

Rebalancing Strategy 2: Invest in Programs and Services that Help Nursing Facility Residents Return to their Communities

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► Impetus for Strategy

Strong commitment among advocates, the *Olmstead* decision and settlements, as well as states' own recognition of the high rates of institutionalization among LTSS beneficiaries, have spurred states to invest in strategies to support the transition of nursing facility residents to the community. States recognize that to successfully transition a person in need of LTSS from an institutional to a community setting—when appropriate for that individual—requires the availability of and access to sufficient community-based services and an affordable and accessible place to live, a particularly difficult barrier that many states have worked to address. Specific services and supports for individuals returning to the community include: (1) assistance locating available housing, paying security deposits, and making home modifications; (2) an adequate supply of direct service workers; and (3) accessible transportation, in addition to other community programs and services. However, comprehensive statewide resources to support institutional to community-based transitions are often lacking. Transition programs need to be developed, and funding for these resources needs to be identified. Doing so requires considerable advanced planning at the state level.

► Strategy Description

Many states have invested in programs that help support transitioning from nursing facilities back to the community. These programs provide individualized care planning and an array of services that allow people to live safely in their community of choice. Prior to transitioning to the community, specially trained counselors meet with individuals living in nursing facilities and their family members, as applicable, to determine their desire to transition to community living and assess their needs to successfully reintegrate to the community. Based on a person-centered plan of care, these counselors make referrals to community-based agencies to assist with their transition and community integration components. In addition to transition supports, states often provide tenancy-sustaining

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million people to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than \$140 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This rebalancing strategy is part of a larger toolkit, ***Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment***, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.



To learn more and view the full toolkit, visit www.chcs.org/ltss-toolkit.

services, such as employment supports and housing-related assistance, to continue providing beneficiaries with support to remain in the community after they have transitioned out of nursing facilities. Given the diverse needs of people living in nursing facilities, some states like Texas have developed targeted programs for specific populations, such as people with serious mental illness and substance use disorders to make their community re-integration successful.

► **Implementation Mechanisms**

Most states pursuing this strategy have used federal funding from the MFP program to support efforts to transition individuals from institutions into community-based programs while building more effective community-based care.¹ Though no new MFP funding is available, states have until 2020 to use remaining MFP funds and seek alternative financing sources. This also provides time during which non-MFP states can learn from the investments that MFP encouraged.

States also may use 1915(c) waivers, as New York did for its Nursing Home Transition and Diversion waiver. To support housing efforts, Arizona, Texas and Maryland are among states that have received federal U.S. Department of Housing and Urban Development funding through the Section 811 program. Texas also uses tax credits to incentivize private developers to set aside housing units for people transitioning from institutions to the community.

Increasingly, though not focused exclusively on the LTSS population, managed care plans are devoting resources to helping their enrollees secure housing. Arizona recently issued a new contract with its health plans to require them to assess all their enrollees' housing needs, particularly individuals with an affordable housing need. It also requires the health plans to network with local housing authorities. Given that states have limited time to use MFP funding, building transition support requirements into Medicaid managed care contracts may become an increasingly used to support nursing facility transitions.

► **Results to Date**

The most recent MFP evaluation found that, as of December 31, 2015, cumulative MFP transitions totaled 63,337, and from 2007 through the end of 2013, transitions achieved an estimated \$204 to \$978 million in total Medicaid savings across 18 states.² States are continuing this effort, but nationally the number of transitions under MFP has been relatively modest. This is attributable to the requirement that states first move people out of nursing facilities before receiving the enhanced federal funding, limiting upfront community infrastructure. In addition, it is challenging to find affordable, accessible housing for people who long resided in institutional settings. Furthermore, these numbers do not reflect transitions of individuals residing in nursing facilities for less than 90 days, nor the number of individuals who were diverted from institutional admission as a result of the increased community resources and infrastructure developed under MFP.

