner indicated she would explore whether George had a friend he could move in with, “somebody to actually assist with the supervision.” Ohio care planners also recommended housing with supervision for George, but waiting lists are a major barrier. While there are mental health community-based programs which help with housing (individual apartments with a care planner supervisor and meals delivered) if George had not been connected to the public mental health system before he was in the nursing home he would go on a waiting list for assignment to a care planner. George could be referred to Section 8 housing but would face waiting lists and care planners would not be able to assist with the application process.

Medicaid care planners are limited in their ability to assist with housing for persons who transition from nursing homes. As a care planner in Ohio reported: “We refer people to Section 8 housing but they have to actually do the process themselves. I had one client who was quadriplegic. He applied for and received a housing voucher that was good for 90 days and he had to find his own place. It expired and then he had to go through the process and apply all over again. He finally ended up going back to the nursing home.”

Florida care planners suggested Section 8 housing or a return to a board and care home for George. New Jersey care planners also looked to board and care homes for George but were not optimistic in the long term about this placement. As one said, “A boarding home

“If he’s insulin-dependent, they (board and care homes) often really drag their heels with having to monitor the needles and the shots. They tend not to take them.” (New Jersey)

would take someone like George, but because they are less restrictive, people like George wind up wandering the streets, being hospitalized, then we find them back in our system. So it's like a rotating door."

A care planner in Washington felt she could draw on one of two adult family homes that are part of a special program (Expanded Community Services). This program, for the hardest-to-care-for clients, has available nurses who could do George's injections and check his blood sugars, as well as mental health providers who could handle his schizophrenia and medications issues. She also reported that all 30 slots in this program were full however. Another care planner felt she "would probably not be able to serve George in my county to tell you the truth." Like the first, she would seek to place him in an enhanced residential care facility, but would have to go to the next county over for this option.

Evaluating care needs

Personal Care

Despite George's mental health and medical care needs, he was unlikely to qualify for home and community-based programs that require ADL impairments and need for assistance with personal care tasks. Louisiana care planners indicated home health could be prescribed once or twice a week to see if George was taking care of himself. Meals on Wheels or church programs might be resources although unlike Mildred "we can't pull on the heartstrings as hard for people like George." He could receive medication management for his schizophrenia

at a mental health clinic, and there are counseling and support groups. But these care planners remained concerned about his medical issues -- whether "the diabetes is going out of control as soon as he gets out." In Ohio, if George's cognitive impairment were severe enough to require that someone be with him 24 hours a day, he could qualify for the Ohio Home Care Waiver program, but this program would not provide 24-hour care. If there were someone he could move in with, then the program (which covers respite) could provide someone to be with George while the caretaker works. One caregiver described a case similar to George's in which a man moved his brother with early-onset Alzheimer's disease into his home, and relied on the Ohio Home Care Waiver to provide respite care for his brother while he worked.

"He could qualify for the waiver if his cognitive functioning is impaired enough. People like George do go to day care, but they don't always fit in as well because of the age difference. We can try George in daycare because the stimulation's good for him but he may look at these other people and say "I don't belong here." (Florida)

The public mental health system was viewed as the source of assistance with medications for George's schizophrenia (although in some states there are waiting lists to see a psychiatrist -- from 3 to 6 months in Ohio). One care planner commented that "the most difficult issue is connecting George to the mental health system." She described another

"George would not be a priority case for those in the mental health system because he's being managed in the nursing home. The mental health system is going to be more concerned about the person out in the community who is not managed at all." (Ohio)

client recently discharged from a nursing home with a long psychiatric history who because she cannot get connected to the mental health system “is definitely teetering on the edge of going back to the nursing home.”

In Florida, if George were in a board and care home, one planner saw the need for an aide to visit a couple of times a week to make sure he is eating and bathing, and to check on whether he remembers to cook his meals if they are delivered frozen, or “whether he needs a hot meal delivered every day.” In-home counseling could be provided once a week for 2 months, then twice a month. Another indicated that if George couldn’t manage in Section 8 housing or board-and-care, then “he might be caught in a black hole.” He would not be old enough (age 65 or older) for the nursing home diversion waiver program which is aimed at keeping Medicaid recipients out of nursing homes.

