kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

February 2013

Roads to Community Living: A Closer Look at Washington State's Money Follows the Person Demonstration

Introduction

Washington State's Money Follows the Person (MFP) rebalancing demonstration project, called Roads to Community Living (RCL), is responsible for assisting over 2,400 individuals with complex long-term services and supports (LTSS) needs in transitioning out of institutions back to community-based care settings. The MFP program funds one-time and ongoing services that help eligible Medicaid beneficiaries prepare to move out of an institutional setting and provides enhanced federal funding for qualified services throughout the first year that they transition home. State officials describe RCL as a "sparkplug" that helped to re-examine Medicaid LTSS rebalancing efforts within the state.

Washington State has been a leader in Medicaid LTSS rebalancing efforts over the last two decades. According to the state, in the early 1990s, 82 percent of long-term care funding went toward institutional services, and by 2010, that percentage dropped to 37 percent. Washington currently spends 63 percent of LTSS spending on home and community-based services (HCBS).

Prior to MFP, Washington State's efforts to increase access to Medicaid HCBS included creating a personal care waiver program called Community Options Program Entry Systems (COPES) in 1983, offering personal care as a State Plan service in 1987, and developing a range of community-based options intended to divert individuals from nursing home care. Starting in 1993, the legislature passed a statute recognizing the need for a broad array of LTSS that support individuals in their own homes or in community-based residential settings and that this availability would reduce the number of nursing home beds needed. From this point forward, the state provided a nursing facility case management transition strategy to ensure that beneficiaries were

The **Money Follows the Person (MFP)** demonstration is a Medicaid initiative designed to reduce reliance on institutional services and expand community-based long-term services and supports options. MFP, first authorized in the Deficit Reduction Act of 2005, was extended until 2016 under the Affordable Care Act of 2010. To be eligible for participation in MFP, Medicaid beneficiaries must reside in an institution, e.g. nursing facility, intermediate care facility for individuals with intellectual disability, for at least 90 qualified days prior to the date of transition to a qualified community residence, e.g. private home owned or leased by beneficiary or his/her family member, a qualified assisted living facility. Under the MFP Program, a participant receives medical and supportive services for 365 days from the date of transition, and the state receives an enhanced federal match on those qualified services provided during an individual's participation year. Currently, 36 states, including DC, have operational MFP programs, eight more states have received funding to begin an MFP demonstration program, and two states' demonstrations are inactive.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, Fax: (202) 347-5274
Website: www.kff.org/kcmu

offered community-based, long-term care services. This initial transition program was designed to limit unnecessary nursing facility stays. In 2007, with the additional federal grant money available through the MFP enhanced match, Washington was able to closely examine the long-term nursing facility resident and individuals with developmental disabilities populations to determine how to best support those individuals who can safely and adequately be served in the community (participation in RCL is voluntary). Since RCL began transitioning individuals in 2008, Washington created a third transition program called Washington Roads, through state-only funding, that has less restrictive eligibility requirements than MFP and more housing and service options.

This brief reports on a case study of Washington State's MFP demonstration. It describes key features of the RCL program and highlights recent program experiences. For this case study, we interviewed staff members within the Washington Department of Social and Health Services (DSHS), and supplemented interview data with background information obtained from state websites and Kaiser Commission on Medicaid and the Uninsured MFP surveys conducted between 2008 and 2012.

Program Features

The RCL demonstration project is managed by DSHS's Aging and Disability Services Administration (ADSA). Within DSHS, three divisions are directly involved with RCL participants: Home and Community Services (HCS), Division of Developmental Disabilities (DDD), and Division of Behavioral Health and Recovery (DBHR). The majority of RCL staff work within HCS and DDD, including a project director, project coordinator, three resource specialists, three housing specialists, two quality improvement staff, and three specialists who focus on training curriculum, data analysis, and LTSS system change. Roughly 90 nursing facility case managers help with relocation for all three of Washington's transition programs. They include 11 RCL specialists in the field whose responsibilities include authorizing MFP demonstration services.

Under RCL, Medicaid beneficiaries who reside in a nursing facility for at least 90 qualified days prior to enrollment can transition to a qualified community-based care setting of their choice and receive a comprehensive set of benefits to ensure a successful transition. Each RCL participant has a person-centered care plan that encompasses HCBS tailored to the circumstances and needs of the individual. RCL care plans are coordinated with primary care, mental health, substance abuse, vocational rehabilitation, and housing services. RCL services include home and community-based waiver services as well as demonstration services and supplemental services which are outside of the typical Medicaid benefit package (examples described below).

