

CRI
Community Relocation Initiative
Questions and Answers

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Bureau of Long Term Support
Division of Long Term Care
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Community Relocation Initiative (CRI) Questions and Answers

This document provides responses to frequently asked questions related to the management of the Community Relocation Initiative (CRI). The following questions and answers are clustered to reflect the order of the CRI process.

CRI Eligibility

1. *What are the **requirements** for a person to be eligible for the CRI funding?*

Participation in CRI is strictly voluntary for individuals living in nursing homes. Refer to DDES memo series 2005-17. To be eligible for this relocation funding the person must be a nursing home resident who meets the following criteria:

- Person's nursing home care must be funded by Wisconsin Medicaid.
- Person must have long-term care needs that will last more than one year or have a terminal illness.
- Person is eligible for the CIP II home and community-based waiver, both functionally and financially.
- Person must need waiver-funded long-term care services in order to relocate.

2. *I understand that a person needs to be in the nursing home for **100 days** before he/she can apply for the CIP II Community Relocation Initiative. Is this true?*

No. The person does not need to reside in a nursing home for 100 days before accessing the CIP II Community Relocation Initiative. The 100 day criterion was added by the Legislature but was **vetoed by the Governor**.

However, this veto included the understanding that if the person applying for CRI was in the nursing home fewer than 100 days, there must be assurance that the person would be a long term nursing home resident if it were not for the relocation initiative. Counties need to document that the stay is expected to be long term based on the COP Guidelines (s. 404.A.1.), the required COP assessment and Long Term Care Functional Screen.

In addition, the person **must** have nursing home costs that have been paid by Wisconsin Medicaid. The CRI is a “money follows the person” directed program. Therefore, the funding for CRI is Wisconsin Medicaid nursing home funding that follows the applicant into the community. Any days in the nursing home, where the person’s care is being funded fully or in part by Medicare Part A, do not meet this requirement.

3. *May a person on a Wisconsin county waiting list, who resides in an **out of state** nursing home, access the CRI funding?*

The person may not access the CRI funding unless the Wisconsin Medicaid data system indicates that Wisconsin Medicaid is paying for that person's care in that out of state nursing home. This also applies to specialty facilities such as The Courage Center.

4. *A person is protectively placed in a nursing home in Wisconsin and wants to return to community living in **another state** under protective placement. Can this person use the CRI funding to move to the other state?*

No. Any change in placement should occur in accordance with laws in the responsible state and needs to be addressed by that state's Medicaid program.

5. *How is **residency** determined for persons living in Wisconsin nursing homes?*

The county of residence for a person living in a nursing home is the county in which the nursing home is located. However, if the person has been protectively placed in a nursing home, the person's county of residence is the county that originated the protective placement.

6. *Our county has **protective placement** of a person in a nursing home in our neighboring county. The person wants to move to a CBRF in our neighboring county. Who is responsible to apply for the CRI program?*

The person is under protective placement orders by your county and it is your county's responsibility to help the person relocate and apply for the CRI through your county agency. As long as the protective placement order is in place in your county, your county is responsible to provide service and follow along for this person should the person relocate to a community living arrangement in your neighboring county or other county.

7. *Is a person residing in a **Traumatic Brain Injury** Unit able to access this CRI funding to relocate from the TBI unit into the community?*

Yes, **if** the person's brain injury occurred at age 22 or after as the individual is considered "physically disabled." If the brain injury occurred prior to age 22, the individual is considered "developmentally disabled" and a determination of "No Active Treatment" (NAT) must occur. (For CIP II, an individual will receive a NAT determination if the individual's IQ is 71 or higher.)

Contact Denise Cox in the Developmental Disabilities Services Section in the Bureau of Long Term Support to discuss including this person on the Brain Injury Waiver waiting list. Her phone is (608) 266-0547. The person must be on or in the process of being considered for the brain injury waiver waiting list before the person will be considered for CRI funding.

Depending on the circumstances and funding availability, the person may be eligible to access the CRI funding. In these situations, you should call either Lisa Kelly at (608) 267-3659 or Sharon Hron at (608) 267-3660 to discuss what may be available. If the person is able to access the CRI funding, the funding will be temporary until the person becomes able to access the Brain Injury Waiver, as is currently the policy with regular CIP II funding.

8. *May a resident of an **ICF-MR** access CRI?*

No.

9. *May a nursing home resident who is **developmentally disabled with mental retardation** but who is **over the age of 65** be served by CRI?*

Yes, **if** the mental retardation (and or brain injury) occurred prior to age 22 and the individual is currently age 65 or older, the individual is considered “elderly” and may not require active treatment. The individual must meet the definition of the “frail elderly” target group **and** the care plan must address the needs of a frail elderly person **and** the individual must receive a NH level of care on the LTC Functional Screen.

10. *May a person with **mental health** needs access this funding?*

Yes, as long as the person is in a waiver allowable target group (a frail elder or a person with a physical disability), meets a nursing home level of care on the LTC Functional Screen and is financially and functionally eligible for CIP II or COP Waiver. In addition, Wisconsin Medicaid must be paying for the person’s nursing home costs in a skilled nursing facility that is not an Institute for Mental Disease (IMD).

Care managers should also consider the Community Opportunities and Recovery (COR) waiver for persons in a nursing home who have a serious mental illness. The COR waiver offers a package of services that may better meet the needs of the individual who is relocating.

