kaiser commission on medicaid and the uninsured

Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities

EXECUTIVE SUMMARY

Prepared by

Laura Summer
Georgetown University Health Policy Institute

for the

Kaiser Commission on Medicaid and the Uninsured

September 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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The majority of expenditures for long-term care financed by Medicaid are for institutional care, but the trend over the last decade for Medicaid long-term care services has been away from institutional care toward more community-based care. As part of efforts to rebalance long-term care systems, states have used nursing home "transition" and "diversion" strategies. "Nursing home transition" generally refers to activities to move individuals from institutional settings to alternative community placements. "Diversion" refers to efforts to provide choices and assistance for consumers who are at risk of admission to nursing facilities unless alternate community-based care can be arranged quickly.

The state Medicaid programs that are most successful at keeping people in the community do not operate separate "transition" or "diversion" programs. Rather they have made systemic changes to increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care. Even these states, however, have not addressed all of the Medicaid rules and practices that traditionally have favored institutionally based long-term care. Nursing home care is a mandatory Medicaid service, but the provision of most community-based care is optional for states. Most states still limit the number of people served through home and community-based waiver programs.

In the majority of state Medicaid programs, the prevailing approach to promoting community-based care is not to completely revamp long-term care systems, but to change some of the established practices that favor institutional care. This report examines policies and practices in eight states. It provides a sense of what state Medicaid programs are doing or could be doing to promote diversion, but it does not identify particular "best practices." Four of the states have made sweeping changes to their Medicaid long-term care systems, where almost half or more of Medicaid long-term spending is for home-based care (Maine, Oregon, Vermont, and Washington) and four have made incremental changes to keep more people who need long-term care in the community. These four states—Indiana, Nebraska, New Jersey, and Pennsylvania—spend smaller proportions of Medicaid funds on home-based care. Regardless of the approach that states take, however, some consistent themes emerge regarding efforts to divert consumers from nursing homes.

A philosophical commitment and legislative direction. The importance of these factors in facilitating change is commonly expressed by state officials. In Vermont, community coalitions have been an integral part of the long-term care system since 1996 with the passage of Act 160, which required reductions in nursing home care and increases in community-based care across the state. States with a mandate for change from the leadership have an advantage as well. For example, the Governor's Office of Health Care Policy in Pennsylvania considers the rebalancing of long-term care a priority and this fosters cooperation among state agencies.

State Example: Oregon's Legislative Commitment

Language in the original legislation to promote community-based care in Oregon laid out a vision for a new system of care and the transition to community-based long-term care became the focus of state program management. Since 1981, when Oregon received the first home and community-based services waiver, the philosophy and standard practice in the state has been to provide as much long-term care as possible in community-based settings. Thus, all program operations are essentially geared to promoting diversion from nursing homes and relocation for nursing home residents who request care in the community.

Fast eligibility determinations. A Medicaid eligibility determination process that takes weeks or months is incompatible with diversion efforts. Commonly, nursing facilities are willing to assume some financial risk and provide services even before Medicaid financial eligibility determinations have been completed. By contrast, many community-based providers are less experienced and therefore less willing to take a risk. "Fast track" systems used in Washington and in a pilot program in Pennsylvania allow applicants to make initial self-declarations about their financial circumstances so that arrangements for care can be made quickly for applicants if they are judged potentially eligible for Medicaid coverage. States have also established standards to ensure that functional eligibility determinations are conducted in a timely manner, but without an expedited financial eligibility determination, this approach is limited.

State Example: Pennsylvania's Rapid Assessment

Applicants or agencies making referrals for Pennsylvania's Community Choice program can call a state hotline which operates seven days a week, 24 hours a day, to request assessment for long-term care services. The hotline operator contacts an "on call" assessor who talks with the caller to determine the urgency of the situation. Assessment interviews can be conducted within 24 hours of the call for people in the community who are at risk of immediate admission to a nursing facility. Assessors are employed by Area Agencies on Aging or other subcontractors. Assessors use a four-page form to make determinations about the level of care needed and to create an interim service plan. Subsequently, a more comprehensive plan of care is developed. The initial application asks for basic information about income and assets. The assessor faxes the completed form to the Medicaid office using a dedicated fax number. At the office, a caseworker makes a preliminary determination about eligibility and enters information about the individual in the system if it appears that he or she will be eligible. The information submitted must be verified in 45 days.

