



The Administration on Aging's Nursing Home Diversion Program

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It is almost becoming rare to hear the phrase “long-term care” without also hearing the word “rebalancing” in the same discussion. This is because of the very active effort underway to ensure that individuals in need of long-term care (LTC) have access to a wide range of noninstitutional options. The focus of “rebalancing” has largely been on Medicaid, and for good reason. Medicaid is the single largest purchaser of LTC in the nation, having paid more than \$101 billion for LTC in 2005 alone.¹ This figure includes payment for home and community-based services (HCBS), as Medicaid provides such coverage through Medicaid “waiver” programs or through state plan services such as home health services and personal care services. However, Medicaid has historically been structured to favor nursing facility (NF) care over community-based care for those in need of LTC.² In order to rebalance Medicaid’s reliance on NF, the Medicaid statute was amended by the *Deficit Reduction Act of 2005* (DRA) to add new community-based LTC options and to offer states the financial incentive to move Medicaid-enrolled individuals back into the community.³

But Medicaid is not the only statute to have been recently amended to facilitate rebalancing. In 2006, Congress added a number of new provisions

to the Older Americans Act (OAA) to increase the Administration on Aging’s (AoA) role in expanding community-based LTC options.⁴ The OAA has for many years authorized funding for community-based services for individuals 60 and over, but the 2006 OAA amendments made the goal of transforming the LTC system a primary mission of the AOA, and in doing so mandated that the agency fund demonstration projects to fulfill this mission.

The AOA’s Nursing Home Diversion Modernization Grant Program is a product of this new mandate. In 2007, the AOA awarded 12 states \$500,000 grants “to assist individuals at risk of nursing home placement and spend down to Medicaid to receive home and community-based services.” The grant period is 18 months, and the AOA expects that the grantees will be able to show by the end of the grant period demonstrable success in diverting individuals from nursing home placement.

What follows is a brief overview of the Nursing Home Diversion program, including a history of the role of the AOA in delivering HCBS, the 2006 OAA amendments, and descriptions of specific state diversion programs. The AOA-supported Nursing Home Diversion program will be the first

1 Georgetown University Long-Term Care Financing Project, National Spending for Long-Term Care (2007), available at <http://lrc.georgetown.edu/pdfs/natspendfeb07.pdf>

2 Medicaid beneficiaries are entitled to NF services, 42 U.S.C. §§1396a(a)(10)(A), 1396d(a)(4)(A), but coverage for packages of HCBS or personal care services is strictly the states’ option to provide.

3 Pub. L. No. 109-171, §§ 6071, 6086, 6087

4 *Older Americans Act Amendments of 2006*, Pub. L. No. 109-365

of many LTC-related programs funded by the AOA, so advocates should be familiar with the overall role the agency will continue to play in reshaping the provision of LTC.

Older Americans Act funding for Home and Community-Based Services

For more than 30 years, the OAA has specifically authorized funding for services to “assist older persons in avoiding institutionalization.”⁵ The available services identified by the statute that are targeted at meeting this goal include case management, homemaker, home health and client assessment services,⁶ although other services available under the OAA also assist individuals in avoiding institutionalization, such as transportation and nutrition services.⁷ In fiscal year 2002, 44% of the more than \$1 billion spent by the federal government on OAA Title III services went toward personal care, homemaker services, chore services, home-delivered meals, adult day care, case management, and assisted transportation, with nearly two million individuals receiving at least one of the services.⁸

In 2000, the OAA was amended to increase the potential of the AOA and state units on aging to accomplish diversion through the creation of the National Family Caregivers Support program.⁹ (“As our nation strives to provide more meaningful home and community-based options, we must strengthen and maintain our support of the main resource upon which these options rely – family caregivers.”¹⁰) This program provides caregivers of aging individu-

als general information about caregiving programs and services, individual counseling, caregiver training, respite care, and, in some case, supplemental services (e.g., home or vehicle modifications or assistive technologies). In fiscal year 2002, more than four million people received general information through the program, while 182,000 received individual counseling, 76,000 received respite care, and 56,000 received supplemental services.¹¹