11. *Will a person who is residing in a **ventilator dependent unit in a hospital** be able to access this funding?*

No. The person must reside in a nursing home.

12. *My client is residing in a **dedicated inpatient hospice bed in a nursing home** and wishes to return home. Will he qualify for the CRI funding when he leaves the nursing home?*

No. Every hospice that is providing services to individuals residing in a nursing home must have a contract with that nursing home to provide these services. The nursing home and the hospice agency negotiate the daily rate for the hospice service between them. Hospice nursing home per diems are paid for by the hospice agency that is paying for the hospice service portion of the daily nursing home service rate. In this rare instance,

Medicaid pays only for the room and board portion of the nursing home daily rate. Medicaid is not paying the nursing home 100% per diem in this situation. Therefore, hospice dedicated beds in nursing homes do not qualify as the type of nursing home stay whereby a person may access the CRI program funding.

13. *Does the **Veteran's Home in King Wisconsin** qualify as an appropriate nursing home to access CRI funding?*

Four buildings on the campus of the King Veteran's Home are licensed as a nursing home and have Medicaid as their funding source: Ainsworth Hall, MacArthur Hall, Olson Hall and Stordock Hall. The key is whether Medicaid is paying for the individual's care in the nursing home. Some residents at King may have their daily care rate covered through the Veteran's Administration, not Medicaid. If you have questions, please contact Sharon Hron at (608) 267-3660.

14. *Does the applicant need to be on the county's **LTS waiting list**?*

The person does not need to be on the county's wait list to be served with CRI. However, out of fairness to those in a nursing home and on the county's wait list, the county should make efforts to find out if those persons are interested and make plans for them first.

15. *The county's current **waiting list policy** addresses "at imminent risk of entering a nursing home." Should we modify the language?*

It may be best to add language and specifically address when funding may be available for special purposes such as nursing home relocation.

CRI Initial Information and Funding Estimate (form DDE-2678)

16. *What is the **purpose** of the CRI Estimate form?*

The CRI Initial Information and Funding Estimate provides information to BLTS regarding the amount of CRI funding that may be required to serve the individual upon relocation from the nursing home. BLTS determines whether the estimated community care costs and the person's estimated community Medicaid card costs can be supported within available CRI funds, while ensuring required Medicaid savings.

17. *Counties are running into problems where **nursing homes don't bill monthly**. They bill quarterly or every 6 months instead. Counties have to wait until billing has occurred so that EDS has a record of costs in the nursing home to facilitate approval of community plan. Do you have any thoughts on how to work around this?*

When the person is eligible for Medicaid in the nursing home, BLTS will accept a letter from the nursing home indicating what the person's Medicaid per diem is/will be in the

nursing home. We do not want people needlessly waiting in nursing homes to access the CRI due to nursing home billing practices and Medicaid payment cycles.

18. *No one seems to know how long my client will have his nursing home care **covered by Medicare** before needing to go on Medicaid. When should I send in the CRI estimate form?*

You should send in the CRI estimate form as soon as you know what the person's community services will be when he leaves the nursing home. You can continue with the transition plans so all is ready when he is ready to move out of the nursing home. Once you know when he will have his nursing home daily rate covered totally by Medicaid, please contact either Lisa Kelly (608) 267-3659 or Sharon Hron (608) 267-3660.

19. *What does the initial **faxed approval** of the CRI estimate assure?*

Faxed approval of this initial estimate is *not* a binding approval of funding for the CRI program. Faxed approval of this estimate is *not* an approval of the service plan for the person. In addition, the final written approval for CRI funding may be more or less than what the original estimate indicates.

20. *I am not able to determine the exact dollar amount of the community **Medicaid card costs**. What should I do?*

Indicate on the estimate form the type of service and the amount of days or hours the service is needed per week or month. For those Medicaid covered community services/items for which you do know the funding amount, please indicate that amount. BLTS can access the Medicaid costs for medications.

21. *How should the estimate form be completed if the care manager has not yet determined how much care will be **Medicaid Personal Care (MAPC)** and how much will be supportive home care or the residential cost?*

Fill in the form with your best estimate. Estimate the number of hours and rate. The BLTS cost comparison compares Medicaid nursing home and other card costs to community waiver and card costs. At this stage, it would not matter whether the costs are MAPC or waiver. However, by the time the final service plan is submitted, these costs need to be clearly delineated in the Individual Service Plan (ISP). The CRI award letter is based on waiver costs only that are identified in the ISP.

22. *The nursing home has recently requested a **level of care determination** from the state (Electronic Data Systems EDS). However, the nursing home knows what the Medicaid daily rate is/will be. Does the person need to wait in the nursing home until the nursing home care level is determined by EDS?*

Yes. If, for some reason, EDS determines the person does not meet a nursing home level of care, the person's nursing home care is not eligible to be paid for by Wisconsin Medicaid. The person would consequently not be eligible for CRI.

23. *Once the nursing home has received an approved nursing home level of care for the person, does the person need to remain in the nursing home until **Medicaid pays his nursing home bill**?*

No. Obtain a memo/letter signed by the nursing home administration indicating the person's approved nursing home level of care and what the daily rate is that the nursing home is billing Medicaid for that person. The person must have at least one day that will be paid in full by Medicaid. Please Fax this document to BLTS along with the person's estimate form. Please consider, however, that a person's nursing home patient liability may cover the cost of a short nursing home stay with no charges being paid by Medicaid.

