Money Follows the Person Initiatives of the Systems Change Grantees

Final Report

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Executive Summary

This paper is one in a series addressing major systems change topic areas in the Systems Change for Community Living Grants Program. It describes the activities of 9 Grantees who received grants in fiscal year 2003 and are using them to develop or support Money Follows the Person initiatives. This paper discusses program and policy issues the Grantees have encountered while developing their Money Follows the Person initiatives.

The paper's primary purpose is to provide information that states and stakeholders will find useful when planning or implementing Money Follows the Person initiatives, particularly when considering the design of a potential CMS Money Follows the Person demonstration under the Deficit Reduction Act of 2005. In particular, the paper will highlight program and state and federal policy challenges and how Grantees might address them.

Over the past 20 years, many states have created LTC systems that enable people with disabilities or long-term illnesses to live in their own homes or other non-institutional settings. However, in fiscal year 2005, spending for home and community-based services (HCBS) waiver programs, personal care, and home health services accounted for just over one-third of all Medicaid LTC expenditures.

To improve the balance of funding spent on HCBS, the Centers for Medicare & Medicaid Services (CMS) and states are developing "Money Follows the Person" (MFP) initiatives. MFP is "a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change." This approach has two major components:

- A financial system that allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community.
- A nursing facility transition (NFT) program that identifies consumers in institutions who wish to transition to the community and helps them do so.

In FY 2003, CMS awarded $6.5 million in grants to states under its Systems Change for Community Living Grants program to improve their LTC systems by implementing Money Follows the Person (MFP) initiatives. Nine states were awarded grants: California, Idaho, Maine, Michigan, Nevada, Pennsylvania, Texas, Washington, and Wisconsin. The nine MFP Grantees' initiatives include a wide range of activities. Seven of the nine states are developing infrastructure for MFP initiatives, while two states—Texas and Wisconsin—are strengthening existing MFP initiatives.

This report focuses on the experiences of Texas and Wisconsin in developing and implementing their MFP initiatives. It also describes the MFP initiatives in the remaining seven states. Finally, the report describes the operational and policy issues states should consider when developing an MFP initiative.

To further encourage states' adoption of MFP initiatives, the Deficit Reduction Act (DRA) of 2005 authorized CMS to implement a Money Follows the Person Rebalancing Demonstration. This demonstration will award grants to states to help Medicaid consumers in nursing facilities and other institutions to move to community settings using flexible financing arrangements. To promote state participation, CMS will increase federal Medicaid matching funds for home and community services for each person transitioned during the first year of the demonstration. Consequently, the report may be helpful to states applying for CMS MFP demonstration grants under the DRA of 2005.

Operational and Policy Issues

Designing and operating MFP programs is complicated with many inter-related components. States interested in developing MFP initiatives similar to those in Texas and Wisconsin should consider the following policy and design issues:

- Addressing LTC industry concerns
- Developing MFP legislation
- Establishing an MFP budgeting mechanism
- Assuring availability of home and community services and housing
- Deciding whether to target specific individuals or establish eligibility criteria
- Developing NFT infrastructure including care management to assess transition readiness
- Developing quality assurance methods and data collection capability to monitor the program

These issues are interrelated and should be considered together.

Addressing Long-Term Care Industry Concerns

To be effective, MFP programs require that nursing facility and other institutional providers cooperate and that home and community services providers have sufficient capacity to serve those transitioning to the community. The nursing facility and ICF-MR industries may have concerns that an MFP policy will affect the institutional occupancy rate as well as the availability and quality of care in both the community and institutions. Especially in states without a Medicaid case-mix reimbursement methodology, institutional providers may have concerns that reimbursement may not be adequate to address a possible increase in average acuity of remaining residents if people with lower levels of need are discharged. If these concerns are ignored, their opposition may prevent the enactment of MFP policies.

Developing MFP Legislation

Virtually all states require new legislation to implement MFP mechanisms because state legislatures almost always appropriate funds separately for Medicaid institutional and HCBS care. Only six states have passed legislation to develop MFP mechanisms for the transfer of funds between institutional and HCBS budgets—Maryland, New Mexico, North Dakota, Texas, Utah, and Wisconsin.

As of May 2006, only two of the nine MFP Grantees—Texas and Wisconsin—had enacted legislation authorizing the transfer of funds across state budget categories. Of the remaining seven states with MFP grants, only Pennsylvania was planning to introduce legislation in the current legislative session. Of the states that did not receive MFP grants, West Virginia considered legislation in the 2006 legislative session, but the bill was referred to a committee for further study.

Establishing an MFP Budgeting Mechanism

A key component of an MFP policy is the flexible transfer of funds between institutional and HCBS budgets. It is through this mechanism that "money can follow the person." States must address three issues: (1) how should the transfer occur; (2) should it be permanent; and (3) how will the state protect potential savings by preventing backfilling of institutional beds?

Amount and Timing of Transfer

When developing a mechanism to transfer funds between Medicaid institutional and HCBS budget lines, states need to determine the amount and timing of the transfer. These decisions depend, in part, on administrative ease and convenience, the availability of data on which to calculate the transfer amount, and the ability of the nursing facility and ICF-MR industry to protect the size of the institutional budget. The Texas MFP initiative and the two Wisconsin MFP initiatives—one for nursing facilities and one for ICFs-MR—differed in how these transfers are calculated and made.

Texas has changed how its MFP program operates. Beginning in September 2005, Texas establishes a separate line item MFP appropriation for each fiscal year, as opposed to the former mechanism which entailed the transfer of Medicaid funds from institutional to home and community budgets. The amount budgeted is based on the number of persons projected to transition over the budget period and the average waiver cost of the entire waiver population. Wisconsin transfers a one-time lump sum amount from the institutional budget to the HCBS waiver budget at the beginning of the 2-year budget period for its entire population of nursing facility residents projected to be transitioned. The amount transferred is based on the waiver costs of a Family Care demonstration population with similar characteristics. To cover individuals transitioning from ICFs-MR, Wisconsin transfers

funds from the institutional budget to the HCBS waiver budget equal to the estimated average community costs of the persons transitioned times the number of individuals moved to the community. These estimated costs are derived from each consumer's community care plan. This transfer is done quarterly based on the actual number of persons transitioned in the previous quarter.

Permanence of Transfer

When transferring funds from the institutional to the HCBS budget, an important issue is whether or not the transfer will be permanent. This decision is often closely linked to whether a state wants to create new permanent HCBS waiver slots with the transferred funds. States must decide whether to fund an additional permanent waiver "slot" within the current ceiling approved by CMS (if the number of funded slots is less than the number of approved slots) or to use existing waiver "slots." In the latter case in states with waiting lists, using existing waiver slots may extend the waiting period for those in the community who are not receiving services.

In Texas, transfers create temporary rather than permanent new waiver slots, and the balance of any unused funds for a person who becomes ineligible or who dies are returned to the institutional budget. In Wisconsin's MFP nursing facility initiative, funds transferred to the community services budget remain there when the person dies or becomes ineligible. Wisconsin's MFP ICF-MR initiative also keeps transitioned funds in the community services budget, in part because an institutional bed closes with each transition.

Closure and Backfilling of Institutional Beds

Although states are generally interested in policies that improve the balance between institutional and community expenditures, controlling total LTC expenditures is a major state concern. To address this issue, states' MFP legislation or policy may include a mechanism for controlling institutional expenditures. Wisconsin's MFP nursing facility legislation mandated that the total number of people served under the initiative cannot exceed the number of beds closed statewide over the biennial funding period. To meet this requirement, Wisconsin is counting a reserve of approximately 2,000 nursing facility bed closures over the past several years for which it had not already added a waiver slot. Thus, for the current budget period, the legislation authorized Medicaid to transfer funds without having to close additional beds.

Partly to address concerns about the backfilling of ICF-MR beds, the Wisconsin MFP ICF-MR initiative requires that a community service plan be developed and reviewed by a court prior to an ICF-MR admission to determine whether an individual can be served in the community. In addition, Wisconsin imposes a substantial bed assessment fee for both occupied and unoccupied beds. As a result, most ICFs-MRs decide to close a bed once

someone has transitioned and this MFP initiative will decrease the State's ICF-MR capacity over time.

When enacting its MFP policy, Texas did not have specific provisions to address backfilling because its nursing facility occupancy rate was low, 78 percent, and has remained constant. State officials believe that the MFP initiative has helped to offset any increase in nursing facility utilization that would have occurred because of the aging of the State's population.

Assuring Availability of Home and Community Services and Housing

Not all states provide the full range of home and community services needed to assure community living for individuals who want to transition. Some states do not cover waiver services for individuals under age 60 and, in FY 2004, 16 states did not cover personal care services under their Medicaid State Plan. In addition, states vary in the scope of services offered under their waiver programs and may not cover the full range of services that transitioning consumers need.

The stringency of a state's institutional level-of-care (LOC) criteria may also affect the amount of services that transitioned individuals require. In states with less restrictive LOC criteria—such as Pennsylvania and Michigan—persons transitioning to the community may have lower levels of impairment and need fewer services than in states with more stringent criteria. States may also need to consider the potential impact of workforce shortages on the availability of services.

Housing

Based on states' experience with NFT activities to date, a major transition barrier is the widespread lack of affordable and accessible housing. According to state officials, many institutional residents remain in nursing homes due to lack of housing. States may need to address the following issues: (1) policies to help newly-admitted residents maintain their community residence, (2) use of residential care facilities, and (3) the lack of affordable and accessible housing.

Maintaining the Homes of Medicaid Residents in Institutions

People transitioning to the community need a home in which to live. Individuals with their own home or apartment at the time of nursing home admission often have trouble keeping them because states limit how long income will be protected for maintaining a home. Because the lack of affordable and accessible housing is a major transition barrier, states may want to consider increasing the amount of time that income is protected for maintaining a residence so that consumers who want to return to their homes are not physically precluded from doing so. For example, Nevada recently changed its rules to increase the amount of time from 60 to 180 days.

Use of Residential Care Facilities

Many nursing facility residents have cognitive impairment and require 24-hour supervision to assure their safety. Thus, a substantial portion of people transitioned from nursing homes move to residential care facilities. For example, 64 percent of people transitioned in Wisconsin and 32 percent of those transitioned in Texas moved to residential care facilities. The remainder in both states lived alone or with family members.

The ability to transition individuals from nursing homes to residential care facilities depends on whether the state allows these facilities to serve people who require a nursing facility level-of-care, which is a requirement for eligibility for Medicaid HCBS waivers. In addition, not all states cover services in residential care facilities under their waivers. Some states cover minimal personal care services in these facilities through the State Plan option. In 2004, 29 states covered services in residential care facilities under a waiver only, 8 under a waiver and the State Plan, and 6 under the State Plan only. Wisconsin officials noted that states that limited personal care services might have difficulty supporting all the needs of transitioned consumers.

Addressing the Need for Affordable and Accessible Housing

The lack of subsidized housing was an important concern in all states, particularly a lack of Section 8 housing vouchers. Nevada cited the unwillingness of local housing authorities to give priority for rental vouchers to consumers transitioning from nursing facilities as a transition barrier. Texas officials stressed the importance of establishing relationships with both the State and local housing authorities in areas in which transitions are to occur in order to secure their assistance with providing rental subsidies.

Deciding Whether to Target Specific Individuals or Establish Eligibility Criteria

States face a difficult task identifying specific individuals who want to transition to the community and can do so at a reasonable cost. In addition, a large number of people admitted to nursing facilities are discharged home under the current system without any additional intervention or only home health services. In order not to use resources on persons unlikely to transition to the community or those who would transfer without any additional help, some states have developed criteria, such as minimum lengths of stay, risk for long stays, and assumed low service needs (based on activities of daily living (ADLs) criteria) to target their efforts. Wisconsin limits its MFP NFT activities to persons with a high risk of long stays in nursing homes, while Texas does not have targeting criteria.

Targeting strategies are difficult to develop because each individual is unique and will have their own transition needs. States that target individuals on single criterion, such as the number of deficits in ADLs or a minimum length of nursing facility stay, may not account for other important factors that affect preparedness for transition, such as cognitive

impairment, substance abuse, and availability of informal care. Targeting by disability level could leave the state open to charges of discrimination if the state does not balance the need to conserve limited resources with the need to assure that severely disabled individuals also have an opportunity to transition if they want.

Developing NFT Infrastructure

NFT programs are key components of MFP initiatives. NFT programs must have a means of informing nursing home residents about home and community service options and to identify individuals who want to transition. Once identified, individuals need to be assessed for their "preparedness" to transition by determining their housing, medical, service and support needs, the availability of informal supports, and the cost of the service package relative to waiver cost limits. Additional issues to be considered are funding sources for transition case management and one-time transition expenses, determining whether institutionalized beneficiaries can bypass waiting lists, and addressing differences in Medicaid eligibility provisions for institutional and home and community services.

Developing Quality Assurance Methods and Data Collection Capability

Collecting data on the experience of persons transitioned allows states to ensure that the MFP program is effective and accomplishing the state's goals. States can also use these data to develop more accurate caseload forecasts for institutional and community budgets. Another important reason to track individuals after transition is to monitor the proportion of beneficiaries that return to institutions and to determine why.

A variety of measures can be used to assess the success of an MFP initiative. A principal individual-level measure is consumer satisfaction, which can be measured in several different ways, including overall satisfaction, independence, quality of choices, and community involvement. The success of MFP initiatives may be assessed using several system-level measures. MFP initiatives should increase the number of home and community services users and expenditures and help stabilize or reduce Medicaid institutional use and expenditures.

Conclusion

MFP is one mechanism to promote a more balanced LTC financing and delivery system. Although there are many definitions of this strategy, what distinguishes MFP from other approaches is the combination of a nursing facility (or ICF-MR) transition program and a budgeting mechanism that transfers funds for the transitioned individual from the institution to HCBS. In reviewing the experience of these grantees, especially the MFP systems in Texas and Wisconsin, three broad categories of themes emerge relating to budget transfers, NFT programs, and program evaluation.

Budget Transfers

States use a variety of mechanisms to transfer funds between budgets, but typically use an estimate based on the average costs of HCBS waiver beneficiaries rather than the institutional costs of the specific individuals being transferred. One state, Texas, created a separate budget line for payment of home and community services for transitioned beneficiaries, replacing the previous practice of budget transfers. States also vary in the extent to which the budgetary transfer from institutional care represents a permanent increase in the HCBS budget. In Texas, for example, the budgetary transfer to community services exists only for the period that a particular individual remains in the community; at the point when the person dies or is otherwise no longer eligible, the funds return to the institutional budget. In Wisconsin, however, the transferred funds remain in the community services budget.

As a practical matter, the budget transfer mechanism of MFP is of less importance in states without waiting lists or in states that do not have a separate budget for institutional and non-institutional services. It is also less important for states with small institutional budgets (e.g., Nevada, Idaho and Maine) and, therefore, relatively few funds to transfer.

Nursing Facility Transition Programs

The experience of Wisconsin and Texas suggests at least four major issues. First, NFT programs are labor intensive and require substantial commitments of administrative resources, few of which can be funded by Medicaid. In part because of the resources required, Wisconsin and Texas have transitioned a fairly modest number of institutional residents given the size of their institutionalized populations.

Second, especially because of the limited resources available to help people transition to the community, targeting people who want to transition to the community and can do so at an acceptable cost to Medicaid is a difficult process. States use nursing facility resident information from the MDS, additional surveys, and ad hoc recommendations to identify candidates for transition. Both Texas and Wisconsin have consciously not limited their initiatives to "light care" residents.

Importantly, the MFP demonstration mandated by the Deficit Reduction Act limits eligible participants to persons who have been in institutions at least 6 months as a way of preventing short-term, post-acute care admissions who already have a high probability of returning to the community from receiving the enhanced federal Medicaid match. However, a third of the Wisconsin NFT beneficiaries had lengths of stay of less than 6 months as did nearly three-fifths of NFT beneficiaries in Texas.

Third, in order to successfully transition people to the community, both housing and community services have to be available. Not all HCBS waivers cover all of the services needed to maintain individuals in the community and not all persons transferred meet the financial and functional eligibility requirements for Medicaid HCBS waivers. Differing eligibility requirements across waivers can also complicate the provision of needed services. The new home and community-based services option enacted as part of the Deficit Reduction Act may help provide Medicaid coverage for these services.

Fourth, while the goal of NFT programs is to transition institutional residents to the community, the "community" to which people transition is often a residential care facility. However, in 2004, only 26 states and the District of Columbia covered services in residential care facilities as part of their HCBS waiver. For the MFP demonstration established by the Deficit Reduction Act, individuals eligible for the enhanced federal Medicaid match may reside in a community-based residential setting where no more than four unrelated residents reside, which will exclude larger assisted living facilities and residential care facilities, which have a high percentage of the available beds.

What is Success?