Care planners demonstrated ingenuity in trying to meet George’s needs. One “wondered how well he does with his diet as far as preparing his own food and remembering to eat, that’s an important part for the diabetes. It might be that he needs at least one meal a day delivered so that he can be checked on. If the nurse is going in she could also, during that hour, make sure that he’s eating at least.” Another suggested that “Some people like George do have coordination problems so if he needs help with getting in and out of the tub to bathe, Medicaid could provide some assistance a couple of times a week to make sure he gets his bath, clean up the bathroom for him, and make sure his laundry gets done.”

Skilled Care

In every state, care planners indicated nursing visits could be used to set up George’s diabetes medication to see that he received proper dosages, and to provide diabetes education to George or a caregiver. The role of the nurse in administering insulin varied however. These variations are tied to differences in Nurse Practice Acts across states which govern nursing practices and the extent to which nurses can delegate what are normally nursing tasks, like injections, to others.⁵ In New Jersey, for example, a nursing visit once every 2 weeks was suggested. But a New Jersey care planner made a point of saying that while the nurse could set up George’s insulin he would have to administer it, not the nurse. New Jersey is one of several states that allows the nurse to educate the consumer and a caregiver, and monitor services, but does not hold the nurse responsible for providing care. In Washington, on the other hand, nurses can decide to delegate some tasks to individuals and caregivers after assessing both, and if all three parties agree. However, injections, including insulin injections, are not a task that can be delegated. If George were unable to administer his insulin injections, only a licensed nurse or LPN could do so. The potential need for daily nursing care no doubt influenced recommendations from many care planners that George be housed in a supervised adult family home where such care would be available.

Determining eligibility for home and community-based services

George was eligible for Medicaid prior to his nursing home admission. Because his personal care needs were few, however, he would have difficulty qualifying for waiver programs that require a nursing home level of care. Supervised community residences that could provide the services needed to meet both his mental and medical care needs were absent or in limited supply.

For these reasons, several care planners commented that George would not likely be identified as a candidate for transition. One care planner commented that “We get calls from the nursing homes when people are being discharged, generally for financial reasons, or from hospitals for folks who are more medically needy. In this case we would be fighting an uphill battle trying to get him out because no one would believe he needs to be out.”

OVERVIEW OF FINDINGS AND CONCLUSION

For care planners, the process of evaluating needs and arranging for provision of home and community based services to older individuals who want to transition from a nursing home, is similar to that for community-resident individuals. But interviews with care planners who work with individuals and their families in making the transition from nursing home to community, highlighted several issues of particular importance in nursing home transition:

- *Reconnecting individuals to community supports – relatives or friends who can supplement formal services – is a critical component to transitioning.* Care planners interviewed for this study typically paid as much attention to whether the necessary amounts and types of informal assistance were available as they did to planning formal services, because they were acutely aware that formal services alone would not be sufficient to maintain individuals in the community. As one care planner noted, “We’d be tapping every resource we’ve got.” For some individuals, nursing home entry disrupts fragile informal supports, and identifying and activating old or new ones is a challenge.
- *The availability of group residential options, such as assisted living, adult family homes, or special supervised residences, makes transition possible for people who otherwise could not be maintained in a community residence.* The hypothetical case of a 60 year-old man with schizophrenia and diabetes illustrates this point. Care planners felt his success in staying out of a nursing home largely hinged on finding a residential setting with supervision for his mental health and medical needs. Group residential options also provide care settings that can serve as a fall back if independent community living can not be maintained. A care planner in Washington who was concerned that the responsibilities of caring for a wheelchair-bound man would prove too much for his 70-year old wife, indicated that in talking to the wife she would let her know that if “his care got too great, it isn’t just her home or the nursing home, there are all these other alternatives in between.”
- *Concerns related to bridging the gap in providing services upon return to community settings because individuals must re-qualify for Medicaid and be assessed to determine which programs and levels of service they can receive, are uppermost in the minds of care planners.* When these gaps raised safety issues – returning a wheelchair-bound older man to a home without a ramp, placing a woman with mild dementia in an apartment without knowing how well she could manage with limited hours of formal assistance – care planners were reluctant to advocate for transition from the nursing home setting. As a care planner from Ohio stated, “My concern for her would be her dementia, and I would have to assess whether she could be left alone safely.” Even when service

eligibility seemed to be assured upon transitioning to the community, gaps between assessment and enrollment in a program could occur (anywhere from a week to months).