24. *What are the **guidelines** for completing the CRI Estimate form?*

Please see Attachment A.

25. *If a person's CRI estimate is **more expensive** than the person's nursing homes costs, will the person's estimate be approved for the CRI?*

Usually. The person could be served if sufficient Medicaid savings have been generated by other CRI participants who relocated with community care costs that are less than their nursing home care costs. It is important to submit the person's CRI estimate form in any type of community cost situation.

26. *BLTS has a "**pending list**" of estimates that have been submitted by counties. What does this list mean?*

The CRI pending list may be implemented when a number of people whose projected Medicaid community care costs are considerably higher than their Medicaid nursing home care costs. These individuals will need to wait for Medicaid savings generated from other CRI relocations.

Application for CRI

27. *What **documents** are **required** in the CRI application?*

Follow the same application requirements as for a CIP II application packet. The only additional required document in the CRI application is the BLTS approved estimate form which should be placed on the top of the CRI application for TMG to immediately identify that the packet is a CRI application. If you include a cover letter with the service packet, include a statement in the cover letter that the submitted plan is for the CRI program.

28. *What if my client **does not leave** the nursing home on the anticipated discharge date?*

If the relocation is delayed, the county may need to update the COP assessment and Long Term Care Functional Screen to be in compliance. If the person chooses to relocate to a different living arrangement than originally planned, the ISP should be updated to reflect the new services and change in costs. The care manager should alert BLTS and TMG when an anticipated relocation is delayed.

29. *How is **transportation** paid for a person to visit a relocation site if the person decides to remain in the nursing home?*

The care manager can collaborate with the nursing home discharge planner who may be able to provide the transportation as part of discharge planning. Families may be able to help. Contact the county's aging office or regional Independent Living Center to ask for available transportation or volunteers.

30. *Does a care manager ask about **divestment** as part of the assessment?*

Typically the county income maintenance (IM) worker who determines the nursing home Medicaid eligibility will ask about divestment. Since there may have been financial changes in the interim, such as the person's home being sold and those assets divested, it may be wise to ask again. Also, financial eligibility is required to be determined annually. Partner with your IM staff on this question.

31. *How is the **start date** determined for CRI relocations?*

The start date for CRI relocations is determined the same way as any other person applying for waiver funding. The effective date of eligibility (or start date) is the date a new applicant becomes eligible for CRI funding. It is the first day services may be billed to the waiver program.

The service plan packet is reviewed for four conditions to determine the effective date. The effective date is the first date upon which **all four** of the following conditions are met:

- The date the individual meets all the criteria to be eligible for Medicaid.
- The date the initial service plan is developed with the participant. This can be the date the care manager first started to discuss a plan of care with the participant, which may be earlier than the date the ISP was typed or signed. This date must be prior to the date the person relocated from the nursing home.
- The date listed as the Screen Completion Date on the Long Term Care Functional Screen (completed by a certified screener).
- The date the individual first resides in a waiver allowable setting.

32. *The nursing home resident I am working with intends to move to an apartment. He has no belongings. The CRI estimate has been approved and included a listing of **start up costs**. As the person moves and the listed start up costs are incurred, how do they get paid?*

Once the person's service plan has been approved by TMG and the final BLTS funding approval letter has been completed, effective the day the person leaves the nursing home you may bill on HSRS for reimbursement for these items. For those items that are covered by CRI funding, you bill CIP II. If you have requested one time COP relocation funding for COP eligible items and BLTS has approved funding for these, you bill COP for these items. See HSRS for coding information.

Also see the Medicaid Waivers Manual, Relocation Related Services, SPC 106.01 and 106.03 starting on page IV-102. Also, review housing assistance for rent, SPC 106.02.

33. *Is there **one time COP funding** available for relocation costs?*

Yes, there is limited *one time* COP relocation funding available for those one time items a person may need in order to relocate from the nursing home that are not covered by Medicaid or the Medicaid waiver. Items such as clothing, groceries to stock the pantry and a TV and/or radio may be considered as a one time COP relocation cost.

Also, COP one time relocation funding could be made available to help the person with room and board or rent for the first 2 to 3 months in the community, while the person applies for and receives community Supplemental Security Income (SSI).

Remember that using 100% COP funds requires a six month Wisconsin residency.

34. *What funds can be used in an **RCAC**?*

CRI is appropriate to be used in an RCAC up to the allowable daily maximum. (For 2008, see DLTC Memo Series 2007-22, November 2007) However, COP is not available for use in an RCAC.

35. *Is there **ongoing COP funding** available at the State level for individuals who do not have enough income to support their room and board expenses in a substitute living arrangement?*

No. There is no *on-going* COP for room and board or for other on-going non-waiver allowable costs. There has been no increase in COP in the State budget so counties will have to use existing allocations or arrange for services in locations that will not need additional COP funding.

36. *How can a county access relocation start up funds that are **not covered under Medicaid, Medicare or CIP II?***

Please, review SPC code 106.03 (Housing Start Up) and SPC code 112.56 (Housing Modifications) in the Waiver manual to verify that the items in question cannot be funded using CIP II. **Include an itemized list in the service plan packet** along with the justification or explanation that neither Medicaid nor Medicare nor CIP II will fund the item. If approved, the amount for the items that are not covered by other funding sources will be included in the BLTS funding approval letter as COP one time relocation funds.

