CSHP
Rutgers Center for State Health Policy
NATIONAL ACADEMY for STATE HEALTH POLICY

January 2007

Meeting Summary

Community Living Exchange

Funded by Centers for Medicare & Medicaid Services (CMS)

Money Follows the Person: Financing and Budgeting

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The Community Living Exchange at Rutgers/NASHP provides technical assistance to the Real Choice Systems Change grantees funded by the Centers for Medicare & Medicaid Services.

We collaborate with multiple technical assistance partners, including ILRU, Muskie School of Public Service, National Disability Institute, Auerbach Consulting Inc., and many others around the nation.

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MEETING SUMMARY

MONEY FOLLOWS THE PERSON: FINANCING AND BUDGETING

Robert Mollica, Susan Reinhard & Jennifer Farnham

January 2007

Introduction

This document will summarize the meeting on Money Follows the Person: Financing and Budgeting, convened by Rutgers Center for State Health Policy (CSHP) and the National Academy for State Health Policy (NASHP), and held September 11-13, 2006 in Olympia, Washington. Attending the meeting were 34 participants from ten states to discuss budgeting and financing approaches states can use to assist their residents in moving from institutions to community settings. This document will provide a brief description of the meeting and a guide to the resources distributed at the meeting, for the benefit of those unable to attend.

Background

The Rutgers CSHP/NASHP technical assistance team is holding a series of meetings to promote collaboration among state leaders who develop and implement policies and programs to assist their residents needing long-term care services in receiving those services in their homes and communities rather than in institutions. The series is called the Money Follows the Person Systems Design Learning Collaborative,[1] and involves discussion of state efforts under the Money Follows the Person Demonstration Program[2] as well as other state policies and programs. This meeting was the second in the series. The resources from the first meeting were incorporated into the Money Follows the Person Toolbox, released in August of 2006.[3]

Meeting Summary

The purpose of this meeting was to discuss different methods of financing and budgeting that make community-based care a viable option. In many states, the method of financing long-term care locks funds in institutional care. Washington state personnel discussed the global budget/pooled financing model they use. Vermont personnel presented their global budget model with HCBS (home and community-based services) entitlement in use under their 1115 demonstration waiver. Texas personnel discussed their method of moving institutional funds to

[1] A list of the meetings can be found in the Agenda on pp.4-5.
[2] The announcement and additional information can be found at http://www.cms.hhs.gov/NewFreedomInitiative/02_WhatsNew.asp
[3] Available at: http://www.cshp.rutgers.edu/cle/Products/MFPToolboxWEB.pdf

pay for HCBS. A former senior budget analyst from Oregon led a discussion on harmonizing program and budget priorities.[4] Finally, state personnel from Indiana and Minnesota talked about financial incentives to close institutional beds.

Resource Guide

After some general references and background material, this guide contains the meeting agenda, participant list, and materials for each state that presented at the meeting. Where materials are available online, the reader is directed to the online address. Other handouts are included here in the summary.

General Reference

Meeting participants were given the following documents:

Mollica, R., Reinhard, S., Farnham, J. & Morris, M. (2006). *Money Follows the Person Toolbox.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.cshp.rutgers.edu/cle/Products/MFPToolboxWEB.pdf

Hendrickson, L. & Reinhard, S. (2006). *Money Follows the Person: State Approaches to Calculating Cost Effectiveness.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.cshp.rutgers.edu/cle/Products/MFPCalcCostEffectivenessWEB.pdf

Morris, M. (2006). *Draft: Reducing Nursing Home Utilization and Expenditures and Expanding Community-Based Options.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available by email request to: jabramo@ifh.rutgers.edu

With input from meeting participants, the following tool was designed:

Mollica, R. & Hendrickson, L. (2006). *Money Follows the Person Modeling Tool.* New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange.

- Narrative available at: http://www.nashp.org/Files/Modeling_Tool_narrative_v_3_4_11.8.doc
- Spreadsheet available at: http://www.nashp.org/Files/MFP_cost_calculator_3.4_final.xls

[4] Paper for talk: Hendrickson, L. & Reinhard, S. (2006). Money Follows the Person: State Approaches to Calculating Cost Effectiveness. New Brunswick, NJ: Rutgers Center for State Health Policy & National Academy for State Health Policy: Community Living Exchange. Available at: http://www.cshp.rutgers.edu/cle/Products/MFPCalcCostEffectivenessWEB.pdf

Background material

Medstat. (2006). *Distribution of Medicaid Long-Term Care Expenditures for A/D Services: Institutional vs. Community-Based Services, FY 2005.* Available at: http://www.hcbs.org/files/94/4693/FY2005InstComm.xls (A/D tab).

New Jersey Global Budget Law http://www.njleg.state.nj.us/2006/Bills/A3000/2823_R1a.PDF

Massachusetts Choices for Care Law http://www.mass.gov/legis/laws/seslaw06/sl060211.htm

Agenda

Money Follows the Person: Systems Design Learning Collaborative

Invitational Forum for

MFP System Change Architects

Financing and Budgeting

September 11-13, 2006
Phoenix Inn
Olympia, Washington

Background

Designing state systems that promote "Money Follows the Person" (MFP) goals requires vision, leadership, and technical expertise. The Rutgers CSHP/NASHP technical assistance team supports and stimulates this vision, leadership and expertise through a **Learning Community for MFP System Change Architects**. Through our technical support and consultation, we will advance pro-active collaboration among these leaders to develop and implement sound and creative MFP policies and programs. The best ideas will come through shared learning that acknowledges the unique needs of each state, while taking full advantage of the experiences and knowledge of other states.

The MFP Systems Design Learning Collaborative will bring together the MFP grantees and guests in a series of invitational forums that focus on specific MFP design elements. With the assistance of MFP National Advisors, we will shape interactive agendas for the following:

MFP Systems Design Learning Collaborative Forums

June 13-15, 2006 **Seeking Potential MFP Participants**
Princeton, New Jersey

September 11-13, 2006	**Financing and Budgeting for MFP** **Olympia, Washington**
January 23-25, 2007	**Nursing Home Transition Process** **Austin, Texas**
April 24-26, 2007	**Local Delivery Systems and Accessing Services** **San Diego, California**
July 24-26, 2007	**Quality Assurance and Improvement** **Portland, Maine**
September, 2007	**Tracking and Evaluation** **TBD**

Forum II: Financing and Budgeting for MFP Programs

This second forum focuses on the financing and budgeting aspects of state MFP initiatives. To improve states' ability to support programs that assist people in nursing homes and other institutions to move to other settings, this technical assistance meeting seeks to meet the following objectives:

- Support the MFP Learning Community to share ideas and tools to promote MFP across the states.
- Define MFP models for promoting community living.
- Identify opportunities for states to invest in MFP programs through provisions of the 2005 Deficit Reduction Act.
- Discuss options for financing services for individuals who move from an institution to a community setting.
- Share successes and challenges in using various financing tools.
- Identify gaps in current methods for financing and budgeting for MFP programs.
- Discuss potential methods for closing unused institutional beds to reinvest in home and community based services.

Financing and Budgeting

Date **Monday, September 11, 2006**

3:00 – 4:00 p.m. Hotel check-in and Conference Registration

4:00 – 5:30 p.m. **Welcome to the MFP System Change Architects**

- Introductions
- Overview of Agenda
- MFP System Change Architects (participants) list their MFP issues, concerns and achievements in their states concerning financing

Susan Reinhard, Co-Director
Rutgers Center for State Health Policy

Robert Mollica
Senior Program Director
National Academy for State Health Policy

6:00 – 8:00 p.m. Dinner & Networking

Date **Tuesday, September 12, 2006**

8:00 – 8:45 a.m. Breakfast

8:45 – 10:45 a.m. **Global Budget/Pooled Financing Models**

This session will discuss global or pooled budgeting; the process for projecting caseloads for programs included in the global budget process; the impact of changes in program policy; management practices to ensure spending does not exceed the appropriation; and the information systems needed to support the process.

Kathy Leitch
Administrator, Washington Aging and Disability Services Administration

Kirsta Glenn
Executive Director, Caseload Forecasting Council

Nick Lutes
Budget Analyst, Office of Financial Management

Judy Fitzgerald
Chief, Budget Office, Department of Social and Health Services

Bill Moss, Director, Home and Community Based Services Division
Aging and Disability Services Administration

Kathy Marshall, Director, Management Services Division
Aging and Disability Services Administration

10:45 – 11:00 a.m. Break

11:00 – 12:30 p.m. **Global Budget and HCBS Entitlement**

This session will present details of the budget analysis and spending projections underlying Vermont's "Choices for Care" Section 1115 demonstration program which creates an entitlement to nursing home and waiver services for beneficiaries that meet the "highest need" criteria. Applicants for nursing home and waiver services who meet high need and moderate need criteria are served as funds are available. What data did the Department of Disability, Aging and Independent Living use to estimate total spending? How will spending be monitored to determine the availability of funds for high and moderate need applicants? What questions were asked by CMS and how was the Department able to convince decision makers to approve the demonstration?

Joan K. Senecal, Deputy Commissioner
Vermont Department of Disability, Aging and Independent Living

12:30 – 1:15 p.m. Lunch

1:15 – 3:00 p.m. **Using Institutional Funding to Pay for HCBS**

The initial Money Follows the Person concept allows funds appropriated for nursing home care to be used to pay for home and community based services for Medicaid beneficiaries who move from a nursing home to the community. Participants will learn about the process for implementing this policy; the impact of waiting lists for HCBS; the impact on nursing home utilization and spending; and potential incentives for consumers to enter a nursing home in order to receive waiver services.

Marc Gold
Texas Department of Aging and Disability Services

3:00 – 3:15 p.m. Break

3:15 – 4:15 p.m. **Crossing Cultures – Harmonizing Program and Budget Priorities**

Expanding HCBS raise tensions between program managers seeking more choice for people with disabilities and budget staff worried about revenue

	limitations, spending priorities, potential backfilling of institutional beds, woodwork effects and cost effectiveness. What information do budget offices need to support the expansion home and community based services programs? This interactive discussion allows policy and budget participants to share different perspectives and test assumptions about the impact of expanding HCBS on spending growth; to discuss the level of data and information needed to make budget decisions; and the limitations of existing data systems/research to answer certain questions. Leslie Hendrickson Rutgers/NASHP Technical Assistance Collaborative
4:15 – 5:00 p.m.	**MFP DRA Proposals** Participants will have an opportunity to discuss issues related to the RFP for the Money Follows the Person Demonstration program.
6:00 – 8:00 p.m.	Dinner
Date	**Wednesday, September 13, 2006**
8:00 – 8:30 a.m.	Breakfast
8:30 – 10:00 a.m.	**Reducing Institutional Capacity** This session will discuss strategies states use to close beds in institutions through financial incentives and bed buy outs. Stephen Smith Indiana Division of Disability, Aging and Rehabilitation Services Robert Held Minnesota Department of Health
10:00 – 10:30 a.m.	Planning for the MFP Learning Collaborative Forum on the Nursing Home Transition Process in Austin, Texas in January, 2007. Participant ideas and feedback

NATIONAL ACADEMY for STATE HEALTH POLICY

Money Follows the Person: Systems Design Learning Collaborative

September 11-13, 2006

Phoenix Inn
Olympia, WA

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Global Budget/Pooled Financing Models: Washington Materials

Online materials

Kane, R.A., Kane, R.L. et al. (2006). *Rebalancing Long-Term Care Systems in Washington: Experience up to July 31, 2005: Abbreviated Report.* Available at: http://www.hpm.umn.edu/ltcresourcecenter/rebalancing_attachments/Washington abbreviated 5.24.2006 FINAL_06.13.06.pdf

Washington State Caseload Forecast Council. (2006). *Long Term Care Caseload Forecasts Year in Review: June 2005 through February 2006.* Available at: http://www.cfc.wa.gov/Pubs/LTC YIR 2006.pdf

Washington State Caseload Forecast Council. (2006). Monthly Monitoring Reports: Home and Community Services – Total, In-Home Services, Residential Services, Nursing Homes. Available at: http://www.cfc.wa.gov/Monitoring/hcs_total.pdf ; http://www.cfc.wa.gov/Monitoring/in_home.pdf ; http://www.cfc.wa.gov/Monitoring/res.pdf ; http://www.cfc.wa.gov/Monitoring/nh.pdf

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Washington State Legislature. (1995). *Certification of Enrollment: Engrossed Second Substitute House Bill 1908.* Chapter 18, Laws of 1995, 54th Legislature, 1995 1st Special Session. http://browsedocs.leg.wa.gov/Browse for Documents from 1991 to 2002/PDF Documents/1995-96/House Passed Legislation/1800-1999/1908-S2.PL.PDF

Printed materials

Figures (2 pages):

Comparison of home and community caseload and nursing home caseload over time

NH Medicaid Caseload (FTE)

Long Term Care Fast Facts (6 pages)