MFP initiatives are designed to achieve several goals, but little is known about whether these initiatives are achieving them. One goal is to balance the LTC financing and delivery system. Monitoring expenditures and numbers of users in institutions and the community should be straightforward. So far, however, relatively few people have been transitioned to the community through these MFP initiatives. In Texas, which has one of the most developed MFP initiatives, only about 2,500 people per year have been transitioned, while there are 60,000 Medicaid nursing home residents in Texas at any one time and perhaps 120,000 Medicaid nursing home residents over the course of the year. Since modest numbers of people have transitioned, the budgetary transfers have also been modest.

Second, while serving institutional residents with services in the community should provide consumers with greater choices and should improve their satisfaction with services, little data is being collected to demonstrate that this is the case. If adequate housing and community supports are not in place or are not provided at the level needed, consumer satisfaction may not be higher in the community. Whether satisfaction is higher is an empirical question on which there is little empirical evidence.

Finally, states seek to reduce LTC expenditures or at least reduce the rate of increase in public spending. The targeting of persons already in nursing facilities or ICFs-MR helps improve the likelihood of cost effectiveness because, by definition, this population has a "high risk" of institutionalization. While it may seem obvious that serving individuals in the

community is less expensive than people in institutions, a careful analysis is needed to make an assessment.

Finally, a key component of the demonstration authorized by the Deficit Reduction Act is the provision of a substantially higher federal Medicaid matching rate for the first 12 months of residency in the community than is normally used. This higher Medicaid match is intended to be a powerful incentive for states to participate in the demonstration. In order to use the money efficiently, however, the federal government and the states need to identify people who would not be discharged from the institution without the MFP intervention. Contrary to common belief, large numbers of residents are discharged annually from nursing facilities to the community, many with services or to residential care facilities.

In conclusion, MFP is an important innovation in the efforts to rebalance the LTC system. It represents a significant departure from conventional approaches for reform. The experiences of the System Change Grantees will add to the policy debate on how to best use this approach.

Section 1
Introduction

The organization, financing, and delivery of Medicaid-funded long-term care (LTC) services is biased towards institutional care. Indeed, prior to 1980, LTC services in the United States were delivered almost exclusively in institutional settings.[1] In this earlier period, older people and younger persons with disabilities received Medicaid-funded services in nursing facilities, and persons with developmental disabilities, such as mental retardation, primarily received services in intermediate care facilities for the mentally retarded (ICFs-MR).

Over the past 20 years, many states have created LTC systems that enable people with disabilities or long-term illnesses to live in their own homes or other non-institutional settings. However, while expenditures on home and community services have increased, in most states, expenditures on nursing facilities and ICFs-MRs still account for the majority of Medicaid LTC spending. In fiscal year 2005, spending for home and community-based services (HCBS) waiver programs, personal care, and home health services accounted for just over one-third of all Medicaid LTC expenditures.[2]

Recognizing the challenges that states face in rebalancing their LTC systems, Congress has provided funds for the Systems Change for Community Living Grants program (*hereafter*, Systems Change Grant program). The purpose of this grant program is to help states increase access to and the availability of home and community services and to improve their quality.

In FY 2003, the Centers for Medicare & Medicaid Services (CMS) awarded $6.5 million in grants to states to improve their LTC systems by implementing Money Follows the Person (MFP) initiatives. CMS specified that the purpose of these grants was "to enable states to develop and implement strategies to reform the financing and service designs of state long-term support systems so that

- a coherent package of State Plan and HCBS waiver services is available in a manner that permits funding to "follow the person" to the most appropriate and preferred setting, and
- financing arrangements enable transition services for individuals who transition between institutional and community settings."[3]

Nine states were awarded grants: California, Idaho, Maine, Michigan, Nevada, Pennsylvania, Texas, Washington, and Wisconsin. These states' approaches varied according to the needs of their LTC systems.

To further encourage states' adoption of MFP initiatives, the Deficit Reduction Act (DRA) of 2005[4] authorized CMS to implement a Money Follows the Person Rebalancing Demonstration. This demonstration will award grants to states to help Medicaid consumers in nursing facilities and other institutions to move to community settings using flexible financing arrangements. To encourage state participation, CMS will provide increased federal Medicaid matching funds for home and community services for each person transitioned during the demonstration for 1 year.

Definition of Money Follows the Person

CMS has defined MFP as "a system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change."[5] This approach has two major components. One component is a financial system that allows Medicaid funds budgeted for institutional services to be spent on home and community services when individuals move to the community. The second component is a nursing facility transition (NFT) program that identifies consumers in institutions who wish to transition to the community and helps them do so.

Two states funded by the 2003 Systems Change Grants MFP initiative (Texas and Wisconsin) embrace this definition. Other states receiving these grants go even further and see MFP as either having (Washington) or working toward (Pennsylvania and Michigan) some form of a global state budget for long term care that would eliminate budgetary distinctions between institutional and non-institutional services.

Conversely, some states, especially those without large institutional populations, have defined MFP broadly as the improvement of community-based services (Maine), community integration (Idaho), or the elimination of barriers in programs, procedures and policies so that financing, services, and supports move with the person to the most appropriate and preferred setting (Nevada). Some states (Idaho, Michigan, and Nevada) have also included diversion from admission to an institution in their definition of MFP. One state funded under the Systems Change Grants (California) is still working to develop a definition of MFP.

In the Deficit Reduction Act of 2005, Congress defined Money Follows the Person more broadly as the "elimination of barriers or mechanisms, whether in state law, the state Medicaid plan, the state budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice."[6]

Methods

Between April and June 2006, we conducted telephone interviews with each grant's Project Director and other state officials. To assure the accuracy of the information obtained, we

further communicated with those we interviewed by phone and e-mail. We also reviewed the nine Grantees' grant summaries and their semi-annual and annual reports submitted to CMS each year. We also reviewed articles and reports on MFP and NFT policies and programs.

Focus and Organization of the Paper

This paper reviews the initiatives of the nine Systems Change MFP Grantees. It briefly describes their initiatives but focuses in depth on the two states—Texas and Wisconsin—that have implemented an MFP funding mechanism to allow Medicaid funds budgeted for institutional services to be moved to HCBS waiver budgets.

This paper is organized into the following sections:

- Section 2 describes the problem that states are attempting to address through rebalancing and the role of MFP and other initiatives in rebalancing efforts.
- Section 3 describes the initiatives of the nine MFP Systems Change Grantees.
- Section 4 describes in detail the MFP funding mechanisms in Texas and Wisconsin. Wisconsin has two different funding mechanisms—one for its population with developmental disabilities, and a separate one for its elderly and younger physically disabled population.
- Section 5 discusses the policy issues that states need to address to assure an effective MFP policy that allows for budget transfers between institutional and community budgets.
- Section 6 summarizes the main findings and draws implications for future policy.
- Appendix A contains state MFP legislation allowing budget transfers between institutional and HCBS budgets.
- Appendix B contains the discussion guide RTI International used in its phone interviews with MFP grant staff and other state officials.

Section 2
What is the Problem?

MFP is a strategy for reducing the institutional bias in the LTC system. The great majority of individuals of all ages with chronic illnesses and disabilities prefer to receive services in their own homes or other settings that allow them maximum independence and the ability to make choices about their daily activities. Despite these strong preferences, only a minority of total Medicaid LTC funding is spent on home and community services (Exhibit 1). In 2005, this proportion ranged from approximately 13 percent in Mississippi to 70 percent in Oregon.[7] Only eight states spent more than 50 percent of their total Medicaid expenditures for long-term care on home and community services. Most Medicaid HCBS spending is for persons with developmental disabilities as compared to spending on elderly persons and younger persons with chronic illnesses and/or physical disabilities.

Waiting lists of individuals eligible for home and community services—and "interest" lists of individuals who would like to receive these services—are also indicators of imbalance in the LTC system.[8] Many Medicaid HCBS waivers have such lists.[9] Among the nine MFP Grantees reviewed for this paper, seven have waiting (or interest) lists (Exhibit 2). Waiting lists for HCBS waivers exist for a variety of reasons, primarily because of a lack of state funds budgeted for waiver services.

This institutional bias is partly a consequence of federal Medicaid law, which mandates the provision of nursing facility and home health services—thereby creating an open-ended entitlement to these services. In contrast, home and community services—whether provided through the Medicaid state plan or an HCBS waiver—are optional. Additionally, HCBS waivers can only serve a fixed number of people determined by the state in accordance with federal law and subject to CMS approval.

For more than two decades, consumers have sought to receive services in settings that allow them to live and make decisions according to their own choosing. In 1999, the Supreme Court decided in *Olmstead v. L.C. and E.W.* that the integration mandate of the Americans with Disabilities Act requires public agencies to provide services "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[10] Persons with disabilities and their advocates are using the *Olmstead* decision to press states to expand home and community-based services and to move consumers out of institutional settings.

Exhibit 1. Home and Community-Based Services as a Proportion of Total Medicaid Long-Term Care Expenditures, by State, Fiscal Year 2005[11]

Rank	State	Total Home Care FY2005 Expenditures	Total Long-Term Care FY 2005 Expenditures	Proportion Home Care
1	Oregon	$600,549,989	$856,186,027	70.1%
2	New Mexico	$450,981,337	$670,606,741	67.2%
3	Alaska	$202,452,251	$321,523,853	63.0%
4	Vermont	$155,953,459	$260,660,066	59.8%
5	Minnesota	$1,490,266,154	$2,520,818,065	59.1%
6	Washington	$962,010,877	$1,671,643,607	57.5%
7	Wyoming	$95,870,119	$177,353,356	54.1%
8	California	$4,091,291,411	$7,781,078,748	52.6%
9	Kansas	$407,190,529	$817,690,207	49.8%
10	Maine	$248,859,307	$508,759,237	48.9%
11	Colorado	$398,926,885	$898,631,322	44.4%
12	Montana	$115,787,986	$266,666,235	43.4%
13	Rhode Island	$227,405,738	$528,967,074	43.0%
14	Texas	$1,886,590,517	$4,407,474,084	42.8%
15	New York	$7,124,118,871	$16,780,165,890	42.5%
16	Idaho	$136,040,368	$320,572,420	42.4%
17	North Carolina	$1,137,797,244	$2,723,714,332	41.8%
18	Wisconsin	$803,963,766	$1,935,184,950	41.5%
19	West Virginia	$308,648,840	$755,210,074	40.9%
20	Utah	$130,737,461	$330,686,491	39.5%
21	Oklahoma	$360,604,674	$933,076,642	38.6%
22	Massachusetts	$1,153,900,297	$3,058,667,950	37.7%
23	South Dakota	$88,994,100	$237,763,496	37.4%
24	Nevada	$105,762,081	$284,334,000	37.2%
25	Hawaii	$121,012,262	$327,866,242	36.9%
26	Connecticut	$737,002,996	$2,007,111,071	36.7%
27	Missouri	$610,291,786	$1,671,868,931	36.5%
28	Maryland	$547,656,963	$1,505,450,846	36.4%
29	Virginia	$500,198,366	$1,414,954,805	35.4%
30	New Hampshire	$180,245,777	$530,743,156	34.0%
31	Iowa	$339,863,445	$1,011,138,080	33.6%
32	Nebraska	$207,680,038	$619,839,774	33.5%
33	Arizona	$11,311,033	$35,345,211	32.0%
34	South Carolina	$300,093,728	$968,149,044	31.0%
35	Delaware	$77,622,769	$258,300,392	30.1%
36	Michigan	$687,639,144	$2,313,491,556	29.7%
37	Arkansas	$260,605,028	$893,265,282	29.2%
38	Illinois	$862,495,223	$2,997,715,869	28.8%
39	New Jersey	$909,947,172	$3,205,189,842	28.4%
40	Kentucky	$322,143,881	$1,151,180,270	28.0%
41	Florida	$939,227,170	$3,469,003,870	27.1%
42	Alabama	$304,733,517	$1,169,887,974	26.0%
43	Louisiana	$364,347,937	$1,441,743,609	25.3%
44	Tennessee	$390,044,735	$1,586,956,776	24.6%
45	Indiana	$496,957,902	$2,075,862,152	23.9%
46	Pennsylvania	$1,513,587,716	$6,428,198,019	23.5%
47	North Dakota	$67,363,502	$293,382,716	23.0%
48	Ohio	$1,101,026,660	$4,836,761,272	22.8%
49	Georgia	$451,904,192	$1,992,872,651	22.7%
50	Washington, DC	$49,188,501	$304,731,820	16.1%
51	Mississippi	$119,720,304	$941,167,655	12.7%
	United States	**$35,158,616,008**	**$94,499,613,752**	**37.2%**

Exhibit 2. Waiting Lists for Medicaid Home and Community-Based Services Waivers in Systems Change MFP Grantee States, Winter or Spring 2006

	Target Population	Type of Waiver or Other Program	Number of People on List
California	Elderly and Physically Disabled	Nursing Facility A/B waiver	250
Idaho	Various	Three different waivers for Elderly and Disabled, Developmental Disability, and Traumatic Brain Injury populations	0
Maine	Mental Retardation and Autism	Comprehensive waiver	100
Michigan	Elderly and Disabled	MI Choice	3,000
Nevada	Disabled	Waiver for Independent Nevadans	96
	Elderly	Home and Community Based Waiver for the Frail Elderly	328
	Elderly and Disabled	Waiver for Elderly and Adult Residence Care	18
	Mental Retardation/ Developmental Disability	Mental Retardation and Related Conditions	316
Pennsylvania	All Populations	13 waivers	0
Texas	Elderly and Physically Disabled	Community Based Alternatives	55,000
	Children	Medically Dependent Children's Program	9,805
	Elderly and Physically Disabled	Community Living Assistance and Support Services	14,933
Washington	Developmental Disability	Four waivers: Basic, Basic Plus, Core, Community Protection	8,500
Wisconsin[a]	Elderly and Physically Disabled	Community Options Program	8,000
	Developmental Disability	Community Options Program	3,700
Total			**104,046**

[a]Each county has its own waiting list.

Source: RTI International Interviews with System Change MFP Grantees.

Rebalancing and Money Follows the Person

Adoption of an MFP policy is a method for changing the distribution of funding between institutional and community service budgets—currently called "rebalancing." CMS has defined rebalancing as "adjusting the State's Medicaid programs and services to achieve a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services—Nursing Facilities and Intermediate Care

Facilities for the Mentally Retarded—and those used for community-based supports under its State Plan and waiver options."[12] The "more equitable balance" is achieved when consumers are allowed to decide where to receive services and are not constrained by funding limits for preferred service settings. The exact proportions that constitute an equitable balance may vary from state to state, but given the current institutional bias in state LTC systems and consumer preferences for community living, the proportion of community-based services should increase from its current level as the State rebalances its LTC system.

The Deficit Reduction Act of 2005 defines rebalancing simply as an increase in the use of home and community-based rather than institutional LTC services, which—if institutional funding remains at its current level—will result in a more equitable balance of overall LTC funding.

Historical Barriers to Rebalancing

States have been slowed in expanding home and community services by three problems:

- The use of separate line-item budgets to pay for institutional services and home and community services.
- The longstanding policy of tying funding to providers and service settings rather than to consumers.
- The excess demand for nursing home care and the resulting high occupancy rates.

The first problem is that state legislatures usually appropriate separate budgets for Medicaid institutional services and for Medicaid home and community services programs, as well as for home and community services financed solely with state funds or federal block grant and Administration on Aging funds. Money in these separate budgets cannot be used for other purposes, and are sometimes managed by different state agencies with different accounting, case management, and service delivery systems and providers. States that currently do not allow transfers from Medicaid institutional services to HCBS budgets generally require specific legislation to permit an MFP policy.

A second problem concerns the near-universal practice of tying funding to service settings rather than to consumers. For both institutional and home and community services, providers are reimbursed for services rendered, as opposed to consumers having a budget to pay for services. This provider-oriented reimbursement system means that funds are used to pay for "bed days" or HCBS "waiver slots" subject to the total of appropriated funds, rather than consumers being funded to receive services. Of course, the entitlement character of Medicaid means that the State ultimately must pay for institutional services, home health, and State Plan personal care for however many consumers use the services, but HCBS waivers are limited to a fixed number of beneficiaries.

The third problem is that nursing homes have historically had very high occupancy rates and long waiting lists for beds.[13] As a result, when nursing residents left the facility, the bed was always filled by a new admission. Thus, states perceived NFT programs as cost-increasing rather than cost saving because they would result in states paying for the same number of nursing home residents and additional HCBS waiver participants.

For many reasons, including the increasing supply of home and community services—particularly assisted living—nursing facility occupancy rates have fallen to unprecedented low levels. Consequently, transferring a resident to the community no longer necessarily means that a bed will be filled by another resident. The national nursing facility occupancy rate fell from 92.9 percent in 1977 to 86.6 percent in 1999.[14] In 2003, the average nursing home bed occupancy rate across states was 85.5 percent, but ranged from 95.6 percent in Hawaii to 64.7 percent in Oregon (Exhibit 3).[15]

In response to these problems, states are developing MFP approaches for modifying the current system of organizing and financing LTC services. For older people and younger persons with disabilities, this strategy of focusing on moving people out of nursing homes is a radical departure from the exclusive focus on admission diversion, which was the dominant strategy for the last 20 years. NFT, facilitated by an MFP policy, recognizes that people of all ages—even those with severe disabilities—can live in the community.