37. *Do I include start up costs, adaptive equipment and home modifications as part of the CRI per diem on the ISP?*

No. Include these items on the ISP as “one time costs” under CRI.

38. *Should the county wait for the **final approval of the service plan** packet by TMG and final approval of the **CRI funding** by BLTS before the person may relocate?*

Yes. It is advisable to wait until the service plan and funding are fully approved. Approval of the estimate amount is not the final approval for the funding or for program eligibility. If the person moves before the service plan and funding are fully approved, funding could be jeopardized if the person is found not eligible or the person’s proposed care plan is determined to be unsafe.

Nursing Home Patient Liability and Discharge From the Nursing Home

39. *What is a person’s **nursing home patient liability** and what happens to the liability amount when a person leaves a nursing home?*

Under Wisconsin Medicaid eligibility, a person, residing in a nursing home and receiving Wisconsin Medicaid, may be required to pay a monthly patient liability amount to the nursing home. This patient liability offsets a portion of the cost that the nursing home bills to Medicaid. The amount of this patient liability is determined by the county Income Maintenance worker. Each Medicaid nursing home resident is allowed a \$45.00 monthly personal needs allowance 49.45(7)(a), Wis. Stats. and other person specific deductibles, before the final monthly patient liability amount is determined.

When an individual leaves a nursing home to return to community living, prior to the last day of the discharge month, there is no patient liability amount for the nursing home to collect from the individual, as directed in the Wisconsin Medicaid Eligibility Handbook at <http://www.emhandbooks.wi.gov/meh-edb/>

Recently (2007), the Department issued a Patient Liability memorandum to all county Income Maintenance personnel to re-emphasize this procedure. Income Maintenance personnel are directed to decrease the patient liability for the calendar month of discharge to zero.

In order for this process to occur in a timely manner, it is imperative that the County Care Manager and the Income Maintenance worker keep each other fully informed of the month of the person's proposed discharge date from the nursing home.

Presumptive Disability

40. *May a nursing home resident, who has a “**presumptive disability**”, relocate to the community under CRI and have his care paid until his disability status is officially determined?*

If the presumptive disability is affirmed by the Disability Determination Bureau (DDB) and the person is determined “disabled”, then, of course, the person continues to be served.

However, if DDB determines that the person is not disabled after all, then the waiver services must be terminated with proper notice. The person may appeal and waiver services will remain in place until the appeal is finalized. There is no over payment assessed for the services provided while the person was deemed “presumptively disabled.” For policies related to presumptive disability see the Medicaid Waiver Manual.

Care Management

41. ***When and how may I bill for Transitional Care Management SPC 604.04?***

SPC 604.04 cannot be opened prior to the CRI start date for services, which is the date the person left the nursing home. Assessment and planning costs are totaled and entered on the start date to SPC 604.04 and then closed that first day. The on-going care management, SPC 604.00, will begin that day also. Don't forget to enter the total units.

You will also open an assessment and plan (603.01 and 603.02) under the COP (LTS code “7”) but you will have zero costs for COP. The units under COP and the units under SPC 604.04 should be the same.

42. *I understand that a county can bill transitional care management to the CRI waiver provided the costs are billed to the waiver after the person relocates. What if something happens and the **relocation fails**? Does the county eat the cost of the assessment and plan?*

Assessment and plan costs incurred while the person was in the nursing home can be billed to the CRI waiver after the person relocates. See Waiver Manual, page IV-27, SPC 604.04 Care Management. If, after the assessment and plan have been completed, the

person does not relocate, the completed COP assessment and plan can be billed to the county's allocation for COP assessments and plans. If these allocations have been fully expended, then costs may be covered by the administrative allowance in COP. Medicaid Targeted Case Management can not be billed while a person is in an institution.

43. *Can care management be **the only service** provided?*

Yes, to assist with the care management of Medicaid card services that are long term care related.

44. *We have a CRI recipient who is also a **Community Support Program (CSP) client**. Can we bill SPC 604.04 Transitional Care Management time or do we have to bill the initial assessment and plan to Medicaid Targeted Case Management as we normally would due to CSP?*

The CIPII Waiver has authority to fund relocation related care management which includes the initial assessment and planning. And "yes" the same hours cannot also be billed to Target Case Management and are usually different from the CSP or Comprehensive Community Services (CCS) benefit.

It is only after the person becomes a CRI participant that the regular SPC 604 for ongoing care management is not allowed as then the service is similar to CCS and CSP and we do not want to be double billing Medicaid. This applies to Medicaid *certified* CCS and CSP only.

Service Plan Cost Decrease or Increase

45. *What is the process to inform BLTS of **decreases** in service plan costs after services have begun?*

Counties do not need to inform BLTS when the care plan costs decrease after services have begun. Counties should either use that money for others who relocated under the initiative whose care plan costs increase or not use it. BLTS will be monitoring HSRS expenses reported and the individual's Medicaid card costs to ensure that the initiative's fiscal projections are met.