It is significant to note that MFP participants consistently reported improvements in their quality of life, particularly related to living arrangements.³ Since many states' nursing facility transition programs are relatively small and their programs vary, it is not clear that one state's outcomes would be transferrable to another; however, it is worth highlighting the positive impacts

that programs have on individuals and the savings potential for states. In Texas, where approximately 500 people have transitioned to the community under the state’s MFP-funded behavioral health pilot, 68 percent of all pilot participants and 72 percent of those who had completed the full year of specialized pilot services remained in the community. The state’s Medicaid program has saved \$24.5 million from the pilot.⁴ In New York, nearly 2,500 people are participating in the state’s Nursing Home Transition and Diversion waiver program, with about 500 people receiving a state-funded housing subsidy.

► Key Lessons

- **Coordinate with state and local housing authorities and private developers to secure affordable housing.** States emphasized the need to work collaboratively across agencies—particularly with state and local housing authorities—as well as with the private sector to secure housing for people exiting institutions. Since locating affordable and accessible housing for people in need of LTSS can be challenging, Arizona developed a close working relationship with its Department of Housing. The partnership resulted in a variety of affordable housing initiatives including the identification of housing opportunities for specialty populations (e.g., people with physical disabilities). Once housing opportunities are identified, the department coordinates with the Medicaid agency and its health plan contractors to facilitate movement for those in need. Critically, states should be thoughtful about where housing is located. For instance, Texas identified that many developers were seeking tax credits for housing in suburban areas, which is not ideal for people exiting institutions who often rely on public transportation, so the state created incentives for developers to focus on urban areas.
- **Separate waiver authorities that guide nursing facility transitions from those that offer housing support to maintain cost neutrality.** Acknowledging how costly housing support services can be, especially in New York, state officials decided to develop a state-funded housing support program outside of the state’s 1915(c) nursing facility transition waiver. This approach helped the state, which judged the investment in housing to be cost-effective, to prevent the cost of housing supports from diluting the actual costs of providing LTSS and to stay within the waiver’s cost neutrality requirements.
- **Analyze data to identify opportunities to target programs to specific populations.** States can collaborate with partner agencies to identify data on people in nursing facilities to help target nursing facility transition efforts. For instance, Texas, in developing a transition program for people with behavioral health conditions, identified residents who had used the mental health system and had prior discharges from psychiatric institutions into nursing facilities. Analyses like these can inform the state’s understanding about their nursing facility population’s needs and opportunities for policy development or programs targeted to promoting community living.
- **Work collaboratively with diverse stakeholders, including beneficiaries and non-traditional partners.** States should engage a diverse set of stakeholders, including Medicaid beneficiaries in nursing facilities or at-risk of institutionalization in developing nursing facility transition efforts. Texas established the “Promoting Independence Advisory Board” following the 1999 *Olmstead* decision and found its contributions to be very useful. The board continues to advise the

state today. Texas also works with university partners to conduct transition related training and provide technical assistance to health plans and providers. Working with non-traditional partners can provide flexibility to states since non-traditional partners often can respond faster than states with their lengthy and involved processes, such as with rulemaking.

- **Provide transition services, which are just as important as tenancy-sustaining services.** States can design and provide transition services, such as assisting with housing searches and paying for rental security deposits, to help individuals prepare for their transition to the community. For Texas this was essential to the success of its behavioral health focused efforts, and it reflects a general need to be more proactive and thoughtful about service planning and provision to ensure its ultimate success.
- **Adjust and adapt as the program or reform continues.** Engaging in continual programmatic reflection allows the state to identify emerging challenges and address them. Tennessee cautioned that failing to evaluate the program as it is implemented prevents the state from soliciting and incorporating valuable feedback from stakeholders. A constant quality improvement process results in better health outcomes, a better program, and lessons for other states to draw from.
- **Memorialize major programmatic requirements but maintain flexibility for evolving practices.** Texas recommended that states should document major program requirements and objectives in clear, measureable terms, but cautioned states not to embed highly detailed information (e.g., evidence-based rehabilitative techniques) into contracts or administrative rules since these practices evolve and improve over time. Texas further suggests that states recognize centers of excellence in practice, and embed requirements and/or incentives in managed care contracts to work with these centers of excellence to continuously improve practices (e.g., training, fidelity reviews).