Most individuals who transition to the community under RCL enroll in the COPES waiver after the first 365 days at home (i.e. when their RCL participation year ends). **Washington State's § 1915(c) waivers and state plan HCBS available to eligible beneficiaries include:**

- Personal Care
- Skilled Nursing
- Home Health Aide
- Adult Day Care
- Caregiver/beneficiary Training
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Transportation

- In-home Nurse Delegation
- Specialized Medical Equipment and Supplies
- Personal Emergency Response Systems
- Community Transition Services
- New Freedom Waiver Services (currently available in King and Pierce Counties only)
- Adult Day Health
- Comprehensive Adult Dental Care

Key services unique to RCL are those that allow an individual and his/her care team to prepare for re-entry into community living. Supplemental services, which are not covered under the state's existing Medicaid waivers but are available under RCL, include the use of a service animal and related training. Officials noted that waiver services are comprehensive, but RCL allows them to offer more specialized services including a community choice guide, a type of life coach who helps with transition activities. When necessary, the community choice guide deals with time-consuming components of the transition plan for Medicaid beneficiaries with complex needs.

RCL Demonstration and Supplemental Services include:

- Community Choice Guide
- Challenging Behavior Consultation
- Transitional Mental Health Services
- Professional Support Services, such as physical or occupational therapy or audiology
- Informal Caregiver Support Services
- Substance Abuse Services
- Respite Services
- Service Animal
- Adult Day Trial Services
- Assistive Technology and Vehicle Adaptations
- Residential Environmental Modifications

Nearly all MFP demonstrations nationwide promote self-direction (or consumer direction) of services. DSHS promotes the self-directed service delivery model which gives beneficiaries control over where, when, and how they receive LTSS included in their care plan. In RCL, self-direction refers to the mechanism by which participants can manage their personal care services rendered by a qualified and contracted independent provider (IP); at any given time, roughly 14 percent of RCL participants use IPs.

Outreach and Enrollment

When Washington State first applied for MFP funding, the state acknowledged the need to focus on long-term nursing facility residents – a population that faces considerable barriers to moving back to the community as their length of stay grows. Prior to MFP, most transition efforts in nursing facilities focused on individuals within the first two months of their stay. State data show that approximately 46 percent of those living in Washington's nursing facilities are there six

months or longer.[1] MFP funding provided Washington with an opportunity to offer additional services and supports in hopes that those services would ensure a successful and permanent transition for those longer-term institutional residents who choose to move home.

Prior to becoming operational in 2008, state officials communicated RCL's goals to potential participants, participating providers, and state outreach/education/intake staff. In the community, outreach efforts included the Senior Lobby; Housing Authorities; the Washington Health Care Association and the Washington Association of Housing and Services for the Aging, Washington State's two professional associations for nursing facilities and residential services; Independent Living Centers, including the Association of Centers for Independent Living of Washington Executive Committee and the Independent Living Center Regional Conference; the Ombudsman statewide supervisory team; the professional association for Homecare Agencies; Service Employees International Union; County Vocational Rehabilitation providers; and the statewide Area Agency on Aging (AAA) Executive Committee. Outreach also included previously existing stakeholder groups in mental health and the DD community.[2] Among the tools that were developed to inform potential participants and their families about the RCL program were informational flyers distributed to institutional settings and various community locations that reached large audiences such as medical clinics and community centers. The program also created a transition handbook which takes someone step-by-step through the RCL enrollment and transition processes.

Washington State's transition system includes collaboration between the state nursing facility case managers, residential case managers, DDD case managers, mental health community liaisons, and in-home AAA case managers. Most referrals to RCL come from case managers. The case managers, who are typically nurses or social workers, perform the assessment, explain all available community options including RCL, discuss risks and benefits of leaving the institution, and work with the beneficiary to create an individual back-up and support plan. After developing person-centered care plan, RCL participants may work with a community choice guide whose role it is to help the participant navigate the challenges of finding, setting up, and maintaining a qualified community residence.

Transition Progress

As of October 2012, 2,484 individuals have transitioned back to the community, and another 360 individuals were in the process of transitioning home (Figure 1).

[1] Washington State's Money Follows the Person Demonstration Project, "Roads to Community Living: Operational Protocol," State of Washington, October 12, 2010, available at: http://www.adsa.dshs.wa.gov/Professional/roads/documents/Operational%20Protocol.pdf.
[2] *Ibid*.