46. *What is the process to inform BLTS of **increases** in service plan costs after services have begun?*

There is no need to inform BLTS. Counties are encouraged to manage these increases within existing CRI funds. Additional community relocation funding will not be made available for provider rate increases. However, if the person has a substantial change in their care needs and the county does not have any available CRI funding, the Department may be able to provide additional CRI funding if there are available uncommitted savings from other relocations. To inquire, contact Lisa Kelly at (608) 267-3659.

47. *The county has been notified that the **rate for a CBRF will be increasing** the first of the year. Will CRI provide added reimbursement to the county for those individuals in this CBRF who are funded by CRI?*

No.

48. *Do “increases” include **cost of living increases** for staff wages?*

The Department will not make CRI funding available for this purpose. However, the county may use any of its own available CRI funding.

Reporting

49. *Which **CARS profile** will CRI funding be reported on?*

Waiver expenses associated with CRI participants are to be reported on CARS profile 368. This profile will allocate to 369 (non-federal portion of expenses) and 370 (federal portion of expenses). All federal funds will be paid. If the non-federal portion of the expenses exceeds the non-federal contract, expenses in excess of the contract limit will roll to the county BCA (basic county allocation – profile 561).

50. *Is the “**waiver start date**” the day the waiver was approved?*

Yes, and this date is the first date that costs may be billed to CRI for services provided prior to the person leaving the nursing home. The CRI approval date is the date the person left the nursing home.

51. *How do we **code** these relocations on **HSRS**?*

Counties must report costs on HSRS for Community Relocation participants using LTS code “N” (field 26) and enter an “N” under type of movement (field 13).

52. *Will the CRI person’s **HSRS code** **always remain** with that person?*

When the funding rolls over to CIP II base funding, counties will change the LTS code for individuals who relocated under CRI. The new LTS code will be a “2” or a “3” (CIP II or COP-W, county’s choice). The person will retain the same episode number; this will allow the Department to see the history of services for the individual.

53. *Will counties need to **track** CRI participants **separately**?*

CRI expenses must be tracked and reported separately from CIP II.

54. *How long does a waiver participant need to be **in a nursing home** before the person should be closed on HSRS?*

Current COP-W/CIP II procedures apply. The person's SPC's should be closed after 30 days of residency in the nursing home. The county should hold the episode open for 90 days per current policy to allow for the potential of a short term nursing home stay. However, if the county has held the episode open for the 90 days, closes it and then later the person seeks to relocate, the county can request CRI funding again.

CRI Funding

55. *At what point in time does the CRI funding **roll into the county CIP II base**?*

As of 1/1/08, all CRI funding for persons who relocated prior to 7/1/07 and who were in the community for at least 180 days was moved to a county's CIP II base. Counties received a memo on June 16, 2008 with additional information regarding changing these people on HSRS. For relocations that occur between July 1, 2007 and June 30, 2009, funding will continue to be in the CRI budget until January 1, 2010 or until a county joins Family Care.

56. *If a person relocates in May 2008 receives CRI funding, will the person's cost roll into the county's CIP II allocation in July or January 2009?*

No – the funds would not roll to a county's CIP II fund until January 1, 2010 or, if the county joins Family Care prior to that date, will follow the person to the Family Care budget.

57. *How will the CRI funding **affect a county's CIP II average**?*

When CRI funding rolls into regular CIP II funding beginning in contract year 2008, counties will be able to average all of their CIP II per diems and spend out their contract. If this CIP II average exceeds the CIP II per diem (currently \$41.86) an approved variance is **not** required unless a county's combined CIP II and COP-W average exceeds the CIP II average. See also DDES numbered memo 2006-03, February 25, 2006.

58. *In "regular" CIP II funding as long as the **average daily rate** for all clients is \$41.86 a day or less, the county receives full funding. If the county has only one client receiving the CRI funding with an initial care plan of \$73.99 per day, will we only receive the \$73.99 per day or will the person be included in the "regular" CIP II funding and be averaged with them?*

The county will receive the relocation funding, \$73.99 in this example, until the CRI is combined with the regular CIP II allocation. This amount will then roll into CIP II at the end of the biennium. Prior to the date the CRI funding rolls to the county base, there can be no combining of CIP II and the CRI funding for an individual.

59. *Can a county use the CRI funding for other more expensive individuals in the COP-W and **switch** them into the CRI funding?*

No. Once a person is on CRI, he/she must stay on that funding (no switching) until the county's CRI funding is combined with regular CIP II. Only then it will be possible to switch clients between CRI funding (at that point CRI funding has become CIP II) and COP-W.

60. *Will the county receive a letter or contract amendment when a relocated person **terminates before 180 days**?*

We do not send the county a letter when a person leaves the program but do update the county's CRI contract several times a year to reflect any changes, including new relocations, rate changes, moves between counties and when a person leaves the program.

CRI Diversions

61. *What care plan amount is considered to **be available after the 180 days**? The original per diem or what actually is being spent?*

If the relocated person leaves the program after 180 days, the county continues to retain the original per-diem to be used for a diversion determined to be at high risk of entering a nursing home (in accordance with criteria in DDES Memo Series 2006-08 issued May 2006).

If the relocated individual leaves the program for whatever reason after 180 days, the county may access this person's funding for a person on the waiting list who meets the special CRI high risk criteria. When this situation occurs, the county will enter the high risk person's expenses on HSRS using the long term support code "N" in field 26 and a "D" for field 13 – diversion.

