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Efforts in States to Promote Medicaid Community-Based Services and Supports

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Introduction

Historically, most long-term services and supports financed by Medicaid have been provided in institutions, but the trend is toward offering more community-based services. States at the forefront in this respect are more likely than others to have certain characteristics in common: a philosophical commitment, sometimes accompanied by legislative direction, to provide more options for consumers; a single administrative agency; and global budgeting for the provision of all long-term services and supports rather than separate budgets for institutional and community-based services. Even without major re-focusing and restructuring, however, states have the capacity to make practical operational changes to promote community-based services and supports. This report describes current options for state Medicaid programs and draws on interviews with state officials to provide details about specific policies and procedures in states. The report is organized around seven objectives, all of which are geared towards the goal of increasing the provision of long term community-based services and supports financed by Medicaid:

- Expand access
- Expedite program eligibility determinations
- Ensure that community services can be provided immediately
- Ensure equal consideration of institutional and community options
- Develop procedures to track and manage placements
- Provide support to maintain or obtain community residences
- Strengthen the long-term service workforce

A companion brief, which reports on a working group discussion with Medicaid experts, provides more information on the current issues and challenges facing Medicaid home and community-based services and some possible solutions.[1] Significant progress can be achieved in meeting these objectives by making changes in state Medicaid policies and practices, but it is important to note that broader reform is also needed to develop an adequate supply of affordable, accessible housing in communities and to strengthen the long-term service workforce.

Expand access

To expand access to home and community-based services, states already have the opportunity to avail themselves of options to amend Medicaid eligibility rules for community-based services so that they are equivalent to the rules for institutional services. States can use a "special income rule" to set the income standard for nursing facilities or for home and community-based long-term

[1] Molly O'Malley Watts, Advancing Access to Medicaid Home and Community-Based Services: Key Issues Based on a Working Group Discussion with Medicaid Experts, Kaiser Commission on Medicaid and the Uninsured, September 2009.

care services as high as 300 percent of the federal SSI payment level ($2,022 per month for a single individual in 2009). In a 2007 survey of HCBS waiver programs, however, almost one-quarter (24 percent) reported using more restrictive financial eligibility criteria than the criteria used for nursing facilities.[2]

Federal Medicaid rules provide some financial protections for the spouse of an individual who receives long-term care services in an institution. The spouse remaining in the community can keep a portion of income and assets to maintain a reasonable standard of living. The federal government establishes minimum and maximum levels for income and resources and states set limits within those parameters. States have the option of applying nursing home spousal impoverishment protections when a married individual applies for home and community-based care. This occurs in 39 states.[3] Individuals who already have Medicaid coverage are financially qualified for long-term care services. In about half of the states other individuals with low incomes can "spend down" by subtracting out-of-pocket medical expenses from income to meet the "medically needy" income limits and qualify financially for Medicaid long-term care services.[4]

Expedite program eligibility determinations

Both functional assessments and financial eligibility determinations are required for the receipt of long-term services and supports financed through Medicaid. A number of states have systems in place to make functional assessments quickly. Financial eligibility determinations often take longer, however. This presents a significant challenge to individuals who want to remain in the community because they may not be able to arrange for the services they need while they are waiting for assurance that the services will be covered. Another challenge is that often different state organizations are responsible for the functional and financial assessments. Thus there may be confusion about who a consumer should contact should questions or problems arise related to eligibility determinations.

The ideal approach is to conduct quick, coordinated determinations of both functional and financial eligibility. The "Rapid Assessment" process used in **Pennsylvania's** *Community Choice* pilot program is a one model. Assessors employed by Area Agencies on Aging are on call at all times and, in 24 hours, if necessary, can not only develop an interim service plan, but also can collect basic information about an individual's financial circumstances. Dedicated fax lines are used to get the information to Medicaid quickly and facilitate quick preliminary financial eligibility determinations. A similar new "Fast Track" pilot in **New Jersey** searches two data bases, one for the state's *Pharmacy Assistance to the Aged and Disabled Program* and one that contains information about participants in benefit programs for low-income individuals. Applicants for long-term services whose names appear in the databases may receive conditional financial eligibility for services.

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[2] Ng, T., Harrington, C., and O'Malley, M., (2008). *Medicaid Home and Community-Based Service Programs: Data Update,* Kaiser Commission on Medicaid and the Uninsured.

[3] Bruen, B., Wiener, J., and Thomas, S. (2003). Medicaid *Eligibility Policy for Aged, Blind, and Disabled Beneficiaries,* AARP, Public Policy Institute**.**

[4] Ibid.