The Caseload Forecasting Council describes the LTC forecast

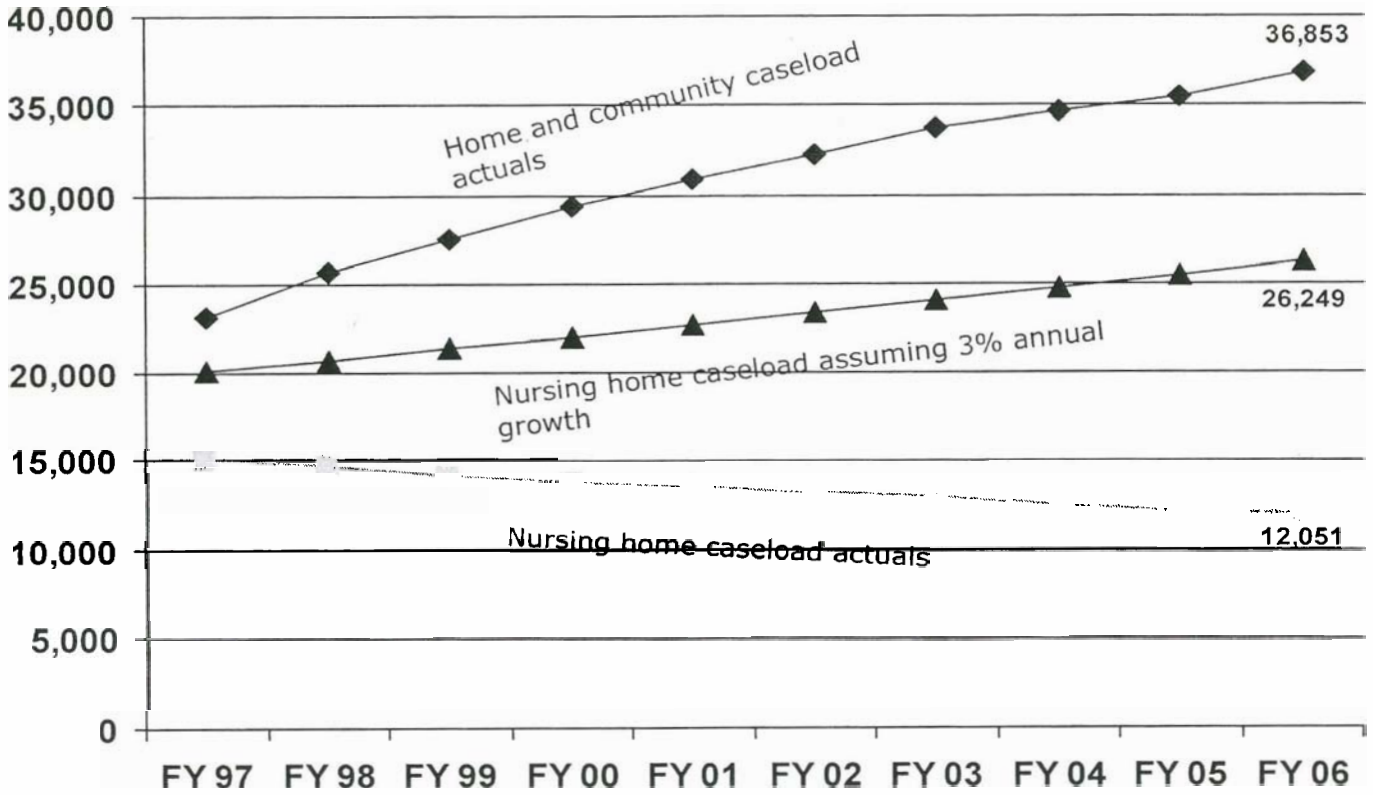
Caseload Forecast Council Presentation (10 pages)

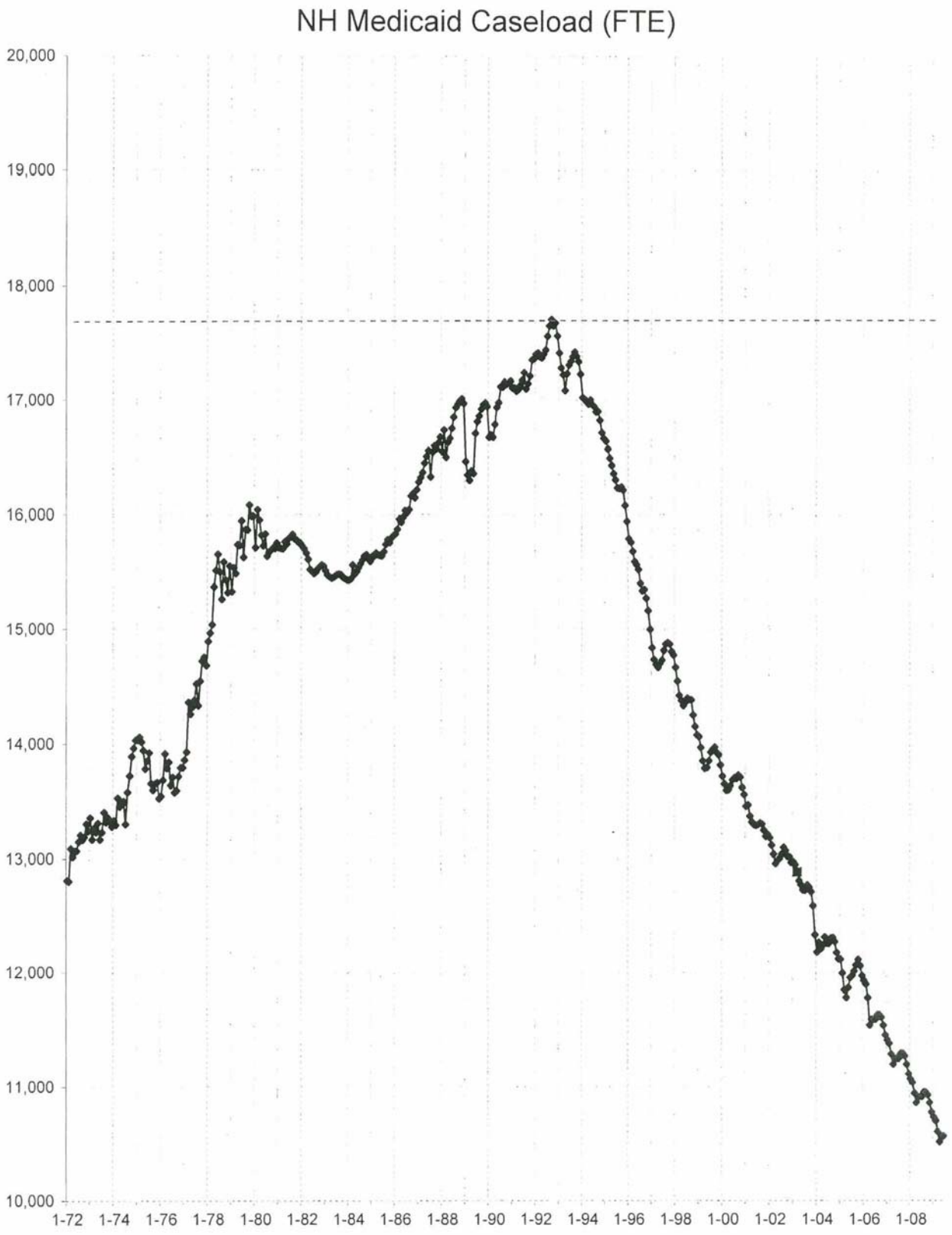
Glenn, K. (2006, September 12). *How Does the Budget Process in Washington State Facilitate Rebalancing?*

Washington State LTC Balancing History: 1981 – 2005 (6 pages)

Aging and Disability Services Administration Information (11 pages)

Comparison of home and community caseload and nursing home caseload over time




NH Medicaid Caseload (FTE)
20,000
19,000
18,000
17,000
16,000
15,000
14,000
13,000
12,000
11,000
10,000
1-72
1-74
1-76
1-78
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LONG TERM CARE
FAST FACTS

The Long Term Care forecast is the sum of two component forecasts, Nursing Homes and Home and Community Services.

The **Nursing Homes** forecast consists of Medicaid eligible clients who receive care in state licensed nursing facilities. Nursing facilities provide care to eligible persons who require short post-hospital recuperative care, are no longer capable of independent living and require nursing services, or are patients with chronic disabilities needing long-term rehabilitation and/or medical services.

Medicaid clients in the Nursing Homes caseload as a percent of the Washington state elderly (70+) population for FY2005 = 2.4 percent.

Washington's Nursing Homes Population
By Funding Source for Calendar Year 2004

Funding Source	Per Day	Percent
Medicaid	12,247	64.6%
Medicare	2,416	12.7%
Private	3,365	17.7%
Other	937	4.9%
Total	18,965	100.0%

Washington's Nursing Homes Population
Funded by Medicaid in Calendar Year 2004

Age Group	Males	Females	Total	Percent	Acc. %
85+	856	3,976	4,832	39.5%	39.5%
80-84	636	1,666	2,302	18.8%	58.2%
75-79	525	1,031	1,556	12.7%	71.0%
70-74	342	556	898	7.3%	78.3%
65-69	264	350	614	5.0%	83.3%
60-64	235	299	534	4.4%	87.7%
35-59	698	665	1,363	11.1%	98.8%
0-34	90	57	147	1.2%	100.0%
Total	3,646	8,601	12,247	100.0%	
	(30%)	(70%)			

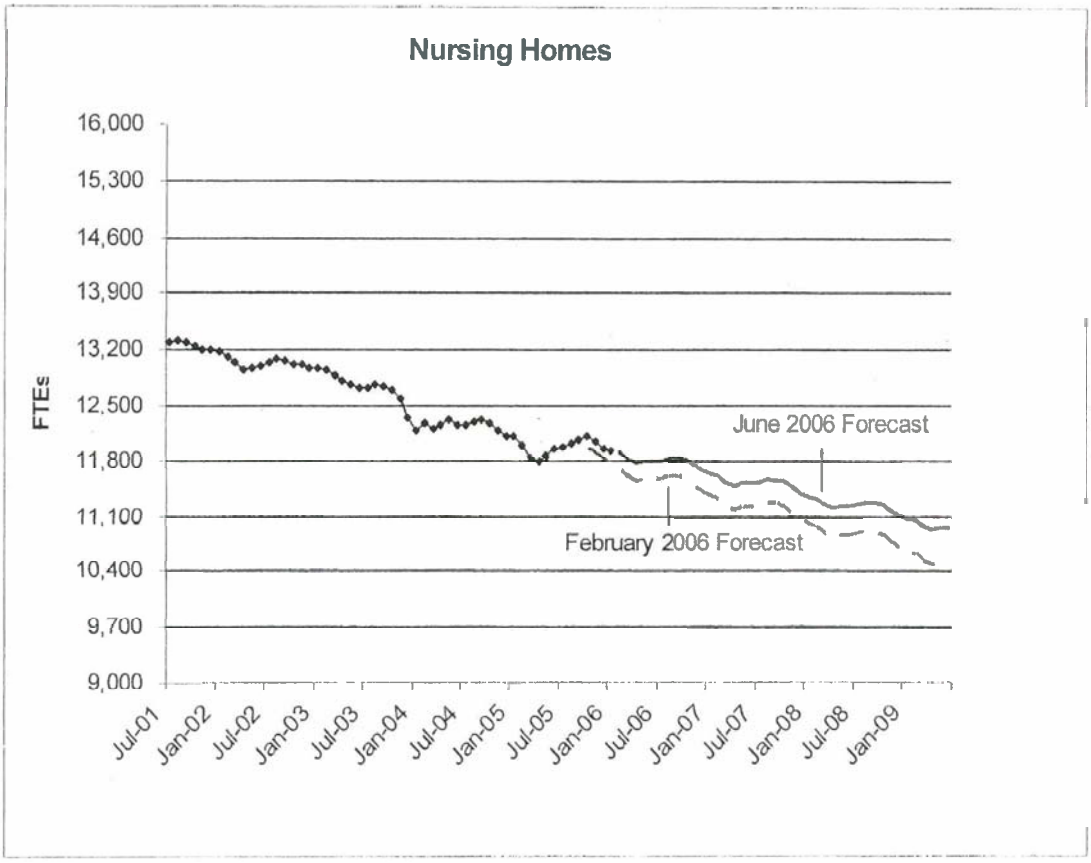
The **Home and Community Services** caseload includes services provided to clients in community-based settings, such as in their own homes, or in residential placements, such as Adult Family Homes. The Home and Community Services forecast is the sum of two separate forecasts for in-home and residential services. The In-Home forecast includes forecasts for Individual Provider, Agency Provider and CHORE. The Residential forecast includes forecasts for Adult Family Homes, Adult Residential Care, Assisted Living, and PACE.

Medicaid clients in the Home and Community Services caseload as a percent of the Washington state elderly (70+) population for FY2005 = 7.0 percent.

Breakdown of Long Term Care Caseload

	FY 2007 Caseload	Percent of Total	2007-09 Average Annual Change	2007-09 Average Annual % Change
Nursing Homes	11,667	23.4%	-279	-2.4%
Individual Provider	14,978	30.0%	0	0.0%
Agency Provider	12,535	25.1%	979	7.5%
CHORE	47	0.1%	0	0.0%
Adult Family Homes	3,935	7.9%	225	5.6%
Adult Residential Care	1,876	3.8%	0	0.0%
Assisted Living	4,663	9.3%	59	1.3%
PACE	247	0.5%	21	8.0%
Total HCS	38,282	76.6%	1,285	3.3%
Total Long Term Care	49,949	100.00%	1005	2.0%

The total Long Term Care caseload is forecast to grow, on average, by 2.0 percent per year for the 2007-09 Biennium, compared to the average projected population growth for persons age 70 and older of 1.6 percent per year for the same time period.



The Nursing Homes (NH) program provides services for Medicaid eligible clients residing in state licensed nursing homes.

Forecast Comparisons (Fiscal Year Averages)

Fiscal Year	Feb-06 Forecast	Jun-06 Forecast	Feb to Jun Difference	Percent Difference
2006	11,843	11,935	92	0.8%
2007	11,400	11,667	267	2.3%
2008	11,053	11,385	332	3.0%
2009	10,705	11,108	403	3.8%

The Nursing Homes forecast for June 2006 is higher than the February 2006 forecast by 2.3 percent for FY 2007. This upward adjustment is due to a slower than anticipated decline in the Nursing Homes caseload over the past several months and to a lower estimate of savings for the Chemical Dependency Treatment Expansion program.

Nursing Homes

Tracking the February 2006 Forecast

	Feb-06 Forecast	Actual	Variance	Percent Variance
Oct-05	**11,988**	**12,114**	**126**	1.1%
Nov-05	11,910	12,053	143	1.2%
Dec-05	11,810	11,965	155	1.3%
Jan-06	11,746	11,943	197	1.7%

Nursing Homes FTEs are tracking, on average, 1.3 percent above the February 2006 forecast for the past four months.