- *Finding a fit between care needs and programs can present a challenge.* Because many home and community-based care programs are oriented toward assistance with severe physical disabilities, it can be difficult to provide sufficient assistance to individuals with mental or cognitive problems who have low levels of ADL impairment but high need for supervision or cuing. In some cases, residential options that would seem to offer such oversight specifically preclude admission of individuals with dementia for example. As one care planner noted “If I had an adult family home that could take mobile dementia clients, I could fill it up today out of a nursing home.” Similarly, some assisted living facilities require that residents be ambulatory. Other issues arise as well. One state-funded program in Florida is open only to persons with an in-home caregiver, so care planners noted this as an option for the older married man if he returned home but not for the older widowed woman. In Ohio, the individual with schizophrenia and diabetes could meet the criteria for unstable medical conditions, but not for serious disabilities, and as a result could not qualify for the waiver program that offered the most extensive range of services including skilled care for diabetes management.

Other studies have documented the variation in home and community-based services that exists across states.⁶ The interviews with care planners in 5 states conducted for this study shows there are multiple programs with extensive variation in eligibility criteria, services offered, and budget and spending caps, within states as well. This complexity clearly limits the ability of nursing home residents and their families to evaluate the feasibility and desirability of transition back to a community setting, and makes the role of care planners in helping people to navigate their options a critical one. The perspective of care planners also highlights issues that affect the success of programs intended to facilitate returning nursing home residents to appropriate, safe and less costly community settings.

Appendix A. Home and community-based programs that would serve individuals who transition from a nursing home to the community

State programs	Program type	Services	Eligibility		Caps on \$, hours, or enrollment
			Income/assets	Other	
FLORIDA¹ Aged and Disabled	Medicaid waiver	a, b, d, e, f, g, h, k, l, m, n	Same as nursing home resident	age 65+ or <65 disabled; nursing home level of care	limited slots and waiting list
Assisted Living for the Elderly	Medicaid waiver	c 14 services (list)	Same as nursing home resident	nursing home resident; age 60+	limited slots and waiting list
Community Care for the Elderly	State-funded	b, e, f, j, k, l, m, n	Functionally impaired (cannot live alone); priority to adult protective services referrals	age 60+	Sliding scale co-payments
Home Care for the Elderly	State-funded	Monthly income subsidy to caregiver for services (most used are: respite and meals)	Same as nursing home resident	age 60+; in-home adult caregiver; at risk of nursing placement	\$106 per month an average
LOUISIANA Long Term Personal Care Services	Medicaid personal care option	k	Medicaid criteria	---	56 hours a week maximum
Elderly and Disabled Adult Waiver	Medicaid waiver	b, d, f, l, transitional service for individuals moving from nursing home to community; Personal supervision (day or night)	Same as nursing home resident	65+ or <65 disabled	\$60 a day maximum; limited slots and waiting list
Adult Day Health Care	Medicaid waiver	b, i	Same as nursing home resident	age 65+	limited slots and waiting list
NEW JERSEY New Jersey Personal Care	Medicaid personal care option	k	Medicaid criteria	nursing home level of care	None

