
Money Follows the Person and Balancing Long-Term Care Systems: State Examples

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Money Follows the Person and Balancing

Long-Term Care Systems: State Examples

State Medicaid Agencies allot one-third of their Medicaid budgets for long-term care services. In 2002, 70 percent of these expenditures were for institutional services rather than for services in the homes and communities of individuals with chronic disabilities. In recent years, CMS has endeavored to correct this imbalance by providing states the tools and resources to balance their service offerings between community and institutional options. This effort is reflected in two recent initiatives:

- 1) A five-year, \$1.75 billion Money Follows the Person Rebalancing Initiative in the President's 2004 proposed budget that would pay for home and community-based services (HCBS) for people leaving institutions in states that develop and implement strategies to rebalance their long-term care systems.
- 2) An initiative offered under the 2003 Systems Change Grants for Community Living to provide up to \$7 million for states to develop and implement strategies that reform financing and service systems so funding can follow people from institutional to community settings.

The 2004 proposed budget initiative and the 2003 Systems Changes Grants for developing rebalancing strategies use two related principles: rebalancing and “money follows the person.” **Rebalancing** means adjusting the state's publicly funded long-term supports – to increase the availability of community options and reduce reliance on institutions – so the supply of available services reflects the preferences of older people and people with disabilities. **Money Follows the Person** refers to a system of flexible financing for long-term services that enables available funds to move with the individual to the most appropriate and preferred setting as the individual's needs and preferences change. To the individual, the movement of these funds may appear seamless. People receiving supports, not providers or program managers, drive resource allocation decisions as they move through the long-term care system.

Background

It has long been recognized that the Medicaid program is structurally designed so that individuals are more likely to have an institutional option available than a community-based option. In its early years, Medicaid *only* provided coverage of institutional services. Moreover, many persons with long-term care needs could only become eligible for Medicaid benefits if they entered an institution.

The federal government has provided states with flexibility to alleviate this institutional bias, starting in the mid-1970s with the addition of personal care as an optional service. The 1981 enactment of the Medicaid 1915(c) Home and Community-Based Services (HCBS) Waiver Program further addressed the imbalance between institutional and community supports. The

HCBS Waiver Program allows states to provide a wide array of community-based options for individuals who meet the states' functional eligibility criteria for institutional placement. HCBS Waiver services became more available after 1994 when the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services (CMS), removed the "cold bed requirement" that required states to document the availability of an empty or closed institutional bed for each waiver participant in order to show a waiver's cost neutrality. As the chart in Appendix 1 shows, states have steadily expanded support for Medicaid-financed community-based service options for more than a decade.

In recent years, CMS has continued to provide states with greater flexibility in designing community-based programs. CMS has also provided guidance, technical assistance, and grants to assist states in redesigning their long-term support systems. These efforts include: (1) the *Independence Plus* waiver templates, (2) letters to State Medicaid Directors, (3) annual Real Choice Systems Change conferences, (4) the implementation of a national technical exchange strategy, and (5) the Real Choice Systems Change and Medicaid Infrastructure Grants.

The degree to which states have taken advantage of the increasing flexibility and resources offered by the federal government has varied. While some states have made tremendous strides in rebalancing their systems and building infrastructure that allows money to follow the person, other states have been less proactive. A few states offer their citizens an effective balance of both community and institutional services. Nationally, however, the vast majority of states spend most of their Medicaid long-term support funding for nursing homes and intermediate care facilities for people with mental retardation (ICF/MR). Therefore, funding for community-based supports is limited and people often face long wait lists for community services.

Historically, much of the progress in the development of HCBS delivery systems has occurred through a process of states learning from other states' experiences. To facilitate this process, this paper provides examples of states that have incorporated the goals of rebalancing and money follows the person into their support delivery infrastructure.

Rebalancing Techniques

Many states have established greater balance between institutional and community services. State successes are documented herein under the context of three types of strategies: 1) *legislative actions* that set a policy of balancing the long-term care system and create budgetary mechanisms to move funding from institutional to home and community-based services; 2) *market-based approaches* that offer participants more community supports and more timely information, allowing participant demand to rebalance the system; and 3) *fiscal and programmatic linkages* that improve coordination among different functions in the support system and encourage more community services and less reliance on institutions. These three types of rebalancing strategies are not mutually exclusive. States often use two or more of these strategies as part of a systemic approach to modify their policies and procedures.

Examples of these strategies are described below. For more information about these examples, Appendix 2 contains a contact person for state examples discussed in this paper and Appendix 3 lists several Web sites with more information about these examples.

Legislative Action

Generally, state legislatures approve all state government spending, including increased spending on HCBS. This section highlights single legislative actions that sparked system balancing or installed “money follows the person” as state policy. In several other states, legislative intervention occurred gradually over several years as legislators approved and evaluated market-based approaches and fiscal and programmatic linkages, adding more options for the long-term care market and more linkages over time.