Overview of MFP Design Issues

States considering an MFP initiative must address four broad program design issues. These issues are:

- How will money from the institutional budget be transferred to fund home and community services?
- Will the housing and home and community services available be adequate to transition and maintain consumers who move to the community?
- How will candidates for transition to the community be identified and how will transitions be implemented?
- How will the MFP activities be monitored and quality assured?

Exhibit 3. Nursing Facility State Occupancy Rate for Certified Beds, December 2003

State	Facilities	Residents	Beds	Occupancy Rate[a]
Hawaii	45	3,777	4,019	95.6%
South Dakota	111	6,695	7,108	94.2%
Rhode Island	90	8,443	9,044	93.4%
New York	658	112,257	120,807	92.9%
South Carolina	176	16,482	17,767	92.8%
Washington, DC	20	2,804	3,036	92.4%
Connecticut	246	27,815	30,169	92.2%
North Dakota	83	5,978	6,508	91.9%
Minnesota	392	32,474	35,389	91.8%
Vermont	41	3,150	3,449	91.3%
Delaware	42	3,831	4,200	91.2%
Maine	114	6,711	7,368	91.1%
Pennsylvania	721	80,259	88,878	90.3%
Virginia	277	28,035	31,146	90.0%
Massachusetts	457	45,108	50,157	89.9%
New Hampshire	82	7,021	7,817	89.8%
Georgia	362	35,962	40,112	89.7%
Alaska	14	622	695	89.5%
Florida	686	72,849	81,645	89.2%
Kentucky	296	23,040	25,816	89.2%
West Virginia	132	9,748	10,929	89.2%
New Mexico	74	6,157	6,909	89.1%
Alabama	228	23,428	26,354	88.9%
North Carolina	421	38,158	42,968	88.8%
Tennessee	329	32,978	37,215	88.6%
Michigan	429	41,649	47,102	88.4%
Wisconsin	398	34,254	38,899	88.1%
Ohio	965	80,417	91,351	88.0%
Mississippi	204	16,086	18,339	87.7%
New Jersey	363	44,877	51,195	87.7%
California	1,296	106,451	123,406	86.3%
Washington	247	19,339	22,472	86.1%
Maryland	237	24,986	29,197	85.6%
Kansas	359	20,246	23,712	85.4%
Indiana	510	40,230	47,991	83.8%
Nebraska	225	13,197	15,809	83.5%
Colorado	212	16,364	19,839	82.5%
Nevada	47	4,405	5,360	82.2%
Iowa	455	27,251	33,363	81.7%
Wyoming	39	2,465	3,051	80.8%
Illinois	803	77,937	97,458	80.0%
Arizona	134	12,859	16,155	79.6%
Idaho	80	4,691	6,065	77.3%
Texas	1,130	88,817	115,313	77.0%
Louisiana	302	28,127	37,420	75.2%
Missouri	518	37,506	50,211	74.7%
Montana	97	5,387	7,329	73.5%
Arkansas	236	17,499	24,151	72.5%
Utah	93	5,408	7,787	69.4%
Oklahoma	350	20,993	31,237	67.2%
Oregon	139	8,212	12,696	64.7%
United States	**15,965**	**1,433,435**	**1,676,413**	**85.5%**

[a]State occupancy is calculated by dividing the sum of all facility patients in the state occupying certified beds by the sum of all the certified beds in the state reported at the time of the current standard survey. OSCAR data only reflects patients who occupy a certified bed. Observations with occupancy less than 0 percent and greater than 100 percent were eliminated from this analysis.

Source: CMS OSCAR Form 671: L18, L37, L38, L39, and Form 672: F78.

Budget and Financing

MFP mechanisms allow funds to follow consumers to settings of their choosing. There are at least three types of mechanisms currently used by the states:

- Global budgets for an entire state LTC system that do not distinguish between institutional and noninstitutional services
- Managed care approaches where providers receive a capitated payment for both institutional and HCBS
- Medicaid (and possibly other) transfers of funds from institutional to HCBS budget categories.

Global budgets function as the state's MFP initiative, allowing funds to be used according to the preferences of a consumer. Managed care arrangements are used in part to divert individuals from institutional settings into community settings by providing plans with a financial incentive to transfer and maintain enrollees in the community. In the remaining sections we primarily discuss design issues related to the third method listed above, transferring funds across state program budgets because they are most closely identified with MFP initiatives.

Housing and Community Services

In order to live in the community, institutional residents need a place to live and services to help them live in the community, but not all states have the needed components. The availability of affordable and accessible housing is a key issue that most Medicaid agencies are not well versed in addressing. The Medicaid personal care option provides an important, but narrow, service and not all states cover this service. HCBS waivers offer the possibility of a broad range of services, but states vary in how much they make use of this flexibility.[16] The approved service package may include services needed to establish and maintain community living such as environmental modifications, respite and adult day care services, training, transportation, and home-delivered meals. In some states, the waiver also funds the costs of transition services for consumers in institutions moving to community living. States also need to find reimbursement for transition costs and one-time expenses not Medicaid reimbursable under waivers, such as the first month of rent. Staff conducting the transitions also need to ensure that services are available and provided from the first day of community living.

Nursing Facility Transition Programs

NFT programs are key components of MFP initiatives. Prior reports on NFT identify the range of activities conducted in states that have received CMS NFT grants.[17,18,19] Components of NFT include:

- *Identifying target population.* States use a variety of methods to identify persons who are likely to successfully transfer to the community at a reasonable cost and

who need assistance to do so. Factors states consider include consumers' preferences, functional status, length of time in facility, the estimated cost of a community care plan, and potential available community supports. Targeting can be a particularly difficult issue because large numbers of nursing facility residents are routinely discharged from the facility with no additional intervention. In 1999, 832,000 persons were discharged from nursing homes, about a third of all discharges, because they had "recovered" or "stabilized."[20] Medicaid financial and functional eligibility can also be problematic, since some persons are eligible for Medicaid in the nursing home but may not be financially or functionally eligible in the community. Eligibility criteria also may differ for elderly and younger physically disabled populations when compared to that of consumers in ICF-MR facilities.

- *Identifying transition candidates.* Once eligibility criteria have been defined, states need to identify specific individual consumers who are eligible. States can use survey or assessment data to help identify eligible consumers. Some states develop local public/private partnerships that can facilitate identification of eligible transition candidates. While states may provide materials designed to inform both consumers and collaborating partners, such as Centers for Independent Living (CILs) about the MFP initiative, states often lack the infrastructure to make contact and provide information to all potentially interested consumers. Resources spent on broad efforts that are not specific to individual consumers seeking transition to the community are not a Medicaid waiver reimbursable service. States without a single point of entry into the LTC system especially may need to reach interested consumers by hiring staff or funding collaborating partners to provide outreach and education of consumers.

- *Assessment, care planning, and implementation*. After identifying potentially eligible consumers, states need to develop an assessment instrument to determine the community support needs of consumers that want to leave institutions. Transition coordinators then arrange for the person to move from the institution to the community and assure that all components of the housing and service plan are in place at the time of the transfer.

Ongoing Monitoring and Quality Assurance

Once consumers have re-entered the community, states transfer daily responsibility for consumers to the waiver case management and service system. States may monitor transitioned consumers to follow them regarding the effectiveness and quality of the community placement. As part of monitoring efforts, states may review case management reports and develop reporting mechanisms to identify consumers who re-enter institutions. Information on continuity of community placement can be used to forecast use of nursing facility services and home and community services.

Section 3
Overview of the Systems Change MFP Grant Initiatives

This section provides an overview of the initiatives of the nine Systems Change MFP Grantees. These initiatives are best viewed as preliminary steps to develop a LTC system that will enable "money to follow the person" by assuring that Medicaid-eligible individuals can receive the services and supports they need in the settings of their choice. Texas and Wisconsin, whose initiatives are more fully developed and allow for the transfer of institutional funds to HCBS budgets, are discussed in detail in the next section.

Focus of MFP Grantees' Initiatives

The nine MFP Grantees' initiatives include a wide range of activities:

- Identifying barriers to MFP policies and developing plans to remove them
- Assisting in the development of legislation to transfer funds from institutional to HCBS budgets
- Developing pilot MFP programs
- Developing NFT program infrastructure and transitioning nursing facility residents to the community
- Developing reimbursement methodologies for home and community services
- Removing barriers to the receipt of community services
- Improving community-based services and community integration
- Developing diversion initiatives through managed care and other programs

An overview of the MFP initiatives undertaken by the nine Grantees is presented in Exhibit 4.

The remainder of this section briefly describes these initiatives. Seven of the nine MFP Grantees described in this section are in the early stages of developing MFP policies. Some are assessing the potential benefits of an MFP approach and others are developing components of their MFP design. Unlike Texas and Wisconsin, these states have either not passed MFP legislation authorizing budget transfers or have indicated that they do not need such legislation. For example, Washington has a global budget for all LTC services, and Pennsylvania has a global budget for its elderly and younger population with physical disabilities. Other states, such as Idaho, Maine, and Nevada, do not have large budgets for institutional care whose funds could be transferred to an HCBS budget. Their initiatives are based on a broader concept of MFP, one that removes barriers to receiving community services or improving components of the community service system so that consumers can be served in the setting of their choice.

Exhibit 4. Nine Grantees' Money Follows the Person Initiatives

Grantee	Initiatives
California	▪ Developing a preference assessment instrument ▪ Assessing approximately 220 consumers in eight nursing facilities ▪ Identifying transition candidates, their needs, the protocols and tools needed for NFT, and the costs of the NFT process ▪ Transition consumers to the appropriate HCBS programs
Idaho	▪ Facilitate community integration through an anti-stigma campaign ▪ Study ways to assist people with disabilities reach their community integration goals through a community-based effectiveness study ▪ Identify ways to reapportion and maximize funding for community-based services through a statewide service utilization and economic analysis
Maine	▪ Develop published Medicaid payment rates for home support services for persons with mental retardation and autism ▪ Develop budgets based on an individual's need for a specific number of units of service instead of the reimbursement needs of providers ▪ Develop assessment instruments to identify individuals with traumatic brain injury in facilities who might be able to live independently ▪ Create a trust fund for persons with traumatic brain injury to fund the provision of information and referral to light case management services
Michigan	▪ Develop a pilot project to divert consumers from institutions through the use of a single point of entry and managed care plans that cover LTC services ▪ Use capitated funds to place more consumers on the MI Choice waiver ▪ Provide funding for rent and housing assistance ▪ Divert consumers from institutions through options counseling
Nevada	▪ Study MFP mechanisms in other states ▪ Evaluate current state policies and procedures to identify specific barriers to MFP ▪ Remove barriers in the LTC system so that financing, services, and supports move with consumers to the most appropriate and preferred setting ▪ Conduct and evaluate current NFT activities
Pennsylvania	▪ Develop three pilot MFP programs in different areas of the State ▪ Expand housing resource connections and build housing capacity ▪ Collect post-transition data from the State's ongoing NFT activities to identify the full costs of transitioning persons to the community

(continued)

Exhibit 4. Nine Grantees' Money Follows the Person Initiatives (continued)

Grantee	Initiatives
Texas	▪ Establish regional transition work groups comprising CILs, aging agencies, and other organizations to conduct NFT activities ▪ Develop educational materials for consumers and training curricula for transition coordinators ▪ Train local personnel on all aspects of the transition process ▪ Conduct monthly assessments of consumers interested in transitioning to facilitate transition to the community
Washington	▪ Develop a comprehensive assessment strategy and tool to facilitate community placement of consumers with developmental disabilities ▪ Assess individuals in institutions interested in community living to identify necessary supports ▪ Assess the needs of consumers who are on waiting lists to determine if their needs differ from those consumers receiving services
Wisconsin	▪ Assist in developing legislation to authorize the transfer of funds from institutional to HCBS budgets ▪ Implement a process to assure that persons with developmental disabilities are reviewed annually to determine if they are living in the most integrated setting ▪ Transition consumers with developmental disabilities and nursing home residents to the community

Source: RTI International Interviews with MFP Grantees.

California

The Office of Long Term Care, working with the UCLA Borun Center for Gerontological Research, is designing a preference assessment tool to identify transition candidates and their needs. California will use the tool to assess 220 nursing facility residents in eight nursing facilities who are Medi-Cal eligible and have been a nursing facility resident for 90 days or more. California will use the tool to ask consumers about their needs, identify alternative services in the community, and obtain consumer permission to transition them to the community and access their minimum data set (MDS) data to aid in developing individual support plans. The State is evaluating existing assessment tools used by California's various HCBS programs to supplement the development of the preference assessment tool and is obtaining feedback on the assessment criteria from stakeholders and consumers.

The State is also developing the protocols and tools needed for NFT. The State is also using existing HCBS waiver care planning models to create a framework for developing individual support plans. The State will then determine the number of people to be transitioned, the HCBS programs to which they should be referred, and then transition them to the

community. The State plans to develop a consumer-focused quality assurance model to analyze the cost and quantity of services delivered and the consumer's self-reported quality of life. The State will also document the costs of the NFT process and determine whether and how money could follow the person when several state agencies sponsor HCBS programs for which consumers are potentially eligible.

At the end of the grant, California will implement one of the following three options: (1) develop recommendations and/or federal funding applications for continuing the development phase of the MFP initiative, (2) develop a plan to expand the project to other geographical areas, or (3) recommend ending the pilot project.

Idaho

The Idaho Department of Health and Welfare, working with Idaho State University, is working to improve the community integration of persons with disabilities and elderly consumers living in the community. The State's goal is to improve the continuity of community placements to prevent the return of consumers to institutions. Idaho has few persons in institutions and focuses on diversion activities to keep consumers in the community.

Under its grant, the State is conducting four major activities: (1) an anti-stigma social marketing campaign, (2) examining the political and fiscal feasibility of increasing resources for community living and exploring ways to create a more hospitable community, (3) conducting a community-based effectiveness study with 15 to 45 people to assess how well they have maintained residence in the community, and (4) conducting a statewide service utilization and economic analysis to identify ways to reapportion and maximize funding for community-based services.

Maine

The Maine Office of Cognitive and Physical Disability Services, working with the Muskie School at the University of Southern Maine, is developing new Medicaid rates to be paid for home support services delivered to individual consumers. The purpose of the effort is to improve the State's community services delivery system by rebalancing funding to assure equitability and portability of funding. The new Medicaid rate system will be used to develop budgets based on a consumer's need for a specific number of units of home support services using the new rates instead of the reimbursement needs of providers. The State is developing a questionnaire to assess the amount of services needed by an individual to be used in conjunction with the new rate system.

The State also worked to redirect resources for persons with brain injury toward more person-centered and consumer-driven services. To do so, the Grantee awarded pilot grants to two nonprofit organizations. One awardee is developing new less-restrictive housing

options, such as supported housing for individuals with brain injury, who are currently living in residential facilities. The other awardee is developing assessment instruments and tools to identify individuals with traumatic brain injury who live in a facility who might be able to live independently. The State is piloting the assessment instrument in one facility with 30 residents. The State plans to transition six to eight individuals to pilot housing programs. In addition, the State will create a trust fund whose proceeds will be used to provide information and referral to light case management services.

Finally, the State is developing and implementing cross-system performance measures to assess state success at expanding community options for persons with all types of disabilities. The process of developing performance measures is being coordinated with the Quality Indicator's project, which is developing cross-system quality indicators under Maine's 2001 Real Choices Systems Change Grant. The Grantee also developed a framework for assessing community integration using four possible domains (access to services, locus of control, place or setting, and participation).

Michigan

The Michigan Office of Consumer Directed Home and Community Based Services in the Department of Community Health is developing a pilot project to divert consumers from institutions through the use of a single point of entry and prepaid health plans. The State will use Medicaid 1915(b)(3) and 1915(c) waiver authorities to convert the LTC system in a few counties into a prepaid plan approach, routing all institutional dollars and decision making to county-level organizations.

Grant staff and consumer task force members serving on the Governor's Medicaid Long Term Care Task Force made nine recommendations for creating a flexible integrated model for LTC services that promotes consumer choice using a single point of entry and managed care approach. The Grantee is working with consumers and state staff to develop an MFP waiver concept paper based on the recommendations, followed by the submission of a waiver request to CMS.

This waiver approach will allow the State to use managed care funds to place more consumers on the MI Choice waiver and provide additional services beyond the usual covered waiver services. In addition, consumers in nursing facilities enrolling in the voluntary prepaid plan receive care management services, which should allow them to receive services in the community less expensively. The State will also divert consumers from institutions through options counseling to help consumers remain in their own homes longer.