Community Care Program for the Elderly and Disabled (CCPED)	Medicaid waiver	b, c, e, f, i, m, prescribed drugs	Same as nursing home	nursing home level of care	limited slots and cap on \$ per person
Jersey Assistance for Community Caregiving	State-funded	Same as CCPED waiver	Same as CCPED waiver	age 60+; nursing home eligible	Sliding scale co-payments
Enhanced Community Options Waiver: Assisted Living and Adult Family Care Caregiver Assistance Program (in home)	Medicaid waiver	Services (individual pays room and board) c, d, f, g, h, i, k, l, m, caregiver/recipient training; home-based supportive care	Medicaid criteria	age 65+ or <65 disabled; nursing home eligible	Cost caps on services and \$ per person. cost sharing
OHIO² PASSPORT	Medicaid waiver	b, d, f, g, h, i, k, l, n, independent living assistance; nutrition counseling	Same as nursing home resident	age 60+; able to remain safely at home; nursing home level of care	60% of monthly nursing home costs
CORE	Medicaid benefit	e, k	Medicaid criteria	---	≤14 hours a week
CORE PLUS	Medicaid benefit	e, k	Medicaid criteria	---	>14 hours with limited \$ range based on level of care
Home Care Waiver	Medicaid waiver	CORE plus PASSPORT and m	Same as nursing home resident	serious disabilities and unstable medical conditions (skilled care needs)	limited slots with limited \$ range based on level of care
WASHINGTON Medicaid Personal Care	Medicaid personal care option	k	Medicaid criteria	---	None
Community Options Program (COPES) in-home care adult family homes adult residential care facilities assisted living facilities	Medicaid waiver	k, a through n depending on site of care	Same as nursing home	age 65+ or <65 disabled	\$135 a day or 90% of average nursing home rate
Medically Needy Residential Waiver Program	Medicaid waiver	Same as COPES	Allows spend-down to nursing home eligibility levels for community residents		None

¹Other waiver programs exist but are limited to specific counties: Adult Day Health; Channeling; Frail Elder; PACE program

²Ohio plans an Assisted Living Medicaid waiver in 2007 to enroll up to 1800 individuals who are Medicaid eligible and meet nursing home level of care. It will be limited to nursing home residents, and existing Medicaid waiver participants who would otherwise enter a nursing home.

Services:

- | | |
|---|---|
| a adult companion | h medical equipment |
| b adult daycare; medical day care; social day care | i medical transportation |
| c case management | j minor home repair |
| d environmental access adaptations | k personal care (hands-on ADL assistance) or attendant care |
| e home health aide and other skilled care (therapy) | l personal emergency response system |
| f homemaker/chore | m respite |
| g meals | n social services; counseling |

REFERENCES

¹ Summer L. 2005. *Diversion efforts in states: Strategies to keep consumers needing long-term care in the community and out of nursing facilities.* At

<http://www.kff.org/medicaid/upload/Strategies-to-Keep-Consumers-Needing-Long-Term-Care-in-the-Community-and-Out-of-Nursing-Facilities-Report.pdf>

² *Nursing Home Transition Programs: Perspectives of State Medicaid Officials on Challenges in Returning Nursing Home Residents to Community Care Settings.* Kaiser Commission on Medicaid and the Uninsured, March 2006. Available at <http://www.kff.org>

³ See Schneider, A., Fennel, D., and Keenan, P. 1999. *Medicaid Eligibility for the Elderly.* Issue Paper for the Kaiser Commission on Medicaid and the Uninsured, May, Pub. No. 2145; Schneider, A., Strohmeyer, V., and Ellberger, R. 2000. *Medicaid Eligibility for Individuals with Disabilities.* Issue Paper for the Kaiser Commission on Medicaid and the Uninsured, May, Pub. No. 2187;

⁴ http://www.cms.hhs.gov/MedicaidEligibility/09_SpousalImpoverishment.asp#TopOfPage

⁵ Reinhard SC. 2001. *Consumer Directed care and Nurse Practice Acts.* At www.aspe.hhs.gov/daltcp/reports

⁶ See GAO-02-1131T *Elderly Individuals could find Significant Variation in the Availability of Medicaid Home and Community Services*, Sept. 26, 2002; Summer L. 2003 *Choices and consequences: The availability of community-based long-term care services to the low-income population.* at ltc.georgetown.edu/pdfs/choicesfull.pdf; Kitchener M, Ng T, Harrington C. *Medicaid 1915c Home and Community-Based Services Waivers: A National Survey of Eligibility Criteria, Caps, and Waiting Lists.* Home Health Care Services Quarterly: The Journal of Community Care 23 (3): 55-69, 2004.

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

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