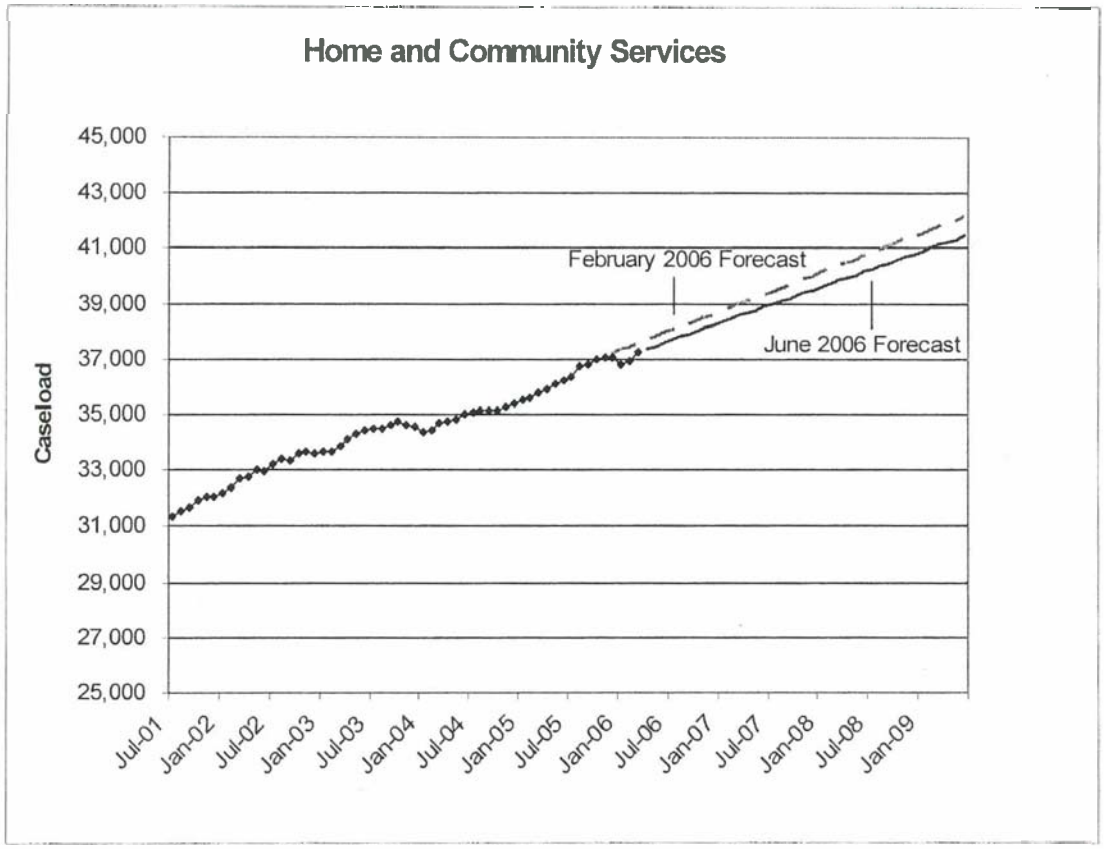
Nursing Homes Fiscal Year FTE Change

Fiscal Year	Caseload Change	Percent Change		Caseload
2004-2005	-362	-2.9%	Actual	12,084
2005-2006	*-149*	*-1.2%*	*Forecast*	*11,935*
2006-2007	*-268*	*-2.2%*		*11,667*
2007-2008	*-282*	*-2.4%*		*11,385*
2008-2009	*-277*	*-2.4%*		*11,108*

Nursing Home FTEs are expected to decline 2.2 percent (or by 268) over FY 2007.

Risk Assessment:
There is a moderate risk that the Nursing Homes forecast is too low due to a further slowing of the decline in the Nursing Homes caseload and to the inability to accurately assess Nursing Home FTE savings from the Chemical Dependency Treatment Expansion program.

Long Term Care



The Home and Community Services (HCS) program provides services to clients in community-based settings such as their own home, or residential placements in adult family homes, adult residential care facilities, and assisted living facilities. HCS also provides services to clients in the Program of All-Inclusive Care for the Elderly (PACE) program.

Forecast Comparisons (Fiscal Year Averages)

Fiscal Year	Feb-06 Forecast	Jun-06 Forecast	Feb to Jun Difference	Percent Difference
2006	37,115	37,033	-83	-0.2%
2007	38,689	38,282	-407	-1.1%
2008	40,096	39,566	-530	-1.3%
2009	41,503	40,851	-652	-1.6%

The Home and Community Services forecast for June 2006 is lower than the February 2006 forecast by 1.1 percent for FY 2007. This downward adjustment is due to a continued flattening of the Individual Provider caseload and to unusual drops in the Adult Family Homes and Program of All-Inclusive Care for the Elderly (PACE) program.

Home and Community Services

Tracking the February 2006 Forecast

	Feb-06 Forecast	Actual	Variance	Percent Variance
Dec-05	37,205	37,061	-144	-0.4%
Jan-06	37,349	36,810	-539	-1.4%
Feb-06	37,460	36,929	-531	-1.4%
Mar-06	37,603	37,227	-376	-1.0%

The HCS caseload is tracking, on average, 1.1 percent below the February 2006 forecast for the past four months.

Fiscal Year Caseload Change

Fiscal Year	Caseload Change	Percent Change		Caseload
2004-2005	880	2.5%	Actuals	35,514
2005-2006	*1,518*	*4.3%*	*Forecast*	*37,033*
2006-2007	*1,250*	*3.4%*		*38,282*
2007-2008	*1,284*	*3.4%*		*39,566*
2008-2009	*1,285*	*3.2%*		*40,851*

The HCS caseload is expected to grow 3.4 percent (or by 1250) over FY 2007.

The Home and Community Services forecast is comprised of two component forecasts for in-home and residential services.

- The In-Home forecast for June 2006 is lower (0.8 percent for FY 2007) than the February 2006 forecast, and the caseload is expected to grow 3.5 percent (or by 941) over FY 2007. The Residential forecast for June 2006 is lower (1.7 percent for FY 2007) than the February 2006 forecast, and the caseload is expected to grow 3.0 percent (or by 308) over FY 2007.

Risk Assessment:
There is a moderate risk that the Home and Community Services forecast is too high as a result of the assumptions made about the unusual drops in the Adult Family Homes and the Program of All-Inclusive Care for the Elderly (PACE) caseloads. Even though we know for the most part why the drops occurred, the June 2006 forecast assumes that the caseloads will resume similar upward trends as prior to the drops. If the declines in the caseloads continue, the Residential portion of the total Home and Community Services forecast will likely be too high.

How Does the Budget Process in Washington State Facilitate Rebalancing?

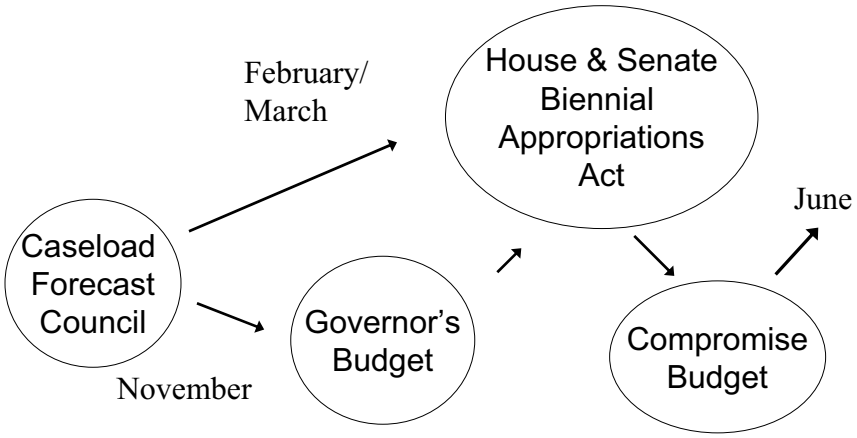
Presentation by Kirsta Glenn
Executive Director of the Washington State
Caseload Forecast Council
September 12, 2006

Background on the Caseload Forecast Council

CFC was created in 1997 with the mandate of producing statewide entitlement caseload forecasts.

The CFC is a small independent agency that reports to a Council with both legislative and executive branch members.

How does the Caseload Forecast Council fit into the state budget process?



Entitlement Forecasts:

	Average 2005 Monthly Caseload	Percent of Total
Common School	**1,158,939**	**53.40%**
Medical Assistance	**866,578**	**39.90%**
Long-Term Care	**48,623**	**2.20%**
Adult Corrections	**44,623**	**2.10%**
Public Assistance	**27,088**	**1.20%**
Foster Care & Adoption Support	**17,630**	**0.80%**
Medicaid Personal Care Services	**5,952**	**0.30%**
Juvenile Rehabilitation	**844**	**0.04%**
Total	**2,170,476**	**100%**

The provision of state entitlements involves about 3/4 of state general fund spending.

Why was the Caseload Forecast Council Created?

- State agencies used to provide caseload forecasts for their programs.
  - Lack of understanding of forecast process
  - Lack of participation of all users
- Legislators and their staff questioned forecasts leading to disagreements on forecasts used in budget process.

Principles underlying the creation of the Council:

- Independent – reports to a joint executive, legislative council.
- Unbiased – reports to a council with not only executive and legislative members, but from both political parties.
- Inclusive – process to develop forecasts involves legislative, agency, and OFM staff.
- Open and Transparent – Council meetings are open to the public, information on forecasts and process are available on the Internet.

Technical Workgroup Process

Organized by program area (medical assistance, K-12 education, corrections, etc.)

Participants include

- **Legislative and executive fiscal analysts**
- **Program experts (i.e. Medicaid, Corrections, etc)**
- **DSHS and OFM forecasting analysts and**
- **CFC staff**

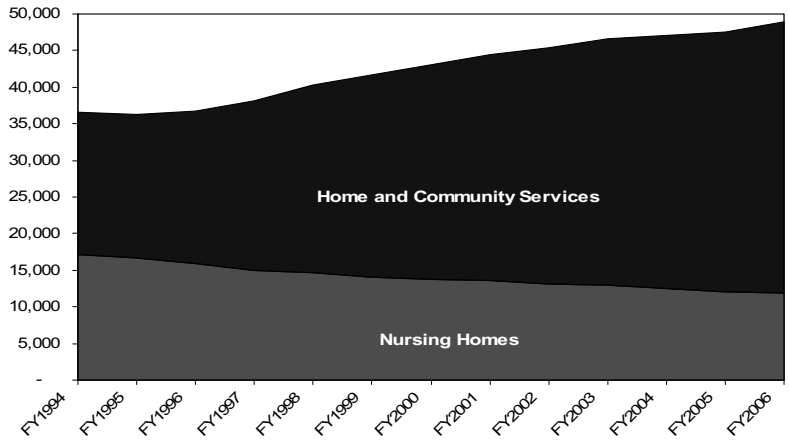
All major decisions affecting the forecast are made in or reviewed by the technical workgroup

Technical workgroups – meet several months before Council meeting:

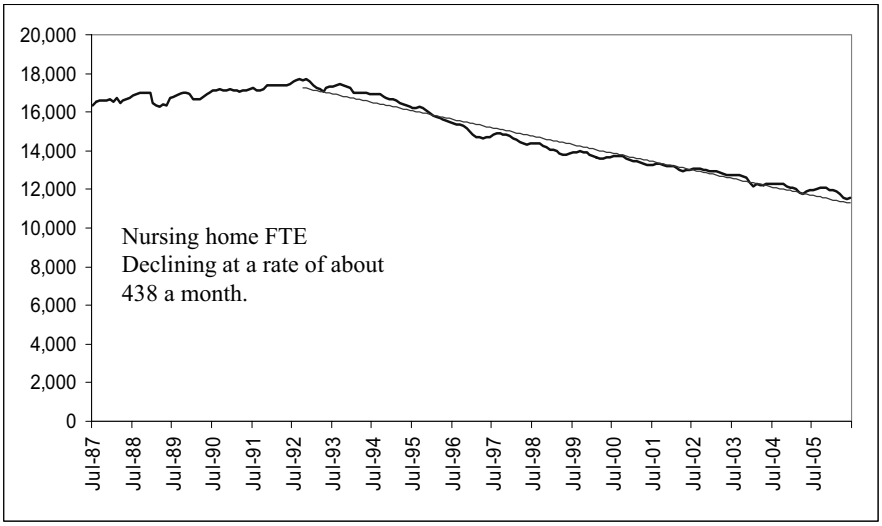
- Review forecast tracking
- Identify changes in forecast drivers
  - Demographic
  - Changes in external environment
  - Federal policy changes
  - Departmental policies
- Estimate any legislative policy impacts
- Review and revise forecast models
- Compare alternatives, agree on new forecast

Long-Term Care caseload forecasts Washington State

Long Term Care



Nursing home FTE have been declining in Washington since mid -1992.

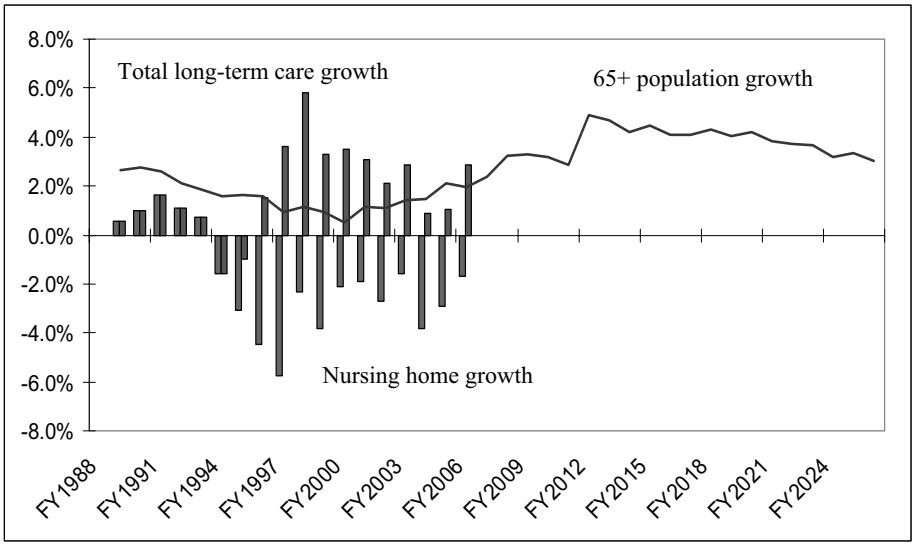


Nursing home residents as a percent of 65+ population.