In 2003, the AOA further expanded its “re-balancing” efforts through a partnership with the Centers for Medicare & Medicaid Services (CMS) to fund state Aging and Disability Resource Centers (ADRCs). ADRC funding is designed to help states establish “one-stop shops” for information on LTC in order to “reduce the confusion” consumers encounter when seeking information about LTC options.¹² “By educating people about the options available and offering them a single ‘one-stop’ process to access the services they need, Resource Centers will ensure that home and community-based support options are easy to access.”¹³

Forty-three states (including D.C.) received three-year grants up to \$800,000 between 2003 and 2005 to initiate at least one ADRC.¹⁴ To receive funding, states had to assure CMS and AOA that, by the end of the grant period, the state ARDC would be: increasing public awareness of LTC support options; providing direct LTC option and benefits counseling; and making Medicaid eligibility determinations (both clinical and financial).¹⁵ States are required to serve everyone over 60 and at least one

5 See *Older Americans Act Comprehensive Services Amendments of 1973*, Pub. L. No. 93-29.

6 42 U.S.C. §3030d(a)(5)

7 “Home-delivered nutrition services enable older adults to avoid or delay costly institutionalization and allow them to stay in their homes and communities.” Coalition for Aging, 30th Anniversary – Older Americans Act Nutrition Programs, available at <http://www.coalitionforaging.org/nutr.pdf>.

8 Enid Kassner, AARP Public Policy Institute, *The Role of the Older Americans Act in Providing Long-Term Care* (2001), available at <http://www.aarp.org/research/longtermcare/trends/aresearch-import-670-FS12R.html>.

9 *Older Americans Act Amendments of 2000*, Pub. L. No. 106-501, §316

10 U.S. Department of Health & Human Services Administration on Aging, *The Older Americans Act National Family Caregiver Support Program—Compassion in Action* (Forward by Assistant Secretary Josephina G. Carbonell) (2004)

11 *Id.*, at 9.

12 Dina Elani, Greg Case, *Aging and Disability Resource Centers: One Contact for Easy to Access Long-Term Care Supports*, TASH Connections (September/October 2004).

13 *Id.*

14 See the ADRC Map on the AoA’s website at http://www.aoa.gov/prof/aging_dis/statemap.asp

15 Administration on Aging and Centers for Medicare & Medicaid Services, *Aging and Disability Resource Center Grant Initiative 8* (April 2005).

target population of younger individuals with disabilities.¹⁶

States must also “meaningfully involve stakeholders in the planning, implementation, and evaluation of their Resource Center program.”¹⁷ And because the awards are designed to achieve “enduring” change, grantees had to include information on the steps they were taking or planned to take to ensure that their ADRCs “will be sustained beyond the grant period.”¹⁸ (Contact information for state ADRCs is available on the ADRC Technical Assistance Exchange, <http://www.adrc-tae.org>).

The 2006 Amendments to the Older Americans Act

The joint CMS/AOA effort giving rise to the ADRC program is part of the federal government’s decade-long effort to “rebalance” LTC, an effort that basically began with the Nursing Facility Transition Demonstration program created in 1998 by CMS and the Office of Assistant Secretary for Planning and Evaluation (ASPE).¹⁹ Between 1998 and 2001, CMS and ASPE gave grants ranging from \$550,000 and \$800,000 to 12 states to help them transition NF residents back to the community. The grants “permitted states to use grant funds for virtually any direct service or administrative item that held promise for assisting nursing home residents’ return to the community.”²⁰

This was followed by the Real Choice Systems Change Grants that CMS began awarding in 2001.²¹ Since then, more than 300 grants have been made to states for NF transition programs and other programs such as “Integrating Long Term Support

with Affordable Housing,” “Quality Assurance and Improvement in HCBS,” and “Respite for Adults.” The ARDCs are part of the Real Choice initiative.

On top of these programs came the statutory changes to Medicaid. In the DRA, \$2 billion was authorized for the Money Follows the Person program, under which 37,000 Medicaid-enrolled nursing facility residents will be transitioned to the community in the next five years. Also, the DRA gave states the option to offer HCBS as a state plan service and to provide more self-direction in personal care services.