Nevada

The Nevada Office of Disability Services is using its MFP grant to remove barriers in the LTC system by restructuring state-funded programs, procedures, and state policies so that financing, services, and supports move with consumers to the most appropriate and preferred setting. The State is evaluating its policies and procedures across all programs to identify specific barriers that prevent funds from following individuals into community settings. The State is also studying MFP mechanisms in other states and will provide a report to the Nevada legislature regarding the feasibility of establishing an MFP mechanism.

The Office of Disability Services is identifying 160 persons for transition to the community and aiding in their transition as needed through a transition fund supported by the grant. The State is also conducting a follow-up evaluation of individuals who returned to the community. Through its nursing home transition activities, Nevada has identified needed systems changes that will result in sustainable system-level improvements in the balance of funds used for community services. The State is also increasing access to affordable housing as a means of supporting the expansion of HCBS programs.

Nevada is also preparing recommendations to expand self-directed care. A consultant is identifying best practices and self-directed service models in other states and making recommendations for the State. One recommendation includes amending existing HCBS waiver programs to include fiscal intermediary and support broker services.

Pennsylvania

The Governor's Office of Health Care Reform is using the grant to enhance Pennsylvania's NFT infrastructure and to develop three pilot MFP programs in different parts of the state. NFT is an important element in rebalancing the State's LTC budget and creating a balanced long-term living system. The State has funded its NFT initiative with general revenues and has transitioned 400 people in a 15-month period. The State plans to reduce nursing facility utilization and would also like to reduce the number of nursing facility beds and facilities.

Each of the three pilot programs covers a limited geographical area—one urban, one suburban, and one rural. The State has proposed budget language to move necessary funds from the nursing facility budget to the HCBS budget for the transitioning populations in each of these areas. The MFP pilots will also develop housing collaborations to build housing capacity in each area and collect post-transition data to identify the full costs of transitioning persons to the community. The pilots will use MDS functional data to identify consumers with lower acuity who are interested in transitioning, and separately those consumers in nursing facilities less than 6 months who need information and education to return to the community.

Texas

Texas now has an annual budget appropriation for MFP expenditures, a strategy adopted in September 2005 to replace the former budget rider strategy. Texas' MFP initiative will be discussed in detail in Section 4. Under the MFP grant, the Department of Aging and Disability Services is creating a system in each region that will more efficiently and effectively help clients transition from nursing homes and address barriers that were impeding full use of the MFP funding mechanism. The grant will provide educational materials and training to staff in regions involved in transitions and address difficult transition barriers through extensive case management.

A principal goal of the grant is to ensure that all community services and supports are considered when assisting individuals to transition to the community from a nursing facility. The State has developed educational packets for consumers and training materials for staff in regional offices and community organizations assisting in transition efforts. Texas is training state office staff, regional staff who interact with consumers, CIL staff, providers, advocates, and other stakeholders about all community living options.

Texas is also developing NFT teams at the local level to enable individuals with significant transition barriers to transition from the nursing facility to the community. The grant will be used to recruit team members from community-based organizations and educate them about available programs and services as well as common transition problems. Team members will assess transitioning consumers monthly to identify a consumer's transition needs, coordinate needed services, and address systemic barriers to transition.

Washington

The Washington Division of Developmental Disabilities is developing a comprehensive assessment strategy and tool to facilitate community placement of consumers in Residential Habilitation Centers who want to live in the community. The assessment tool will be used to determine the level of supports needed by these persons and how to support them. In the future, the State will use the assessment data to create individualized budgets for use in the community. The State will assess any of the 950 consumers in these centers who want an assessment.

After pilot testing, grant staff will implement the assessment and related service plan statewide, develop training, and provide on-site support for end users in developmental disability field offices. The assessment will also be used to understand the needs of consumers who are on waiting lists to determine if their needs differ from those consumers presently served by the State either in state-funded programs or through waivers.

Washington will develop a quality improvement system that is consistent with providing consumer-based services. Staff will develop and distribute user surveys to measure the

level of satisfaction with the newly-developed assessment tool. Staff will use survey responses to evaluate the new assessment tool and measure program objectives, budget, and goals.

Wisconsin

The Wisconsin Department of Health and Family Services helped develop and implement two MFP funding mechanisms called the ICF Restructuring Initiative and the Community Relocation Initiative for nursing homes, both of which are discussed in detail in Section 4. Under these MFP initiatives, institutional funds for transitioning consumers are used to pay for community services. Consequently, Wisconsin is identifying ICF-MR facilities to be downsized or closed and closing nursing facility beds. The State is also developing reporting to track expenditures on a person-by-person basis.

In support of the ICF Restructuring Initiative, Wisconsin is creating a regional support system that will enable consumers and their guardians, county administrators, and other key stakeholders to understand and choose alternatives to ICF-MR facilities. Grant staff help educate guardians and other judicial personnel about the initiative and about their roles and responsibilities during the planning process and through the relocation process.

Section 4
MFP Policy and Programs in Texas and Wisconsin

Both Texas and Wisconsin have enacted legislation authorizing the transfer of funds from institutional to HCBS budgets. This section describes their policies and programs in detail to provide an understanding of how both the MFP funding mechanism and the NFT component of these initiatives were implemented. We report on the single MFP initiative in Texas and two MFP initiatives in Wisconsin—one for its elderly and younger physically disabled population, and one for its population with developmental disabilities.

Texas

Texas' MFP initiative addresses many aspects of the state's LTC policy. Box 1 provides an overview of key features of the State's LTC system.

The MFP initiative in Texas was first authorized by the Texas Legislature through a "rider"[21] to the state's budget appropriation bills for FY 2002–2003 (Rider 37). While the MFP policy was estimated to be cost neutral, many lawmakers anticipated it would save money since the policy approved community-based services used by transitioning nursing facility residents only up to the amount of their nursing facility expenditures. Individuals with developmental disabilities residing in ICFs-MR are not covered by the MFP initiative. The State is currently exploring ways to do so.

Texas officials noted several factors in the development of its MFP policy. First, the 1999 Olmstead decision and the resulting Executive Order of Governor George W. Bush requiring a study and recommendations for improving community services in Texas provided legal and gubernatorial support for rebalancing. Second, the MFP policy was estimated to be at the least cost neutral and many lawmakers anticipated it would save money as annual costs for waiver services were about three-quarters of nursing facility costs. According to data from Texas' FY 2004 waiver report, Community-Based Alternatives waiver services were 77.6 percent of nursing facility costs on an annualized basis. Third, consumer advocates had been working to enact an MFP policy for many years prior to the Olmstead decision and had already worked out many of its details. Finally, the nursing facility industry did not initially publicly oppose the rider in 2001 because of the belief that, principally, the younger disabled population, as opposed to the elderly population, would be affected.

Box 1. Overview of Key Features of Texas' Long-Term Care System

- As a result of a recent reorganization consolidating responsibility for long-term care into a single agency, the Department of Aging and Disability Services, which manages Medicaid long-term care, now includes the State Unit on Aging. Counties do not play a major role in long-term care.
- In FY 2004, 64 percent of total Medicaid LTC expenditures were for institutional care, slightly lower than the national average of 65 percent.[22]
- Texas' supply of nursing facility beds is higher than the national average. In 2004, Texas had 58 beds per 1,000 persons age 65 and over compared to 51 beds nationally.[23] In 2005, its nursing home occupancy rate was 77 percent, significantly below the national rate of 86 percent.[24]
- Texas covers the optional personal care benefit, known as primary home care services, through its Medicaid State Plan and is the only state to cover the 1029 (b) provisions or "Frail Elders" option. Texas operates eight Medicaid HCBS waivers, of which the largest is the Community-Based Alternatives program for older people and younger persons with disabilities. There are large "interest" lists for the waivers.
- Although assisted living is a covered service in the Community-Based Alternatives waiver, demand is relatively low and residential care facilities are not a major focus of state policy initiatives.
- Beginning in 1998, STAR+PLUS in Harris County (Houston) became the nation's first mandatory Medicaid managed care program for both acute and LTC services for older people and adults under age 65 with disabilities who are SSI.

The legislature re-authorized the MFP initiative in FY 2004–2005 (Rider 28). The nursing facility industry won concessions in this rider to lessen the impact on nursing facility expenditures. The new rider authorized that when a consumer loses waiver eligibility, any unused funds go back to the nursing facility budget, in effect authorizing access to waiver services without use of general revenue funded waiver slots. The State's MFP policy was codified into law on September 1, 2005.[25]

The State's MFP policy allows individuals in Medicaid-certified nursing facilities to move into the community-funded service system by having their nursing facility Medicaid funding pay for community services under four of the State's eight HCBS waivers: the Community-Based Alternatives waiver, the Medically Dependent Children's Program waiver, the Community Living Assistance and Support waiver, and the 1915 (c) nursing facility waiver under STAR+PLUS. The MFP policy also allows institutionalized individuals who are transitioning to the community to bypass the waiver interest list. Texas uses the term interest list, as opposed to waiting list, because the State does not determine eligibility for waiver services until a person is at the top of the list. As of February 2006, each of these waivers has a substantial interest list ranging from 9,805 persons to 55,000 persons; the average wait time on the Community-Based Alternatives waiver is 1.5 years.

Between September 1, 2001, and June 30, 2006, Texas' MFP policy assisted 11,300 residents to transition to the State's HCBS waivers. As of June 30, 2006, 5,661 individuals were receiving services under the MFP policy, the vast majority in the Community-Based Alternatives waiver, with a few individuals transitioning to the other two waivers. By comparison, 88,817 individuals were residing in nursing facilities.

Budget and Financing Mechanism

Initially, the State's MFP policy established a financing mechanism to enable transfers between the State's Medicaid nursing facility budget and the HCBS waiver budget. On a quarterly basis, funds were transferred retrospectively based on the average cost of the entire waiver population, rather than the waiver costs of the transitioned population. The average monthly waiver cost of approximately $2,600 was transferred from the nursing home budget to the Community-Based Alternatives waiver. The amount was determined using an algorithm incorporating the costs of 11 functional categories. Waiver costs are 78 percent of institutional costs on an annualized basis.[26]

For example, for 100 consumers transitioned under MFP, Texas multiplies 100 persons by $2,600 per month by 3 months ($780,000) to determine the amount to transfer to the HCBS waiver budget. Only the funds needed for community-based waivers, as opposed to the full nursing facility costs for transitioned individuals, are transferred between the State's budgets. This budgeting process does not affect providers directly because Medicaid pays HCBS waiver vendor bills using waiver funds as with any other consumer served.

Prior to September 1, 2005, Texas used its rider mechanism to make quarterly transfers equal to the average waiver cost for its entire waiver population multiplied by the number of transitioned individuals receiving waiver services. In a change in policy beginning September 1, 2005, the Texas legislature, during its 2005 legislative session, created a separate MFP line item appropriation from funds formerly budgeted for nursing facility services to pay for the community-based services to be used by individuals relocating from nursing facilities through MFP. This strategy replaces the rider mechanism and periodic budgetary transfers. This change was made because the legislature had sufficient experience with expenditures during the preceding years to budget a separate line item appropriation of $65.5 million for FY 2006 and $78.7 million for FY 2007. The budget estimate for each year is based on the number of persons projected to transition and the average waiver cost for the entire waiver population.

Housing and Community Services

Consumers transitioned under MFP receive services as needed from the array of approved waiver services, subject to the waiver cost cap. Texas has consumer direction using fiscal intermediaries, but not individualized budgets or support brokerages. Texas also operates

one of the country's largest personal care programs. Most of the Medicaid waivers have long waiting lists.

To address the affordable housing issue, Texas developed a Housing Voucher Program in conjunction with the Texas Department of Housing and Community Affairs and local public housing authorities to establish a set-aside for 35 Section 8 housing vouchers to be used by people transitioning from nursing facilities. These 35 vouchers were recycled by many of the local public housing authorities, which resulted in a total of 85 vouchers. In addition, Texas has approximately $4 million in Tenant-Based Rental Assistance set-asides for use by consumers transitioning to the community. According to Texas officials, approximately 46 percent of Rider 28 consumers live with family, 28 percent live in assisted living settings, 22 percent live alone, with the balance living in foster care, with other waiver individuals, or in other settings.

Nursing Facility Transition Infrastructure

Identification of transition candidates

Any Medicaid resident of a certified nursing facility may be transitioned under the MFP policy, as long as the costs for community services do not exceed Medicaid costs for nursing facility care. Demographic and residency data from Texas concerning 4,746 consumers transitioned using Rider 28 from August 2003 to March 2006 are shown in Exhibit 5.[27] Texas officials noted that the Rider 28 population is similar to consumers on the Community-Based Alternatives waiver, which does not support clients with medically complex diagnoses, children aging out of their institutional programs, and consumers with behavioral health issues.

Exhibit 5. Demographic and Residency Characteristics from Texas Rider 28 Users

	Percent
Age	
Under age 21	2.8
Age 21–64	33.7
Age 65 plus	63.5
Gender	
Female	65.7
Male	34.3
Living arrangements in community	
Client lives with family	45.7
Assisted living	27.8
Client alone	21.8
Client lives with other waiver recipients	3.4
Adult Foster Care	0.7
Other	0.5
Length of previous stay in NF before moving to the community	
Under 1 month	3.0
1–3 months	27.9
3–6 months	26.7
6 months to 1 year	16.4
1–3 years	14.3
3 years plus	6.6
Unknown	5.1

Texas regional office staff conducts substantial outreach and education activities to inform nursing facility residents about the State's MFP policy. To facilitate the development of these efforts, Texas used a CMS Systems Change MFP Grant to address outreach and education regarding community services options. In addition, the grant helped Texas establish local public-private community teams in each region to assist nursing facility residents in their transitions and to help develop solutions to system-level barriers in the transition process. Texas sent letters to consumers, their family members, CILs, and state ombudsmen informing them of the program. Consumers may identify by self-selection, or may be referred by CILs, ombudsman, families, or nursing facility social workers.

Assessment, Service Planning, and Transition Implementation

Each of the 10 regions of the State has at least one nursing facility MFP transition team. Each team comprises local public and private entities who are partnering to assist nursing

facility residents to transition. They develop person-centered transition plans, coordinate services and supports to assure successful transitions, and identify and address transition barriers at both the individual and system level. Transition teams also help coordinate the supports needed beyond the amount of services that a home health agency can provide (e.g., 24-hour care). The Texas Legislature continues to support the MFP initiative with $1.3 million of general revenue each year to fund the activities of relocation specialists affiliated with each regional transition team.

Two different programs have paid for individual transition costs over time. The first program, called Transition to Life, was funded with general revenue funds. Beginning September 2004, CMS approved funding for transition services, including rent and utility deposits, basic household goods, moving costs, and payment of services to ensure the health and safety of consumers, under Texas' HCBS waivers. Up to $2,500 for transition services are automatically approved for one-time use within the individual's waiver cost cap.

Home health agencies assess each consumer interested in transitioning to identify all supports needed to live in the community and to determine whether these services can be provided within an individual's waiver cost cap. Occasionally, consumers' requests for waiver services are denied because the agency does not believe it can assure their health and safety in the community setting. Texas re-assesses waiver eligibility periodically for the first year and, when indicated, assigns permanent eligibility status, e.g., for an individual with a condition or disability that is not expected to change, such as quadriplegia.

Ongoing Monitoring and Quality Assurance

Consumers transitioned under MFP are monitored through waiver case management services. However, Texas officials reported that they would like to track persons transitioning under MFP to determine: (1) whether those transitioned return to nursing facilities and, if so, why; (2) whether, and to what degree, it is less expensive to serve a consumer in the community; and, (3) whether a consumer is getting enough care coordination. Texas also would like to provide short-term intensive case management for consumers and respite care for caregivers. Texas noted that CILs occasionally, but not consistently, provide these services.

Wisconsin

Wisconsin has two MFP initiatives. The State has used its CMS MFP grant to assist in the development of an initiative for persons with developmental disabilities who are transitioning from private ICFs-MR to the community, and for a separate initiative for transitioning individuals of all ages in nursing facilities. Both initiatives are discussed in this section.

In 2003, the Wisconsin Legislature passed the ICF Restructuring Initiative, authorizing the use of ICF-MR institutional funds for the Community Integration Program I, a funding mechanism for the Community Options Program, Wisconsin's home and community services waiver and state-funded home care program.[28] In 2005 the legislature passed the Community Relocation Initiative allowing for the use of nursing facility funds for the Community Integration Program II, also a funding mechanism for the Community Options Program.[29]

See Box 2 for an overview of key features of Wisconsin's LTC system.

Wisconsin Intermediate Care Facility (ICF-MR) Restructuring Initiative

The ICF-MR Restructuring Initiative was developed to transition persons with developmental disabilities from private and county-owned ICF-MR facilities. The purpose of the legislation was to increase funding for community services, decrease funding for institutional services, and facilitate the closing of ICF-MR beds and facilities. Wisconsin's institutional costs had been increasing annually, no ICF-MR facilities had been closed, and community funding had not increased in several years. To address these problems, the MFP legislation provided access to funding to transition consumers from institutions to the Community Integration Program (CIP-1) funding mechanism of the Community Options Program waiver. The ICF-MR budget was frozen at its 2003 level of funding and was placed in one account within the community services budget to provide funding for service plans for transitioning individuals.