Figure 1

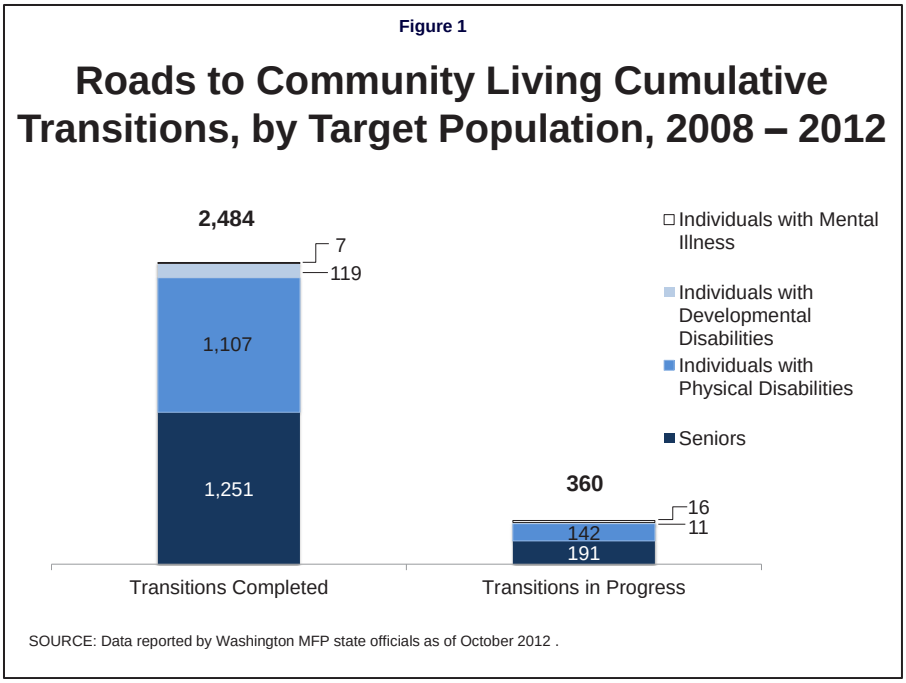


Table 1 below shows the total number of RCL transitions by population group as of July 2012. Seniors and individuals with physical disabilities are the target groups most likely to transition as RCL participants. The average age of a RCL participant is 64 years old. However, RCL helps transition individuals across the life span, including a child as young as 13 and a senior as old as 100.[3]

Washington State is increasing its efforts to target individuals with mental illness for transition to community-based care settings. To date, 20 Medicaid beneficiaries with mental illness have transitioned home under RCL, ranking Washington State fourth among MFP states transitioning individuals with mental illness. Efforts to transition this population utilizing MFP demonstration funds have been hampered by MFP eligibility restrictions. Specifically, MFP excludes adults, ages 22–64, residing in Institutions for Mental Disease (IMDs). Going forward, RCL staff will focus on identifying children under age 22 who are moving from IMDs and wish to return to community living. IMD staff, Regional Support Networks (contracted managed care mental health providers), and DBHR are working together to identify eligible individuals. Under a new state contract, the managed care providers will benefit from the enhanced match on qualified services, and the state will continue to focus on improving the coordination of benefits between the state Medicaid program and DBHR.

[3] Washington State Department of Social and Health Services, "Roads to Community Living Washington State's Money Follows the Person Demonstration Project," June 2012, available at: http://www.aasa.dshs.wa.gov/Professional/roads/documents/RCL%20Factsheet.pdf.

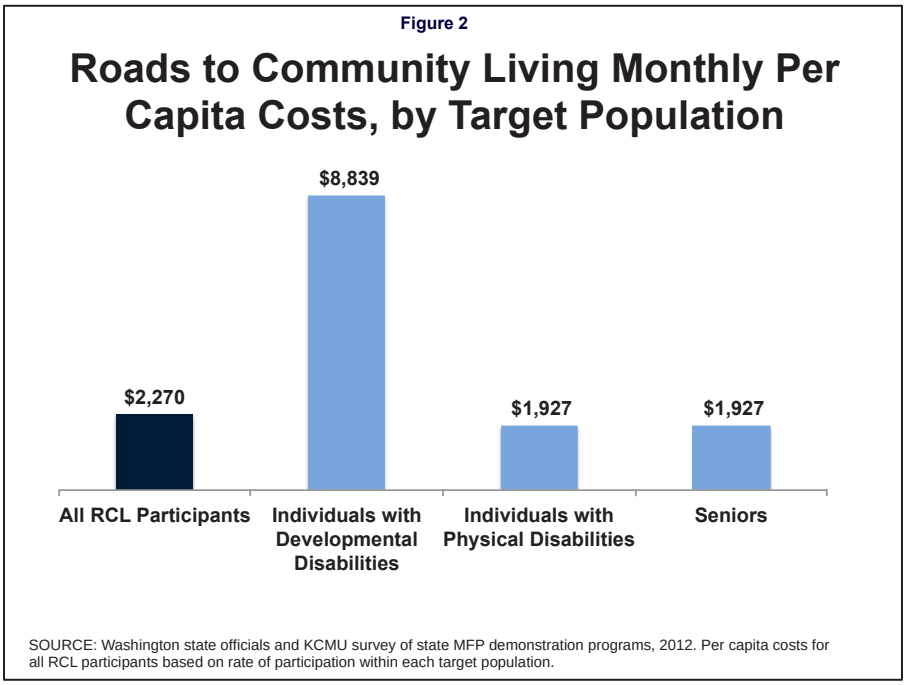
TABLE 1. Road to Community Living Transitions, by Target Population, 2008 - 2012