Texas

The Texas legislature added Rider 37 to the two-year state appropriations act that took effect in September, 2001. This rider allows the Texas Department of Human Services (TDHS) to move Medicaid funding from its nursing facility budget to its budget for state and Medicaid-funded HCBS when a Medicaid participant transitions from a nursing facility into a community-based residence. Any Medicaid nursing facility resident may apply for transition into the community and immediately use community supports rather than be placed on a waiting list as was required before the rider. Interested residents must remain in the nursing facility until eligibility is determined. Once eligibility is determined, the transitioning individual may use any Community Care Program for which he or she is eligible, such as Medicaid HCBS waivers, Medicaid state plan options, and state-funded services. Each month TDHS identifies the people who left nursing homes using the rider, and estimates the cost of their community services for the rest of the fiscal year. TDHS moves the cost of the community services from the nursing home budget to the community supports budget.

Over 1,900 Medicaid participants in Texas have transitioned from nursing facilities into the community under Rider 37. This year the Texas legislature extended the rider for a second biennial budget (until August, 2005).

Utah

Utah’s 1998 Portability of Funding for Health and Human Services law created an open enrollment process that allowed Medicaid participants in an ICF/MR to move to the community using HCBS waiver services. Upon transition, the cost of a person’s institutional services moved from the ICF/MR budget to the HCBS budget. Forty-eight people moved to the waiver in state fiscal years 2000 and 2001. This number was six percent of the total number of people in state institutions or private ICF/MR during 2000. The law also allowed people on the HCBS waiver to move to an ICF/MR with a similar funding transfer, although no individuals chose this option in 2000 or 2001. Portability of Funding stopped in 2002, when the contract between the state’s Medicaid agency and the separate state department that operates with waiver expired.

Vermont

Vermont legislators sought to shift the balance from an emphasis on nursing facility utilization to a greater development and utilization of home and community based services in a 1996 law called Act 160. Act 160 linked increased funding for HCBS to a reduced growth in nursing facility expenditures. In 1996, the state projected future nursing facility expenditures, assuming spending continued to increase eight percent per year as it did between 1983 and 1996. In each year Vermont spent less than the projected amount, the state could use the cost savings to finance more community options. Between 1997 and 2000, the nursing facility share of Vermont's Medicaid long-term care expenditures for older people and people with physical disabilities decreased from 90 percent in 1997 to 75 percent in 2000.

The state's Department of Aging and Disabilities (DA&D) made several policy changes to meet the goals of Act 160. For example, it changed Medicaid nursing facility reimbursement policy to encourage facilities to focus on individuals who need rehabilitation or who have the most significant care needs. Previously, Vermont paid nursing facilities based in part on the case-mix of all their residents. The state changed this factor to consider only the case-mix of Medicaid participants.

Using Act 160 savings, the state expanded participants' opportunities to use Medicaid HCBS waivers. DA&D added community residential care and self-directed service options, and increased HCBS waiver funding to serve more people. In addition, the state changed the waiting list policy for its waivers for older people and people with physical disabilities. Instead of serving applicants on a "first come, first serve" basis, Vermont gave higher priority to nursing home residents, hospital patients awaiting nursing home placement, people at risk of significant harm unless waiver services are provided, and people who had applied for nursing home admission.

One requirement of Act 160 is the creation of a statewide system of local Long Term Care Community Coalitions to work on ways to improve the infrastructure for HCBS and the overall coordination of the local long-term care system. Coalition members include participants, advocates, and many providers of long-term support, including Area Agencies on Aging, home health agencies, adult day centers, nursing facilities, hospitals and community residential care homes.

Other States with Legislative Interventions

In addition to the states listed here, state legislatures in Missouri, Maryland, Nevada, and North Dakota have passed "money follows the person" legislation in some ways similar to the laws in Texas and Utah.

Market-Based Approaches

Market-based approaches increase HCBS usage by 1) providing participants free election of this option over institutionalization through equal access, service availability and quality or 2) using

managed care models to create incentives to serve people in less expensive community settings. Participants are offered a comprehensive selection of services and supports, with available traditional and independent providers and a variety of living environment options. Through fair market-based approaches, participants affect rebalancing as they choose HCBS over institutionalization.

Arizona

The Arizona Long Term Care System (ALTCS) uses a managed care model to provide long-term support for older people and people with physical and developmental disabilities at risk of institutionalization. In Arizona's largest county, Maricopa County, three managed long-term care plans compete with one another in serving elderly and physically disabled persons who require long-term care services. The plans are contractually responsible for providing the complete array of all Medicaid-covered services for their members, including acute care services, long-term supports, behavioral health, and the provision of prescription drugs. New applicants to the ALTCS program are provided information about each of the three managed care plans in Maricopa County and are asked to choose one of the three plans. Thus, the money follows the person when the enrollee selects his or her plan.