- 42 **Washington** 2.7%
- 43 **New Mexico** 2.6%
- 44 **Florida** 2.4%
- 44 **Rhode Island** 2.4%
- 44 **Utah** 2.4%
- 47 **Oregon** 1.8%
- 48 **Nevada** 1.7%
- 49 **Arizona** 1.6%
- 49 **Hawaii** 1.6%
- 51 **Alaska** 1.4%

Kaiser Family Foundation: 2003 data.

Total long-term care population likely to experience strong growth in future.

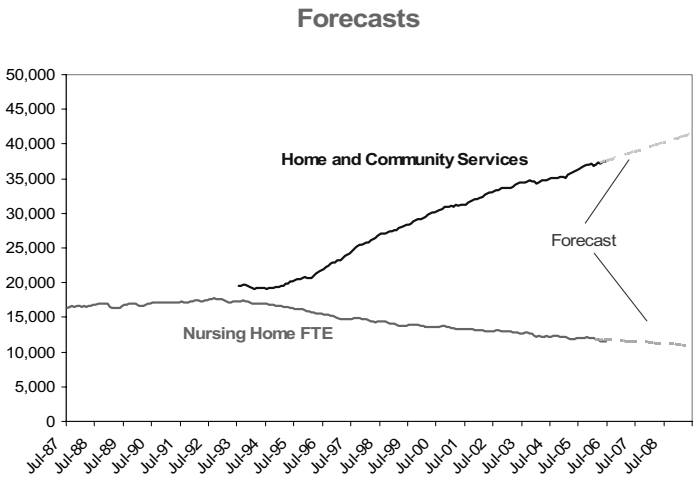


Growth in long-term care services has outpaced population growth in Washington State.

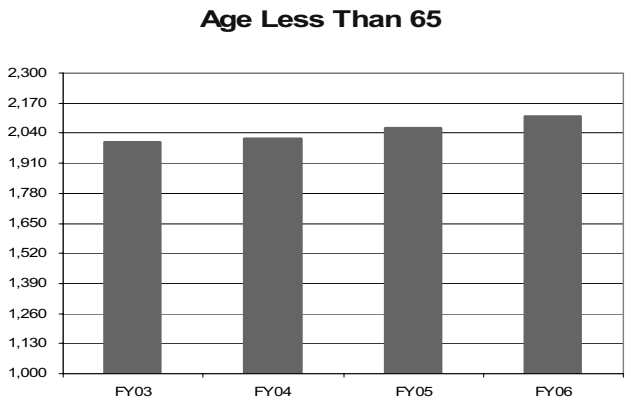
Average fiscal year growth between 2000 and 2006

- Nursing homes -2.4%
- Home and community based services 4.3%
- Total Long-term care 2.3%
- 65+ population 1.4%
- Under 65 population 1.3%

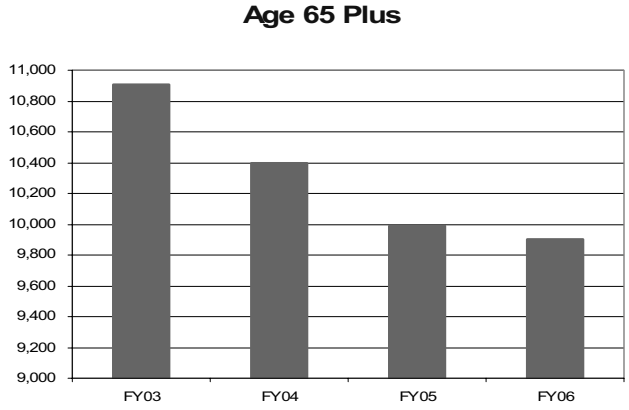
Long Term Care



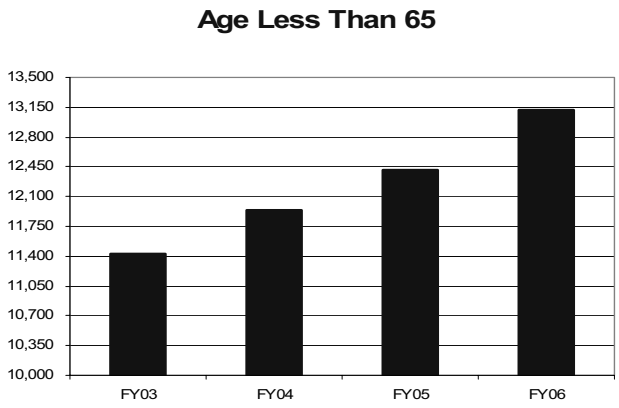
Long Term Care
Nursing Homes



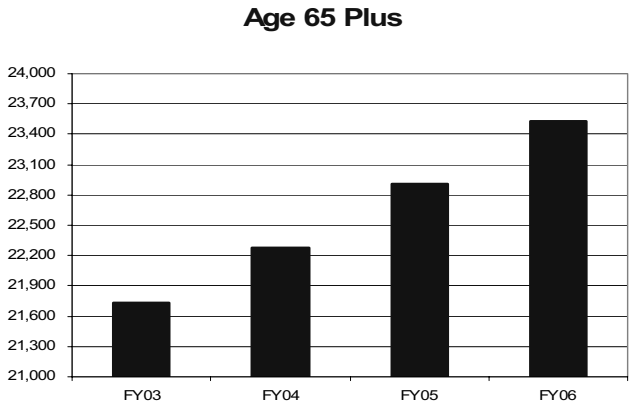
Long Term Care
Nursing Homes



Long Term Care
Home and Community Services



Long Term Care
Home and Community Services



Conclusions:

- Long-term care growth is determined by
  - Growth in population
  - Growth in use of care (population penetration)
- Nursing home penetration still has room to decline in Washington state
- Increase in 65+ population, use of long-term care services, and decline in nursing home residents would all put pressure on home on community services.

Washington State LTC Balancing History
1981 - 2005

1981 **Long-Term Care System Development Project**

Funded by a federal DHHS grant, DSHS established a long-term care task force of all the departmental offices involved in long-term care. The task force was organized in response to (1) a rapidly growing demand for publicly funded long-term care services, (2) fragmented and inadequate community alternative services and (3) the growing costs of providing institutional care which were increasing disproportionately to the overall economy. Results of the project included the CARES pre-admission screening model of Medicaid community-option waivers, expanded case management services, and a better-coordinated delivery system based on individualized assessment and care planning.

The Chore Program was restructured to eliminate non-essential services and tighten income eligibility levels. As a result, over 4,000 clients were dropped from the program. In lieu of the full Chore Program, funding was made available for a Volunteer Chore program administered by the AAAs.

1982 **Pre-admission Screening and Assessment Model Adopted**

Washington adopts the Comprehensive Adult Resources Evaluation System (CARES), a pre-admission screening and assessment model. CARES provides a multidisciplinary assessment of the strengths and needs of persons at risk of entering a nursing home or other residential setting. The goal of the assessment is to develop a recommended service plan which best matches the clients' needs with available services.

1983 **Public Hearings on Long-Term Care**

Public hearings co-sponsored by the House Social and Health Services Committee and the State Council on Aging. The hearings were intended to provide state policy-makers with local perspective on perceived problems and potential improvements in the state's long-term care service system. Public testimony provided substantial support for respite care, resulting in a legislative initiative for a respite care demonstration. Results also provided evidence of growing understanding and support for case management as a crucial element in the long-term care system.

1983 **COPES Waiver**

DSHS granted a home and community-based care Medicaid waiver from the federal Department of Health and Human Services. The waiver program, dubbed COPES (Community Options Program Entry System), offers in-home personal care, congregate care, adult family home care, and

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case management services to persons who would otherwise require care in a skilled or intermediate nursing care facility.

1984 **Respite Care**
Legislature authorized three respite care demonstration projects. Respite services provide temporary care of disabled adults, and give caregivers a break from the physical, psychological and financial demands of continuous care.

1984 **Long-Term Care Planning Group**
DSHS transforms Long-Term Care Systems Development Project Task Force (see 1981) into on-going Long-Term Care Planning Group (LTCPG).

1984 **DSHS Long-Term Care Policy**
DSHS adopts Long-Term Care Policy recommended by the LTCPG. Policy calls for expansion of home and community-based care in conjunction with reduced emphasis on nursing homes.

1984 **Nursing Home Bed Need Target Revised**
The State Health Coordinating Council amended the State Health Plan to revise the nursing home bed need target downward from 60.2 beds/1000 persons age 65+ to 53.7 beds/1000. The revision was intended to promote development and funding for home/community care programs. Nevertheless, 900 new beds were allowed from 1984-1987.

1985 **Public Hearings on Long-Term Care**
Public hearings on long-term care were co-sponsored by the Senate Human Services and Corrections Committee, House Social and Health Services Committee, and the State Council on Aging. Results of the hearings underscored the need:

- For a statutory base for long-term care providing a clear policy direction for the implementation of a comprehensive and cost-effective system of services;
- To support family caregivers in order to prevent burn-out and also counter the potential for elder abuse;
- To expand case management services to keep pace with the growing need for long-term care;
- For maximizing independence and utilizing community-based services

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1986 **Statewide Adoption of Case Management Standards**
These standards describe case management provided by state field staff and aging network staff and how these entities will work together. Statewide standards and implementation established a foundation on which to build a comprehensive and coordinated service delivery system.

1986 **Creation of Aging & Adult Services Administration (AASA)**
Activities formerly performed by the Bureau of Aging and Adult Services and Bureau of Nursing Home Affairs are combined into the Aging and Adult Services Administration. This significant change in administrative structure meant that, for the first time, one administrative entity was responsible for the full array of services available to meet long-term care needs including in-home services, community residential services, and nursing homes.

1989 **Significant Legislative Developments**

- Title XIX Personal Care approved
- Statewide Respite Program enacted
- Mental Health decentralization mandated (RSN system)

1989 **Nursing Home Bed Need Target Revised**
The State Health Coordinating Council proposed and the Governor approved an amendment revising the nursing home bed target downward from 53.7 beds/1,000 persons age 65+ to 45 beds/1000. The revision is intended to promote development and funding for home/community care.

1989 **DSHS Strategic Plan for Long-Term Care**
The DSHS Long-Term Care Policy Group conducted a strategic planning process and prepared a report, Long-Term Care in Washington State: Critical Issues and Strategies.

1992 **Assisted Living Emerges as Major New LTC Option**
Both the private sector and AASA promote development of Assisted Living as cost-effective alternative to nursing home care. A national association is formed to assist in developing standards that emphasize personal dignity and autonomy associated with individual living space.

1992 **State Budget Crisis Threatens LTC Progress**
Faced with the need for major human services budget cuts, Governor Gardner supports AASA proposal to offer relocation assistance to nursing home residents who would prefer to receive services at home or in community-based residential settings. Part of the resulting nursing home budget savings would be used to offset the budget shortfall. The remainder would enhance home and community-based LTC options.

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1993 **Legislature Enacts Community Options Program**

New state law articulated state policy favoring the development of home/community care for the functionally disabled, strengthened the nursing home certificate-of-need process, expanded the number of authorized Assisted Living units and provided modest enhancements for priority LTC service options.

1994 **Legislature Calls for LTC Report**

State statute required AASA to prepare recommendations on how long-term care programs could be restructured to better comply with cost growth limitations established under State Voter Initiative 601. The report, issued in Fall 2004 became the basis for the LTC Options Program enacted by the Legislature the following year.

1995 **AASA LTC Options Program Enacted**

State statute was passed limiting unnecessary nursing home utilization by diversion and voluntary relocation. Budget savings were targeted to satisfy I-601 spending limits and for investment to expand and improve home/community care. Case management was expanded and nurse delegation authorized in non-medical residential settings.

1996 **AASA LTC Options Program Strategic Plan**

AASA prepared a six-year strategic plan and related budget proposals premised on further expansion and quality improvement in home/community services. Planning assumptions include reducing Medicaid nursing home caseload from the 15,000 level in 1996 to the 12,000 level in 2003.

1997 **Caseload Forecasting Council established**

The legislature passed a final budget for AASA/LTC that was $38 million short of the Governor's budget. Controversy surrounded the caseload projections. AASA was forced to launch a regulatory process to raise the threshold of eligibility as a hedge against the odds of losing a bid for supplemental budget. In the end no eligibility changes were necessary and the legislature established a Caseload Forecasting Council that included executive representatives. The Council ushered in a new era of rational caseload projections and related budget planning.

1998 **Oversight for boarding homes transferred to AASA/DSHS**

Oversight responsibility for boarding homes was transferred from Department of Health to DSHS following three consecutive years of bad quality reports from the Ombudsman. The transfer was controversial. The Governor took the initiative following cases of client abuse surfacing during the tail end of the session.

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1998 **Washington moves to case-mix payment system for nursing homes**
The 15,000-word statute codifying the cost-reimbursement nursing home payment system was amended to include a case-mix payment system.

1999 **Self-directed care becomes an option**
Legislation authorized the Self-Directed Care program allowing a person with a functional disability to choose to direct his or her own health related tasks through a non-licensed, paid personal aide.

2001 **Expansion of Home/Community Care**
Medically Needy waiver is authorized to expand Medicaid home/community care eligibility for clients with income above the SSI categorically needy standard. This expands access and controls costs for clients who otherwise have no alternative to nursing home placement.

AASA begins project to establish a rate structure for community residential rates based on the assessed needs of clients.