As of May 31, 2006, Wisconsin's MFP policy has transitioned approximately 379 people to community living. As of 2006, 69 of Wisconsin's 72 counties[30] have Community Integration Program (CIP-1) waiting lists totaling more than 3,700 consumers across the State.

Box 2. Summary of Wisconsin's Long-Term Care System

- The Department of Health and Family Services manages Medicaid and includes the State Unit on Aging. Counties play a major role in administering Medicaid HCBS waivers, the state-funded Community Options Program, and other state- and county-funded LTC services.
- In FY 2004, 61 percent of total (older and younger persons with disabilities) Medicaid LTC expenditures were for institutional care, slightly lower than the national average of 65 percent.[31]
- Wisconsin has a higher-than-the-national average supply of nursing facility beds. In 2004, Wisconsin had 62 beds per 1,000 persons aged 65 and over compared to 51 beds per 1,000 persons aged 65 and over in the United States.[32] In 2005, its nursing facility occupancy rate was slightly above the national average—88 percent compared with the national occupancy rate of 86 percent (American Health Care Association, 2006).[33]
- Wisconsin covers the optional personal care benefit through its Medicaid State Plan. The Community Options Program-Waiver (COP-W) is the main Medicaid HCBS waiver for younger persons with physical disabilities and elderly persons. Some of the state funding for the waiver is through the Community Integration Program II (CIP II), which links the number of waiver "slots"

to the closure of nursing facility beds. Historically, the State has had a large waiting list for its Medicaid HCBS waivers and state-funded LTC services. The Community Integration Program waiver is the main Medicaid HCBS waiver for persons with developmental disabilities.

- Both the state- and Medicaid-funded Community Options Programs cover services for a substantial number of clients in residential care facilities. Residential care services are covered in residential care apartment complexes (i.e., assisted living facilities), community-based residential facilities (i.e., board and care homes), and smaller adult family homes (one to four beds).
- Operating in a limited number of counties, the Family Care demonstration combines a single point of entry with access to a full spectrum of long-term care, both in community and institutional settings, in a capitated, managed care setting. The Family Care program has two components: Aging and Disability Resource Centers (ADRCs) and Care Management Organizations.

Budget and Finance

The Department of Health and Family Services developed a financial mechanism for the transfer of funds between the institutional and waiver budgets. Wisconsin transfers funds formerly used for institutional care to the waiver budget on a quarterly basis. Wisconsin has enough funding through the current biennium, but additional funding will be needed in the next biennium to transition the remaining 1,000 consumers still in institutions.

Counties develop an annual community plan for the transitioning consumer with family input and fully fund those costs, which were projected to average $224 per day, but are currently averaging $185 per day, the same as average institutional costs. Originally, the Department of Health and Family Services had planned to calculate the community daily rate by backing out both patient liabilities in the facility and the costs of nonwaiver personal care services from the daily ICF-MR rate of $185, but the remaining $140 a day was not enough to cover the costs of community living.

Housing and Community Services

Consumers transitioned under MFP receive services as needed from the array of approved services. Counties prepare individualized budgets for each consumer being transitioned. Wisconsin amended the waiver to allow counties to have a self-directed program under certain conditions, but the process is complicated and some observers believe that more infrastructure supporting self-directed supports is needed for the program to be effective.

ICF-MR Transition Infrastructure

At the time of passage of the MFP legislation, 1,400 consumers resided in 21 private ICF-MR facilities, exclusive of the two state institutions, which are not part of the MFP initiative. To qualify for the MFP initiative, consumers had to have been in the institution prior to January 1, 2005, and must be at least age 21.

The legislation created a new requirement such that anyone residing in an ICF-MR who has a legal guardian and has court-ordered protective placement must have an annual review by a judge who makes a determination of "most integrated setting." The State has put in place an elaborate administrative system to make sure that these annual reviews take place. As part of the court review, the county must present an annual community plan for the purpose of assisting the court in making an appropriate setting determination for each consumer. The community plan is a framework that requires a full assessment, identification of the community support preferences and needs of the consumer, and a description of the potential options for community living. The MFP legislation requires the funding and development of a consumer's person-centered plan to fully support all of their needs for community living. Transition costs are paid through the HCBS waiver and are very individualized.

Ongoing Monitoring and Quality Assurance

The Department of Health and Family Services has community integration specialists that work with county agencies to monitor the experience of consumers that have moved to the community. These specialists conduct 30- and 60-day reviews of consumers and are closely monitoring consumers for the first year. Wisconsin also has a critical incident reporting system to identify interruptions in a consumer's community placement. Wisconsin will track the utilization and costs of transitioned beneficiaries through the State's claims data system to assess the costs of community living.

Wisconsin Community Relocation Initiative for Nursing Facilities

Wisconsin developed the Community Relocation Initiative to facilitate an ongoing transition of consumers in nursing facilities to the community. The Department of Health and Family Services had been conducting NFT activities since the late 1990s using state funds, but the State slowed these transitions when state revenues decreased. The Community Options Program waiver has 8,000 elderly persons and younger consumers with disabilities on waiting lists, although a transition candidate does not have to be on the waiting list. Wisconsin has had long waiting lists for its HCBS waivers almost since their inception.

As of June 2006, 381 persons had transitioned to the community and 89 additional persons had been approved for relocation. By comparison, the State had 34,448 nursing facility residents in December 2005.

The Department of Health and Family Services transfers funds without having to close the specific nursing facility bed that the consumer vacated. Previously, Community Integration Program II could be used to fund waiver services using nursing facility funds tied to a consumer's recently closed nursing facility bed. The new MFP initiative removes this linkage to a specific bed closure and allows for the permanent transfer of nursing facility funds to the waiver budget.

The legislation was not particularly controversial given that it allowed consumers to leave nursing facilities and would produce savings for the State in a tight budget environment. The nursing home industry was skeptical partly because the State expected that about 25 percent of all nursing facility beds would close over an 8-year period, although not solely because of the MFP initiative. The number of nursing facility beds in Wisconsin has been declining, which presented a positive environment for expanding community services. The State planned to use some of the savings from the initiative to establish a more acuity-based Medicaid reimbursement methodology for nursing homes.

Budget and Finance

Under the initiative, Wisconsin transfers nursing facility funds to the Community Integration Program II, a funding mechanism for the Community Options Program waiver. At the state level, the total anticipated costs for the approximately 1,400 persons expected to transition under the Community Relocation Initiative were transferred before the start of the initiative to a special account within the Community Integration Program II. Wisconsin estimated that the MFP initiative would produce savings of approximately $9 million for the 1,400 people to be transitioned, which the legislature took as savings rather than reinvesting in home and community services. The consumers transitioned through April 2006 had average daily facility costs of $133 and average daily community costs of $104, resulting in LTC savings of approximately $29 per day, a 22 percent decrease over nursing facility costs. However, this comparison does not include acute care costs or any potential backfilling of the institutional beds.

Wisconsin counties play a major role in administering long-term care, especially HCBS waivers. Under the MFP program, the Department amends a county's annual waiver contract for any persons transitioning; the amendment gives the county the funds for the remainder of the year for all persons transitioned. The amount counties receive is based on the care plan for the transitioned individual.

Housing and Community Services

Wisconsin offers a very wide range of home and community services through its Medicaid state plan, Medicaid waivers, and state-funded programs. Transition services, including housing relocation, security/utility deposits, start-up costs, environmental accessibility modifications, and transition case management, but not first month's rent are approved under the HCBS waiver. Personal care is a covered Medicaid service, although it is fairly medically oriented. The Community Options Program waiver and state-funded program are nationally recognized for their flexibility in service coverage, although counties vary in how much flexibility they provide. The State and county fund a significant amount of home and community services outside of the Medicaid program.

Nursing Facility Transition Infrastructure

Identification of Transition Candidates

To qualify for relocation funding, a consumer must be a Medicaid nursing home resident, have LTC needs that will last more than 1 year or have a terminal illness, be eligible for the Community Options Program waiver both functionally and financially, and need waiver-funded, LTC services. County agencies assess the consumer's needs, strengths, and preferences and estimate the cost of a care plan. The county then submits a request to the Department of Health and Family Services for relocation funding, along with estimated care plan costs.

Demographic and residency characteristics for the 381 consumers that have transitioned are shown in Exhibit 6. A substantial majority of consumers were older people, had been in the nursing home for less than a year, and moved to some type of residential care facility.

Wisconsin developed informational materials about the MFP initiative and conducted seven forums with county care management agencies, CILs, aging advocates, and nursing facility staff to determine how they could identify potential candidates. Nursing facility staff suggested that they could identify transition candidates by talking to consumers during a consumer's quarterly review and identifying transition candidates during the nursing facility residents' council meetings. Nursing facility residents have been contacting their local aging office or county care management offices to learn how to participate. County providers also initiate contact with interested individuals, such as consumers on the county waiver waiting list, to discuss service options.

Assessment, Care Planning, and Transition Implementation

Wisconsin has had an existing NFT infrastructure since the mid-1990s. County agencies perform assessments, develop care plans, and coordinate transitions of consumers from facilities to the community.

Exhibit 6. Demographic Characteristics of Community Integration Program II Transition Beneficiaries, 2005-2006

	Percent
Age	
Age 18–64	31
Over age 65	69
Length of previous stay in nursing facility before moving to the community	
1–3 months	12
3–6 months	21
6 months to 1 year	27
More than 1 year	40
Living arrangements in community	
Community-based residential facilities with five plus residents	49
Homes or apartments	36
Adult family homes	11
Residential Care Apartment Complex	4

Source: *Community Relocation Initiative Annual Report*, July 2005 – June 2006.

Ongoing Monitoring and Quality Assurance

Wisconsin has an individual-level data system that monitors cost and utilization against a consumer's approved care plan. The State also asks care managers to follow beneficiaries 30 and 90 days after transition to assess the adjustment to the community environment in addition to normal waiver case management contact and reviews (e.g., monthly telephone contact and face-to-face contact every 90 days).

Section 5
Cross-Site Analysis of MFP Policy and Design Issues

Designing and operating MFP programs is complicated with many inter-related components. States interested in developing MFP initiatives similar to those in Texas and Wisconsin should consider the following policy and design issues:

- Addressing LTC industry concerns
- Developing MFP legislation
- Establishing an MFP budgeting mechanism
- Assuring availability of home and community services and housing
- Deciding whether to target specific individuals or establish eligibility criteria
- Establishing a method to identify those interested in transition
- Developing NFT infrastructure including case management to assess transition readiness
- Developing quality assurance methods and data collection capability to monitor the program

For an MFP program to be efficient and effective, all of these issues should be considered together to understand their interrelationship.

Addressing Long-Term Care Industry Concerns

To be effective, MFP programs require the cooperation of nursing facility and other institutional providers and that home and community services providers have sufficient capacity to serve those transitioning. The nursing facility and ICF-MR industries may have concerns that an MFP policy will affect the institutional occupancy rate as well as the availability and quality of care in both the community and institutions. In states without a Medicaid case-mix reimbursement methodology, institutional providers may have concerns about a possible increase in average acuity of remaining residents if people with lower levels of need are discharged. If these concerns are ignored, their opposition may prevent the enactment of MFP policies, particularly if they require legislative action.

To address potential opposition, Wisconsin and Pennsylvania informed institutional providers that the State could no longer afford the cost of increasing institutional utilization and encouraged the industry to consider other strategies for increasing revenues, such as providing rehabilitation services. Texas officials reported that the initial lack of opposition from the nursing home industry may have been due to its assumption that the MFP initiative

would affect a relatively small number of younger residents because elderly residents would not be interested in moving to the community. While this assumption proved to be incorrect, the effect of Texas's MFP policy on the average nursing facility has been small. If the approximately 1,300 nursing facilities in Texas were equally affected by the MFP initiative, only about two residents per year would have transitioned from each facility.

Developing MFP Legislation

Virtually all states require new legislation to implement MFP mechanisms because state legislatures almost always appropriate funds separately for Medicaid institutional and HCBS budgets. Only six states have passed legislation to develop MFP mechanisms for the transfer of funds between institutional and HCBS budgets—Maryland, New Mexico, North Dakota, Texas, Utah, and Wisconsin. The legislation authorizing each of these MFP mechanisms is in Appendix A.

As of May 2006, only two of the nine MFP Grantees—Texas and Wisconsin—had enacted legislation authorizing the transfer of funds across state budget categories. Only Pennsylvania of the remaining seven states with MFP grants was planning to introduce legislation in the current legislative session. Of the states that did not receive MFP grants, West Virginia considered legislation in the 2006 legislative session, but the bill was referred to a committee for further study.

States with global budgets that pool all state funds for LTC services into one budget do not require additional legislation to transfer funds across service categories. Few states (New Jersey, Oregon, Washington, Pennsylvania, and, soon under Section 1115 waiver authority, Vermont) have chosen this framework for providing services to elderly consumers and younger consumers with disabilities.[34] Global budgets, in effect, are an MFP policy because they allow funds to be used according to consumer's preferences. A global budget, though, does not assure that services will be available if waiver slots are capped.

Establishing the MFP Budgeting Mechanism

A key component of an MFP policy is the flexible transfer of funds between institutional and HCBS budgets. It is through this mechanism that money can follow the person. States must address three issues: (1) how should the transfer occur; (2) should it be permanent; and (3) how will the state protect potential savings by preventing backfilling of institutional beds?

The Budgetary Transfer

When developing a mechanism to transfer funds between Medicaid institutional and HCBS budget lines, states need to determine the amount and timing of the transfer. These decisions depend, in part, on administrative ease and convenience, the availability of data on which to calculate the transfer amount, and the ability of the nursing facility and ICF-MR

industry to protect the size of the institutional budget. The Texas MFP initiative and the two Wisconsin MFP initiatives—one for nursing facilities and one for ICFs-MR—differed in how these transfers are calculated and made as shown in Exhibit 7.

Exhibit 7. Payments/Transfers from Medicaid Institutional to HCBS Waiver Budget in Texas and Wisconsin

Budget issue	Texas MFP	Wisconsin MFP for Nursing Facilities	Wisconsin MFP for ICFs-MR
Permanency of payment or transfer	Not permanent	Permanent[a]	Permanent[b]
Timing of transfer	Once at the beginning of budget period	Once at the beginning of budget period	Quarterly
Calculation of amount to be transferred based on. . .			
Size of population served	Total number of consumers projected to be transitioned	Total number of consumers projected to be transitioned	Total number of transitioned consumers actually served
Cost per person served	Projected average cost for entire waiver population	Costs derived from waiver costs of Family Care enrollees having characteristics similar to the transitioned population plus upward adjustment	Projected average cost for transitioned population

[a]Wisconsin will close an equivalent number of facility beds as consumers transitioned over the 2-year period.

[b]ICF beds from which consumers transition close when funds are transferred to CIP I waiver.

Source: RTI International Interviews with state officials in Texas and Wisconsin, 2006.

This exhibit reflects Texas' new strategy created in September 2005 of a separate line item appropriation for each fiscal year, as opposed to the former rider mechanism entailing the transfer of funds across budgets. Alternatively, Wisconsin transfers a one-time lump sum amount at the beginning of the 2-year budget period for its entire population of nursing facility residents projected to be transitioned. The amount transferred is based on the waiver costs of a Family Care population with similar characteristics. Family Care is a Wisconsin program that combines funding for institutional and HCBS into a single capitated payment to a Care Management Organization. The amount transferred is adjusted upward to account for the anticipated higher costs of the actual transitioned population. When funds transferred at the beginning of the 2-year budget period are exhausted, consumers remaining to transition must wait for additional funding from the legislature in the next budget period. To cover individuals transitioning from ICFs-MR, Wisconsin transfers retrospectively on a quarterly basis an amount equal to the projected average community

costs of the individuals to be transitioned. These projected costs are derived from each consumer's community care plan.

It should be noted that the term Money Follows the Person implies that the specific funds used by an individual (or some portion of them) follow that individual person into the community. Instead, Texas and Wisconsin transfer an amount equal to the average HCBS costs for a group of individuals according to the criteria in Exhibit 7. They do this primarily for administrative ease and convenience and to control the costs expended on those transitioned. In neither state is the actual cost of services for each individual transitioned used to determine the amount of money to be transferred.

Permanence of Transfer

When transferring funds from the institutional to the HCBS budget, an important issue is whether or not the transfer will be permanent. This decision is often closely linked to whether a state wants to create new permanent HCBS waiver slots with the transferred funds. States must decide whether to fund an additional permanent waiver slot within the current ceiling approved by CMS (if the number of funded slots is less than the number of approved slots) or to use existing waiver slots. In the latter case in states with waiting lists, using existing waiver slots may extend the waiting period for those in the community on the waiting list.