The state's capitation methodology serves as a policy tool for rebalancing the system. ALTCS pays a blended capitation rate to the health plans, meaning the plan is paid the same amount whether a person lives in a nursing home or in a home or community residential setting. In setting the capitation rate, the state assumes that a certain percentage of each plan's enrollees will be served in the community. In a sense, that assumption is a target. If the plan serves more people in HCBS settings, it will make more money; if it serves fewer people in HCBS settings it will make less money, or lose money. Each year, the state adjusts the target rate of people to be served in HCBS settings.

New Jersey

New Jersey's Department of Health and Senior Services, Division of Aging and Community Services implemented several initiatives in the late 1990s to give older people comprehensive information about available health and social services and to increase the supply of long-term support options for people who choose to stay in a home or in a community residential setting. Information and assistance gave participants the knowledge to make informed choices about their supports. The increased options reduced waiting lists for home and community-based services, so funding for services could more readily follow people to their chosen location. Between 1997 and 2002, the number of Medicaid-funded nursing facility residents in the state decreased by more than 3,000 (10 percent).

To make information more accessible, New Jersey created a statewide toll-free phone number that provides one contact for a variety of health, social, financial, and other resources for older people. Area Agencies on Aging in each of New Jersey's 21 counties staff the toll-free number and assist people in identifying and obtaining available services. In addition, the state's nursing facility transition program provides information and assistance to nursing facility residents who are Medicaid eligible, or who would be Medicaid eligible after six months in a facility. The

program's counselors assess residents, provide information about community options, and work with residents, family members, and nursing facility discharge planners to facilitate transitions. Counselors first contact and assess new nursing facility residents soon after their admission, ensuring people admitted for short-term stays can quickly work toward a return to the community. Counselors also work with many long-term residents.

To increase community support options, New Jersey started a new Medicaid HCBS waiver that, for the first time in New Jersey, covers self-directed services, assisted living, and adult family care in addition to traditional in-home services. The wide range of services allows older people and people with physical disabilities to move from one type of service to another seamlessly. For people not eligible for Medicaid, the state started a state-funded in-home services program in which participants pay a sliding scale fee for self-directed and traditional in-home services.

Michigan

Michigan combined the principles of person-centered planning and a managed care framework in its community service system for persons with developmental disabilities and serious mental illness. In 1996, Michigan's legislature changed the Mental Health Code to establish the right to a person-centered planning process for all individuals receiving publicly funded services regardless of their age, disability, or residential setting. This right applies to services for people with mental illness and developmental disabilities.

Centralized access centers provide information and referral, assessment, crisis intervention, and service planning. These centers are also required to conduct a range of outreach activities to the general public through such vehicles as media campaigns, public advertising, the Internet, and service fairs. Each center employs a customer service representative who provides new enrollees with an orientation about how to access supports. The representative also answers questions relating to benefits, addresses participant complaints, and tracks recurring organizational problem areas.

The state provides capitated payments for mental health services and long-term supports for people with developmental disabilities to county-based, public Community Mental Health Services Programs (CMHSP) who serve as the Prepaid Health Plan for a geographic service area. The Prepaid Health Plans are contractually required to offer a full range of services. The capitated payment system allows CMHSP to offer a wider range of services while determining at a local level how to control costs. This system is decentralized to ensure that services are locally managed.

Other Effective Market-Based Approaches: Self-Directed Services and the Use of Individual Budgets

While self-direction alone does not directly promote the principles of money follows the person and rebalancing long-term care budgets, it does significantly improve the quality of home and community-based services and deserves comment.

Since 1996, states have gained experience with self-direction and using individual budgets through the National Cash and Counseling Demonstration and Evaluation Project (Arkansas, New Jersey and Florida), the Developmental Disability Self-Determination Projects (29 states), and other national and state initiatives. Based on the experiences and successes of these programs, CMS developed the *Independence Plus* Initiative in May 2002 to assist states that want to offer self-direction. To date, New Hampshire, South Carolina, Florida and Louisiana have used this initiative to operationalize self-direction with Medicaid HCBS and demonstration waivers.

Evaluations of programs using self-direction and individual budgets reveal that offering participants a high degree of choice, control, and responsibility improves service quality, enhances participant satisfaction, expands the workforce providing HCBS, and provides flexible supports and services which better meet participants' needs. Each of the self-directed states has made unique contributions to this innovative approach and offers valuable insight into creating viable home and community programs. These states, with a brief notation about each, are listed in Appendix 3.