Against this backdrop came the reauthorization of the OAA in 2006, which in final form made the expansion of HCBS opportunities a central mission of the Aging Services Network. The amended OAA added to the list of the AoA’s duties the responsibility to help establish “comprehensive, coordinated systems at Federal, State, and local levels that enable older individuals to receive long-term care in home and community-based settings.”²² This same mandate was also given to state units on aging,²³ and area agencies on aging.²⁴

The OAA’s broad new mandate for the Aging Services Network, and the law’s specifics about how it should be achieved, were in large part adopted from HHS’ *Choices for Independence* Initiative. Before the 2006 reauthorization of the OAA, HHS proposed the *Choices* pilot to fund state efforts to strengthen the Aging Services Network’s “role in promoting consumer choice, control, and independence in long-term care.”²⁵ Three central goals were included in the plan: empower individuals to make informed choices about their LTC services;

16 Id.

17 Id., at 6-7. Listed examples of organizations “that should be involved” include Alzheimer’s Association chapters, disability/aging advocacy groups, Long-Term Care Ombudsman programs, and Independent Living Centers.

18 Id., at 21.

19 See Martin Kitchen et al., UCSF National Center for Personal Assistance Services, Federal Systems Change Grants to State and Territories: 2001-2005 (2006), available at <http://www.pascenter.org/systemschange/index.php>.

20 See, e.g., Michael Schaefer, Steve Eiken, Passages: Arkansas’ Nursing Home Transition Program 1 (2003).

21 See <http://www.cms.hhs.gov/RealChoice>

22 42 U.S.C. §3012(b)

23 42 U.S.C. §3025(a)(3)

24 42 U.S.C. §3026(a)(7)

25 See U.S. Department of Health & Human Services, *Choices for Independence—Modernizing the Older Americans Act* (2006), available at http://www.aoa.gov/about/legbudg/oa/Choices_for_Independence_White_Paper_3_9_2006.doc.

expand “prevention” programs to help frail individuals maintain themselves in the community; and expand choices and services for individuals at risk of institutionalization. All three goals were incorporated into the missions of the AoA, state units on aging and area agencies on aging.²⁶ The law directs that the Assistant Secretary “conduct research and demonstration projects” to achieve these goals.²⁷

The “informed choices” element is in large part facilitated by the AoA’s new mandate to “implement in all states Aging and Disability Resource Centers.”²⁸ For prevention, the Assistant Secretary is now authorized to design, implement and evaluate “evidence-based programs to support improved nutrition and regular physical activity for older individuals.”²⁹ And then there is the overall mandate to expand choices, which is what has given birth to the AoA’s Nursing Home Diversion program. The Nursing Home Diversion program “is designed to support the initial implementation of the third component related to the Aging Services Network’s role in helping individuals who are not Medicaid eligible to avoid unnecessary nursing home placement.”³⁰

The Nursing Home Diversion Program

The AoA invited states in 2007 to apply for grants designed to modernize the states’ current efforts to help individuals avoid nursing home placement. “This opportunity supports the new long-term care provisions in the 2006 Older Americans Act and is intended to support States’ long-term care rebalancing efforts. It is designed to complement the CMS Money Follow the Person program initiative by strengthening the capacity of states to reach older adults before they enter a nursing home and spend down to Medicaid.”³¹

Each state was required to submit a project narrative that included a summary of the proposed program, the projected outcomes, and information on the current status of the state’s nursing home diversion efforts. States would be given considerable freedom in designing and implementing their programs, and could use their grants to, among other things, provide direct services and supports to individuals and their family caregivers, and develop systems to support cash and counseling and consumer-directed models of care.

State applications were evaluated on the degree of progress the states proposed to make in enhancing the “service” and “system” elements of their existing diversion efforts.³² Service elements include providing “flexible service dollars” to individuals, targeting individuals at high risk of either Medicaid spend down and/or nursing home placement, and giving consumers the option to use a consumer directed model. “System” elements include state use of a single entry point system, infrastructure to support consumer directed approaches, and quality assurance and performance measurements. “A state’s nursing home diversion program must include a performance measurement program that can be used to continually track and evaluate the program’s performance in achieving its goals and objectives.”³³ Funding was to approximate \$500,000 for 18 month grant periods, with states having to provide a 25% match.