	Number of Transitions Completed	Number of Transitions in Progress	Rate of Reinstitutionalization
Seniors	1,251	191	14%
People with Physical Disabilities	1,107	142	13%
People with Developmental Disabilities	119	11	2%
People with Mental Illness	7	16	8%
Total	**2,484**	**360**	**9%**

SOURCE: Data reported by Washington MFP state officials as of October 2012.

On average, it costs $2,270 per month to serve an RCL participant in the community (Figure 2). RCL participants with developmental disabilities have the highest monthly per capita cost ($8,839), which is over four times what it costs to serve seniors and people with physical disabilities in the community under RCL ($1,927). These average costs are on par with HCBS waiver expenditures across the state, and are lower than the average costs of serving Medicaid beneficiaries in institutional settings ($4,493).

Figure 2



SOURCE: Washington state officials and KCMU survey of state MFP demonstration programs, 2012. Per capita costs for all RCL participants based on rate of participation within each target population.

On average, RCL participants took 86 days to transition home after the transition planning process was initiated in the institution. This compares to a national average of 105 days.[4] The amount of time it took to transition home varied by target population. Individuals with physical disabilities averaged 101 days before transition occurred while the average senior returned home in just 62 days. It is important to note that transition times vary from the national average for several reasons. One reason is related to acuity level of RCL participants. Washington State utilizes a number of relocation resources in addition to MFP, such as the Washington Roads program, that assist more short-term, less acute residents in transitioning home. Also, the date Washington considers an individual "assessed" is the original date that the individual expressed interest in transitioning home. At this point their name is entered into a SharePoint site. Some individuals might express interest and then change their mind or have their circumstances change, only to express interest again at a later date. Once an individual's name is listed on the SharePoint site, that initial date is used.

During the transition planning period, participants work with community choice guides to complete housing searches and make connections with community-based service providers. RCL participants may move to the qualified living arrangement of their choice according to their individual needs. Regardless of population grouping, most RCL participants transitioned to a house or apartment. The state has a sufficient supply of adult family homes that are also frequently chosen by both seniors and individuals with physical disabilities. Qualified assisted living facilities, especially those that will accept Medicaid beneficiaries, are in shorter supply. Individuals with mental illness are most likely to transition to adult family homes.

About nine percent of RCL participants have been reinstitutionalized either in a hospital, nursing facility, or intermediate care facility for people with developmental disabilities (ICF/DD). The rate of reinstitutionalization was highest among seniors (14%). Nationally, states reported an average reinstitutionalization rate of 8 percent across all MFP populations.

Key Partnerships

Key partnerships that help support the Washington MFP program include:

- **Public Housing Authorities**: DSHS partnered with local public housing authorities to bring 215 Housing Choice Vouchers to RCL participants. Recently, RCL partnered with the Department of Commerce to apply for federal Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities program. HUD provides funding to develop and subsidize rental housing with the availability of supportive services for very low-income adults with disabilities. DDD has benefitted from the Washington State Housing Trust Fund which provides funding to local communities to help meet the housing needs of low-income and special needs populations.

  Also, with 100 percent federal administrative funds made available through the MFP grant, Washington State hired three full-time Housing Program Managers who coordinate efforts to increase capacity statewide for MFP beneficiaries. Since housing is a critical

[4] M. O'Malley Watts, "Money Follows the Person: A 2012 Survey of Transitions, Services and Costs," Kaiser Family Foundation's Commission on Medicaid and the Uninsured, February 2013, available at: http://www.kff.org/medicaid/8142.cfm.

component of the RCL program, the RCL housing program managers are continuously looking for different ways to utilize subsidized housing channels throughout the state.