2001 **Home Care Quality Initiative**
Initiative 775 (Quality Home Care) was passed indicating strong public support for in-home care as an alternative to nursing home placement. Major issues include setting up the board of the new Home Care Authority, conducting an election for the workers, bargaining for wages and benefits and securing necessary funding.

2001 **Quality Assurance for Home & Community-Based Care**
AASA created a specialized QA unit to oversee LTC eligibility, client assessment, care planning and case management by HCS and AAA staff.

2002 **DDD+AASA = Aging & Disability Services Administration (ADSA)**
The DSHS Secretary mandated the merger of Aging & Adult Services Administration and the Division of Developmental Disabilities. The new organization, ADSA was expected to improve the planning, coordination and accountability of DD services.

2003 **Revised LTC Client Assessment (CARE) is Implemented**
The new CARE system, with revised content and improved automation features, passed through the pilot and training phase and statewide implementation was underway.

Start of project providing specialized dementia care in boarding homes for individuals who have been discharged from a nursing home.

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As directed by the Legislature, ADSA changed functional eligibility for Medicaid Personal Care program and put steps in place to limit caseload growth for COPES waiver program to 1.1%.

ADSA begins development of Expanded Community Services program to more appropriately serve elderly and disabled individuals with mental health needs in less restrictive community settings. The state budget set a target for reduced state hospital usage for these individuals.

2004 **Further expansion of home and community services**

COPES waiver clients began to be authorized for nurse delegation in-home. By state law, nurse delegation had previously been allowed only in residential settings.

Waivers serving Medically Needy clients in-home and in residential settings opened during 2003-04

ADSA begins "Coming Home Program", a collaboration with the Robert Wood Johnson Foundation and NCB Development Corporation to demonstrate the viability of creating modest assisted living facilities in small communities.

2005 **Expansion of Chemical Dependency Treatment options for LTC clients**

Budget moves $6.9 million from LTC budget to the budget for the division of alcohol and substance abuse, doubling the numbers of aged and disabled clients expected to receive chemical dependency treatment services. The additional services are expected to reduce medical assistance and LTC expenditures sufficient to offset at least 80% of the short-term cost of the service expansion.

LTC Financing Task Force Established

State law establishes a joint legislative and executive task to review public and private mechanisms for financing long-term care.

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ADSA

AGING
and
DISABILITY
SERVICES
ADMINISTRATION

Kathy Leitch
Assistant Secretary

Mission Statement

The Aging and Disability Services Administration (ADSA) assists adults with disabling conditions due to aging, disease or accident and children and adults with developmental disabilities to gain access to the high quality, cost effective supports they need.

ADSA Core Values

We believe that people with disabilities and their families:

Are entitled to maximum feasible choice and participation in their care

- Have the right to expect "quality of life"
- Have the right to choose and/or direct a care plan
- Have the right to public services and individual choices bounded by reasonable consideration of cost-effectiveness

Washington's LTC system

- Targets seniors and disabled adults in one LTC delivery system
- Uses MPC and HCBS waivers to expand home & community care options
- Uses comprehensive client assessment to target resources to high risk clients
- Uses case management to set up and monitor individualized care plans

Uses diversion and relocation to minimize Medicaid nursing home caseload

Washington's LTC system

- Supports family caregivers as primary resource for long term care
  Consolidates a full array of options: in-home, community residential, nursing home
- Controls & coordinates entire LTC budget (nursing home, home & community, AOA/AAA funding)
- Controls and coordinates residential care QA and regulatory compliance

No One Service is Most Important

Washington provides an array of services– the most important service is the one the client needs .

- Nursing home
- Adult family home
- Boarding home
- Personal care in-home
- Supportive services such as adult day health, respite, client training, skilled nursing, home delivered meals, etc.

LTC Rebalancing History

- 1976 Senior Citizens' Services Act implemented to prevent premature institutionalization. The state-funded program was a first in the U.S. and captured federal OAA matching funds for the program.
- 1981Long-Term Care System Development Project funded by a federal grant, resulting in expanded case management services and a better coordinated delivery system
- 1983 Home and community-based care Medicaid waiver (COPES) approved.
- 1984 DSHS adopts Long-Term Care Policy calling for expansion of home and community-based care in conjunction with reduced emphasis on nursing homes. Nursing home bed need target reduced.

LTC Rebalancing History

- 1986 Single state agency created to administer the full array of services available to meet long-term care needs
- 1989 Medicaid Personal Care program approved. Statewide Respite Program enacted.
- 1992 Assisted Living emerges as major new LTC option
- 1993 Legislature approves relocation of 750 nursing home clients and further development of home & community services.
- 1995 Legislature approves additional reduction in nursing home census and increase to home and community services
- 1997 Caseload Forecasting Council established

"Global budgeting" – a key to rebalancing

The budget is a key policy tool

- WA's single LTC appropriation allows decisions based on client needs rather than funding silos.

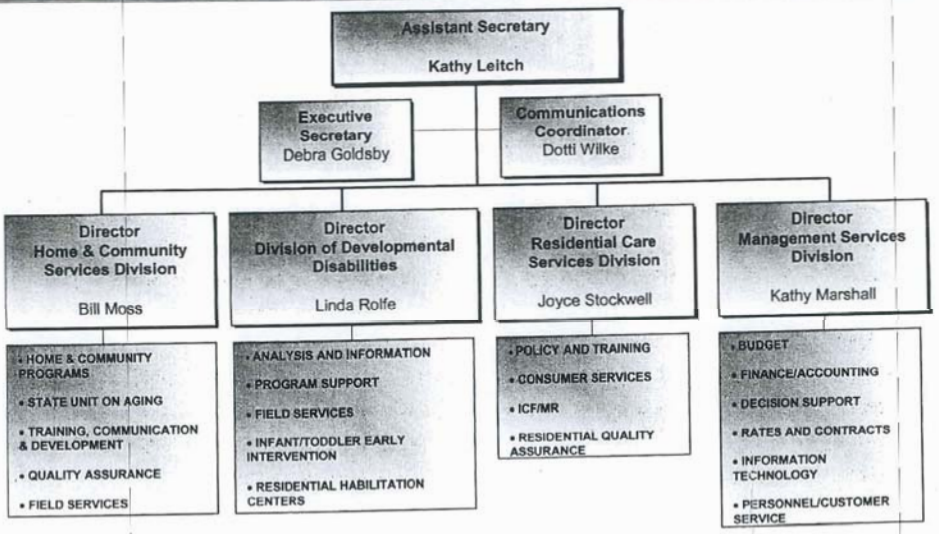
Many states are not organized in a way that supports global budgeting.

Integrated Administrative Structure

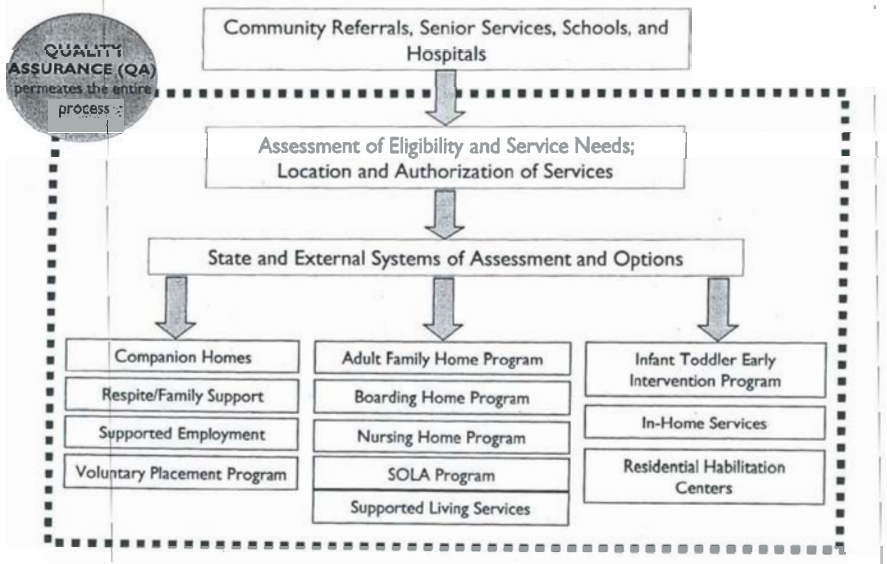
Unlike many states, Aging and Disability Services Administration brings together under one administrative organization the major aging, long-term care and developmental disabilities programs.
Statewide network of:

- Access points for program/financial eligibility determination and case management services
- Area Agencies on Aging providing in-home case management, Senior Information and Assistance, and other community-based resources
- County DD services such as employment and day programs
- Statewide residential quality assurance programs
- Consolidated management functions

The ADSA Organization

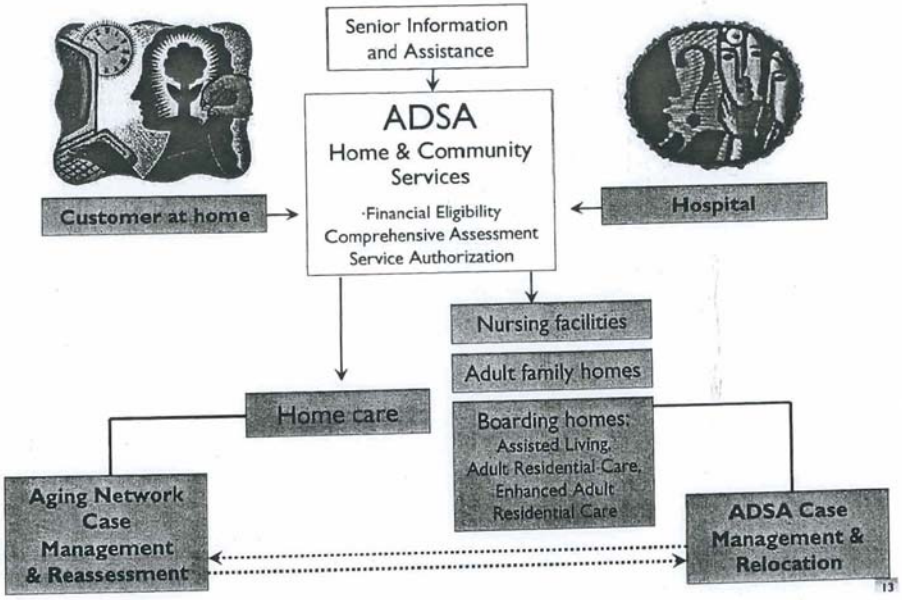


How Does ADSA Work?



The result : Quality choices for people who are securing long-term services

Long-term Care Service Delivery System



Long-term Care Services Settings

Setting	Number / Size of facilities (Oct 05)	Number of residents (Oct 05)	Rate range
Adult family home	2,348 licensed facilities Average 5.5 beds	3,812 state-funded residents 12,873 licensed beds	$45.90 to $87.15 per day
Boarding home: (Assisted Living, Adult Residential Care, Enhanced Adult Residential Care)	549 licensed facilities Average 47 beds	6,360 state-funded residents 26,054 licensed beds	$45.27 to $101.84 per day
In-home	N/A	26,596 state-funded clients	$9.20 to $15.28 per hour
Nursing home*	252 facilities Average 89.8 beds	11,977 state-funded residents 22,723 licensed beds	$146.78 average per day

SOURCES: ADSA FACILITY DATABASE, MMIS, SSPS, EMIS, ADSA RATES JAN 2006

*Nursing homes that are Licensed and Certified, Licensed only, and Hospitals with long-term care wings

ADSA Budget Summary 2005-2007 Biennium

Long-term care budget

Services	Oct 05 caseload	Percent of caseload	05-07 biennium allotment (number rounded)	Percent of total cost
Nursing facilities	12,086	26%	$1 billion	41.4%
In-home care	26,596	54%	$788 million	31.3%
Community residential	10,172	20%	$294 million	11.7%
HCS field staff			$109 million	4.4%
RCS quality assurance staff			$46 million	1.8%
Administration staff			$30 million	1.2%
AAA staff			$140 million	5.5%
Other community services			$66 million	2.6%
Long-term care total	48,854	100%	$2.5 billion	100%
ADSA total			$3.96 billion	

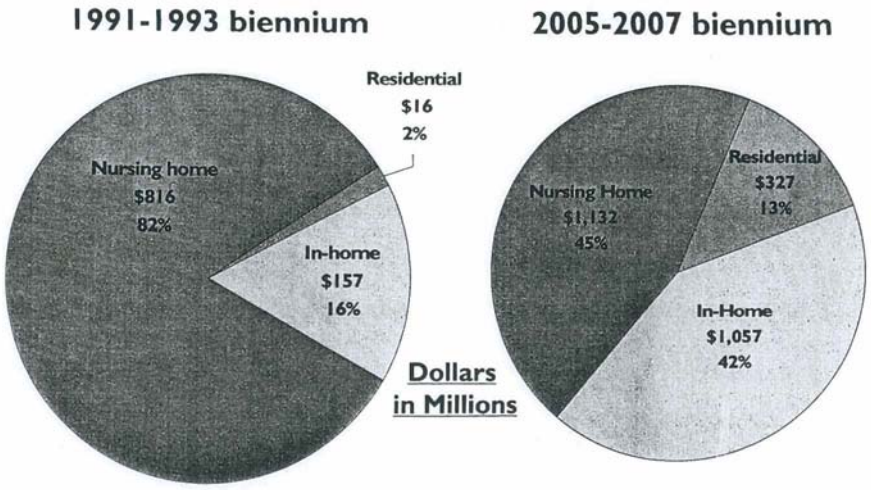
SOURCES: ADSA BUDGET OFFICE, EMIS

ADSA

AGING and DISABILITY SERVICES ADMINISTRATION

Kathy Leitch
Assistant Secretary

Long-term Care Expenditure Shift

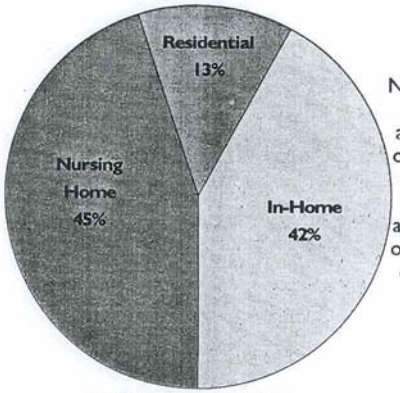


SOURCE: ADSA BUDGET OFFICE AUG 2005

Long-term Care Budget and Caseload

2005-2007

Budget

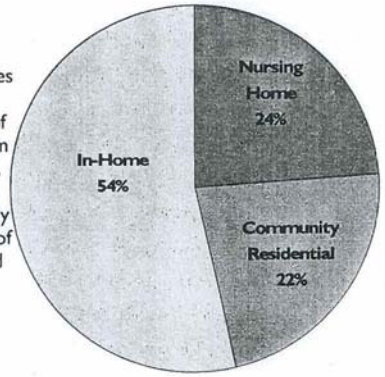


Total = $2,517,105,000

SOURCE: ADSA BUDGET OFFICE AUG 2006

Nursing homes represent almost half of our long-term care budget, but approximately one-quarter of our caseload