► Case Studies

New York's 1915(c) Waiver Seeks to Divert and Transition Medicaid Enrollees from Nursing Facilities.

New York received approval for its 1915(c) Nursing Home Transition and Diversion Medicaid Waiver on July 30, 2007, and began enrolling people in 2008. The impetus for the waiver came from the state legislature in response to advocacy from the disability community. After the legislation passed, the state developed its waiver with stakeholder input and implemented a 5,000 person cap on the program to control costs. The waiver provides an array of services for younger individuals with physical disabilities and older adults, including respite, service coordination, assistive technology, community integration counseling, congregate and home delivered meals, environmental modifications, home and community support services, and community transitional services (e.g., paying for security deposits, moving belongings, furnishings, and setting up utilities). All waiver participants—whether they are transitioning out of nursing facilities or accessing waiver services to

remain in the community—have access to the same services, with the exception of community transitional services, which are solely for people transitioning from a nursing facility to a home or apartment in the community.

The state administers the waiver through the state’s DOH, which contracts with nine Regional Resource Development Centers. These centers employ transition specialists called Regional Resource Development Specialists who are responsible for, among other things, meeting with prospective waiver participants and their family members to determine their interest and ability to transition to community-based care. The Regional Resource Development specialist helps enroll an individual in the waiver, makes referrals to community-based services, and with the support of a service coordinator, connects a waiver participant to providers for service coordination. To address a lack of affordable housing, New York initiated the Nursing Home Transition and Diversion Housing Subsidy program funded with state-only appropriations. DOH contracted with local housing authorities to administer the day-to-day responsibilities of the subsidy program, including executing rental agreements with waiver participants who are referred to the program by their service coordinator and approved by a Regional Resource Development specialist. As of October 2017, approximately 2,450 people are enrolled in the waiver and of those, about 545 receive a housing subsidy.

Texas’ MFP Behavioral Health Pilot Enhances Benefits for People with Serious Mental Illness to Support Their Community Transitions.

In response to the 1999 *Olmstead* decision, a state executive order directed the Texas Health and Human Services Commission to develop a plan to promote community-based alternatives for people with disabilities to foster independence and provide the opportunity for people to live productive lives in their home and communities.⁵ As a result in 2001, Texas pioneered a nursing facility transition program that predates the current MFP program. Through both the state funded program and the MFP program, Texas has transitioned more than 46,000 nursing facility residents to the community. However, after rigorously analyzing state data on those who transitioned and those who remained in nursing facilities, Texas recognized that a significant number of people with serious mental illness and substance use disorders co-occurring with physical health conditions remained in nursing facilities. This was in part because its Medicaid program lacked the necessary specialized services to support this population, whose behavioral health conditions further complicated transition.

In 2008, with funding from the federal MFP demonstration, the Department of State Health Services and Department of Aging and Disability Services partnered to create a MFP Behavioral Health Pilot, integrating mental health and substance abuse services into the existing standard HCBS benefit. Adults who have lived in nursing facilities for at least three months, meet nursing facility medical criteria and have a serious mental illness or a behavioral health condition with serious functional impairment are eligible for the pilot. The pilot uses cognitive adaptation training to help people establish daily routines, build social skills, make environmental modifications, and ultimately, gain increased independence. It also includes substance use services such as individual counseling, group therapy and referral to community programs to help individuals maintain sobriety in the community. Critically, the pilot makes these services available to participants for up to six months prior to transition (i.e., while the participant is in the nursing facility) and up to one year after community transition. These

services are in addition to the ongoing HCBS that all participants receive. Over the course of the pilot, additional features have been added to address unmet needs, such as enhanced relocation services and limited case management.

As of Fall 2017, 454 individuals have transitioned into the community under the pilot. Sixty-eight percent of all pilot participants and 72 percent of those who had completed the full year of pilot services remained in the community. To date, the pilot has saved the state's Medicaid program \$24.5 million.⁶

As MFP funding ends, Texas plans to: (1) continue supporting the transition of individuals from nursing facilities to community settings; (2) create a statewide technical assistance program for evidence-based practices, such as cognitive adaptation training; and (3) establish policies and processes and engage stakeholders to foster inclusion of mental health self-direction in the state's managed care system—all intended to further increase the use of HCBS.