In Texas, transfers create a temporary rather than a permanent new waiver slot, and the balance of any unused funds for a person who is no longer eligible or who dies returns to the institutional budget. This feature allows Texas to keep the number of permanent waiver slots constant. Formerly, in mid-2001 to mid-2003, Rider 37 allowed for the number of permanent waiver slots to increase within the current CMS-approved ceiling. But in mid-2003 to mid-2005, Rider 28, as well as legislation passed in 2005, required that any unused funds be returned to the nursing facility budget when a participant is no longer receiving waiver services.

In Wisconsin's MFP nursing facility initiative, funds transferred to the community services budget remain there when the person dies or becomes ineligible. Wisconsin state officials commented that they were trying to get away from the notion of waiver "slots," preferring to think more about "funds for waiver services," which would allow for a more flexible approach for using waiver services. Wisconsin's MFP ICF-MR initiative also keeps transitioned funds in the community services budget because an institutional bed closes with each transition.

Closure and Backfilling of Institutional Beds

Although states are interested in improving the balance between institutional and community expenditures, controlling total LTC expenditures is a major state concern. State

officials in Michigan, Pennsylvania, and Wisconsin noted that state budget officials are unwilling to increase HCBS budgets without some method for slowing or stopping increases in institutional spending. They are concerned that without a means to prevent the backfilling of beds vacated by transitioned residents, both the institutional and community budgets may increase.

To address this issue, a state's MFP legislation or policy may include a mechanism for controlling institutional expenditures. Wisconsin's MFP nursing facility legislation mandated that the total number of people served under the initiative cannot exceed the number of beds closed statewide over the biennial funding period. To meet this requirement, Wisconsin is counting a reserve of approximately 2,000 nursing facility bed closures over the past several years for which it had not already added a waiver slot. Thus, for the current budget period, the legislation authorized Medicaid to transfer funds without having to close the specific bed that a consumer vacated. Apart from its MFP initiative, Wisconsin noted that the State's nursing facility bed supply has been declining for the past several years.

Partly to address concerns about the backfilling of ICF-MR beds, the Wisconsin MFP ICF-MR initiative requires that a community service plan be developed and reviewed by a court prior to an ICF-MR admission to determine whether an individual can be served in the community. Most ICFs-MR decide to close a bed once someone has transitioned, in part because Wisconsin imposes a substantial bed assessment fee for both occupied and unoccupied beds. As a result, this MFP initiative will decrease the State's ICF-MR capacity over time.

When enacting its MFP policy, Texas did not have specific provisions to address backfilling because its nursing facility occupancy rate was 78 percent and had remained constant both before and after the MFP imitative. The state officials with whom we spoke believe that the MFP initiative has helped to offset any increase in nursing facility utilization that would have otherwise occurred based on the aging of the State's population.

Bed closure can be a contentious issue, especially for ICFs-MR. Some consumers, their families, and institution staff may oppose bed closures because they believe institutions are needed to provide services in secure settings as well as to provide employment for the communities in which they are located. For example, in Washington, families and employees affiliated with the local Service Employees International Union (SEIU) successfully lobbied the governor to delay and perhaps prevent closure of an ICF-MR near Seattle.

Some states limit their financial exposure by limiting the number of waiver slots that are available for individuals who want to transition. In 1998, the Utah Legislature enacted the Portability of Funding for Health and Human Services law (House Bill 372), which created an MFP mechanism for ICFs-MR. For individuals transitioning, the average cost of a consumer's

institutional services could be moved from the ICF-MR budget to the HCBS budget. Rather than establishing a fixed number of new waiver slots for those transitioning, the State created an open enrollment process for the waiver for consumers in institutions wanting to move to the community. Lawmakers thought that vacated ICF-MR beds would remain empty, but when 50 ICF-MR beds that had been vacated were refilled, the project was suspended. The State then established a new policy to limit the number of waiver slots available and discontinued the open enrollment period. The new policy allows the vacated ICF-MR beds to be available for people in need of institutional services, while ensuring limited funding for community-based services.[35]

Assuring Availability of Home and Community Services and Housing

The vast majority of people transitioned to the community will need home and community services and all will need housing. States must address the adequacy of their home and community service systems and the need for affordable and accessible housing.

Home and Community Services

Not all states provide the full range of home and community services needed to assure community living for individuals who want to transition. Some states do not cover waiver services for individuals under age 60 and, in FY 2004, 16 states did not cover personal care services under their Medicaid State Plan.[36] In addition, states vary in the scope of services offered under their waiver programs and may not cover the full range of services that transitioning consumers need.[37]

The stringency of a state's institutional level-of-care (LOC) criteria may also affect the amount of services that transitioned individuals require. In states with less restrictive LOC criteria—such as Pennsylvania and Michigan—persons transitioning to the community may have lower levels of impairment and need fewer services than in states with more stringent criteria. Until recently, Michigan required only a physician's signature to authorize nursing home services, which led to individuals with very low levels of impairment being admitted. Consequently, about 41 percent of a group of 102 residents that Michigan transitioned under a CMS NFT grant required no services after discharge.[38] In contrast, Wisconsin found that only a few persons who were transitioned did not need waiver services.

States may also need to consider the potential impact of workforce shortages on the availability of services. California reported that they were not certain that their home and community services infrastructure was capable of serving additional consumers, particularly those with complex medical needs. In rural areas, a consumer-directed service option may help alleviate shortages by allowing consumers to hire neighbors, friends, and relatives to provide care.

Housing

Based on states' experience with NFT activities to date, a major transition barrier is the widespread lack of affordable and accessible housing. According to state officials, many institutional residents who could be served in the community remain in nursing homes due to lack of housing. States may need to address the following issues: (1) policies to help newly-admitted residents maintain their community residence, (2) use of residential care facilities, and (3) the lack of affordable and accessible housing.

Maintaining the Homes of Medicaid Residents in Institutions

Individuals with their own home or apartment at the time of nursing home admission often have trouble keeping them because states are free to place a limit on how long income will be protected for purposes of maintaining a home. Because the lack of affordable and accessible housing is a major transition barrier, states may want to consider increasing the amount of time that income is protected for maintaining a residence so that consumers who want to return to their homes are not physically precluded from doing so. For example, Nevada recently changed its rules to increase the amount of time from 60 to 180 days.

Use of Residential Care Facilities

Many nursing facility residents have cognitive impairment and require 24-hour supervision to assure their safety. Thus, a substantial portion of people transitioned from nursing homes move to residential care facilities. For example, 64 percent of those transitioned in Wisconsin and 32 percent of those transitioned in Texas moved to residential care facilities.[39] The remainder in both states lived alone or with family members.

The ability to transition individuals from nursing homes to residential care facilities depends on whether the state allows these facilities to serve people who require a nursing facility LOC, which is a requirement for eligibility for Medicaid HCBS waivers.[40] In addition, not all states cover services in residential care facilities under their waivers. Some states cover minimal personal care services in these facilities through the State Plan option. In 2004, 29 states covered services in residential care facilities under a waiver only, 8 under a waiver and the State Plan, and 6 under the State Plan only.[41] Wisconsin officials noted that states that limited personal care services might have difficulty supporting all the needs of transitioned consumers.

Addressing the Need for Affordable and Accessible Housing

With the exception of nursing home residents eligible for Medicaid through the medically needy provisions, Medicaid eligible residents have low incomes. The Supplemental Security Income (SSI) program, which is the income eligibility standard for Medicaid in many states, is set at about two-thirds of the federal poverty level. With the increase in housing costs throughout the country, apartments and houses cost more than Medicaid beneficiaries can afford without rental subsidies.

The lack of subsidized housing was an important concern in all states, particularly a lack of Section 8 housing vouchers. Nevada cited the unwillingness of local housing authorities to give priority for rental vouchers to consumers transitioning from nursing facilities as a transition barrier. Texas officials stressed the importance of establishing relationships with both the State and local housing authorities in areas in which transitions are to occur in order to secure their assistance with providing rental subsidies.

In addition, persons with disabilities lack access to accessible housing. For example, the Low Income Housing Tax Credits (LIHTC) program provided more than $600 million in credits in FY 2004 for more than 76,000 housing units. However, only 2 percent of the total number of units were used by consumers with a physical disability, 1 percent by consumers with mental illness, and 1 percent by consumers with developmental disabilities.[42]

Deciding Whether to Target Consumers for Transition

States face a difficult task identifying specific individuals who want to transition to the community and can do so at a reasonable cost. In addition, a large number of people admitted to nursing facilities are discharged home under the current system without any additional intervention or only home health services. Between mid-2003 and mid-2005, 11 percent of the nearly 2.8 million discharges from nursing facilities were to the consumer's home with no additional services, and 28 percent went home with only home health services.[43] In order not to use resources on persons unlikely to transition to the community or those who would transfer without any additional help, some states have developed criteria, such as minimum lengths of stay, risk for long stays, and assumed low service needs (based on activities of daily living (ADLs) criteria) to target their efforts. As already noted, Wisconsin limits its MFP NFT activities to persons with a high risk of long stays in nursing homes, while Texas does not have targeting criteria.

Opponents of targeting argue that it is both ineffective and inequitable. Targeting strategies are difficult to develop because each individual is unique and will have unique transition needs. States that target individuals on single criterion, such as the number of deficits in ADLs or a minimum length of nursing facility stay, may not account for other important factors that affect preparedness for transition, such as cognitive impairment, substance abuse, and availability of informal care. Targeting by disability level could leave the state open to charges of discrimination if the state does not balance the need to conserve limited resources with the need to assure that severely disabled individuals also have an opportunity to transition if they want.

Developing Nursing Facility Transition Infrastructure

NFT programs are key components of MFP initiatives. NFT programs must have a means of informing nursing home residents about home and community service options and to

identify individuals who want to transition. Once identified, individuals need to be assessed for their "preparedness" to transition by determining their housing, medical, service and support needs, the availability of informal supports, and the cost of the service package relative to waiver cost limits. Additional issues to be considered are funding sources for transition case management and one-time transition expenses, determining whether institutionalized beneficiaries can bypass waiting lists, and addressing differences in Medicaid eligibility provisions for institutional and home and community services. These issues have been discussed extensively in other publications and are only briefly considered here.

Establishing a Method to Identify Individuals Who Want to Transition

States need methods to identify residents who want to transition. While many may self-refer, many more might do so if they were informed of the home and community service options available to them. Given that there were 940,000 Medicaid nursing facility residents in December 2005, this is a major task. States can identify individuals who are interested in transition using three approaches.

- The quickest way that involves no extra cost is to use waiver waiting or "interest" lists. States that have a long waiting list that includes consumers in nursing homes or ICFs-MR may not need to conduct additional outreach activities until everyone on the list is either out of the nursing home or the state determines that they cannot be transitioned. However, Wisconsin officials noted that not all consumers who expressed an interest in transitioning applied to the waiting list.

- States can use the MDS to identify individuals who express a desire to return to the community. The MDS is a federally mandated data system that regularly collects extensive information about the health needs and functional status of nursing facility residents. MDS item Q1a instructs the facility to interview the resident and family and review all facility records to ascertain if the resident expresses an interest in or indicates a preference to return to the community.

  While 18,000 Texas nursing home residents answered "yes" to this question, Texas officials did not report using the data. Wisconsin chose not to use the MDS, believing the data was not reliable. Two limitations of the MDS data are: (1) a blank is interpreted as no preference or interest, whereas it may mean that the question was not asked or not answered; and (2) residents may not have expressed an interest because they were unaware that home and community services were available and, thus, presumed that community living was not an option.

- States can conduct outreach activities to encourage self-referrals and third-party referrals by nursing facilities, ICFs-MR, relatives, friends, CILs, and other organizations.

Assessment, Service Planning, and Implementation

States must also address issues of assessing the preparedness of consumers for transition, obtaining funding for NFT activities and services, assuring Medicaid eligibility for transitioned beneficiaries, and addressing the bypassing of waiting or interest lists.

Assessing the Preparedness of Consumers for Transition

Once they have identified individuals who want to transition, states must have a system for determining "preparedness" for a successful transition. Some states, such as Massachusetts, ask consumers to fill out a self-assessment form to determine their readiness to transition. Using this method, states may be able to quickly identify those with a high priority for transition, such as those who are at immediate risk of losing existing housing and those at risk of becoming long-stay residents without immediate assistance. In some cases, individuals who require very few services and can live with a family member or other person can be quickly transitioned.

For all consumers prepared to transition, service plans should be developed to determine their costs. Case managers can then inform consumers of the scope and amount of services for which they are eligible, allowing them to determine if they will be able to live in the community with this level of support. In addition to understanding the type and amount of services for which they will be eligible, residents also need to understand the type and location of housing they will be able to afford. To assure sustained community living, residents must have realistic expectations before leaving the institution.

Providing Nursing Facility Transition Services and Coverage for Transition Expenses

States have three options for covering case management for transition activities: as a service under a 1915(c) waiver, an administrative activity, or targeted case management, which is an optional service under the state plan. States need to choose the method or combination of methods that best meets their needs.

However, transitioning institutional residents to the community can be highly labor intensive and states may not have the staff needed to perform this work. States may need to provide funding to train case managers and to address other staffing issues that impede timely transitions such as high caseloads and inadequate reimbursement rates.

States must also have a funding source to cover one-time transition expenses, such as rent and utility deposits and household goods. One-time transition costs cannot be considered Medicaid administrative costs, but states have the option to cover them under the waiver.

Texas initially paid for transition costs with general revenue funds prior to September 2004 when CMS approved payment of up to $2,500 per consumer under the waiver. Since January 2003, Wisconsin's MFP nursing facility initiative also paid for transition costs through the waiver, but does not set a fixed amount per transition.

Despite the availability of Medicaid waiver funding, not all states use this option to fund transition expenses. Washington pays for transition expenses through four different sources, including civil monetary penalties assessed against nursing facilities.[44] Wisconsin attempts to fund the first month of rent for transitioning individuals who need this assistance through other state funding sources. Texas and Wisconsin fund transition infrastructure costs not covered by Medicaid with general revenue funds or with grants obtained from federal or other funding organizations.

The Texas legislature provides $1.3 million annually to fund the State's transition infrastructure. In Texas, these costs include education campaigns for informing consumers, training programs for staff involved in transition activities, funding for community organizations that assist in transition efforts, and intensive case management to facilitate transitions, which is provided by relocation specialists. CILs and ombudsmen with aging agencies work under contract to the State to identify transition candidates and develop a transition assessment plan to assess a consumer's preparedness for community placement. Texas has also used its CMS-funded MFP grant to develop and support transition teams in each region of the State. Pennsylvania also collaborates with and funds private agencies to develop their transition infrastructure. For example, Pennsylvania is funding its Area Agencies on Aging to help conduct transition activities.

Ensuring Medicaid Eligibility for Community Services

Nursing facility residents transitioning to the community may face barriers related to Medicaid eligibility rules. First, because of the high cost of nursing facility care,[45] many residents are Medicaid eligible through the medically needy option and may not meet the financial eligibility criteria and other financial rules for home and community services.[46] Additionally, most but not all states use the special income eligibility rule for waivers that they use for nursing homes: allowing individuals with incomes up to 300 percent of the SSI level (roughly 200 percent of the federal poverty level) to be eligible.[47] In those states that do not, individuals eligible for Medicaid in a nursing home will not be eligible for home and community services.

Occasionally, Medicaid nursing facility residents who want to transition are found to be ineligible for waiver services because they do not meet the institutional LOC criteria. This anomaly can occur when individuals are admitted for medical conditions that resolve over time or functional limitations that improve but, when ready for discharge, have nowhere to go. Additionally, although they may meet the service eligibility rules for personal care and

home health services provided under the State Plan, they do not meet the financial eligibility criteria for these services because it is more stringent than the criteria for institutional and waiver services.

Addressing Bypassing of Waiting Lists

In Wisconsin and Texas, individuals who apply for waiver services wait a long time to receive them. In both states, eligibility for funding through the MFP program requires institutional residence and individuals who transition from institutions bypass the waiting or interest list.[48] This policy raises two issues: (1) whether persons will seek admission to nursing facilities solely for the purpose of bypassing the waiting list and obtaining waiver services through the NFT and MFP mechanisms, and (2) whether this process is fair to consumers living in the community who are waiting for services.

Data from Texas on the length of stay of persons who use the MFP mechanism suggest that few people enter nursing homes as a way to obtain waiver services. Only 3.0 percent of consumers had a nursing facility stay of less than 1 month, and only 30.8 percent had a nursing facility stay of less than 3 months.

Wisconsin crafts the eligibility for MFP assistance to persons to exclude short-stay residents. Although Wisconsin does not set a minimum requirement for prior length of nursing facility stay, counties are required to assess whether the consumer would be a long-term nursing facility resident if it were not for the relocation initiative. For persons in the nursing home for fewer than 100 days, counties are required to document that the stay is expected to be long-term based on specific guidelines in addition to the required assessment and functional screen.