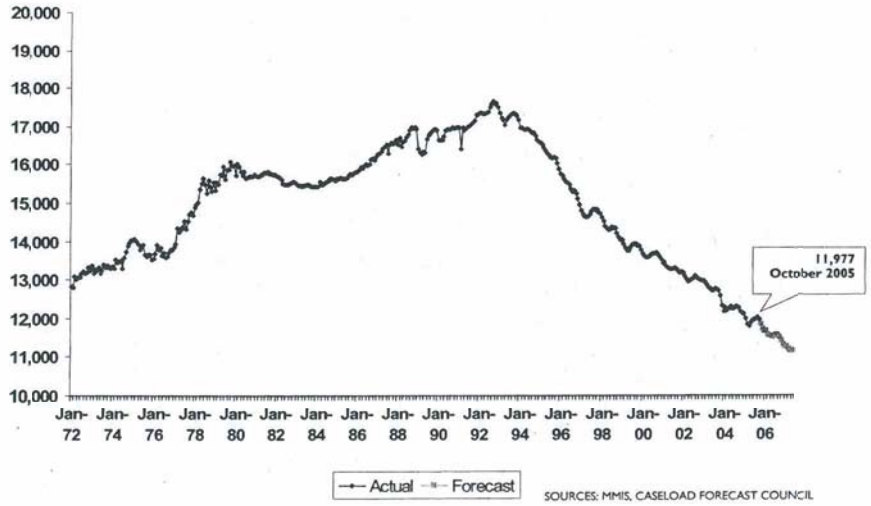
Caseload



SOURCE: CASELOAD FORECAST COUNCIL JAN 2006

Nursing home Medicaid FTE Caseload Trend

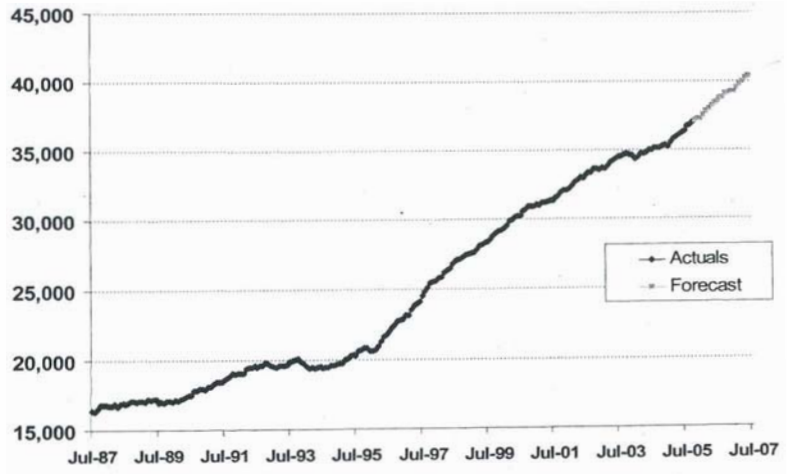
January 1972 through June 2007



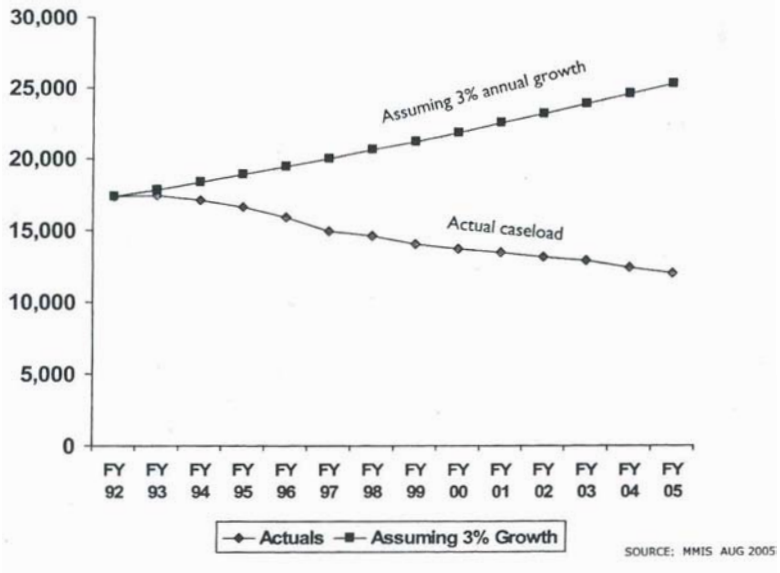
SOURCES: MMIS, CASELOAD FORECAST COUNCIL

Home and Community Long-term Care Caseload Trend

July 1987 through June 2007



Estimate of Medicaid nursing home clients if Washington had not expanded home and community options



Global Budget and HCBS Entitlement: Vermont Materials

Online materials:

Vermont Department of Aging and Disabilities. (2003, October 1). *The Vermont Long-Term Care Plan: A Demonstration Waiver Proposal to the Centers for Medicare & Medicaid Services.* Available at: http://www.dad.state.vt.us/dail/1115Waiver/VTLTCWaivernoappendices.pdf [pp. 1-13 included in meeting packet]

Vermont Department of Aging and Disabilities. (2004, May 7). *Vermont 1115 Demonstration the Vermont Long-Term Care Plan: Revised Budget Neutrality Projections: May 7, 2004.* Available at: http://www.dad.state.vt.us/1115Waiver/VTLTCPlan5704.pdf

Printed materials:

Vermont's Choices for Care 1115 Demonstration Waiver: Services by Eligibility Group (1 page)

Figures (4 pages):

Total Nursing Facility Residents: January 1994 to June 2006

Choices for Care: Medicaid Nursing Home Residents and Home & Community-Based Participants--July I, 2006 Changes (Yellow) Needed to Achieve 60/40 Balance

Choices for Care: Total Number of Enrolled Participants October 2005 – August 2005 (excludes moderate needs group)

VT Nursing Facility Resident Days--Total & Medicaid 2000 – 2006

Vermont Monthly Monitoring FY06 (3 pages)

VERMONT'S CHOICES FOR CARE
1115 DEMONSTRATION WAIVER

Services by Eligibility Group

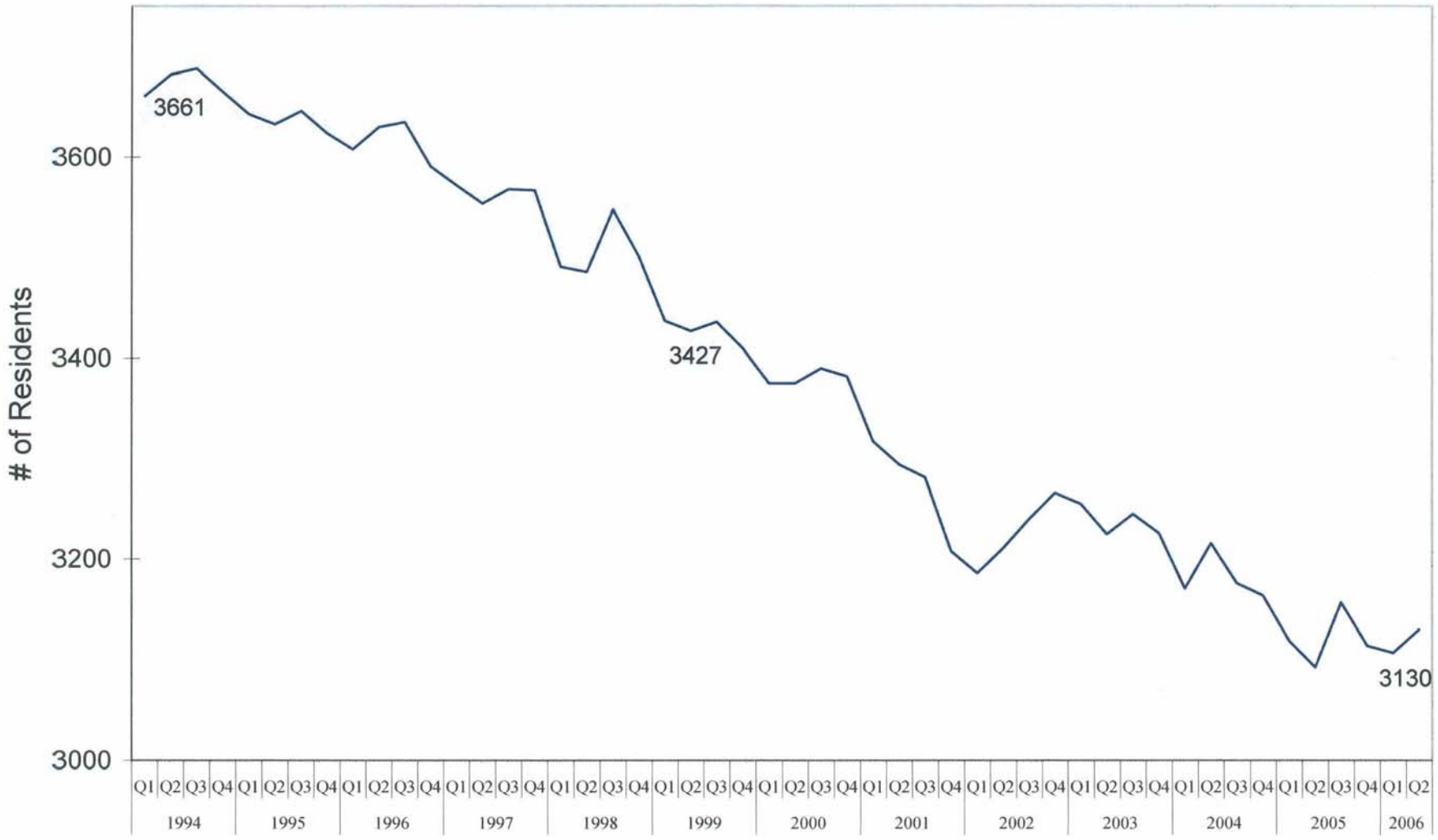
Services for the Highest and High Need Groups

- Nursing Facility care
- Case Management – capped at 48 hours/year
- Personal Care
  - ADLs – as shown on the care plan
  - IADLs – capped at 5.5 hours/week
- Adult Day – capped at 12 hours/day
- Respite – capped at 720 hours/calendar year in combination with Companionship hours
- Companionship – capped at 720 hours/calendar year in combination with Respite hours
- Assistive Devices and Home Modifications – capped at $750/calendar year
- Personal Emergency Response Systems
- Enhanced Residential Care – provided in an approved Level III Residential Care Home or Assisted Living Residence: nursing overview (1 hr/wk), ADL assistance, medication management, recreation activities, 24-hr on-site supervision, laundry and household services.

Services for the Moderate Needs Group

- Case Management – capped at 12 hours/year
- Adult Day – capped at 30 hours/week
- Homemaker – capped at 6 hours/week