The AoA received applications from 30 states and awarded grants to 12. The grantee states are: Arkansas, Connecticut, Georgia, Illinois, Kentucky, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, Vermont and West Virginia.³⁴

26 42 U.S.C. §§3012(b)(1)-(4), 3025(a)(3), 3026(a)(7)

27 42 U.S.C. §3012(b)(2)

28 42 U.S.C. §3012(b)(8)

29 42 U.S.C. §§3012(b)(3), 3016(a)(2)

30 U.S. Administration on Aging, *Nursing Home Diversion Modernization Grants—Program Announcement and Grant Application Instructions* 3 (2007)

31 *Id.*, at 2

32 *Id.*, at 1

33 *Id.*, Attachment A-7

34 Only Minnesota, Vermont and West Virginia did not also receive Money Follows the Person grants under the DRA-authorized program. See Gene Coffey, National Senior Citizens Law Center, *Money Follows the Person* 101 (2008).

Here are the basic outlines of three of the diversion programs based on the information from the states' project narratives.

West Virginia's Fair Plus Nursing Home Diversion Project

West Virginia will be using its grant to support family caregivers of individuals with Alzheimer's disease or other cognitive impairments by awarding them "flexible dollars" to purchase "support, services and goods" that the caregivers believe are necessary to maintain caregiving roles.

West Virginia currently operates a state-funded program called the Family Alzheimer's In-Home Respite Program (FAIR), under which a family caregiver of an individual diagnosed with Alzheimer's disease or a related dementia may receive up to 16 hours of respite care per week from trained workers employed by local county aging providers. There are no income or asset criteria applied for eligibility, but some caregivers may owe a fee for each hour of respite care according to a sliding scale fee schedule. Those with incomes below roughly \$21,000 owe no fee, while the maximum hourly fee of \$14 is assessed to caregivers whose incomes are higher than roughly \$51,000. In 2007, FAIR provided more than 9,000 hours of respite care to more than 250 caregivers.³⁵

According to West Virginia's narrative, FAIR was a product of the success of West Virginia's AOA-funded Alzheimer's Disease Demonstration Grants to States (ADDGS), in which "[d]ata from 16 county ADDGS programs gave substance to the belief that a family-centered approach to health

care and long-term care may help curb rising costs of care, and, more importantly, that older persons prefer a family-centered approach."³⁶ With the state having made its investment in FAIR, and with its knowledge of the role unrelieved caregiver burden plays in forcing many into institutions,³⁷ West Virginia's diversion program will create a FAIR Plus program. Fair Plus will provide up to 50 FAIR-participating caregivers a stipend to pay for both traditional and non-traditional services and goods that will meet the caregivers' needs and/or help make the caregivers' responsibilities more manageable.

The services and goods the caregiver may choose include homemaker services, assistive devices, home modifications, medicines, personal care, medical alert devices, nutrition services, durable medical equipment, incontinence products, and medical services. As the narrative emphasizes, the services and goods purchased by the caregiver will be *self-directed*. Caregivers will receive between \$300 and \$425 a month over the course of a nine month period.

The diversion program will actually kick off with a seven-month planning period during which four separate workgroups will be established to help design different elements of the program. The *targeting* workgroup will help develop "a holistic, state-of-the-art tool"³⁸ to identify those care receivers most at risk of institutionalization. ("Although the client in FAIR [Plus] is the caregiver . . . , targeting will be directed to the care receiver."³⁹) The *assessment* group will be charged with developing a tool that will help shape "a care plan that includes services and supports chosen by the caregiver."⁴⁰ This tool will screen for "specific information about the caregiver and the care receiver to determine as-

35 West Virginia Bureau of Senior Services 2007 Annual Report 3.

36 West Virginia Nursing Home Diversion Program Narrative, p. 5.

37 *Id.*, at 9, citing Lynn Friss Feinberg, Kari Wolkwitz, Cara Goldstein, Ahead of the Curve: Emerging Trends and Practices in Family Caregiver Support, National Center on Caregiving, Family Caregiver Alliance, AARP Public Policy Institute (2006)

38 *Id.*, at 11

39 *Id.*, at 14

40 *Id.*, at 11

pects of the caregivers' situation that threaten both individuals' everyday functioning and well-being."⁴¹ A *quality* workgroup and *practices and procedures* workgroup will also be at work. The workgroups are schedule to be finished with their groundwork by April 2008, and enrollment will begin in July.