Making community care available immediately. Recognizing that community-based providers may be reluctant to assume the financial risk associated with serving consumers whose Medicaid eligibility has not yet been confirmed, the President's proposed budget for fiscal year 2005 would provide federal reimbursement when states opt to grant "presumptive eligibility" to individuals discharged from a hospital to a community-based waiver program, even if they were later found to be ineligible for Medicaid. Although federal reimbursement for services is not available currently, some states guarantee payment. In Washington and in Pennsylvania's pilot program, state funds can be used, if necessary. Officials note that although there is some risk to these arrangements, the potential financial benefit of serving people in the community rather than in nursing homes is great. Experience to date indicates that such arrangements do not pose substantial financial burdens for states.

Even if community-based providers are willing, their ability to provide services may be limited by an inadequate supply of workers, which can be a barrier to diversion efforts.

State Example: Nebraska's Waiver While Waiting Program

Nebraska's program allows service coordinators to authorize waiver services for individuals who will likely be eligible for Medicaid coverage. Based on simple financial information provided by the applicant, the service coordinator consults with a Medicaid eligibility worker who can judge whether it appears that the applicant will be eligible for Medicaid. If ultimately the applicant is not eligible, the state uses funds from the Social Services Block Grant to pay for services. The need to use block grant funds has occurred only twice over a two year period. The Waiver While Waiting program was established in response to findings from market research conducted by the state which indicated that the time lag between consumer's needs for home and community-based services and the availability of the services were a major barrier to the choices consumers make about where they want to receive care.

Procedures to track and manage placements. Decision-making about long-term care is a dynamic process. The logical time and place to help consumers avoid nursing home admissions would seem to be in the community or at the hospital just prior to discharge. Some states mandate that anyone seeking admission to a nursing home have a pre-admission assessment so that they will be informed about all options for long-term care. With the trend towards shorter hospital stays, some states maintain that there is a need and an opportunity to counsel consumers early in their nursing facility stay.

State Example: New Jersey's Pre-admission Screening

During the pre-admission screening process for all nursing home admissions in New Jersey, Medicaid beneficiaries are designated as "Track One" or "Track Two" depending on whether they are likely to remain in the facility for a long or short-term period of time. All short-term residents receive a letter indicating that they are certified for six months or less. They are contacted by Community Choice counselors who work with them to develop a relocation plan.

In an effort to ensure that short-term nursing home stays do not become long-term stays, another practice is to certify individuals for nursing facility care for specific periods of time, after which reassessment must occur. Indiana, Maine, Nebraska, New Jersey, Oregon, and Pennsylvania's pilot program all have policies that distinguish between short and longer-term stays. Regardless of whether consumers are diverted from nursing homes entirely or spend a short time in a facility, the key to successful placements in the community is to ensure that a plan for care is formulated early in the decision process and that the consumer has support throughout the process.

Assuring financing for community care. States that have legislative mandates to reinvest cost-savings from reductions in institutional care have increased their capacity over the years to provide community-based care. A related approach, in which "money follows the person" from a nursing home to the community can also enhance community capacity, but unless the funds remain in the budget for community-based care, the enhancement is temporary. State Medicaid programs' ability to show that, on average, the cost of long-term care is lower in the community than in nursing homes has been important in making the argument that some initial investment may be required to increase community capacity. In states such as Oregon and Washington that have pooled funds for all long-term care services, limited funding for home and community-based services relative to institutional services is not problematic. In other states, however, limited budgets for community-based care can hamper diversion efforts. Some states with waiting lists for community-based care have policies that favor diversion.