Total Nursing Facility Residents*
January 1994--June 2006



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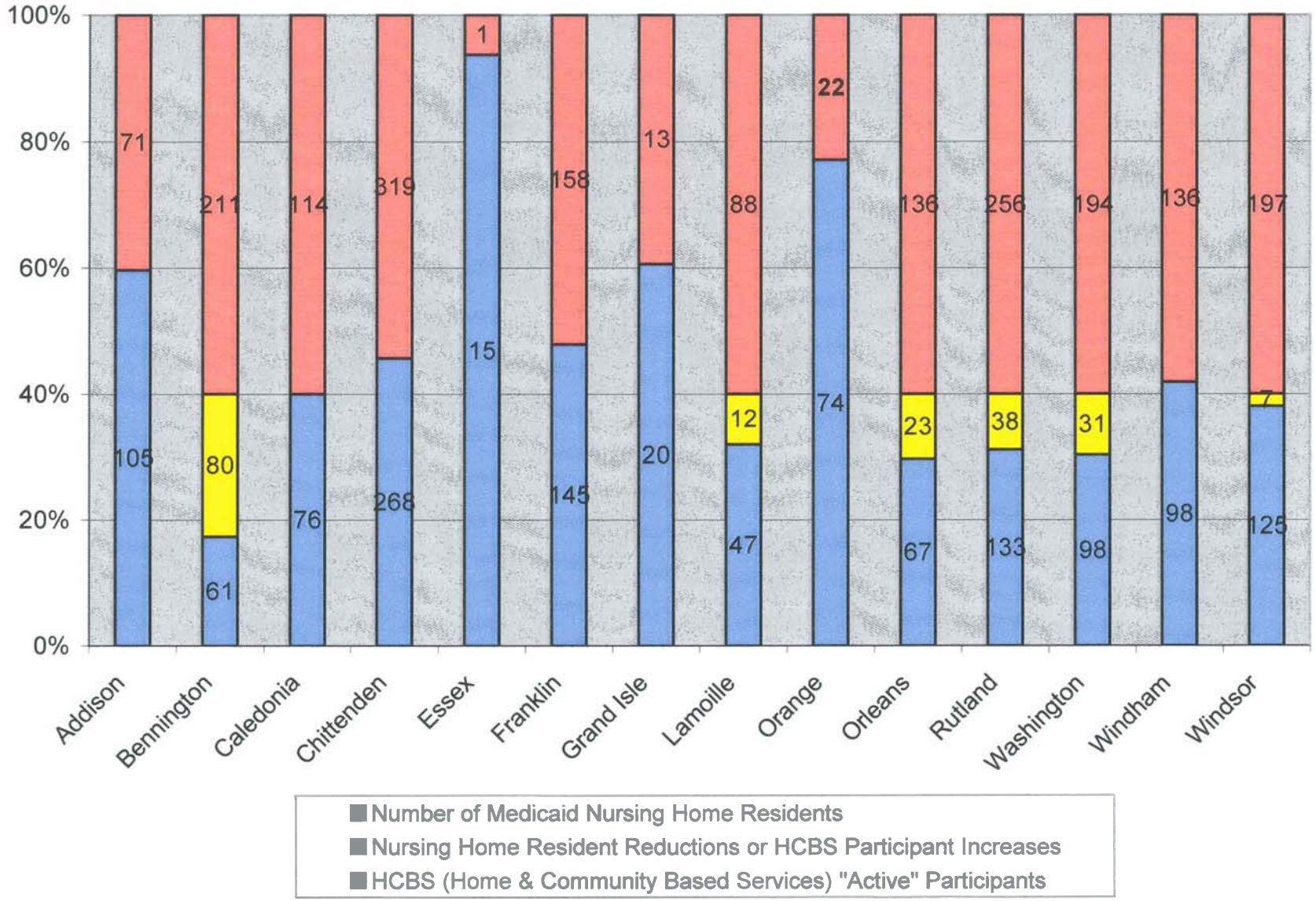
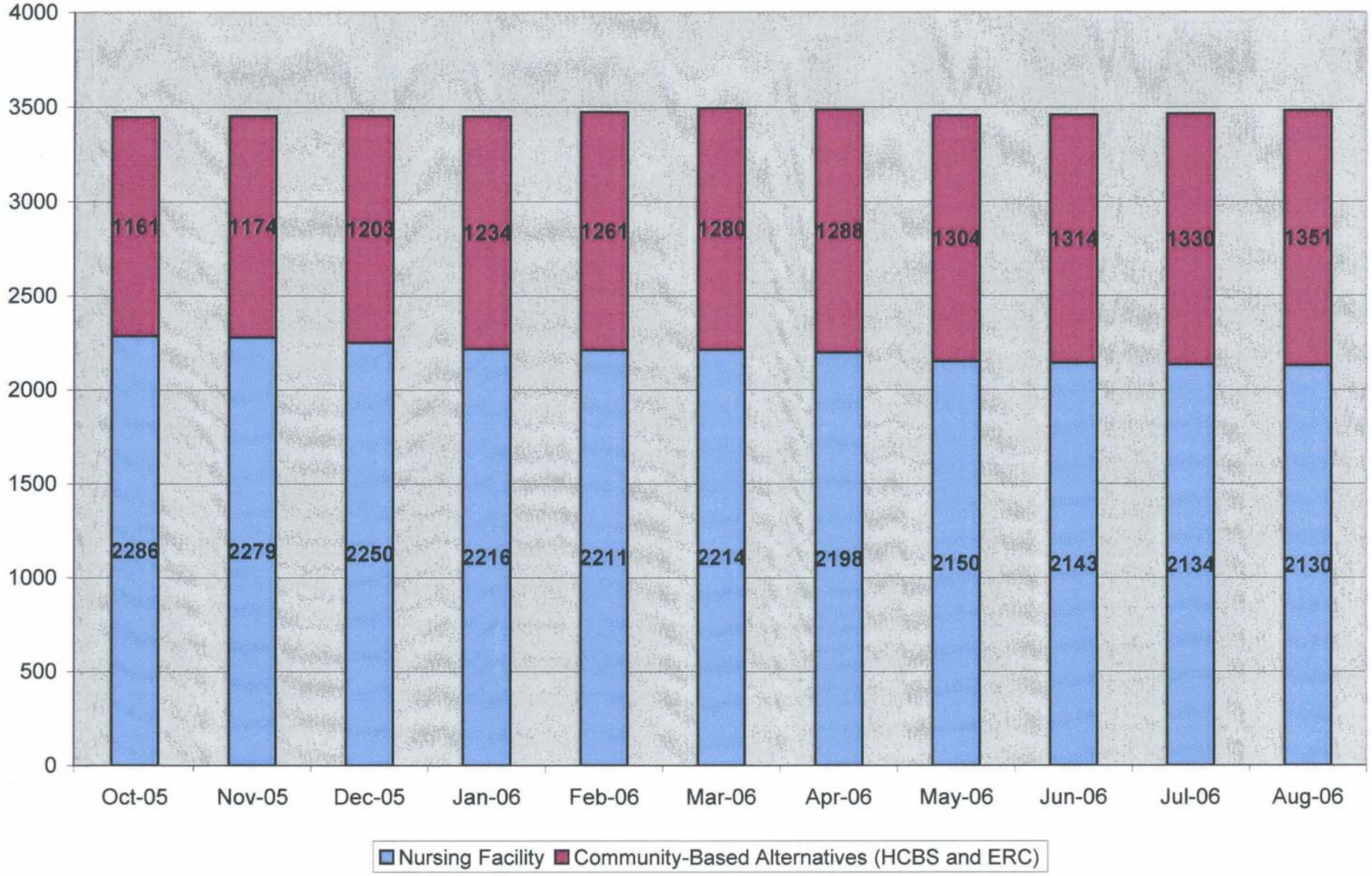
8/30/0 V@DAIL

* Excludes Wake Robin, Arbors, Gertens

Choices for Care: Medicaid Nursing Home Residents and Home & Community-Based Participants--July 1, 2006 Changes (Yellow) Needed to Achieve 60/40 Balance



Choices for Care: Total Number of Enrolled Participants
October 2005 - August 2006
(excludes moderate needs group)

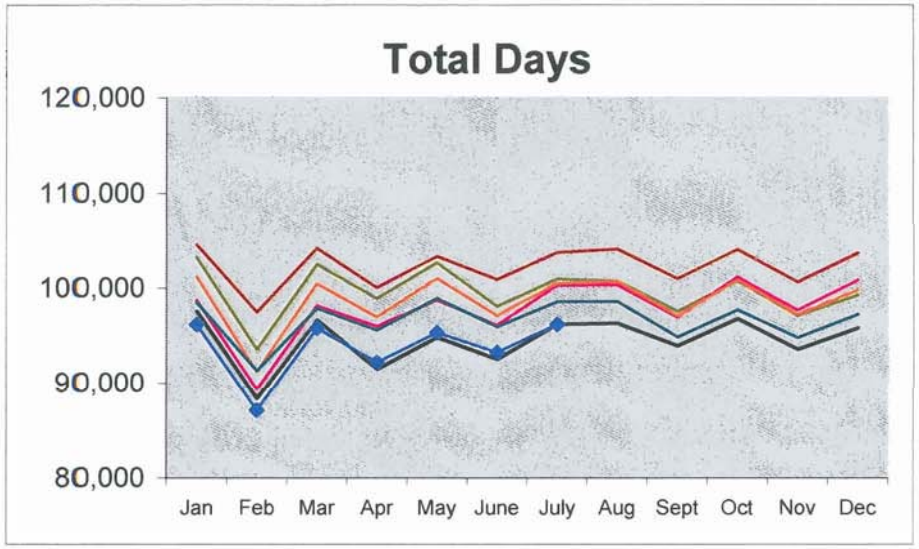


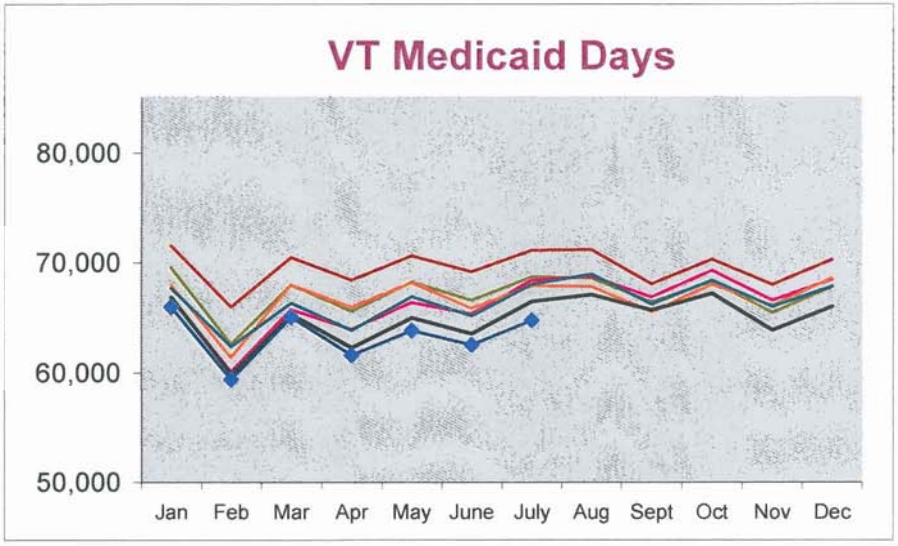
data source: SAMS database

brh, ahs/dail/ddas
Active participants for joan s as of 0806

VT Nursing Facility Resident Days--Total & Medicaid 2000 - 2006

Resident Days data from Division of Rate Setting





	Total							Vermont Medicaid						
	2006	2005	2004	2003	2002	2001	2000	2006	2005	2004	2003	2002	2001	2000
Jan	96,201	97,563	98,491	101,211	98,716	103,216	104,558	65,993	66,869	67,696	68,020	66,870	69,555	71,559
Feb	87,130	88,353	91,343	91,236	89,357	93,572	97,493	59,433	59,915	62,407	61,430	60,128	62,643	65,988
Mar	95,836	96,662	97,890	100,453	98,156	102,496	104,171	65,073	65,321	66,343	67,992	65,775	67,986	70,483
Apr	92,257	91,519	95,611	96,992	96,025	98,916	100,081	61,639	62,289	63,874	65,984	63,975	65,608	68,415
May	95,366	94,847	98,933	101,043	98,768	102,669	103,339	63,848	65,005	66,926	68,205	66,399	68,247	70,630
June	93,290	92,536	95,943	97,110	96,127	98,110	100,902	62,549	63,578	65,178	65,892	65,355	66,600	69,179
July	96,228	96,212	98,602	100,518	100,299	100,979	103,732	64,770	66,482	68,043	67,911	68,384	68,725	71,122
Aug		96,305	98,592	100,718	100,330	100,731	104,071		67,082	68,943	67,846	68,765	68,605	71,175
Sept		93,944	94,886	97,095	96,945	97,542	100,994		65,702	66,245	65,565	66,882	66,433	68,069
Oct		96,788	97,730	100,855	101,183	100,761	104,053		67,205	68,409	68,029	69,303	68,301	70,292
Nov		93,582	94,814	97,216	97,693	97,124	100,636		63,888	66,037	66,144	66,600	65,478	68,025
Dec		95,822	97,273	99,807	100,822	99,267	103,690		66,033	67,841	68,570	68,458	67,808	70,264
Total		1,134,133	1,160,108	1,184,254	1,174,421	1,195,383	1,227,720		779,369	797,942	801,588	796,894	805,989	835,201

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8/30/06 JW@DAIL

VERMONT

AGENCY OF HUMAN SERVICES

Department of Disabilities, Aging and Independent Living
Commissioner's Office
103 South Main Street
Waterbury VT 05671-2301
http://www.dad.state.vt.us/
Phone/TTY (802)-241-2400
Fax (802)-241-2325

TO: **Patrick, Adele, Bard, Bill K, Camille, Diane D., Nancy, Jennifer G., Joan S., Laine, Lorraine W., Julie W., Sheila, Terrie P., Theresa , & Tracey H.**

FROM: **Jim**

DATE: **August 2, 2006**

SUBJECT: **Monthly Monitoring FY06**

Attached find the monthly monitoring report that includes service authorization information through June. Overall Nursing Home, Homebased, and ERC Services were $1,696,051 less than planned.

Nursing Homes
Total Days and dollars were 2% below the planned amount.

HB portion of the LTC 1115 Waiver
Homebased expenses in the last two ~~moths~~ months started to show the increases for the additional people served.

ERC portion of LTC 1115 Waiver
No comments

TBI Waiver
Dollars came in very close to the planned amount.

Personal Care Services
Authorized hours have increased by 1% for July and 2% for August. Paid claims represent 76% of the authorized amounts.