Linkages that Encourage Rebalancing

Linking strategies create a coordinated and seamless system for home and community services and supports. Financial linkages build connections between funding streams, either by combining them or by linking an increase in the HCBS budget to a decrease in institutional expenditures. Programmatic linkages increase coordination of services throughout the system, such as the establishment of local single access points for all long-term supports, or the introduction of person-centered planning processes throughout the system so people in any setting have the same tools to select services that meet their unique needs.

Maine

In response to a state fiscal crisis in 1993, Maine reformed its long-term care system to reduce Medicaid nursing facility utilization and to respond to participants who preferred services in the community. The savings realized from the decrease in Medicaid institutional spending allowed expansion of several HCBS options funded by the Medicaid state plan, Medicaid HCBS waivers, and state general revenue. To ensure people know about their options before entering a nursing home, Maine requires pre-admission screening and periodic reassessment for all nursing home residents, regardless of the payment source. Maine also implemented a case-mix payment system for Medicaid nursing facilities and tighter Certificate of Need controls on nursing home growth. The state rapidly expanded HCBS options and encouraged development of more community residential care.

Between 1995 and 2002, the number of Medicaid nursing home residents in Maine decreased 18 percent while the number of people receiving Medicaid and state-funded home and community-based services increased 78 percent. The proportion of state and Medicaid long-term support spent on HCBS increased from 16 to 39 percent. Total long-term care expenditures increased by only 17 percent over the seven-year period.

Indiana

In 2002, Indiana began an initiative to reduce excess utilization in its nursing facility industry by providing HCBS to people at imminent risk of nursing facility admission and to people in nursing facilities that are closing. Indiana funds this initiative using the dollars that would have been spent serving these individuals in nursing facilities. Indiana plans to serve an additional 1,000 people with Medicaid HCBS waivers through this initiative.

To divert people from nursing facility admission, Area Agency on Aging case managers work with hospital discharge planners to identify hospital patients who may be admitted to a nursing facility from the hospital. The case managers offer these people home and community based services options. Some people use community supports immediately after their hospital discharge, while others use the services after a short nursing facility stay. In 2002, this effort provided HCBS for 316 people.

To assist people in nursing facilities that are closing, Indiana developed a formal process to ensure people have an option to select HCBS. Indiana established Senior Care Teams to assist residents after their facility gives the federally required 30-day notice that it is closing. Senior Care Teams inform all residents of their rights and service options, and assist people in obtaining housing and supports in the community or in another institution. The teams include the local nursing home ombudsman, case managers from the local Area Agency on Aging, and staff from the Department of Health, the state Medicaid agency, and the agency that administers Medicaid and state-funded home and community-based services.

Systemic Approaches to Rebalancing

The above examples offer a variety of techniques states have used to balance their long-term care systems and allow money to follow the person. While these are extremely valuable, some states have made significant progress toward equalizing state institutional and home and community-based services using a systematic approach including all three strategies. Following are four such states.

Oregon

Over half (57 percent) of Oregon's Medicaid long-term care spending for seniors and adults with physical disabilities is devoted to home and community-based care. Oregon's success in achieving this more equitable balance between community-based and institutional supports is attributed to several related initiatives developed over the past two decades under an expressed set of goals and values. These initiatives include:

Legislative Action:

- *A Single Budget* - Oregon consolidates Medicaid long-term care funding for seniors and persons with physical disabilities into a single budgetary line item. In establishing the total size of the long-term care budget, the legislature projects the

proportion of persons anticipated to receive supports in various settings and enacts payment rates for all types of publicly funded supports. Once the long-term care budget is appropriated, the executive branch manages it as one allocation that can be spent at the individual level for either community-based supports or for nursing home care. The single budget approach allows decisions to be made based on the needs and preferences of individuals as they move through the long term care systems.

Market-Based Approaches:

- *Equal Access Through the Level of Care Determination Process* – Oregon bases its eligibility for long-term care services on the level of care determination for each participant, irrespective of the setting in which they seek services. Each individual receives an identical comprehensive assessment conducted by a case manager employed by the single entry point. The assessment information is then electronically entered into a database that calculates whether a person meets the state’s nursing facility level of care criteria. Through the single long-term care budget, sufficient funds are available to provide HCBS and nursing facility services to all people who meet these criteria.
- *Pre-Admission Screening* – Like most states, Oregon requires applies a pre-admission screening to Medicaid applicants seeking home and community-based, residential and institutional services. The state also requiring a pre-admission screening to private pay individuals who enter a Medicaid certified nursing home. While the screening is less comprehensive than the screening applied to Medicaid applicants, the outcome ensures that all those receiving long-term care services are aware of the full range of available options.
- *Funding Broad Selections of Community Services and Supports* – Offering individuals a range of support options under various service delivery options enables persons to make meaningful choices about their living arrangements, types of supports, and the manner in which services are provided. Oregon offers a wide array of services under a person-centered service system adhering to the principles of independence, choice, and control through self-direction. Participants selecting community options are offered the opportunity to employ and manage independent providers whom they select, and in the Independent Choices program participants may control their entire service plan under a program similar to the Cash and Counseling Demonstration.