Ensure that community services can be provided immediately

Traditionally, institutional entities have been more willing than others to provide services before Medicaid eligibility is definitively established. More recently, some states have taken steps to assure community-based providers that they will receive payment for services they provide to individuals who are "provisionally" or "presumptively" eligible for Medicaid. In **Washington**, for example, services can be authorized for up to 90 days while the Medicaid application is completed and reviewed. Generally, the state asks individuals to sign an agreement indicating that they will be responsible for payment should they ultimately be found ineligible for Medicaid. States also have contingency funds available to cover payments, but reports from officials indicate that these funds are rarely used, primarily because of the careful screening that occurs early on to make determinations about who qualifies for this type of arrangement.

Ensure equal consideration of institutional and community options

Over the years more and more states have changed their approach from one that uses setting-specific assessments to one that starts with a needs assessment, continues with a discussion of options for the delivery of services, and concludes with decisions about how services will be delivered. Uniform pre-admission reviews are associated with the provision of more care in the community.[5] The state of **Washington** has been a leader in this regard. The state uses a single, comprehensive, automated assessment tool called CARE to make functional assessments and to develop care plans. The tool can also be used on an on-going basis to monitor the receipt of services. For example, the system can flag individuals whose needs are expected to change so that they receive the appropriate support to make a transition at the appropriate time. The system also provides data that can be used to examine and improve program operations.

Another approach that states use is to mandate pre-admission assessments for all individuals entering nursing facilities to ensure that everyone seeking long-term services is aware of all of the options for care. Some states have established a "no wrong door" policy or use a "single entry point" approach. The idea is that any initial inquiry is met with information and some level of assistance in understanding all of the service options. Most states are working to establish Aging and Disability Resource Centers (ADRCs). All ADRCs serve as an information source, but they have the potential to perform a range of functions. Centers that offer more comprehensive services are better able to promote all options for care. **New Hampshire**, for example, has statewide ADRC coverage. The Centers maintain a database of resources and services. They conduct pre-admission screening for nursing facilities and provide options counseling. The co-location of staff who conduct functional assessments and staff who determine financial eligibility for Medicaid shortens the time from intake to eligibility determination and is helpful as applicants consider their service options.

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[5] Summer, L., (2007). *Community-based long-term services financed by Medicaid: Managing resources to provide appropriate Medicaid Services*, Georgetown University Health Policy Institute. Gillespie, J. (2005). *Assessment Instruments in 12 States*, Rutgers Center for State Health Policy and National Academy for State Health Policy. #26 Gillespie, #27 Pepe, C., Applebaum, R. Straker, J. and Mehdizadeh, S., (1997). "Evaluating the Effectiveness of Nursing Home Pre-Admission Review: A State Example," Journal of Long-Term Home Health Care16, no.3.

Develop procedures to track and manage placements

Procedures to track and manage placements are sometimes called "diversion" activities when they are designed to keep people in the community and out of institutions or "transition" activities when the emphasis is on helping people return from institutions to the community. A significant amount of activity, employing a variety of strategies, has occurred in this regard in states in the last several years.

Some states assign case managers to hospitals or institutional facilities to identify individuals who are likely candidates for community-based services. Other states require that Medicaid be informed of admissions that are likely to involve long-term services or supports. Data are used in some instances to identify nursing home residents for transition, contact and potentially assist them in making a transition. Another approach is to contact residents periodically to re-assess their service needs and preferences. A strategy that has become increasingly popular among states is to make initial distinctions during the pre-admission assessment between short or longer-term institutional stays. **New Jersey**, for example, has a two-track system. *Community Choice* counselors contact all short-term residents with Medicaid coverage and work with them to plan the next phase of their care.

There is a growing recognition among states that individuals who choose to remain in or return to the community may need extra support as they arrange for and begin to use new services and supports. Thus, some case managers' roles in diversion and transition activities have expanded so that their involvement overlaps with other service providers and they can be actively involved for a substantial period of time if necessary. The state of **Oregon** recently created new "diversion/transition specialist" positions. Specialists are located in each region of the state to identify people interested in arranging for community-based services, then work with them through the diversion or transition process and for up to 90 days. The specialists are part of a team that may include other case managers who will stay involved over the longer term. The new positions were created after state officials saw an increase in the nursing facility census for the first time in 20 years.

Provide support to maintain or obtain community residences

An inadequate supply of accessible affordable housing in the community is a factor that poses a significant challenge to planning for and providing community-based services. Efforts beyond those currently available through Medicaid are needed to build community capacity, but states can use certain Medicaid options to promote the use of community-based services.