State Example: Indiana, Washington And Pennsylvania—Serving People In The Community Can Be Less Expensive Than Institutional Care

Cost estimates from Indiana indicate that three people can be served in the community for every two who receive services in nursing homes. Officials in Washington estimate that the cost of caring for people in a nursing home is equal to the cost of providing services for two to four people at home. Estimates from Pennsylvania indicate that under the state's Aging Waiver, on average, 2.2 people can receive services in the community for each aged individual receiving services in a nursing home.

The availability of accessible and affordable housing. Sometimes there is a need to make modifications or repairs so that an existing home will be livable or it may be necessary to move to a more appropriate residence to stay in the community. Consumers who enter institutions, but ultimately wish to receive services in the community on an ongoing basis must be able to maintain or secure appropriate housing. Medicaid rules that allow states to pay for services such as home modifications before consumers leave an institution to return home can be very helpful in arranging for community-based care. When Medicaid eligibility is pending, however, consumers may not be able to return to the community immediately from a hospital or other institutional setting unless funding for modifications is available on a "presumptive" basis.

In addition, when people with Medicaid coverage enter nursing facilities they are at risk of losing their homes unless they can keep some income to maintain them. States do have the option under Medicaid rules to exempt some income for this purpose. When this approach is used, as it is in Maine, New Jersey, Washington, and Pennsylvania's pilot program, the resident's payment is lowered and the amount that Medicaid pays to the nursing facility is higher. Some states have

also increased the asset disregards used in calculating financial eligibility for Medicaid. As a result, consumers can retain assets to pay for home maintenance. These accommodations are particularly useful when short nursing home stays are part of a plan to return to the community. Finally, without efforts in most states to increase the supply of appropriate housing, diversion will continue to be problematic for many consumers.

State Example: Pennsylvania, Vermont, And Maine's Increased Asset Disregard

Pennsylvania increased the resource disregard used in determining financial eligibility for Medicaid from $2,000 to $8,000 for individuals receiving home and community-based waiver services through the Community Choices program. Under Vermont's 1115 waiver proposal, individuals who are single, own their homes, and wish to stay in them could keep additional assets above the current $2,000 level. Vermont will start at the $3,000 level, but has permission to go as high as $10,000. The higher asset rules would also apply for short nursing home stays so that consumers can maintain their homes and move back to the community. Maine has increased the disregards for assets so that beneficiaries can have assets of $10,000 or less. This has the effect of allowing individuals to retain assets that can be used to maintain homes or for other purposes.

Consumers and professionals need information about the options for care. The alternatives to nursing homes are better known in states that have been promoting community-based care for some time, but in most states, systems are evolving quickly and community-based options for long-term care are relatively new. State officials are stressing the importance of publicizing the availability of community-based alternatives both to consumers and to the professionals who work with them.

State Example: Vermont's Outreach Program

Vermont mounted an Options Education campaign to publicize the availability of options for long-term care services. A set of outreach materials that can be used statewide and locally was developed for immediate and ongoing use. They urge state residents to call the Senior HelpLine and talk with Information Assistance Specialists. Grant funds were used to develop the materials and mount the initial campaign. The state anticipates that maintaining the campaign should be less costly now that the materials have been developed. In the future, the campaign will be financed with funds from the long-term care budget.

Conclusion

Regardless of whether state Medicaid programs have undergone major restructuring to promote community-based care or whether they have made changes in certain practices that traditionally have favored institutional care, there has been an increase is efforts to divert people from nursing homes by providing options for care in other settings initially or to move individuals from institutional settings to alternative community placements. Although states continue to consider policy changes to promote community-based long-term care in Medicaid, the issue

that overshadows all others for state Medicaid programs is the challenge posed by the growing need for services at a time when funding is limited. Most states already were considering plans to reduce the growth of Medicaid spending, but with the passage of the Congressional budget resolution for fiscal year 2006, which calls for a $10 billion reduction in federal spending for Medicaid over the next five years, there is even more emphasis on controlling program costs. It is worth noting, however, that many of the innovations to rebalance long-term care services and provide more care in the community were initiated at times when budgets were tight precisely because policy makers were willing to consider plans presented as lower cost alternatives.