- **Area Agencies on Aging (AAAs):** In-home waiver and RCL participants receive case management services from their local AAA following transition. AAA staff authorize those MFP demonstration services which provide stabilization throughout the transition process and increase the likelihood of a successful move for the RCL participant. AAAs are also the contracting agencies which develop and execute contracts with authorized local providers to deliver demonstration services within the service area by both HCS and AAA staff.

- **Centers for Independent Living (CILs):** RCL partners with CILs throughout the state to provide a variety of support services to participants. CILs are contracted to provide peer support and independent living skills training for RCL participants.

- **Aging and Disability Resource Centers (ADRC):** The Affordable Care Act (ACA) appropriated $10 million a year for five years (2010–2014) to expand ADRCs which serve as single-entry community access points for individuals seeking information and referrals for LTSS. Forty states, including Washington, reported partnering with ADRCs to assist with MFP referrals and to help coordinate transitions. DSHS is using its ADRC grant to improve infrastructure and participant data collection efforts across the state to better track RCL participants' transition activities and service use.

Quality and Data Evaluation

The Centers for Medicare & Medicaid Services (CMS) requires all states with operational MFP programs to file quarterly enrollment and expenditure reports. CMS contracted with Mathematica Policy Research (MPR) to analyze the MFP program, and this evaluation of MFP is designed to assess the effects of the transition program moving individuals back to the community as well as states' progress in rebalancing their long-term care delivery systems using the federal enhanced matching funds generated by these transitions.[5] As required by the grant, Washington State participates in the CMS MFP *Quality of Life* participant survey which is given to participants just prior to discharge from the institution and one and two years post transition to the community.

The state is currently developing a web-based critical incident tracking system that will enable DSHS to pursue allegations of neglect, abuse, and exploitation across state administrations by type of incident and waiver/program, improve coordination between complaint investigation and case management entities, and better integrate provider background checks and reports of critical incidents. The first phase of implementation of the critical incident tracking system included individuals with developmental disabilities and children. The state conducts a DSHS client survey that includes RCL participants as well as other beneficiaries every two years. Together, these tools allow state officials to better understand the community resources and networks

[5] For more information on Mathematica's evaluation of the MFP demonstration, see: http://www.mathematica-mpr.com/Health/moneyfollowsperson.asp.

needed to reduce to rate of reinstitutionalization and allow RCL participants to succeed in the community during and after their participation year.

Outlook

Washington State's MFP demonstration is part of a larger long-term care rebalancing effort which utilizes HCBS waiver and Medicaid state plan services, all of which are available through the RCL demonstration as well. Through MFP, Washington added several demonstration services which provide more support for individuals with longer institutional stays who desire to return to the community. Looking ahead, the Washington State is considering a number of new ACA LTSS options that will expand access to HCBS and better coordinate care for Medicaid's high cost, high need beneficiaries. Additionally, Washington was awarded federal funding to design an integrated care model for people who are dually eligible for Medicare and Medicaid and recently finalized an MOU with authority to test/implement a managed fee-for-service model focusing on health homes. The goal of this model is to improve the coordination of services and quality of care for dual eligible beneficiaries and possibly reduce costs over the long-term.

Future plans for the RCL program include continued development of housing options with a focus on local resources (working with landlords and Public Housing Authorities) to increase housing capacity for MFP participants statewide. Efforts to better quantify progress of goals are also underway now that the state can draw from several years of experience. Additional goals for the state include continuing to address barriers to transition and increasing the availability of the resources needed to ensure a successful and longstanding community placement for RCL participants throughout the state. The state also plans to expand its participant population by working with behavioral health supports to target broader populations than it is currently serving. Additionally, officials hope to fund more RCL services not included in their HCBS waivers and to improve transportation services. Ultimately, the state would like to integrate more demonstration services into its § 1915(c) HCBS waivers and receive a federal matching for pre-transition services. By adding or modifying these key services, the state hopes to help future MFP participants bypass some of the existing barriers to transition. State officials noted that a healthy Medicaid LTSS system is one that is focused on developing community resources to meet the changing needs of populations served, rebalancing, institution diversion, and supporting the transition of institutionalized beneficiaries to the community.

This brief was prepared by Molly O'Malley Watts, Principal of Watts Health Policy Consulting for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Special thanks to Liz Prince and Debbie Blackner of the Washington State Home and Community Services Division and to MaryBeth Musumeci and Erica Reaves of the KCMU who contributed to the content and review of this case study brief.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

This report (#8413) is available on the Kaiser Family Foundation's website at www.kff.org.

THE HENRY J. KAISER FAMILY FOUNDATION

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.