Wisconsin counties are also required to assess whether a consumer has a long-term or irreversible illness or disability and without appropriate waiver-funded services would be unable to leave the nursing home. Criteria to determine whether the stay is expected to be long-term include the need for assistance in one or a combination of the following areas: long-term health care needs, considerable limitations with ADLs, uncertain or insufficient caregiver assistance, cognitive impairments that would make community living without support unsafe, and/or imminent loss of the consumer's current community living arrangement.[49]

In terms of equity between persons living in the community and in nursing facilities, state officials and advocates appear to agree that nursing facility residents should have priority to waiver services. The potential cost and quality of life implications of long stays in nursing facilities are given greater weight than the value of moving people already in the community onto the waiver. In Texas, which has an interest list rather than a waiting list, it is not

known whether individuals on the list qualify financially and functionally until an assessment is done when they reach the top of the list.

Establishing Data Collection Capability and Quality Assurance Mechanisms to Monitor the Program

Collecting data on the experience of persons transitioned allows states to ensure that the MFP program is effective and accomplishing the state's goals. States can also use these data to develop more accurate caseload forecasts for institutional and community budgets. Another important reason to track individuals after transition is to monitor the proportion of beneficiaries that return to institutions and to determine why. Wisconsin and Texas are either tracking or have plans to track consumers after transition. Wisconsin tracks cost and utilization of individuals transitioned against their approved care plan, and care managers conduct follow-up interviews 30 and 90 days after discharge to identify any problems with the community placement that need addressing.

A variety of measures can be used to assess the success of an MFP initiative. A principal individual-level measure is consumer satisfaction, which can be measured in several different ways, including overall satisfaction, independence, quality of choices, and community involvement.

The success of MFP initiatives may be assessed using several system-level measures. MFP initiatives should increase the number of home and community services users and expenditures and help stabilize or reduce Medicaid institutional use expenditures. Some possible measures of system-level outcomes include:

- the ratio between HCBS and institutional expenditures
- the rate of change over time in HCBS expenditures relative to rate of change over time in institutional expenditures
- the ratio between the number of persons in HCBS and the number in nursing facilities or ICFs-MR
- the number of nursing facility and ICF-MR beds or residents
- the proportion of individuals transitioned who returned to the nursing facility within 6 months for reasons other than an acute medical incident.

Section 6
Conclusion

The LTC financing and delivery system is biased towards institutional care. As a result, many people with disabilities are not provided the home and community services that they prefer. CMS and many states are supporting a number of initiatives to change the balance of the LTC system to provide support for more home and community services.

MFP is one mechanism to promote a more balanced LTC financing and delivery system. Although there are many definitions of this strategy, what distinguishes MFP from other approaches is the combination of a nursing facility (and/or ICF-MR) transition program and a budgeting mechanism that transfers funds for the transitioned individual from the institution to HCBS. This report describes the nine Systems Change Grants that focus on this approach. It also analyzes the state approaches of Texas and Wisconsin, the two Grantees that most embody this definition.

In reviewing the experience of these grantees, especially the MFP systems in Texas and Wisconsin, three broad categories of themes emerge relating to budget transfers, NFT programs, and program evaluation.

Budget Transfers

The budget transfer component of MFP is a mechanism to increase state budgets for home and community services, especially Medicaid HCBS waivers. Typically, states have separate budgets for institutional care and for home and community-based services. While institutional care, home health, and personal care are open-ended entitlements, home and community services are not and are limited to the number of persons that states choose to serve, subject to approval by CMS. As a result, waiting lists for home and community-based services are common because state budgets are not high enough to serve all of the people who qualify for services. As a practical matter, the budget transfer mechanism of Money Follows the Person is of less importance in states without waiting lists or in states that do not have a separate budget for institutional and non-institutional services. It is also less important for states with small institutional budgets (e.g., Nevada, Idaho and Maine) and, therefore, relatively few funds to transfer.

States use a variety of mechanisms to transfer funds between budgets, but typically use an estimate based on the average costs of HCBS waiver beneficiaries rather than the institutional costs of the specific individuals being transferred. One state, Texas, created a separate budget line within its institutional budget for payment of home and community services for transitioned beneficiaries, replacing the previous practice of budget transfers. States also vary in the extent to which the budgetary transfer from institutional care

represents a permanent increase in the HCBS budget. In Texas, for example, the budgetary transfer to community services exists only for the period that a particular individual remains in the community; at the point when the person dies or is otherwise no longer eligible, the funds return to the institutional budget. In Wisconsin, however, the transferred funds remain in the community services budget.

Nursing Facility Transition Programs

Transitioning individuals from ICFs-MR to the community has been a central component of LTC policy for people with developmental disabilities for over three decades. On the other hand, the recent emphasis on identifying people in nursing homes who want to live in the community and actively working to transition them out of the institution is a radical change in approach for older people and younger persons with physical disabilities. For the past 25 years, the overwhelming focus has been on preventing admissions to nursing homes, not discharging residents from them. This new approach takes as its premise that there are people living in nursing facilities who want to return to the community and can do so for a reasonable cost, and that some people admitted to nursing facilities improve rather than decline in functional status and also may desire to return to the community. It also reflects an increasing view that people with severe disabilities can successfully live in the community.

The experience of Wisconsin and Texas suggests at least four major issues. First, NFT programs are labor intensive and require substantial commitments of administrative resources, few of which can be funded by Medicaid. In part because of the resources required, Wisconsin and Texas have transitioned a fairly modest number of institutional residents given the size of their institutionalized populations.

Second, especially because of the limited resources available to help people transition to the community, targeting populations who want to transition to the community and can do so at an acceptable cost to Medicaid is a difficult process. States use nursing facility resident information from the MDS, additional surveys, and ad hoc recommendations to identify candidates for transition. Both Texas and Wisconsin have consciously not limited their initiatives to "light care" residents.

Importantly, the MFP demonstration mandated by the Deficit Reduction Act limits eligible participants to persons who have been in institutions at least 6 months as a way of preventing short-term, post-acute care admissions who already have a high probability of returning to the community from receiving the enhanced federal Medicaid match. However, a third of the Wisconsin NFT beneficiaries had lengths of stay of less than 6 months as did nearly three-fifths of NFT beneficiaries in Texas.

Third, in order to successfully transition people to the community, both housing and community services have to be available. Not all HCBS waivers cover all of the services needed to maintain individuals in the community and not all persons transferred meet the financial and functional eligibility requirements for Medicaid HCBS waivers. Differing eligibility requirements across waivers can also complicate the provision of needed services. The new home and community-based services option enacted as part of the Deficit Reduction Act may help provide Medicaid coverage for these services.

All of the Systems Change Grantees identified affordable and accessible housing as key barriers to transitioning people to the community. While housing accessible to people with disabilities is a major problem, finding any housing at all at prices that people can afford, especially if they are on SSI, appears to the states to be an even more pressing problem. Medicaid agencies are only beginning to build alliances with housing agencies to address this problem in a systematic fashion.

Fourth, while the goal of NFT programs is to transition institutional residents to the community, the "community" to which people transition is often a residential care facility. In Texas, nearly 30 percent of transitioned beneficiaries live in assisted living facilities or adult foster homes; in Wisconsin, almost two-thirds of transitioned beneficiaries live in assisted living facilities or board and care homes. While many residential care facilities truly offer residents more choices and more amenities than institutions, some do not. In addition, in 2004, only 26 states and the District of Columbia covered services in residential care facilities as part of their HCBS waiver.[50] For the MFP demonstration established by the Deficit Reduction Act, individuals eligible for the enhanced federal Medicaid match may reside in a community-based residential setting where no more than four unrelated residents reside, which will exclude larger assisted living facilities and residential care facilities, which have a high percentage of the available beds.

What is Success?

MFP initiatives are designed to achieve several goals, but little is known about whether these initiatives are achieving them. One goal is to balance the LTC financing and delivery system. Monitoring expenditures and numbers of users in institutions and the community should be straightforward. So far, however, relatively few people have been transitioned to the community through these MFP initiatives. In Texas, which has one of the most developed MFP initiatives, only about 2,500 people per year have been transitioned, while there are 60,000 Medicaid nursing home residents in Texas at any one time and perhaps 120,000 Medicaid nursing home residents over the course of the year.[51] Since modest numbers of people have transitioned, the budgetary transfers have also been modest.

Second, while serving institutional residents with services in the community should provide consumers with greater choices and should improve their satisfaction with services, little

data is being collected to demonstrate that this is the case. If adequate housing and community supports are not in place or are not provided at the level needed, consumer satisfaction may not be higher in the community. Whether satisfaction is higher is an empirical question on which there is little empirical evidence.

Finally, states seek to reduce LTC expenditures or at least reduce the rate of increase in public spending. The targeting of persons already in nursing facilities or ICFs-MR helps improve the likelihood of cost effectiveness because, by definition, the population has a "high risk" of institutionalization. While it may seem obvious that serving individuals in the community is less expensive than people in institutions, a careful analysis is needed to make an assessment. For example, Wisconsin's Medicaid costs in the community are 77 percent of the Medicaid costs in the nursing facilities, which does not include the costs of other government support, such as Supplemental Security Income, food stamps or housing subsidies for people in the community. For the ICF-MR target population in Wisconsin, the Medicaid community care costs are the same as the Medicaid institutional rate. In addition, community-based beneficiaries may use more acute care services than persons in the institution.[52]

In addition, the premise of MFP as a cost-saving strategy is that beds that become empty by transitioning individuals to the community are not filled by other people. While nursing home occupancy levels are at historically low levels, there is currently no empirical evidence available on the extent of backfilling of empty beds. On the other hand, if states are paying for persons in hospitals waiting for placement in nursing facilities and they are discharged to nursing homes or to the community because of these initiatives, then states may incur lower costs for these individuals.

Finally, a key component of the demonstration authorized by the Deficit Reduction Act is the provision of a substantially higher federal Medicaid matching rate for the first 12 months of residency in the community than is normally used. This higher Medicaid match is intended to be a powerful incentive for states to participate in the demonstration. In order to use the money efficiently, however, the federal government and the states need to identify people who would not be discharged from the institution without the MFP intervention. Contrary to common belief, large numbers of residents are discharged annually from nursing facilities to the community, many with services or to residential care facilities.[53]

In conclusion, MFP is an important innovation in the efforts to rebalance the LTC system. It represents a significant departure from conventional approaches for reform. The experiences of the System Change Grantees will add to the policy debate on how to best use this approach.

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Appendix A
MFP Legislation

H.B. No. 1867

AN ACT

relating to the transfer of money appropriated to provide care for certain persons in nursing facilities to provide community-based services to those persons.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.082 to read as follows:

Sec. 531.082. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services.

(b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the person after the person leaves the nursing facility.

SECTION 2. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 3. This Act takes effect September 1, 2005.

Wisconsin Community Relocation Initiative (for Nursing Homes)

CIP II Statute
46.277 Community integration program for persons relocated or meeting reimbursable levels of care.

(1) LEGISLATIVE INTENT. The intent of the program under this section is to provide home or community−based care to serve in a noninstitutional community setting a person who meets eligibility requirements under 42 USC 1396n (c) and is relocated from an institution other than a state center for the developmentally disabled or meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, except that the number of persons who receive home or community−based care under this section is not intended to exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department.

The intent of the program is also that counties use all existing services for providing care under this section, including those services currently provided by counties.

(1m) DEFINITIONS. In this section:

(a) "Medical assistance" means aid provided under subch. IV of ch. 49, except s. 49.468.

(ag) "Delicensed" means deducted from the number of beds stated on a facility's license, as specified under s. 50.03 (4) (e).

(am) "Plan submitted by the facility" means an individual relocation plan under s. 50.03 (14).

(at) "Private nonprofit agency" has the meaning specified in s. 46.27 (1) (bm).

(b) "Program" means the community integration program for which a waiver has been received under sub. (2).

(2) DEPARTMENTAL POWERS AND DUTIES. The department may request a waiver from the secretary of the federal department of health and human services, under 42 USC 1396n (c), authorizing the department to serve medical assistance recipients, who meet the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, in their communities by providing home or community−based services as part of medical assistance. The number of persons for whom the waiver is requested may not exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department. If the department

requests a waiver, it shall include all assurances required under 42 USC 1396n (c) (2) in its request. If the department receives this waiver, it may request one or more 3−year extensions of the waiver under 42 USC 1396n (c) and shall perform the following duties:

(a) Evaluate the effect of the program on medical assistance costs and on the program's ability to provide community care alternatives to institutional care in facilities certified as medical assistance providers.

(b) Fund home or community−based services provided by any county that meet the requirements of this section.

(c) To the maximum extent possible, authorize the provision of services under this section to serve persons, except those institutionalized in a state center for the developmentally disabled, in noninstitutional settings and coordinate application of the review criterion under s. 150.39 (5) with the services provided under this section.

(d) Unless s. 49.45 (37) applies, review and approve or disapprove each plan of care developed by the county department under sub. (3).

(e) Review and approve or disapprove waiver requests under sub. (3) (c), review and approve or disapprove requests for exceptions under sub. (5) (d) 3. and provide technical assistance to a county that reaches or exceeds the annual allocation limit specified in sub. (3) (c) in order to explore alternative methods of providing long−term community support services for persons who are in group living arrangements in that county.

(3) COUNTY PARTICIPATION. (a) Sections 46.27 (3) (b) and 46.275 (3) (a) and (c) to (e) apply to county participation in this program, except that services provided in the program shall substitute for care provided a person in a skilled nursing facility or intermediate care facility who meets the level of care requirements for medical assistance reimbursement to that facility rather than for care provided at a state center for the developmentally disabled.

The number of persons who receive services provided by the program under this paragraph may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

(b) 1. If the provision of services under this section results in a decrease in the statewide nursing home bed limit under s. 150.31 (3), the facility affected by the decrease shall submit a plan for delicensing all or part of the facility that is approved by the department.

2. Each county department participating in the program shall provide home or community−based care to persons eligible under this section, except that the number of

persons who receive home or community−based care under this section may not exceed the number of nursing home beds, other than beds specified in sub.

(5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

(c) Beginning on January 1, 1996, from the annual allocation to the county for the provision of long−term community support services under sub. (5), annually establish a maximum total amount that may be encumbered in a calendar year for services for eligible individuals in community−based residential facilities.

(3m) PARTICIPATION BY A PRIVATE NONPROFIT AGENCY. A private nonprofit agency with which the department contracts for service under sub. (5) (c) shall have the powers and duties under this section of a county department, as specified in sub. (3) (a).

(4) ELIGIBILITY OF RESIDENTS. (a) Any medical assistance recipient who meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility is eligible to participate in the program, except that the number of participants may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department. Such a recipient may apply, or any person may apply on behalf of such a recipient, for participation in the program. Section 46.275 (4) (b) applies to participation in the program.

(b) To the extent authorized under 42 USC 1396n, if a person discontinues participation in the program, a medical assistance recipient may participate in the program in place of the participant who discontinues if that recipient meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility, except that the number of participants may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

(5) FUNDING. (a) The provisions of s. 46.275 (5) (a), (b) 1. to 4. and 6. and (d) apply to funding received by counties under the program.

(b) Total funding to counties under the program may not exceed the amount approved in the waiver received under sub. (2).

(c) The department may contract for services under this section with a private nonprofit agency. Paragraphs (a) and (b) apply to funding received by a private nonprofit agency under this subsection.

(d) 1. In this paragraph, "physically disabled" means having a condition that affects one's physical functioning by limiting mobility or the ability to see or hear, that is the result of injury, disease or congenital deficiency and that significantly interferes with or limits at least one major life activity and the performance of one's major personal or social roles.

1m. No county may use funds received under this section to provide services to a person who does not live in his or her own home or apartment unless, subject to the limitations under subds. 2., 3., and 4. and par. (e), one of the following applies:

a. The services are provided to the person in a community−based residential facility that entirely consists of independent apartments, each of which has an individual lockable independent entrance and exit and individual separate kitchen, bathroom, sleeping and living areas.

b. The person suffers from Alzheimer's disease or related dementia and the services are provided to the person in a community−based residential facility that has a dementia care program.

c. The services are provided to the person in a residential care apartment complex, as defined in s. 50.01 (1d).

d. The services are provided to the individual in an adult family home, as defined in s. 50.01 (1).
e. Subdivision 1n. applies.

1n. A county may also use funds received under this section, subject to the limitations under subds. 2., 3., and 4. and par. (e), to provide services to a person who does not live in his or her own home or apartment if the services are provided to the person in a community−based residential facility and the county department or aging unit has determined that all of the following conditions have been met:

a. An assessment under s. 46.27 (6) has been completed for the person prior to the person's admission to the community−based residential facility, whether or not the person is a private pay admittee at the time of admission. The county may waive this condition in accordance with guidelines established by the department.

If the county waives this condition, the county must meet with the person or the person's guardian to discuss the cost−effectiveness of various service options.

b. The county department or aging unit documents that the option of in−home services has been discussed with the person, thoroughly evaluated and found to be infeasible, as determined by the county department or aging unit in accordance with rules promulgated by the department of health and family services.

c. The county department or aging unit determines that the community−based residential facility is the person's preferred place of residence or is the setting preferred by the person's guardian.

d. The county department or aging unit determines that the community−based residential facility provides a quality environment and quality care services.

e. The county department or aging unit determines that placement in the community−based residential facility is cost−effective compared to other options, including home care and nursing home care.