62. *My client was **close to being on the CRI program for the 180 days** required for the funds to revert back to my county. However, his lasts days were in the nursing home where he passed away. Will his funding be available to the county?*

No. If the CRI person is residing in a waiver allowable setting and is receiving CRI services for 180 days or more and passes away, then the county would be entitled to the CRI funds. An in patient nursing home or hospital is not a waiver allowable setting.

63. *A client relocated through CRI and resides in the community for 200 days. He passes away. His approved care plan per diem was \$75.00 per day. However, his actual costs were \$50.00 per day. How much does the county have available for a new diversion person, \$75.00 or \$50.00 per day?*

The county has available to use, for diversions that meet high risk criteria, the amount approved for the relocated person. In this example that would be \$75.00. (Refer to DDES memo series 2006-08)

RCAC

64. *Can CRI funding be used for **RCAC** services?*

Yes. But, COP-Regular cannot be a funding source in an RCAC.

CBRF

65. *What is the effect of CRI on a county's **CBRF Cap**?*

Counties are required to set a limit on the amount of their COP and COP-W and CIP II allocation that they will use in CBRFs. This policy enables counties to make local decisions about the extent to which these limited funds may be used for alternative residential care. Using funds from a home care program for out of home care must be done deliberately and equitably to advance the goals of the program for participants.

When a person relocates to a CBRF from a nursing home, the cost of that individual's care plan will be figured into the county's existing CBRF cap. If there is concern that CRI will cause the county to exceed its local CBRF cap, consider the following:

- a. The long-term support planning committee can raise or lower the CBRF limit each year. It is a county established maximum. The policy cannot exclude nursing home relocations from the established cap. As you are considering the county's cap you may wish to consider the effects of the relocation initiative on the need for increasing the cap for CBRF services.
- b. The county could establish a local policy creating a "working" percentage but allowing that percentage to be exceeded under certain or unanticipated circumstances up to a specified higher percentage. This higher percentage is what would be reported to the Department. This gives the county some room to respond to problems that are unforeseen, like a closing nursing home, or to accommodate relocations.
- c. When the Department reviews the county set maximums, we do so against dollars actually spent each year for people who reside in CBRFs. If projected expenditures exceed the proposed county cap, we will ask the county to describe (in the annual COP Plan Update) its plan for progressing toward its goal, including timeframes. We will look for patterns of inappropriate use of funds and will do what we can to provide guidance to counties who are struggling with maintaining the home-care intent of the program.

- d. The four conditions for CBRF placement are required for all individuals that are considering relocating to a CBRF. These conditions ensure that home-care and residential options are explored and discussed with the individual, that the person prefers a CBRF over other settings, that it is cost effective, and a quality setting. Variances are required if the CBRF under consideration is larger than 20 beds.

66. *Are relocations subject to the same conditions as any other CBRF placement?*

Yes. Since the passage of 2007 Wisconsin Act 20 in October 2007, the “five conditions were reduced to four,” as the requirement for a preadmission consultation was repealed. The remaining four conditions for CBRF placement must still be met for individuals to receive CIP II or COP-W funding in a CBRF (s. 46.27(11) (5n). The conditions apply to all persons, including those relocating from a nursing home. These conditions ensure that home care and residential options are explored and discussed with the individual, that the person prefers a CBRF over other settings, that it is cost effective, and is a quality setting.

The CBRF variance requirements apply to relocations as well. If the CBRF under consideration is larger than 20 beds a person specific variance must be obtained. Facilities larger than twenty beds are waiver allowable for all CIP II and COP-W participants with an approved variance.

If the facility is structurally connected to a nursing home a variance must be obtained. CBRFs that are structurally connected to a nursing home are an allowable living situation for frail elders age 65 and older, but are not a waiver allowable living arrangements for participants with a disability who are under age 65. (See DLTC Memo 2008 – 04)

67. *Will CBRF expenses for individuals receiving CRI funding be included in the **current monthly CBRF report** sent to counties?*

CRI funds are a separate funding stream and a different code on HSRS (Field 26, Code N), so they will not be incorporated into the current report. Rather, a new report that mirrors the original CBRF report was developed that reflects costs for CRI funding individuals. (The report name is LTS015A - LTS NHR/CIO 2 FT - CBRF Expenditure Report. This report incorporates the expenses incurred for individuals who reside in a CBRF and who use either CRI funding or Family Care Transition funding.) Because CRI funding is a part of the CIP II, the CBRF cap applies to that money as well. To accurately determine the county's percent of spending relative to its CBRF cap, you will need to combine the expense totals of this report with the original CBRF report. The CBRF Cap is a percent of the county's total allocation(s), not a percent of total spending.

68. *Will an assisted living **facility refusing to accept Medicaid** continue to be able to refuse?*

Yes. The current COP-W/CIP II program policies apply. Counties also can refuse to contract with a facility that will not comply with contracting, fiscal or other program

requirements which may mean persons relocating may need to choose a facility willing to comply.

Nursing Home Relocations and Moves from County to County:

69. *What should happen if a **nursing home resident is interested in relocating to the community, however the community of choice is in a different county than the nursing home?** For example: Mr. E. wants to leave a nursing home in county A and live in the same city as his son who lives in county B.*

The county that is first contacted by Mr. E. and/or his relative should call the other county involved. Between the two counties, they can decide who will complete the assessment and care plan and bill the cost to the COP assessment and plan in the event that the person does not relocate and billing it to transitional care management might not be possible.