As noted earlier, states can pay for services on a "presumptive" basis. Thus, home modifications that are necessary to keep an individual in the community can be made for applicants whose Medicaid eligibility is pending. Medicaid rules allow states to pay for services, including home modifications, provided up to 180 days before individuals leave an institution to return home. These rules are very helpful for people who already have Medicaid coverage. Home maintenance allowances, which permit states to exempt a portion of the income that consumers would otherwise pay to an institution can be authorized for up to six months if a physician

certifies that an individual is likely to be able to return home in that period. In recognition of the fact that people who stay in the community will likely have ongoing expenses related to maintaining a home, states can also increase the resource disregard used in determining financial eligibility for Medicaid. All individuals applying for Medicaid may keep $2,000 of resources. In **Maine**, and additional $8,000 is disregarded, or not counted, when making eligibility determinations for consumers who choose community-based services.

States also can provide an expansive set of services through their waiver programs to facilitate the provision of community-based services and supports. For example, services to make the home livable such as pest control or one-time cleaning as well as coverage of moving expenses or security and utility deposits can be covered by waivers. Recently **Pennsylvania** expanded coverage to include a set of assistive technology services that can be used to remotely monitor activity, adherence to medication regimens, or measures such as blood sugar or blood pressure.

Other state activities are geared to increasing the supply of community living options. One approach is the permanent conversion of nursing facility beds to assisted living units. Another is to alter the "Certificate of Need" formula used to regulate the supply of nursing facility beds so that fewer institutional options are available.

Strengthen the long-term service workforce

Given provider shortages, Medicaid programs that promote home and community-based services have relied to a great extent on strategies that give consumers more leeway regarding who they can hire. Some Medicaid programs let consumers hire independent providers, either family members or others. Consumers may also have the opportunity to direct their own care. In **Vermont**, which made substantial program changes starting in 2005 to help low-income seniors and persons with disabilities receive long-term services and supports in the community, more than 60 percent of personal care hours are directed by consumers or their surrogates.[6] Early opportunities for self-directed services were available in a few states through "Cash and Counseling" demonstration projects, which proved more effective relative to more traditional arrangements not only in meeting individuals' needs, but also in reducing the emotional, physical, and financial stress experienced by informal caregivers.[7] An optional state plan benefit for self-directed personal assistance services is now available. CMS reports that as of August 2009, state plan amendments had been approved for six states: Alabama, Arkansas, New Jersey, Florida, Oregon and Texas.[8]

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[6] Crowley, J. and O'Malley, M., (2008). *Vermont's Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges As the Program Concluded its Third Year*, Kaiser Commission on Medicaid and the Uninsured.

[7] Brown, R., Cash and Counseling Demonstration Evaluation, (2009). Home and Community-Based Services: Examining the Evidence Base for State Policymakers, Hilltop Institute Symposium.

[8] Personal communication, August 4, 2009.

Often, the use of community-based services is not feasible without the participation of family caregivers. Thus, some states assess the needs of family caregivers at the same time that they assess the needs of individuals requesting services. **Washington** state is developing a separate assessment tool for caregivers' needs to use routinely on a statewide basis. A pilot program in **Maine** is designed to identify signs of depression among family caregivers who provide services for individuals with dementia. When necessary, referrals are made for appropriate services or supports for the caregivers.

With the exception of scattered efforts to recruit providers, particularly in rural areas, Medicaid programs generally have not been engaged in activities to increase the numbers of formal caregivers in communities. States have, however, been active in developing nurse delegation programs, which make it possible for caregivers who are not licensed or highly trained to receive training and supervision in order to perform tasks normally performed by a nurse. Medicaid has sponsored relatively few caregiver-training initiatives. Efforts to recruit and train service providers as well as initiatives to increase pay and fringe benefits for workers are essential, both within Medicaid and more broadly, to ensure that states have the capacity to meet the demand for community-based services.

Conclusion

Even if they are not inclined to revamp their systems of long-term services and supports, states can take advantage of options to promote community-based services by adopting some of the policies and procedures related to program eligibility and benefits as well as workforce development. All states, even those with more balanced service systems, have the potential to increase access to community-based services. States may be reluctant to take on new initiatives during difficult financial times, but some structural or procedural changes can be accomplished with minimal or no additional cost. And, there is evidence from states that providing services in the community can be less expensive than providing institutional care.[9] Additional federal support to states, provided under certain conditions, could provide a strong incentive for a shift to increase the availability and accessibility of community-based services financed by Medicaid.

[9] Kaye, S., LaPlante, M. and Harrington, C, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?" Health Affairs 28, no1 (January/February 2009).

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