

Community Living Exchange Collaborative: A National Technical Assistance Program

Funded by Centers for Medicare and Medicaid Services (CMS)



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States in Action.....

Building Nursing Home Transition into a Balanced Long Term Care System: The Washington Model

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November 2003

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In collaboration with: Independent Living Research Utilization (ILRU)

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Introduction

The Washington Aging and Disability Services Administration (ADSA) operates a comprehensive array of services for elders and adults with disabilities. This brief summarizes one aspect of Washington's mature and balanced long-term care system – a successful effort to identify and assist nursing home residents to relocate to community settings. Like most states in the later 1980s and early 1990s, most Medicaid beneficiaries in Washington were served in nursing homes. In 1987, the Aging and Adult Services Administration prepared a strategic planning document that noted that nursing home spending was growing so rapidly that it -prevented expansion of in-home services, despite consumer preferences for them. The document recommended policy and budget steps to expand in-home services and curtail institutional care. Ten years later, 63% of the agency's clients were served in residential and in-home settings. Washington is among the leaders among states seeking to create and maintain a balanced long-term care system that offers real choices for consumer among an array of settings and service options.

Service trends

Prior to the development and expansion of home and community based services; Washington relied on nursing homes to serve people who needed long term supports and assistance. The number of Medicaid nursing home residents grew from about 13,000 in 1972 to a peak of just under 18,000 in 1993.¹ With the expansion of residential and in-home services, the census has steadily declined to 12,900 in January 2003. The number of people receiving home and community-based services grew from about 20,000 in 1993 to 33,000 in January 2003. Spending totaled \$414 million for home and community based services to average of 32,213 clients a month in FY 2002 and \$489 million was spent for nursing home care for an average of 13,144 people. Although 54% of the state's long term care spending pays for care in a nursing home, HCBS spending rose 362% between 1992 and 2002 compared to a 25% increase in nursing home spending. Seventy one percent of the beneficiaries are served in community and residential settings. By continuing to rebalance its system, state officials expect that the number of people receiving care in nursing homes will drop to 12,500 by January, 2004.

¹ Caseload and spending figures were provided by the Aging and Disability Services Administration.

Long term care spending				
Area	FY 1992		FY 2002	
	Clients	Spending	Clients	Spending
HCBS	19,330	\$89.7 million	32,213	\$414.4 million
Nursing home	17,353	\$392.4 million	13,144	\$489.4 million
Total	36,683	\$482.1 million	45,357	\$903.8 million

Programs

ADSA operates four community programs. The **Community Options Program Entry System** is a Medicaid HCBS waiver program that covers personal care and a range of other in-home services, and care in three residential settings: Adult Family Homes, Enhanced Adult Residential Care facilities, and Assisted Living facilities.

The **Medicaid Personal Care** is a state plan personal care program for Medicaid beneficiaries who do not meet the COPES eligibility criteria. Services are cover in a person's own home, Adult Family Homes and Adult Residential Care facilities.

Medically Needy Residential Waiver is a new waiver program that pays for personal care and other services for aged, blind, or disabled individuals residing in Adult Family Homes, Assisted Living and Enhanced Adult Residential Care facilities. It serves beneficiaries whose income is too high to qualify for other programs.

CHORE is a state-funded program that provides in-home personal care services to non-Medicaid eligible, low-income, disabled or very frail adults who still live in their own homes. The program is closed to new applicants except for adult protective service referrals.

Case management services

Washington administers long term care services through a single entry system. The initial assessment, functional eligibility determination and care plan are completed by state employed nurses and social workers. Ongoing case management is done by state staff for beneficiaries in nursing homes, adult family homes and assisted living settings and by Area Agencies on Aging for in-home participants.

ADSA is implementing a very sophisticated computerized assessment tool that nurses and social workers use to determine functional eligibility, develop care plans with the consumer that reflect their preferences, allocate resources and authorize payment for services. The tool is built on a series of three algorithms that simplify eligibility and resource allocation decisions.