Linkages:

- *Merging Administrative and Regulatory Responsibilities at the State and Local Level* - A single state agency is responsible for managing all Medicaid community and institutional long-term care programs. This integration of long-term care programs is achieved not only at the state level but also at the local level. Oregon’s single entry points throughout the state allow for an effective exchange of information about the full range of available options and combine responsibilities for assessing, determining

eligibility, and case coordination. This approach permits Oregon to coordinate policies and procedures that promote common goals across all programs on many levels and have resulted in achieving greater success in negotiating a balance among competing programs.

- *Contract Registered Nurse Services and Coordination with the Nurse Practice Act* – To address program participants’ health care needs and to provide a formal structure for incorporating nurse delegation within the HCBS waiver program, the state developed a deliberate strategy to maximize nurse delegation. The Nurse Practice Act permits nurses to delegate broad and largely unspecified functions to unlicensed persons, including participant-employed providers. The Act protects a nurse from liability due to the actions of the unlicensed provider unless the provider is acting on specific instructions from the nurse or the nurse failed to leave written instructions.

The need for nurse delegation under the waiver is identified during the assessment. If nurse delegation is necessary, the assessment triggers a referral to Oregon’s Contract Registered Nurse Services. These nurses, under contract with the state, assess an individual’s need for health services, deliver one-on-one training to an unlicensed provider on specific nursing tasks to be performed for a specific individual, leave the provider written instructions, and periodically monitor the individual’s health status. The training and oversight enhances the capabilities of independent providers performing medically related tasks, thus strengthening Oregon’s ability to provide comprehensive and appropriate services in the community.

- *Monitoring Expenditures* - To effectively manage the financial aspects of their flexible long-term care system, Oregon monitors expenditures using an automated system linked to the eligibility and assessment process. The state compiles data weekly on the number of people currently receiving services, the cost of their authorized service plans, and their assessed priority level. This information allows the division to accurately project the amount of funds required to cover all people in each level of need, regardless of their service setting. This close scrutiny of expenditures ensures the state’s adherence to their long-term care budget. In instances of budget shortfalls, which the state is now experiencing, program changes can be based on the level of need rather than service reductions to specific programs.

Washington

Washington, like its neighbor Oregon, has accomplished many innovations that promote rebalancing the long-term care system, including a single long-term care budget and a single state operational structure for both nursing facility and home and community-based services. The state’s Aging and Disability Services Administration (ADSA) continues to make significant progress to promote HCBS for older people and people with physical disabilities using a variety of initiatives. Between state fiscal years 1997 to 2002, the average number of Medicaid-eligible nursing home residents per month decreased by over 1,800 (12 percent), while the average HCBS caseload increased by 9,000 (39 percent). In state fiscal year 2002, Washington served

almost two and a half times as many participants in the community as they served in nursing facilities. Washington's efforts to offer a balanced long-term care system include the following:

Legislative Action:

- *A Single Budget* - Washington consolidated the administration of all long-term supports for older people and people with physical disabilities in 1986, creating a single agency. This agency has a single budget line item for both community and institutional long-term care.

Market Based Approaches:

- *High Risk Response Time Schedule* - Washington has developed a rigorous response system to ensure people at high risk of institutionalization receive information about their long-term options quickly. If individuals are being discharged from a hospital or rehabilitation center or if an applicant resides in the community and is in immediate risk for admission to a nursing facility, local staff must perform a face to face interview within one working day of the referral. Other applicants are interviewed within five working days.
- *Fast Track* - Washington's Fast Track process authorizes vital home and community services prior to the completion of a formal financial eligibility determination. If staff determines that a person will in all probability be financially eligible for waiver services, services may be immediately authorized for a maximum of 90 days if the person applies for waiver services within the first ten days of the 90-day period.
- *Nursing Facility Case Managers* – Case managers located in nursing facilities must contact residents within seven days of their admission, conduct a functional assessment, and discuss the potential for transitioning with the resident. If a resident or their family declares an interest to transition, the case manager presents information on community options, performs an assessment to determine eligibility for community long-term care services, assists the person in developing and implementing a transition plan and a community plan of care, and monitors the person's services once the transition is complete.
- *Transition Costs* - Washington offers a variety of funding sources to support Medicaid residents with transition expenses or to enable residents to maintain their homes while temporarily in an institution. Permanent funding sources include: 1) the Medical Institution Income Exemption (MIIE), which allows residents to exempt income up to 100 percent of the federal poverty level from Medicaid eligibility calculations to maintain a residence while in an institution, and 2) the Residential Care Discharge Allowance (RCDA) which allows residents to receive up to \$816 to assist with the relocation. Funds may be used to manage personal assistants, purchase affordable and accessible housing, and improve transportation and assistive technology.