FAIR Plus will be implemented in West Virginia's Upper Potomac Area (Region III of the state's four AAA regions), which was chosen in part because of the diversity of its sub-regions—the fifteen county area contains a “comparatively” urban region, a mountainous, isolated region, and a mountainous but less isolated region (i.e., with greater access to services). The state also chose this area because of the unique expertise of the staff of the region's ADRC. Targeting for Fair Plus will begin with current FAIR clients, and then extend to those not currently FAIR enrollees who seek assistance from the ADRC.

FAIR Plus participants will also receive a “Continuum of Contact” provided by the Alzheimer's Association, West Virginia Chapter. This will provide participants with books, videos, and other resources “to increase their knowledge of Alzheimer's disease and their ability to cope.”⁴² As part of the continuum, FAIR Plus participants will also be invited to participate in conference calls and will have a 24-hour hotline available.

Ultimately, the goal is to test the belief that the self-directed caregiver benefit of FAIR Plus will improve the caregivers' quality of life (which will actually be measured through surveys and other methods as part of the program).⁴³ This improvement will allow the caregivers to maintain their roles, thereby diverting their care receivers from nursing home placement. Additionally, the role of the ADRC in the successful implementation of

FAIR Plus will help dramatically raise the profile of the ADRCs statewide.

New Hampshire: *Customized Services in NH: A System Reform Strategy*

New Hampshire's diversion program aims to decentralize its AoA-funded Family Caregiver Support Program (FCSP) from a single state office to local ADRCs (called “ServiceLink Resource Centers” in New Hampshire), while also enhancing the consumer directed element of the program and providing more education opportunities for caregivers. The Institute on Disability at the University of New Hampshire will be partnering with New Hampshire's Bureau of Elderly and Adult Services (BEAS) in operating the program.

Under New Hampshire's FSCP, participant caregivers receive a maximum of \$1,500 a year in respite funds and \$500 for supplemental services.⁴⁴ The program provides “timely interventions and support to family caregivers” who are serving individuals not eligible for Medicaid, and features consumer direction, in which the caregivers may choose their respite providers and “flexibly” use their supplemental services. Caregivers seeking support apply at the ServiceLink Resource Centers, of which New Hampshire is currently operating 10.

One relative shortcoming of the program, as the agency sees it, is that eligibility decisions and payment authorizations are made centrally through the BEAS, instead of at the community level by the workers meeting with the prospective FSC participants.⁴⁵ Furthermore, caregivers that become program participants and who wish to employ nontraditional respite providers (e.g., a neighbor not otherwise licensed to provide care) are at times

41 Id., at 12

42 Id., at 16

43 Id., at 18

44 Generally, states may provide coverage for “supplemental services” under the Family Caregiver Support program for, among other things, transportation services, home or vehicle modifications, assistive technologies. 42 U.S.C. §3030s-1(b)(5). See also, U.S. Dept. of Health and Human Services, The Older Americans Act National Family Caregiver Support Program, Compassion in Action 8 (2004)

45 New Hampshire Narrative, at 4

hampered by the requirement that prospective providers register with the BEAS.

Through its diversion grant, New Hampshire will make two modifications to its FSCP. First, it will decentralize eligibility and payment authorization decisions from the BEAS to the local SLRCs in order to make the provision of support more timely and efficient. Second, it will allow FSC-supported caregivers to choose their respite providers, including family, friends, and neighbors, without forcing them to go through the “cumbersome provider enrollment process.”⁴⁶

Targeting for participants will be made through the use of the same criteria currently being employed by the state in its FSCP. These criteria include: assessment of functional status (care recipient must need assistance in two activities of daily living); health status (care recipient has at least one chronic condition); cognitive/emotional status (care recipient cannot be left unattended); capacity of caregiver to continue role in lieu of identified difficulties (e.g., burnout); and availability of other resources, including both public and private.