Next the counties will need to decide who will be providing the ongoing care management services which will involve implementing the care plan, securing services, establishing contracts and making the move a reality, as well as assuring the health and safety of the individual.

CRI funding will be allocated to the county who implements and monitors the care plan. (Usually that will be the county where the individual will physically reside after the move from the nursing facility.) Also please see Attachment B: “Community Relocation Initiative (CRI) and Relocations Between Family Care and Waiver Counties”

70. *What if **neither county has COP assessment or plan funding?***

For those individuals relocated, counties may bill the cost of the assessment and care plan to the waiver. These costs as well as the transitional case management should be coded on HSRS as 604.04. Additionally, counties should enter on HSRS an assessment and plan date to COP (LTS code 7). No costs should be entered – however a county should enter the units.

For those individuals who do not relocate, but for whom the county has conducted an assessment and plan, the cost may be charged to the COP assessment and plan allocations. If these funds have been expended, costs are allowed as administration costs for COP.

71. *What if the individual is under a **protective placement** completed by the county where the nursing home is located?*

The county that completed the protective placement will need to take responsibility for the “least restrictive placement”, will implement the relocation and will receive the relocation funding. An interagency agreement, as in other similar situations, could

include contracting with the placement county or another qualified agency, for the ongoing care management. Also please see Managed Long-Term Care Expansion Planning Information #6 “County Residency and Transition to Managed Long-Term Care” at <http://dhfs.wisconsin.gov/managedltc/grantees/pdf/info6residency.pdf>

Family Care and CRI

72. *What happens to CRI funding when my county rolls to Family Care?*

As the person is converted to Family Care, the funding follows in the form of the Family Care capitation payment.

73. *Can my county continue to access the CRI funding during the **Family Care rollover period**?*

No, once Family Care begins in a county new CRI funding is no longer available. Persons who are interested in relocating from institutions should be referred to the Aging and Disability Resource Center. The limit on serving only one-twenty-fourth of the county waiting list each month during the first two years of Family Care does not apply to persons leaving institutions.

Appeal Rights

74. *If an **estimate** for CRI is submitted to the BLTS and the BLTS deems the **cost as excessive**, does the person have a right to appeal the decision?*

It is important to remember that there are two processes:

- a. determination of a person’s waiver eligibility – which can be appealed (see Waiver Manual)
- b. determination of funding availability – which the person may appeal, however the Division of Hearings and Appeals may find that they do not have jurisdiction.

Any applicant can appeal their denial of waiver eligibility as described in the Waiver Manual. The lack of CRI funding is similar to lack of funding at the county level when people have to be put on a waiting list.

BLTS will inform the county that CRI funding is either “not available at this time” because there is not sufficient funding available for this person’s costs, or, that the person’s community costs are so high that CRI funding is not appropriate. In either situation, the county can serve the person with its regular COP-Waiver or CIP II allocation when the person comes to the top of the county waiting list.

Quality Assurance

75. *What is the **process to assure** that persons who relocate will be **well cared for**?*

The person's care manager and the county's program have the primary responsibility and fulfill that responsibility by having monthly contacts with the participant and/or providers, quarterly face-to-face contact with the participant to assess the adequacy of services and providers, identifying changing needs, and making necessary changes in the plan of care. In addition, the state implements a quality assurance monitoring process, hears complaints and remedies/resolves problems that arise. Special follow up will occur with participants at the required 30 and 90 day intervals and with people (or their families) who have left the program to ascertain why.

76. *How will the **state assure quality** in the CRI program?*

The state will assure the following:

- The applicant meets waiver functional and financial eligibility and the plan addresses any unmet needs or health and safety issues
 - Initial care plan review by The Management Group, Inc. (TMG)
- The care plan is cost effective and CRI funding is maximized
 - Initial care plan review BLTS/Community Options Section
- Participant has positive adjustment to relocation transition
 - 30/90 day questionnaire completed by county agency
- Adequacy of care plan and appropriateness of ongoing services
 - Monitor care plan, health and safety and satisfaction as part of State's quality assurance monitoring reviews and home visits (conducted by TMG)
- There are no negative outcomes to participants relocating
 - Follow up surveys for individuals who have returned to the nursing home or passed away.

**GUIDELINES FOR COMPLETING
COMMUNITY RELOCATION INITIATIVE
INITIAL CARE PLAN INFORMATION AND FUNDING ESTIMATE (DDE-2678)**

Please type or use black ink so that forms are legible when faxed.

Name of Applicant, County Applying and Date of Birth of Applicant: self-explanatory. If there is more than one agency in the county, please specify the agency that will be serving the individual.

Medicaid Number: Forms *must* include the person's Medicaid number. Estimates cannot be approved until the person's Medicaid nursing home expenses are verified using the Medicaid number. Save time: do not submit the estimate form until you know the MA number.

Nursing Home Information (Name, status, date of admission): Please provide the name of the nursing home for tracking purposes. Indicate in the space provided whether or not the nursing home is closing or downsizing. It is helpful for data reporting purposes to know the date of admission. The date of admission should be when the person entered the nursing home regardless of funding source.