Linkages:

- *Merging Administrative and Regulatory Responsibilities at the State and Local Level* – A single state agency is responsible for managing all Medicaid community and institutional long-term care programs. This agency’s district offices determine Medicaid eligibility for all institutional and community services. These offices provide case management for people receiving nursing facility or community residential services. Area Agencies on Aging provide case management for people receiving Medicaid-financed in-home services, often coordinating these services with other programs the Area Agencies on Aging administer.
- *Medicaid Integration Project* – The Medicaid Integration Project integrates Medicaid health care, mental health care, substance abuse treatment, and other long-term care services to improve access and outcomes for high-risk individuals. The long range goal is to offer Medicaid participants an integrated package of services that slows the progression of illness and functional disability, improves participant satisfaction, reduces unnecessary emergency room and hospital visits, and lowers the overall cost of care. This project serves individuals with complex medical conditions, cognitive impairment, mental illness, addiction disorders, and physical and developmental disabilities who are experiencing higher utilization of medical, prescription drug, emergency room, hospital, mental health and chemical dependency treatment, nursing home and other long-term care services.

Wisconsin

Building upon its extensive experience and capacity as a national leader in establishing creative long-term support systems, Wisconsin launched a new initiative called Family Care that redesigns its long-term supports system by reducing its complexity and increasing participant choice. Family Care covers a broad range of services and integrates multiple funding streams with the expressed goal of implementing the principles of “money following the person” and reducing institutional bias. Family Care serves older people, people with physical disabilities, and people with developmental disabilities with the following features:

Legislative Action:

- *Entitlement for Home and Community-Based Services* – When establishing Family Care, Wisconsin’s legislature made HCBS an entitlement, rather than a service with limited slots, in counties with the Family Care services benefit. This feature directly aligns with the principle of money following the person. The entitlement eliminates waiting lists for community supports and offers participants timely access to community services.

Market-Based Approaches:

- *Aging and Disability Resource Centers* – These centers, through contracts with the state, provide a clearly identifiable single point for information, advice, and access to a wide range of community resources for older people and persons with disabilities. The centers also provide crisis and emergency intervention, community education on health prevention, and community outreach to promote themselves as service entry points. Resource Center staff determine functional and financial eligibility and complete pre-admission consultation for community and institutional settings in the five counties with the Family Care services benefit. Resource Centers provide information and assistance and determine eligibility for Medicaid HCBS waiver services in four additional counties.

Linkages:

- *Care Management Organizations* – In the five counties that fund direct services through Family Care, Care Management Organizations (CMO) provide this benefit through a managed care model. These organizations work with participants to develop service plans and purchase long-term care services on the participants’ behalf. The state pays CMO a single capitated payment that combines funding streams for nursing facilities, a Medicaid HCBS waiver, state-funded HCBS, and Medicaid state plan funding related to long-term care. CMO are financially at risk to meet the long-term care needs of their members. The state expects that cost incentives will enable participants to live in their own homes rather than in institutions.
- *Stakeholder Involvement* - Program participants compose over one-half of the membership of state and local governing councils and boards, advising policy development and guiding Family Care implementation. This strong commitment to stakeholder involvement assures that governing bodies receive substantive and continual input into the development of Family Care and the home and community-based services that people most prefer.

Conclusion

Many states have successfully developed and implemented strategies that improve the balance between spending for institutional and community-based services. We have highlighted only a few examples. Other states have made similar progress and deserve recognition. Developing a balanced long-term care system in which “money follows the person” requires, at a minimum, changes in the state’s policies and procedures. State successes have included many common elements:

- Access to the System: States with balanced systems offer equal access to institutional and community services. Methods to offer equal access include: 1) providing information and outreach to inform people about options; 2) creating an efficient eligibility determination system under a single, easily accessible and visible entry point; 3) establishing consistent assessment processes for institutional and community services