Arizona and Texas Leverage Federal and State Funding and Private Sector Development to Provide Housing Supports to Individuals with Disabilities Exiting Institutions. States recognize that securing affordable, accessible, and integrated housing is one of the most difficult barriers in achieving state rebalancing goals. Both Arizona and Texas are among those recently launching initiatives to assist individuals to transition from institutions to living at home or in group settings. Both states received grants from the U.S. Department of Housing and Urban Development (HUD) Section 811 Supportive Housing for Persons with Disabilities program to fund rental assistance for eligible beneficiaries to live in the community and have collaborated across agencies and the private sector to develop additional housing supports.⁷

The Arizona Division of Developmental Disabilities uses HUD Section 811 funding to help make affordable housing available to individuals with developmental disabilities. In May 2017, the state announced that \$2.7 million in project-based rental assistance was available for eligible developers and existing properties to create up to 64 housing units for individuals wanting to move from a less integrated setting into their own home, and who were in need of affordable housing.⁸ In addition, under its 1115 waiver, Arizona provides assistance for all eligible individuals leaving institutions to assist with funding and providing utility deposits, furniture, and other relevant transition items through its community transition service. Case managers authorize brokers—who are typically providers in the community already offering LTSS to the beneficiaries (e.g., attendant care services)—to assist them in procuring the services needed for the individual to transition successfully into the community. Notably, the community transition service does not provide rental assistance. Generally, utilization of this service has been relatively low since only people moving from an institutional to an individual home may use it, and not people moving from an institution to group home or group home to individual home. However, from the state's perspective, it is an important service to promote, even if it only helps a few people each year, because Arizona is constantly looking for ways to advance its rebalancing efforts. Beginning October 1, 2017, Arizona initiated a new contract with the LTSS health plans that includes new requirements to identify and understand their enrollees' housing needs, and partner with public housing authorities to respond to them.⁹

In Texas, the Section 811 program—known as Project Rental Assistance—is administered collaboratively by the Texas Department of Housing and Community Affairs in partnership with the Texas Health and Human Services Commission and Texas Department of Family and Protective Services. Since 2015, the Department of Housing and Community Affairs has incentivized participation in the Project Rental Assistance program by creating points and threshold incentives for applicants seeking federal tax credits and other multifamily program funds, if they agree to set aside units for the program’s target population (i.e., people with disabilities exiting institutions, people with serious mental illness, and youth and young adults exiting foster care).¹⁰ Section 811 funding subsidizes the rent and utilities in these units, making them affordable to extremely low-income individuals, while additional program rules waive the fees normally charged by properties and reduce security deposits. The Health and Human Services Commission and Department of Family and Protective Services conduct outreach, refer potential tenants, and provide ongoing LTSS on a voluntary basis under Medicaid.

The Texas Department of Housing and Community Affairs also operates Project Access, a program which sets aside state-administered Section 8 housing vouchers for people with disabilities leaving institutions and state psychiatric hospitals. Since demand for vouchers exceeds availability, Texas also makes rental assistance available for up to five years through its HOME Tenant Based Rental Assistance program for people on the Project Access waitlist and other housing assistance programs. By using the HOME program as a bridge, individuals are able to exit institutions while waiting to get off the Section 8 or other programs’ waiting lists. Furthermore, the state uses MFP administrative grant funding and authority to partially fund positions at the Department of Housing and Community Affairs to assist in expanding housing opportunities for individuals with disabilities. MFP demonstration funds also support housing navigators at 22 Aging and Disability Resource Centers who work to increase the inventory of affordable housing for people with disabilities by building relationships with public housing authorities, local housing programs, and private developers.¹¹