New Hampshire will also determine the care recipient’s risk of Medicaid spenddown, specifically those “who are within six to twelve months of spending down their assets” using income and asset tests developed in Minnesota and Connecticut.⁴⁷

In addition to these modifications to the FSCP, the state will also implement the *Powerful Tools for Caregiving Program* developed by Legacy Health Systems of Oregon. “The program was initiated in 1995 in Oregon to provide caregiving training to caregivers. The educational course is designed to help caregivers develop self-care tools to reduce personal stress, take better physical and emotional care of themselves, communicate their needs to family members and make difficult caregiving decisions when a family member can no longer live at

alone, drive safely, and/or manage his/her finances.”⁴⁸

The program will operate in the Grafton County and Monadnock region (Cheshire County, New Hampshire rural southwestern county). During the 18-month grant period, New Hampshire aims to help 100 care recipients avoid Medicaid spend down and provide 100 caregivers training and support to assist them in their roles.

Kentucky: *Kentucky Nursing Home Diversion Project*

Kentucky will be using its grant primarily to introduce consumer direction to its state-funded Home Care program, while also using other grant funds to help pay for “critical services” that some Home Care recipients may need.

Kentucky’s Home Care program, initiated in 1982, provides coverage for case management, home management, personal care, home delivered meals and other services to individuals age 60 or older who essentially meet the state clinical eligibility standard for Medicaid long-term care coverage. A fee is assessed for some services in accordance with a sliding scale. Recipients with incomes less than 130% of the federal poverty level (FPL) are charged no fee, while others with higher income are responsible for a co-payment but may have it waived in “extraordinary” circumstances. The program is administered by the state Area Agencies on Aging and currently serves more than 5,000 individuals, with an almost an identical number on a waiting list.

The Homecare program currently utilizes “a traditional case management and provider approach that gives clients little input into who will provide their services, when they will be provided, and how they will be provided.”⁴⁹ Kentucky’s diversion program will thus “explore the effect of utilizing a

46 Id., at 8.

47 Id., at 9.

48 Id., at 11.

49 Kentucky Diversion Narrative, at 3

consumer directed approach for services provided through the state funded Homecare Program on nursing home diversion.”⁵⁰ Support brokers will be available in participating AAAs who will be responsible for targeting clients “at risk of either Medicaid spend down or immediate nursing home placement.”⁵¹

Those who agree to participate will work with a case manager to choose which services the recipients consider most important to their stay in the community. Clients will be given a monthly budget to hire employees, service providers, purchase goods and supplies based on their preference. “Transportation to medical appointments, therapy offices, community events, grocery shopping, and other interactive components of community based daily life will be included in the client’s budget.”⁵²

In addition to evaluating the effect of consumer direction in the Homecare program, Kentucky’s diversion program will also study how diversion might further be facilitated through the provision of “critical goods and services.” “We know from anecdotal experience that at times clients need just one critical piece of equipment or supply to get them over a crisis.”⁵³ Kentucky will therefore be using a portion of its grant to pay for services such as non-medical transportation, appliances, overnight respite care and other goods and services covered under the “supplemental services” category of Title III-E’s National Family Caregiver Support Program.

The program will operate in the Big Sandy and Kentucky River Area Development Districts, which were chosen because of their rural population and lack of traditional providers. The AAAs in these two regions will work with the state’s Department

of Aging and Independent Living to manage the project.

SUMMARY

AoA-funded community-based services might be overshadowed a bit by the enormous role played by the Medicaid program. However, the AoA-funded services, and the Aging Services Network that delivers them, are critically important to those in need of assistance. This importance will only increase now that the Network has a new statutory mandate to play a lead role in reshaping the nation’s delivery of LTC.

While modest in its scope and representing a mere start to the Network’s new mission, the Nursing Home Diversion program will not only provide immediate benefit to aging individuals and their caregivers, but should also have a lasting effect on the delivery of community-based services. Given that the diversion programs aim in part to further develop the state ADRCs, the expectation is that the programs will have an impact beyond the 18 months of their grant periods. And because each program must be designed in a way that lends to a fast measurement of its performance, the question of whether they should be supported going forward should be easily answered. Advocates hoping for expansion of community-based service opportunities for their clients should therefore keep a close watch on these 12 state programs.

50 Id., at 1

51 Id., at 9

52 Id., at 10

53 Id., at 6