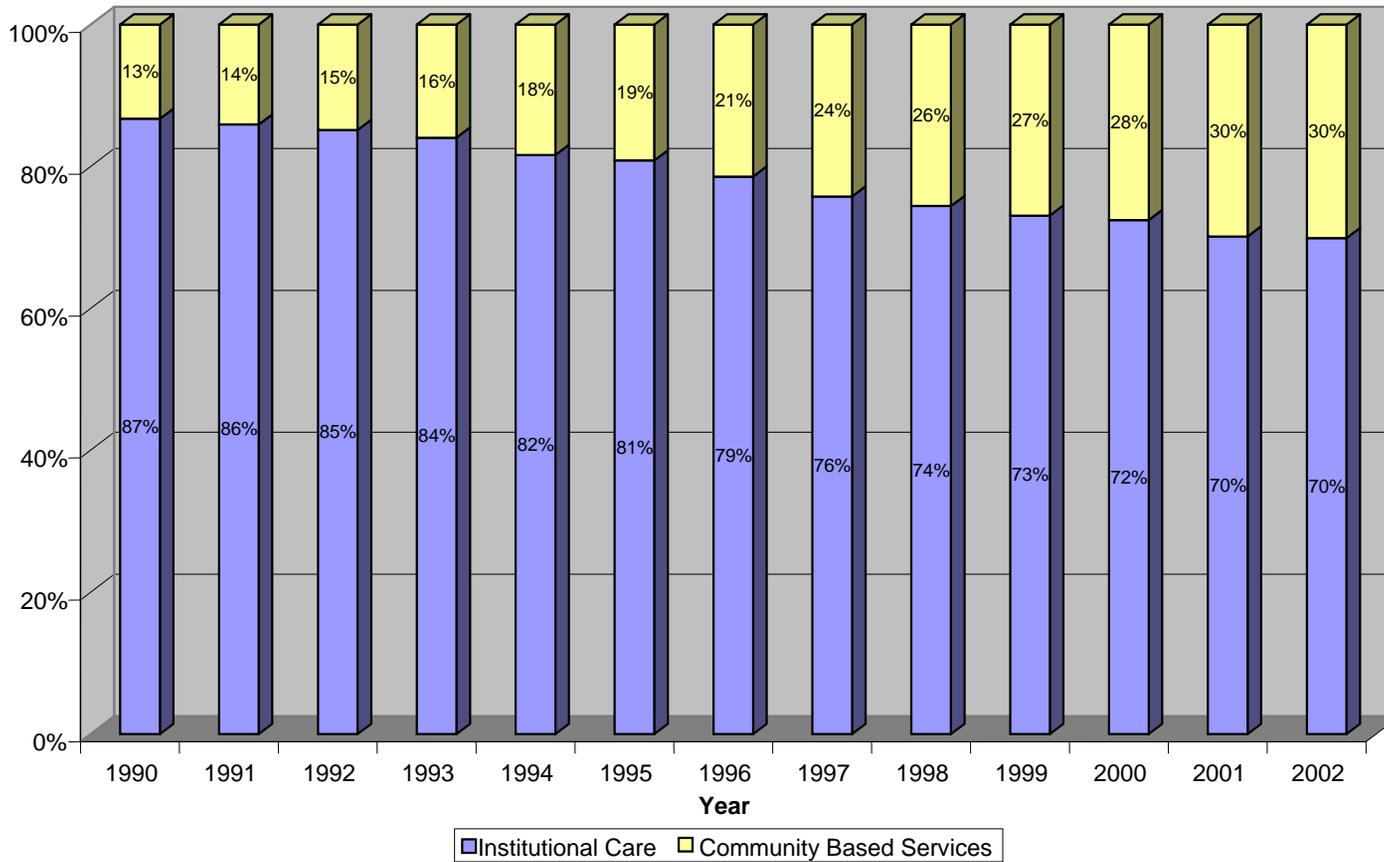
by the same staff; and 4) developing a mechanism to quickly serve individuals at imminent risk of institutionalization.

- Financing of Programs and Services: Many states changed their long-term care budgetary practices to enable funds to follow people as they choose community supports. Some states allow funds allocated to one program to transfer to another as the individual moves within the system. Others have created a single long-term care budget instead of separating budgets between facility and community services. Generally, state legislatures have established these budgetary changes. A legislative mandate can set the expectation that state decision-makers are responsible for improving the balance between institutional and community services, allow for consistent policies across state agencies, and ensure the vision of a balanced system will remain intact through administrative changes.
- Service Sufficiency and Provider Capacity: Offering a variety of service options provides flexibility to meet the variety of individual needs. In addition to funding more services, supports and items, many states have actively worked to build provider capacity to provide new or underutilized services. Several states expanded their service options beyond traditional medically oriented, agency-based services to include self-directed service models and social models for services.
- Quality Assurance and Improvement: In addition to offering individuals an authentic choice among services, the long-term support system must provide quality services that meet the needs of individuals with chronic conditions. CMS is striving to develop the resources that will enable states to design or enhance their quality systems. These resources include assistance in implementing person-centered planning, obtaining participant feedback, and ensuring stakeholder involvement.

Each of the state examples highlighted in this report have one common theme: a strong commitment to rebalance their long-term care systems at several levels of program and system design. Through such fundamental change, states have shown not only decreased reliance on institutional services, but in some cases also short and long-term financial savings.