Tennessee’s Nursing Facility to Community Transition. Recognizing its long-standing reliance on institutional care for LTSS beneficiaries, Tennessee deliberately focused on increasing access to community-based services during the design and implementation of its Medicaid MLTSS system in 2010, called TennCare CHOICES.¹² The state’s HCBS program was operating at the time, but under constrained funding, making it difficult to expand access to HCBS. Additionally, the LTSS system was fragmented, with health plans responsible for physical and behavioral health services and the Area Agencies on Aging and Disability overseeing community-based LTSS. Tennessee aimed to reorganize care delivery for LTSS populations by transitioning LTSS to a capitated managed care system and aligning financial incentives to encourage HCBS utilization.¹³

Tennessee designed its new MLTSS program to ensure access to both nursing facility and community services for beneficiaries at nursing facility level of care by setting the fully integrated capitation payment for these beneficiaries at the same level whether the beneficiary received services in a nursing facility or in the community. This encouraged plans to drive utilization toward the most cost-effective, appropriate service option for their enrollees.¹⁴ Furthermore, Tennessee built in specific requirements and timelines for nursing facility diversion planning to incentivize health plans to reach out to beneficiaries in nursing facilities to assist them in choosing the most appropriate care setting for their needs, and check in with them frequently on their community transition wishes. Finally, beneficiaries could receive transition allowances when

they moved from institutional to community-based settings to use for rent, housing deposits, basic furnishings, and other necessary items for transitioning.¹⁵

Tennessee subsequently leveraged MFP funding to support its existing 1115 and 1915(c) waiver authorities for HCBS, and to provide financial incentives for health plans around length of community stay, development of institutional alternatives, and other metrics.¹⁶ While enhanced MFP funds and flexibilities connected to the program will phase out over time, Tennessee believes that its health plans will continue to support its rebalancing efforts as the system has already undergone an effective transformation in moving to community-based LTSS through the capitated rate structure.¹⁷

Tennessee reported significant achievements as a result of these changes, including the elimination of a waiting list for 1915(c) services and a substantial expansion of the number of beneficiaries receiving LTSS in the community. The number of beneficiaries in nursing facilities decreased from over 20,000 to fewer than 17,000, and the number in HCBS increased from 4,700 to nearly 13,000 between 2010 and 2015, with over 600 transitions a year since the inception of the program.¹⁸ Over 2,000 beneficiaries in institutions for at least 90 days have transitioned to HCBS under the state's MFP demonstration, nearly reaching the state's rebalancing targets.¹⁹

ENDNOTES

¹ See Money Follows the Person sidebar on page 19 for more information.

² C.V. Irvin, N. Denny-Brown, A. Bohl, A. Wysocki, K. Stewart, R. Coughlin, et al. "Money Follows the Person 2015, Annual Evaluation Report." Mathematica Policy Research, May 11, 2017. Available at: <https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf>.

³ *Ibid.*

⁴ Updated MFP BHP Medicaid Cost Analysis, Provided by TX on 10/19/17.

⁵ Tex. Exec. Order No. GWB 99-2 (September 28, 1999). Available at: <http://www.lrl.state.tx.us/scanned/govdocs/George%20W%20Bush/1999/GWB99-2.pdf>.

⁶ Updated MFP BHP Medicaid Cost Analysis, Provided by TX on 10/19/17

⁷ U.S. Department of Housing and Urban Development. "Section 811 Supportive Housing for Persons with Disabilities." Available at: https://www.hud.gov/program_offices/housing/mfh/progdesc/disab811

⁸ Arizona Department of Housing. "Section 811 Project Rental Assistance Program Notice of Funding Availability." May 31, 2007. Available at: <https://housing.az.gov/sites/default/files/documents/files/5-31-17-HUD-811-NOFA.PDF>.

⁹ Interview with Arizona, October 12, 2017.

¹⁰ The Texas Department of Housing and Community Affairs. "Section 811 Project Rental Assistance Program." Available at: <https://www.tdhca.state.tx.us/section-811-pra/>.

¹¹ Interview with Texas, October 19, 2017.

¹² Tennessee Division of TennCare. "TennCare Timeline". Available at: <https://www.tn.gov/tenncare/article/tenncare-timeline>.

¹³ Interview with Tennessee, October 30, 2017.

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ *Ibid.*

¹⁹ *Ibid.*