The eligibility algorithm for the (also MPC) Medicaid HCBS waiver, (COPES) looks at activities of daily living, treatments and skin conditions, and cognitive impairments requiring supervision due to memory impairment or impaired decision making, and behaviors such as wandering. The information is scored and grouped into 14 categories (see table).

The Resource Allocation algorithm converts the categories to hours of service and assigns a base number of hours, which is modified by the availability of informal supports and other adjustments (e.g., offsite laundry, distance to essential shopping). Instrumental Activities of Daily Living (IADLs) are not considered as part of the functional eligibility determination however, unmet IADLs are reflected in the hours generated for the care plan. The resulting hours of care can be used to authorize in-home services, adult day care, home delivered meals, (and residential services by levels)

The Resource Classification Model is based on four types of information: clinically complex conditions, mood and behavior, cognitive performance and ADLs. Based on combinations of these four areas, assessment data is assigned to one of fourteen groups in all care settings (adult family homes, assisted living, adult residential care, expanded adult residential care and in-home).

Clinical complexity is based on the presence of a health condition (e.g., ALS, CP, pressure ulcers, incontinence) or treatments. Based on their ADL and cognition

Washington State Resource Classification Model		
Classification	ADL Score	Group
Exceptional care group (in home only) Diagnosis + ADL >=22 + Treatment + Programs	ADL score 26-28	14
	ADL score 22-25	13
Severely impaired cognition (CPS 4-6) And Clinically Complex	ADL score 21-28	12
	ADL score 13-20	11
	ADL score 2-12	10
Cognition intact-moderately impaired (CPS 0-3) and Clinically complex	ADL score 18-28	9
	ADL score 9-17	8
	ADL score 2-8	7
Mood & behavior – Yes Not clinically complex CPS = 0-6	ADL score 15-28	6
	ADL score 6-14	5
	ADL score 0-5	4
Mood & behavior – No Not clinically complex CPS = 0-6	ADL score 10-28	3
	ADL score 5-9	2
	ADL score 0-4	1

scores, people meeting the clinical complexity criteria are assigned to groups 7-12.

Mood and behavior factors include a range of specific behaviors that may be current or addressed through current interventions. In other words, scores are not reduced if the person no longer engages in the problem behavior because of successful interventions.

Separate algorithms are used for residential settings such as adult family homes, enhanced adult residential care and assisted living.

Nursing home transition services

ADSA assigns case managers to each nursing home to work with residents. Each case manager is responsible for working with residents in 2-3 facilities. Case managers had been assigned to hospitals to work with discharge planners but ADSA found that people being discharged from hospitals frequently needed rehabilitation services before they could return home. ADSA shifted staff from hospitals to nursing homes to work with residents as their potential to move home improves.

Case managers, who may be social workers or registered nurses, contact residents within seven days of admission to the nursing facility to inform them of their right to decide where they will live, discuss their preferences, likely care needs and the supports that are available in the community, and other service options. A full comprehensive assessment is completed when the consumer indicates their readiness to work with the social worker to relocate and the nurse/social worker develops a transition plan with the consumer.

Support for transition expenses

Perhaps the most important barrier a nursing home resident faces in relocating to the community is a lack of funds to maintain an existing home or to re-establish a residence. ADSA prepared a one page Transition Tool Kit that summarizes five sources of support to help nursing home residents maintain an existing independent living arrangement during a temporary nursing facility stay, to relocate from a nursing home to a less restrictive residential setting, or to establish an independent residence. (Note: check tool). The "tools" include a Medical Institution Income Exemption Fund (MIIE), a Residential Care Discharge Allowance, a Civil Penalty Fund and the Assistive Technology Fund.