Appendix 1

**Percentage Distribution of Medicaid Long Term Care Expenditures
by Community Based Services and Institutional Care, Fiscal Years 1990-2001**



Source: CMS Form 64 data as reported by Brian Burwell, Steve Eiken and Kate Sredl in *Medicaid HCBS Waiver Expenditures, FY 2002*. (Medstat, May 13, 2003)

Appendix 2

Contact Information

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Resources for Specific State Programs

Legislative Action

- **Texas**
http://www.hhsc.state.tx.us/pubs/tpip02/02_12TPIPrev.html#dhs
<http://www.cms.gov/promisingpractices/tx-rider37.pdf>
- **Utah**
<http://www.dhs.utah.gov/pdf/The%20Olmstead%20Plan.pdf>, page 22
- **Vermont**
<http://www.dad.state.vt.us/Reports/Act%20160%20info.htm>
<http://www.cms.gov/promisingpractices/vt-divdol.pdf>

Market-Based Approaches

- **Arizona**
<http://www.ahcccs.state.az.us/Services/altcs/altcspgm.htm>
<http://www.ahcccs.state.az.us/Publications/reports.asp>
- **New Jersey**
<http://www.state.nj.us/health/senior/index.shtml>
<http://www.cms.gov/promisingpractices/njiapnf.pdf>
<http://www.milbank.org/reports/030314newjersey/030314newjersey.html>

Self-Direction and Individualized Budgets

- **Alaska**
Consumer-directed personal care agencies increase self-direction
<http://cms.hhs.gov/promisingpractices/alchange.pdf>
- **Arkansas**
Cash and Counseling Demonstration
<http://cms.hhs.gov/promisingpractices/arca.pdf>
<http://cms.hhs.gov/medicaid/1115/arwaiversum.pdf>
http://www.hcbs.org/cashandcounseling/MPR_Results.ppt
- **Arkansas, Florida, and New Jersey**
Evaluation of Cash and Counseling Demonstration projects
<http://www.hhp.umd.edu/AGING/CCDemo/info.html>
<http://www.mathematica-mpr.com/3rdLevel/cashcounseling.htm>

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- **Colorado**
The Consumer-Directed Attendant Support Program combines Medicaid home health aide and personal care funding into one stream, paid in monthly disbursements to individuals hired by participants
<http://chcpf.state.co.us/cdas/cdasindex.html>
<http://www.cms.gov/promisingpractices/coipc.pdf>
- **Florida**
Cash and Counseling Demonstration program, which is now an *Independence Plus* 1115 waiver
<http://cms.hhs.gov/promisingpractices/flca.pdf>
<http://cms.hhs.gov/medicaid/1115/flcdcipamdappran.pdf>
- **Georgia**
Voucher program increases family-direction of services
<http://cms.hhs.gov/promisingpractices/gaisf.pdf>
- **Louisiana**
Independence Plus 1915(c) waiver
<http://cms.hhs.gov/newfreedom/528lanow.pdf>
- **New Jersey**
Cash and Counseling Demonstration
<http://cms.hhs.gov/promisingpractices/njca.pdf>
<http://cms.hhs.gov/medicaid/1115/njccfact.pdf>
- **New Hampshire**
Independence Plus 1915(c) waiver
<http://cms.hhs.gov/medicaid/1915c/nh0397apl.pdf>
- **Massachusetts**
Culturally competent self-determination promoted with the establishment of community governing boards.
<http://cms.hhs.gov/promisingpractices/mafcc.pdf>
- **South Carolina**
Independence Plus 1915(c) waiver
<http://www.hhs.gov/news/press/2003pres/20030311.html>
- **Oregon**
Pilot project enables Medicaid-eligible individuals to manage a cash budget for personal care and related services.
<http://cms.hhs.gov/promisingpractices/ormpc.pdf>

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- **Wyoming**
Individual budget strategy that determines individualized, equitable expenditure limits for HCBS with systems that allow local planning teams to negotiate provider payment rates.
<http://cms.hhs.gov/promisingpractices/wyib.pdf>

Linkages that Encourage Rebalancing

- **Maine**
http://www.state.me.us/dhs/beas/ltc/2002/ltc_2002.htm
- **Indiana**
<http://www.in.gov/fssa/seniorsec.html>

System-Wide Approaches

- **Michigan**
<http://www.michigan.gov/mdch/0,1607,7-132-2941---,00.html>
<http://cms.hhs.gov/promisingpractices/mipcp.pdf>
- **Oregon**
<http://www.sdsd.hr.state.or.us/pubs/03-09-1998.pdf>
<http://www.cms.gov/promisingpractices/orhcbss.pdf>
- **Washington**
<http://www.aasa.dshs.wa.gov/programs/default.htm>
<http://cms.hhs.gov/promisingpractices/wa-offvar.pdf>
- **Wisconsin**
<http://www.dhfs.state.wi.us/LTCare/INDEX.HTM>
<http://www.cms.hhs.gov/promisingpractices/wifamcare.pdf>

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