1p. a. Subject to the approval of the department, a county may establish and implement more restrictive conditions than those imposed under subd. 1m. on the use of funds received under this section for the provision of services to a person in a community−based residential facility. A county that establishes more restrictive conditions under this subd. 1p. a. shall include the conditions in its plan under sub. (3) (a).

b. If the department determines that a county has engaged in a pattern of inappropriate use of funds received under this section, the department may revoke its approval of the county's conditions established under subd. 1p. a., if any, and may prohibit the county from using funds received under this section to provide services under subd. 1n.

2. No county may use funds received under this section to provide residential services in any community−based residential facility, as defined in s. 50.01 (1g), unless one of the following applies:

a. The requirements of s. 46.27 (7) (cm) 1. a. or c. are met.

b. The department approves the provision of services in a community−based residential facility that entirely consists of independent apartments, each of which has an individual lockable entrance and exit and individual separate kitchen, bathroom, sleeping and living areas, to individuals who are eligible under this section and are physically disabled or are at least 65 years of age.

3. If subd. 2. a. or b. applies, no county may use funds received under this section to pay for services provided to a person who resides or intends to reside in a community−based residential facility and who is initially applying for the services, if the projected cost of services for the person, plus the cost of services for existing participants, would cause the county to exceed the limitation under sub. (3)

(c). The department may grant an exception to the requirement under this subdivision, under the conditions specified by rule, to avoid hardship to the person.

4. No county may use funds received under this section to provide residential services in a group home, as defined in s. 48.02 (7), that has more than 5 beds, unless the department approves the provision of services in a group home that has 6 to 8 beds.

(e) A county may use funds received under this subsection to provide supportive, personal or nursing services, as defined in rules promulgated under s. 49.45 (2) (a) 23., to a person who resides in a certified residential care apartment complex, as defined in s. 50.01 (1d). Funding of the services may not exceed 85% of the statewide medical assistance daily cost of nursing home care, as determined by the department.

(f) No county or private nonprofit agency may use funds received under this subsection to provide services in any community−based residential facility unless the county or agency uses as a service contract the approved model contract developed under s. 46.27 (2) (j) or a contract that includes all of the provisions of the approved model contract.

(g) 1. The department may provide enhanced reimbursement for services provided under this section to an individual who, on or after July 27, 2005, is relocated to the community from a nursing home by a county department or to an individual who meets the level of care requirements for Medical Assistance reimbursement in a skilled nursing facility or an intermediate care facility and is diverted from imminent entry into a nursing home. Except as provided in subd. 3., the number of individuals served under this paragraph may not exceed the number of nursing home beds that are delicensed as part of plans submitted by nursing homes and approved by the department, and the number of individuals diverted from imminent entry into a nursing home may not exceed 150.

2. The department shall develop and utilize a formula to determine the enhanced reimbursement rate for services provided under subd. 1. The department shall also develop and utilize criteria for determining imminent entry into a nursing home under subd. 1. that shall include an imminent loss of current living arrangements and an imminent risk of a long−term nursing home stay. The department need not promulgate as rules under ch. 227 the criteria required to be developed and utilized under this subdivision.

3. If it is likely that the number of individuals for whom an enhanced reimbursement for services is provided under subd. 1. and who are diverted from imminent entry into nursing homes will exceed 150, the department may submit a request to the joint committee on finance for approval to provide enhanced reimbursement for services provided under subd. 1. for diversion from imminent entry into nursing homes for a number of individuals in excess of 150. Notwithstanding s. 13.101 (3) (a), the committee is not required to find that an emergency exists. If the cochairpersons of the committee do not notify the secretary within 14 working days after the date of the department's submittal that the committee intends to schedule a meeting to review the request, approval of the request is granted. If,

within 14 working days after the date of the department's request submittal, the cochairpersons of the committee notify the secretary that the committee intends to schedule a meeting to review the request, the request may be granted only as approved by the committee.

(5g) LIMITATIONS ON SERVICE.

(a) The number of persons served under this section may not exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department.

(b) This section does not apply to the delicensure of a bed of an institution for mental diseases of an individual who is aged 21 to 64, who has a primary diagnosis of mental illness and who otherwise meets the requirements of s. 46.266 (1) (a), (b) or (c).

(5m) REPORT. By October 1 of each year, the department shall submit a report to the joint committee on finance and to the chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3), describing the cost and quality of services used under the program and the extent to which existing services have been used under the program in the preceding calendar year.

(5r) RULE MAKING. The department shall promulgate rules that specify conditions of hardship under which the department may grant an exception to the requirement of sub. (5) (d) 3.

(6) EFFECTIVE PERIOD. The effective date provisions of s. 46.275 (6) apply to this section.

History: 1983 a. 27; 1985 a. 29 ss. 896nc to 896u, 3202 (23); 1985 a. 176; 1987 a. 27, 186, 399; 1989 a. 31; 1991 a. 39; 1993 a. 16; 1995 a. 27; 1997 a. 13, 27, 114; 1999 a. 9; 2001 a. 16; 2003 a. 33; 2005 a. 25, 355.

Cross Reference: See also ch. HFS 73, Wis. adm. code.

Wisconsin ICF Restructuring Initiative

2003 biennial budget bill (Act 33)

WI State Statutes, Chapter 46.279 titled Restrictions on placements and admissions to intermediate and nursing facilities.

46.279 (2) Placements and Admissions to Intermediate Facilities. Except as provided in sub. (5), no person may place an individual with a developmental disability in an intermediate facility and no intermediate facility may admit such an individual unless, before the placement or admissions and after having considered a plan developed under sub. (4),a court under s. 55.06(9) (a) or (10) (a) 2. finds that placement in the intermediate facility is the most integrated setting that is appropriate to the needs of the individual, taking into account information presented by all affected parties. An intermediate facility to which an individual who has a developmental disability applies for admission shall, within 5 days after receiving the application, notify the county department that is participating in the program under s. 46.278 of the county of residence of the individual who is seeking admission concerning the application.

46.279 (4) Plan for Home or Community-Based Care. …a county department that participates in the program under s.46278 shall develop a plan for providing home or community-based care in a noninstitutional community setting to an individual who is a resident of that county.

46.279 (bm) "Most Integrated Setting" means a setting that enables an individual to interact with persons without developmental disabilities to the fullest extent possible.

Maryland

House Bill 478 Maryland General Assembly 2003 Session –Money Follows the Individual Act Signed May 13, 2003

DHMH Paul Althoff 410 767 6504 Find out for sure that $ are transferred from NFT to HCBS line.

"This bill prohibits the Department of Health and Mental Hygiene (DHMH) from denying an individual access to a home- and community-based services waiver due to a lack of funding for the waiver services if: (1) the individual is living in a nursing home at the time of the waiver services application; (2) the nursing home services for the individual were paid by the Medicaid program for at least 30 consecutive days immediately prior to the application; (3) the individual meets all eligibility criteria for participation in the home- and community-based services waiver; and (4) the home- and community-based services provided to the individual would qualify for federal matching funds in the Medicaid program."

North Dakota

SENATE BILL NO. 2330 Fifty-eighth Legislative Assembly of North Dakota In Regular Session Commencing Tuesday, January 7, 2003

"Any aged or disabled individual who is eligible for home and community-based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. To the extent permitted by any applicable waiver, the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service."

New Mexico

HOUSE BILL 353 47TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2006 – Money Follows the Person in New Mexico Act—"An individual. . .shall be allowed to choose. . .the type of service that best meets that individual's needs. The individual's medical assistance funds shall be made available for the individual for the service option the individual selects, not to exceed the cost of the service."

Utah

Enrolled Copy H.B. 372

PORTABILITY OF FUNDING FOR HEALTH
AND HUMAN SERVICES

1998 GENERAL SESSION

STATE OF UTAH

Sponsor: Dave Hogue

AN ACT RELATING TO HEALTH AND HUMAN SERVICES; REQUIRING THE DEPARTMENT OF HUMAN SERVICES AND THE DIVISION OF HEALTH CARE FINANCING TO REPORT ON THE PORTABILITY OF HEALTH AND HUMAN SERVICES FUNDING; REQUIRING THE DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES AND THE DIVISION OF HEALTH CARE FINANCING TO CONDUCT A STUDY TO IDENTIFY ALTERNATIVES FOR INCREASING THE PORTABILITY OF STATE AND FEDERAL FUNDING TO PERSONS WITH DISABILITIES; AND PROVIDING REPORTING REQUIREMENTS.

This act enacts uncodified material.
Be it enacted by the Legislature of the state of Utah:

Section 1. **General Portability Report.**

(1) No later than the November 1998 meeting of the Health and Human Services Interim Committee, the Department of Human Services and the Division of Health Care Financing within the Department of Health shall report to the committee on the portability of state and federal funding to persons wishing to move:

(a) from services provided by the Division of Health Care Financing to services provided by the Department of Human Services; and

(b) from services provided by the Department of Human Services to services provided by the Division of Health Care Financing.

(2) The report shall highlight regulatory, structural, and fiscal impediments to portability.

(3) The Department of Human Services and the Division of Health Care Financing shall provide to the committee prior to the 2000 Annual General Session of the Legislature a more detailed report with recommendations for increasing portability.

Section 2. **Portability study for persons with a disability.**

(1) As used in this act:

(a) "Disability" has the same meaning as provided in Title 62A, Chapter 5, Services to People With Disabilities.

(b) "Persons in intermediate care facilities" means:

(i) persons in intermediate care facilities for the mentally retarded; and

(ii) persons with a disability in nursing facilities who if they were to receive home and community-based services would receive services under the Division of Services for People with Disabilities within the Department of Human Services.

(2) Following the 1998 Annual General Session of the Legislature, the Division of Services for People With Disabilities within the Department of Human Services, and the Division of Health Care Financing within the Department of Health shall conduct a study to identify alternatives for increasing the portability of state and federal funding for services to persons with disabilities. The study shall:

(a) be limited to increasing the portability of funds to:

(i) persons in intermediate care facilities who wish to receive home and community-based services; and

(ii) persons with a disability receiving home and community-based services under the Division of Services for People with Disabilities who wish to move to intermediate care facilities for the mentally retarded or nursing facilities;

(b) identify federal barriers to portability of funds, including federal Medicaid laws and regulations;

(c) identify state barriers to portability of funds, including departmental structures and processes and service provider delivery systems;

(d) (i) compare the total cost of providing services to persons in intermediate care facilities to the total cost of providing services through home and community-based providers; and
(ii) control the total cost comparison for severity of disability classifications; and

(e) (i) estimate as accurately as possible the number of persons who would be interested in moving between:

(A) intermediate care facilities for the mentally retarded or nursing facilities; and

(B) home and community-based services; and

(ii) estimate the total cost to the state and facilities if individuals move to the facilities or services of their choice; and

(iii) control the total cost estimate for service type and level of service intensity.

(3) In the conduct of their study, the divisions shall solicit information and recommendations
from representatives of at least the following:

(a) intermediate care facilities for the mentally retarded and nursing facilities;

(b) home and community-based services;

(c) persons in intermediate care facilities or receiving home and community-based services and their families and guardians; and

(d) persons waiting to receive services through intermediate care facilities for the mentally retarded, nursing facilities, or home and community-based services and their families and guardians.

(4) The divisions shall report on their study to the Health and Human Services Interim Committee as follows:

(a) no later than the June 1998 meeting of the committee, the divisions shall provide a preliminary report to the committee;

(b) no later than the October 1998 meeting of the committee, the divisions shall provide a final report of their study, including recommendations for increasing the portability of funds. The recommendations to the committee shall include:

(i) methods for increasing portability within existing state funding levels; and

(ii) methods for maximizing portability in an environment of additional state funding; and

(c) the divisions may recommend how to increase state funding through the reallocation of existing resources or the identification of new revenue sources.

(5) The divisions shall provide a copy of their final report to members of the Joint Appropriations Health and Human Services Subcommittee no later than November 1, 1998.

Appendix B
MFP Topic Paper Discussion Guide

Money Follows the Person Discussion Guide

Introduction

Thank you for taking the time to meet with us today. Our discussion should take about 75 minutes.

As you know, CMS has contracted with RTI to conduct formative research on the Systems Change for Community Living Grants Program. A primary purpose of this research is to gain an understanding of important policy issues that Grantees are addressing and to share this information with policy makers, Grantees and other interested parties.

As part of this research, we are preparing a paper on the initiatives of the nine Money Follows the Person Grantees.

We have reviewed your semiannual and annual reports and would like to gather more in-depth information about your initiative and any challenges you are experiencing.

We will summarize the information from the nine Grantees and prepare a paper on our findings. The paper will be made available on the CMS website and on HCBS.org. Nothing that you say to us will be attributed to you personally in the paper. We will identify our findings only by Grantee.

To get started, could you tell us what agency (organization) you work for—or are affiliated with—and in what capacity? We would also like to know your specific role in the Grant's initiatives.

FILL IN FOR ALL BEING INTERVIEWED

Name: _____

Title: _____

Affiliation/Organization Name: _____

Role in MFP initiatives: _____

1. What is the definition of Money Follows the Person (MFP) in your state? How does that differ from nursing facility transition (NFT)? How do MFP and NFT relate to the concept of rebalancing?

2. Does your state have a waiting list for HCBS waiver programs? Which waiver programs are affected and approximately how many individuals are on each list? Approximately how long is the wait on each list? How does this affect the need for MFP legislation or MFP financing mechanisms?

3. If your state has (or is now trying to develop) legislation authorizing MFP, what was the process and who were the players involved? If you are not working on legislation, what pre-planning activities are occurring toward that end?

4. Please describe the specific needs/problems your grant is designed to address. (I will quickly state what I know about these needs/problems from your grant application, and will ask you to identify the one or two critical needs that your MFP initiative is designed to directly address.)

5. How do (or will) you identify eligible persons for MFP who would not have been discharged from a nursing facility (NF) without your existing (or proposed) MFP initiative?

6. Generally, please describe the target population your initiative is designed to help by:

   - types of disability (MRDD, Aged and Disabled, persons in state mental hospitals, etc.)
   - age group(s) (0–17 years, 18–45 years, 45–64 years, 65 years plus)
   - number of individuals to be served during the grant period
   - estimated number of individuals that could be served over the 5-year period after the grant ends if the state continued the grant's MFP activities or implemented your MFP design

   If you have collected any data on the characteristics of the population served or to be served, will you provide it to us?

7. Please describe if/how the following MFP design issues pertain to your MFP initiative:

   - Eligibility (e.g., length of time in institutions, presence on HCBS waiver waiting list)
   - Access (e.g., assessment of need, provision of information about HCBS)
   - Financing/Budget (e.g., mechanism for money to follow the person, calculation of the amount of money to follow the person, reimbursement/rate methodologies, funding of transition costs, use of global or portable budgets, linkages between state program budgets, individualized budgets)
   - Services and associated methodologies (e.g., ways to integrate services across state programs, self-directed services, support brokerages, fiscal intermediaries)

- Pre-transition activities (e.g., NFT policy and infrastructure, use of MDS to identify interested consumers, options counseling, relocation planning, availability of housing and transportation)
- Post-transition planning and support

8. What types of system and/or individual-level outcomes are you trying to improve with your grant activities?

9. What challenges have you faced in implementing your MFP initiative? Have you made any changes in grant activities to address these challenges?

10. Does (or will) your state provide adequate funding of transition expenses to allow MFP to work?

11. Please highlight what change(s) you have made in operations to make sure your MFP initiative is successful?

12. Are there specific products you have developed that would be useful to other states? If yes: Have you posted them on the HCBS Resource Clearinghouse?

13. If another state wanted to replicate your initiative, what would you tell them?

Endnotes

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[5] Letter from CMS's Director for Center for Medicaid and State Operations to State Medicaid Directors dated August 17, 2004.

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[7] Burwell, B., K. Sredl, and S. Eiken (July 7, 2006). Medicaid Long Term Care Expenditures in FY 2005. Cambridge, MA: Medstat.

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[16] Wiener, J.M., J. Tilly, and L.M.B. Alecxih (2002). "Home and Community-Based Services for Older Persons and Younger Adults with Disabilities in Seven States." *Health Care Financing Review*, Vol. 23, No. 3, pp. 89–114.

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[20] Jones, A. (2002). *The National Nursing Home Survey: 1999 Summary.* National Center for Health Statistics. Washington, DC: Government Printing Office.

[21] Rider 37 to the 2002–2003 General Appropriations Act (Sept 1, 2001–August 31, 2003) Rider 28 to the 2004–2005 General Appropriations Act. A rider is a direction by a legislature on how already appropriated money is to be used, but does not have the force of law.

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[25] Texas House bill 1867.

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[49] Department of Health and Family Services DDES Memo Series 2005-17 issued September 30, 2005.

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