Medical Institution Income Exemption Fund Beneficiaries who qualify for Medicaid under the Special Income Level or Medically Needy program have

income that is paid to the nursing facility. The state uses the post-eligibility treatment of income rule (CFR435.832) that permits states to exempt income so it can be used to maintain a home or to pay for costs related to moving to a residential or community setting. Exempting income raises the Medicaid payment to the nursing home during this transition period.

ADSA limits the amount of income that may be exempted to 100% of the poverty level. The exemption is allowed for up to six months. A physician must certify that the length of stay will be for no more than six months. The exempt income is used to cover rent, mortgage, property taxes, insurance, and utilities. Case managers must verify these costs through canceled checks, bills, or receipts.

Residential Care Discharge Allowance The Residential Care Discharge Allowance provides up to \$816 in state general revenues to help a beneficiary move from a nursing home, hospital, adult residential care facility, enhanced residential care facility, assisted living facility, or adult family home to a less restrictive setting. This grant may be used in addition to the MIIE. The grant may be used to cover the first month's rent, damage deposits, moving expenses, furniture, utilities, groceries, cleaning services, telephone or the purchase of necessary equipment including handrails, ramps, assistive devices, furniture, bedding, and household goods and supplies.

Civil Money Penalties ADSA uses fines paid by nursing homes with deficiencies, Civil Money Penalties (CMPs), to help people residing in nursing facilities that have been listed by the licensing agency as deficient to move to another nursing facility or to an alternate residential setting. The CMP grant is limited to \$800 per resident but exceptions may be allowed if the facility has been de-certified or an emergency exists in which several or all residents must be relocated. Requests that exceed the limit are reviewed by the Regional Administrator. CMPs are also used for other purposes such as to support operation of a facility, which is being closed, and to reimburse residents for lost personal funds or property.

Assistive Technology Fund State general revenues were used to create an assistive technology fund which can be used to pay for assistive, adaptive or durable medical equipment, evaluations, training or minor home modifications. The average request is approximately \$2,000. Expenditures that exceed \$10,000 are reviewed by the Office Chief of State Unit on Aging. Decisions are made on a case-by-case basis. The fund was financed by an appropriation of \$95,000 per fiscal year in state general revenues. This fund is used only if there is a denial from Medicare/Medicaid or if the service/device is not a covered item under the state plan.

Assistive technology funds are also available to cover intervention services, which are evaluations or consultations by professionals in occupational or physical therapies, independent living, nutrition, psychology or registered nurse or rehabilitation specialists. These services are available for people who are likely to gain improved functioning, health or independence. Services must meet the consumer's need.

CMS' Nursing Home Transition Grant Finally, the Tool Kit includes funds from the CMS Nursing Home Transition Grant, awarded in 2001, that may be used to cover transition services for people moving from a nursing facility to the community such as adaptive or medical equipment, environmental modifications (ramps, wider doorways, and bathroom adaptation to promote accessibility and safety) and independent living services.

Conclusion

Since the mid-1980s, Washington has been a leader in creating a comprehensive long-term care system that combines policy development, regulation, licensing, payment and management of all services in one state agency. This ability to manage all aspects of the system was reported by state administrators to be an important factor in their ability to create a balanced system by shifting funds from institutional to community services through a multi-year plan. Unlike community home care programs in some states, nursing home residents receive case management services and relocation to the community is a continuing priority. The state's ability to successfully relocate between 100 – 300 people a month is due to the availability of a range of different settings, an array of services and funds to support transition expenses and ongoing services in the community.

This summary was prepared by Robert Mollica based on a site visit to the state of Washington in April 2003 organized by the Rutgers Center for State Health Policy/National Academy for State Health Policy Technical Assistance Exchange Collaborative. Thirteen representatives from Nursing Home Transition Grantees from Alaska, California, Delaware, Indiana, Maryland, Massachusetts and New Jersey participated in the site visit.

This document was developed under Grant Number P-91512/2 from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government. Please include this disclaimer when copying or using all or any of this document in dissemination activities.