Date of Planned Relocation/Discharge: When completing this item, remember that the individual should not relocate until the care plan and funding have been approved by the Department. There are many factors that must be taken into account before all approvals are given.

If Nursing Home stay is less than 100 days, document why the stay is expected to be long term: The Department must ensure that the people being relocated would not have left the nursing home without the help of the Community Relocation Initiative. The care manager must complete this section if the stay will be under 100 days.

Proposed New Living Arrangement: Please indicate where the person will live. If the person will go to a residential setting, please provide the name if it is known when estimate is submitted.

Estimate of the person's Daily Waiver Cost: Daily waiver costs should include **all** on-going costs that will be billed to CIP II, including care management. Do **not** include the following in this box: room and board; cost share; administrative costs; Medicaid card costs. Also, do **not** include one time costs in the daily waiver total even if waiver allowable, instead report these costs under the "other" box.

Detail (Supportive Home Care, CBRF/AFH Service per diem, Transportation, Adult Day Care, Adaptive Aids, one-time Home Modifications, Other): Please provide the estimated daily costs in each area. Use the "other" box for one-time costs. These do not need to be

calculated as daily costs. If more room is needed, write in, “see attached sheet.” This will enable these one-time costs to be factored in but not as on-going daily costs.

Care management: *On-going* care management costs should be included in the daily waiver cost estimate. Please indicate that you have included care management; for example, waiver rate is “\$70/day incl. \$3 cm.” Put one time relocation related care management or assessment and plan costs in the “other” box.

Medicaid card costs: If you know the exact Medicaid card costs for the services that will be needed in the community, please indicate these dollar amounts on the estimate form, e.g., MA personal care. If you do not know the Medicaid card costs for the services that will be needed in the community, please indicate the amount of the service the person will need, such as hours/day, times/week, etc. BLTS will generate an estimate. You do not need to supply the costs for medications and physician services. BLTS will make assumptions about those based on history.

Substitute care room and board (CBRF, AFH): Please supply the room and board costs for the substitute care setting; this amount is used to estimate the feasibility of the living arrangement. Please be aware, additional COP funds are not available to help cover room and board.

SSI and income: Indicate if the person will be on SSI and/or SSI-E in the community. If possible, please indicate what the person's income will be upon return to the community. If the community income cannot be obtained, please indicate what the person's income is in the nursing home setting and the source of that income.

One time start-up costs: Itemize those one time costs that will be covered by CIP II-CR and those one time costs for which the county is requesting one time COP regular relocation funding (a special allocation of exceptional expense funding set aside for this initiative). Attach a separate sheet if necessary.

Estimate of the nursing home costs: Some have asked if we can provide the rates of nursing homes or give counties an idea of what the person's costs are. The Medicaid allowable rates do not really reflect what that individual's costs are as there may be patient liability. The rates also do not include an individual's other card costs in the nursing home. These can vary considerably from person to person. Counties should provide the community care estimate based on a safe care plan. The Department will research the nursing home costs.

COMMUNITY RELOCATION INITIATIVE (CRI) AND RELOCATIONS BETWEEN FAMILY CARE AND WAIVER COUNTIES

Scenario 1 - Person resides in a nursing home, is currently enrolled in Family Care (minimum of six months) and voluntarily moves to the community in a Waiver County (No nursing home Medicaid expenses incurred)

- Person is placed on the receiving County's wait list.
- Family Care funds are used to fund the person until they come to the top of the wait list.

Scenario 2 - Person resides in a nursing home, is currently enrolled in Family Care (does not meet the six month requirement), and voluntarily moves to the community in a Waiver County. (No nursing home Medicaid expenses incurred, but Department can use a nursing home cost average to do cost comparison.)

- Person is **not eligible** for Family Care Transition funding.
- Person is **eligible** for CRI funds.
- Person counts as a waiver relocation.
- County where the person moves receives the CRI funding.
- Assessment and Plan is done by receiving County.
- FC care manager works collaboratively with receiving county care manager to assure smooth transition.

Scenario 3 - Person resides in a nursing home in a Family Care County – is not currently enrolled in Family Care and chooses to move to the community in a Waiver County. (Nursing home Medicaid expenses may have been incurred – no Family Care capitation payment in place.)

- Waiver County care manager notifies Family Care County of the person's intent to relocate to the waiver county.
- Waiver County does the assessment and care plan.
- Waiver County receives CRI funding.
- Individual counts as a waiver relocation.

Scenario 4 - Person resides in a nursing home in a Family Care County – is not currently enrolled in Family Care, chooses to move to a community in a Family Care County, and chooses to enroll in Family Care. (Medicaid expenses may have been incurred – no FC capitation payment involved until enrollment)

- Resource Center determines eligibility and enrolls person in Family Care.
- Family Care counts individual as a NH relocation.

Scenario 5 - Person resides in nursing home in a waiver county and chooses to move to the community in a Family Care county.

- County of first contact (may be waiver county or may be Family Care county) alerts the other county of the person's intent to relocate.
- County where the person is moving to does assessment and plan.
- Person enrolls in Family Care (only other choice would be fee-for-service).
- No CRI funding is involved.

Scenario 6 - Person resides in a nursing home in a waiver county and chooses to move to the community in a different waiver county.

- County of first contact notifies the other county of the person's intent to relocate.
- County where the person moves to does the assessment and plan.
- County where the person moves to receives the CRI funding.