I will send out a FY07 plan as soon as we finalize it.

c Ira Sollace,
Alan Merritt,
Jim Reardon
Jan Westervelt (electronic)

Comparison to plan		Monthly Monitoring Report for Vermont's Choices for Care 1115 Demonstratation Waiver											
	July	August	September	October	November	December	January	February	March	April	May	June	Total/Avg.
ESTIMATED													
SLOTS/Persons													
ERC	169	169	169	173	177	177	177	177	177	177	177	177	175
HCBS	1,092	1,092	1,092	1,122	1,130	1,140	1,140	1,140	1,140	1,140	1,140	1,140	1,126
TBI	41	43	43	44	44	44	44	44	45	45	45	45	44
DOLLARS													
ERC	252,646	252,646	252,646	252,646	258,625	264,605	264,605	264,605	264,605	264,605	264,605	264,605	3,121,443
HCBS	2,636,044	2,620,800	2,626,042	2,631,294	2,708,989	2,733,761	2,763,470	2,768,997	2,774,535	2,780,084	2,785,644	2,788,015	32,617,673
TBI	216,029	227,039	234,047	234,495	240,176	240,636	241,097	241,559	242,022	247,770	248,246	248,722	2,861,839
Avg $/Slot													
ERC	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495	1,495
HCBS	2,400	2,400	2,405	2,410	2,414	2,419	2,424	2,429	2,434	2,439	2,444	2,446	2,422
TBI	5,200	5,538	5,443	5,453	5,459	5,469	5,479	5,490	5,501	5,506	5,517	5,527	5,465
Nursing Homes													
Medicaid Days	64,932	67,096	67,096	64,932	67,096	64,932	67,096	67,096	60,603	67,096	64,932	67,096	790,000
Dollars	8,715,701	9,006,919	9,006,919	8,715,701	9,006,919	8,715,701	9,006,919	9,006,919	8,133,266	9,006,919	8,715,701	9,006,915	106,044,500
Active													
SLOTS/Persons													
ERC	169	169	169	169	190	210	228	232	234	232	241	242	207
HCBS	1,092	1,092	1,092	1,092	1,143	1321	1418	1563	1597	1642	1705	1682	1,370
TBI	42	45	40	41	47	48	48	46	47	49	49	49	46
DOLLARS													
ERC	236,476	222,873	315,080	248,600	219,353	292,522	304,071	299,569	281,557	291,140	293,230	359,613	3,364,084
HCBS	2,591,031	2,249,776	2,648,194	2,261,219	2,490,322	3,344,840	2,744,312	3,064,225	2,804,888	2,753,088	2,720,526	3,372,495	33,044,917
TBI	214,377	222,287	183,298	208,637	235,758	220,978	280,771	255,105	224,392	240,893	277,100	252,971	2,816,567
Avg $/person													
ERC	1,374	1,378	1,421	1,422	1411	1401	1396	1389	1366	1356	1343	1354	1,384
HCBS	2,456	2,423	2,378	2,339	2,394	2,398	2,413	2,367	2,324	2,281	2,209	2,165	2,346
TBI	5,048	4,970	4,946	4,970	4,907	4,962	5,051	4,960	4,949	4,983	5,021	5,112	4,990
HCBS $/slot is calculated using a running 12 months of total cost/avg # slots for preceding 12 months													
Nursing Homes									march - high due to recoupment and repayment issues				
Medicaid Days	61,647	65,521	70,037	60,385	64,406	65,968	64,561	65,230	59,057	66,882	63,019	67,501	774,214
Dollars	7,968,352	8,333,596	8,813,432	8,619,253	8,600,075	8,637,174	8,727,227	8,952,509	12,997,034	4,389,682	8,215,186	9,425,044	103,678,564
Difference from Plan													
SLOTS/Persons													
ERC	0	0	0	(4)	13	33	51	55	57	55	64	65	32
HCBS	0	0	0	(30)	13	181	278	423	457	502	565	542	244
TBI	1	2	(3)	(3)	3	4	4	2	2	4	4	4	2
DOLLARS													
ERC	(16,170)	(29,773)	62,434	(4,045)	(39,273)	27,917	39,466	34,964	16,952	26,535	28,625	95,008	242,641
HCBS	(45,013)	(371,024)	22,152	(370,074)	(218,667)	611,078	(19,157)	295,228	30,354	(26,996)	(65,118)	584,480	,427,244
TBI	(1,652)	(4,752)	(50,750)	(25,858)	(4,417)	(19,658)	39,674	13,546	(17,631)	(6,878)	28,854	4,249	(45,273)
Avg $/Person													
ERC	(121)	(117)	(74)	(73)	(84)	(94)	(99)	(105)	(129)	(139)	(152)	(141)	(1,327)
HCBS	56	23	(27)	(71)	(21)	(21)	(11)	(62)	(110)	(158)	(235)	(280)	(917)

TBI	(152)	(568)	(497)	(483)	(551)	(507)	(429)	(530)	(552)	(523)	(495)	(415)	(5,704)
Nursing Homes													
Medicaid Days	(3,285)	(1,575)	2,941	(4,547)	(2,690)	1,036	(2,535)	(1,866)	(1,546)	(214)	(1,913)	405	(15,786)
Dollars	(747,349)	(673,323)	(193,487)	(96,448)	(406,844)	(78,527)	(279,692)	(54,410)	4,863,768	(4,617,238)	(500,515)	418,129	(2,365,936)
Nursing Homes Exp $/days	129.26	127.19	125.84	142.74	133.53	130.93	135.18	137.25	220.08	65.63	130.36	139.63	

Using Institutional Funding to Pay for HCBS: Texas Materials

Online materials

Promoting Independence Plan: http://www.dads.state.tx.us/business/pi/independence_plan.html

Promoting Independence Reports:
http://www.dads.state.tx.us/business/pi/piac_reports/index.html

Legislative appropriations request for fiscal 2008 & 2009 from Department of Aging and Disability Services: http://cfoweb.bdm.dhs.state.tx.us/lar/2008_09/DADS 08-09 LAR Vol 1.pdf [pp. 93-95; 145-151; 155-156 handed out (numbers refer to those printed on bottom center of pages, .pdf pages are 102-104; 154-160; 164-166)]

Printed materials:

Texas Department of Aging and Disability Services Presentation (9 pages):
Gold, M.S. (2006, April 10). *Texas Promoting Independence Initiative: Money Follows the Person.*

Figures (3 pages)

Community Care/Nursing Facility/Waiver Clients: Average Monthly Caseload 1980-2007

Texas LTC Utilizers Per 1,000 75+ Population, 1980-2007

Funding Growth for Services: Nursing Facilities and community Care, 1980-2007

Interest List information (3 pages)

Rider 28 Demographics as of May 31, 2006 (1 page)

Centers for Medicare and Medicaid Services
Transforming Systems: Keys to Success

Coalition Building for Legislative Change

TEXAS PROMOTING INDEPENDENCE INITIATIVE: MONEY FOLLOWS THE PERSON

Marc S. Gold
Texas Department of Aging and Disability Services
Baltimore, MD
April 10, 2006

Texas Demographics

- Total population: 20,851,820
- 65-74 years: 1,142,608 (5.5%)
- 75-84 years: 691,984 (3.3%)
- 85+: 237,940 (1.1%)
- Total 65+: 2,072,532 (9.9%)

TX ranks 46th with 75+ population (Kaiser Family Foundation)

*2000 Census

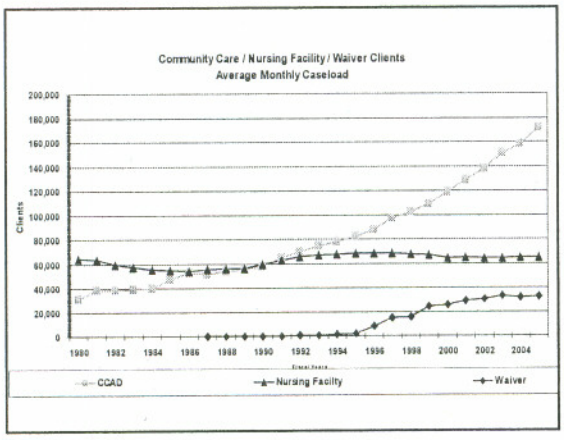
Texas Medicaid Statistics

Aged, Disabled and Blind make up @ 20% of Medicaid recipients; however utilize 62% of overall Medicaid expenditures

Long Term Care Budget* (06)

- Overall budget: $3,123,474,882
- Medicaid Nursing Facility: 1,628,325,185
- Total CC: 1,495,149,697
- Community Care (CC) entitlement: 1,015,260,254
- 1915 (c) waiver: 479,889,443

* LTC numbers do not include programs for persons w/mental retardation or developmental disabilities; SNF payments; Hospice; PACE. R28 dollars included w/(c) waiver.



TX 1915 (c) Waivers – NF/ICF

- Community Based Alternatives
- Medically Dependent Children's Program
- Home and Community-Based Services
- Texas Home Living
- Community Living Assistance and Support Services
- Deaf-Blind Multiple Disabilities
- Consolidated Waiver
- STAR+PLUS

It's the Timing!! and Collaboration

- Transforming systems or mind-sets
- Growth of HCBS
- Proactive/strong advocate organizations
- Olmstead Decision
- Governor's Executive Order

Key Players

- Governor's Office
- Legislature
- General Public
- Disability Advocates
- State Agency
- Nursing Facility/Home Health Providers
- Relocation Contractors
- Area Agencies on Aging
- Independent Living Centers
- Housing Authority
- Other community based organizations
- Hospitals/Discharge Planners

Promoting Independence History

- June 1999: US Supreme Court Olmstead
- September 1999: Governor George W. Bush Executive Order GWB 99-2
- 2001 Legislative Session: Senate Bill 367
- 2001 Legislative Session: Senate Bill 368
- April 2002: Governor Rick Perry Executive Order RP-13
- 2003 Legislative Session: House Bill 2292
- 2005 Legislative Session: House Bill 1867

GWB 99-2

- GWB 99-2 was issued in September 1999; the order required HHSC to:
- Conduct a comprehensive review of all services and support systems available to people with disabilities in Texas
- Analyze the availability, application, and efficacy of existing community-based alternatives
- Report to Governor due January 2001

Promoting Independence Advisory Committee/Plan

- PI Plan submitted to the Legislature on January 9, 2001 contains a historical perspective on services within the state of Texas
- A discussion of the declining rates of institutionalization and the shift of resources to the community
- An overview of the current system of long-term care
- A discussion of limitations and deficits in the current system.

PI Plan – con't

- System Improvement Recommendations
  - Identification and Assessment
  - Access Issues
  - System Capacity and Funding Issues
  - Legislative considerations
  - Medicaid Benefits
  - Children and Their Families
  - Cost Neutrality Issues
  - Comprehensive Care Coordination System

Senate Bill 367

- SB 367 commonly referred to as the Promoting Independence Bill passed during the 2001 Legislative Session.
- Permanently established PI Advisory Committee
- Ensures that the PI Plan will be revised and submitted to the legislature every two years, starting December 1, 2002.
- Task Force will make recommendations to HHSC every September 1 on findings and recommendations.

SB 367 – con't

- Expands population to include individuals w/mental health issues who have 3 hospitalizations within 180 days.
- Sets into law the Community Living Options Information Process of DADS, Adds the MH population
- Sets into law the information and assistance regarding care and support options
- Asks the Commission to attempt a housing voucher program for transitional living assistance
- Sets into law the DADS relocation specialist pilots

PI Initiatives

- Long Term Care Options Notification Initiative
- Permanency Planning
- Rider 37/28
- Relocation Services
- Transition Assistance Services/Transition to Life in the Community (TLC) Priority community placements for residents of large ICFs/MR or state schools
- Community Living Options for MR

PI Initiatives con't

- Priority community placements for residents of large ICFs/MR or state schools
- Housing Voucher Program
- Nursing Facility Transition Workgroups
- Real Choice Grants
- Intensive services for persons with three state hospitalizations (MH) within 180 day period
- Over 70 recommendations in PI Plan

CBA

- §1915(c) Home & Community-based Medicaid waiver. Alternative to services in a Nursing Facility
- Personal Assistance
- Adaptive Aids
- Adult Foster Care
- Respite
- Assisted Living
- Therapies
- Nursing

CBA con't

- Persons age 21+ who meet criteria for NF admission
- Persons on interest list: 64,992
- % of persons receiving some type of service 34%
- Budgets slots for FY 06 26,867

CBA – Time on Interest List

- 0-1 yr 21,716 33%
- 1-2 yr 17,279 27%
- 2-3 yr 16,792 26%
- 3-4 yr 6,786 10%
- 4-5 yr 2,390 4%
- 5+ yr 29 <1%
- Earliest request date on interest list: 9.5.95
- Average LOS 1.7 yrs

*January 2006

Rider 37/28 – House Bill (HB) 1867

- Created as an appropriation rider to the then DHS (DADS) Budget as Rider 37
- It is the intent of the legislature that as clients relocate from nursing facilities to community care services, funds will be transferred from Nursing Facilities to Community care Services to cover the cost of the shift in services.

Rider 37/28/HB 1867 con't

- TDADs periodically transfers funds (on a retrospective basis) from the NF Strategy to the CC strategy.
- The amount transferred is = to the amount expended for Community care- NOT- the amount spent in the facility.
- Funds are monitored, analyzed, and transferred on a global basis. The agency looks at expenditure levels for all Rider 37 individuals, rather than on an individual by individual basis.

Rider 37/28/HB 1867 con't

- Texas occupancy rate for NF is approximately 77.77% and has been flat for several years. Therefore, potential for backfilling is lower.
- Texas limits the number of "regular" 1915 (c) waiver slots based on the number of slots funded by the State Legislature, the waiver slots funded through Rider 37 are allowed to increase based upon demand.
- The fact that only the amount for the community care is transferred allows for a cushion.

Rider 37/28/HB 1867 con't

- The 2003 Legislature changed Rider 37 to Rider 28 and made a slight variance by not allowing for the expansion of the base number of appropriated waiver slots through Rider 28 transfers.
- The new Rider 37, requires that Consumers utilizing Rider 28 shall remain funded separately through transfers from the Nursing Facility strategy, and those slots shall not count against the total appropriated community care slots.

Rider 37/28/HB 1867 con't

- Rider 28 funding through the nursing facility strategy shall be maintained for those consumers as long as the remain in the transferred slot. When a Rider 28 consumer leaves a waiver program any remaining funding for the biennium shall remain in the nursing facility.
- House Bill 1867: 2005

Rider 37/28 Statistics

As of 12.31.05 the number of clients are:

- Total: 10,156
- Number of active Rider 37 and Rider 28 clients is 5,596.

Rider 28 Statistics as of 12.31.05 – Service Group

- Total enrollment – 4746
- CBA – 4586
- CLASS - 40
- MDCP – 118

Rider 28 Statistics - Age

0-9	84	70-74	503
10-17	40	75-79	591
18-20	10	80-84	651
21	9	85-89	491
22-44	347	90-94	263
45-64	1242	95-99	72
65-69	431	100+	12
		Total	4746

Rider 28 Statistics - Gender

Female	3117
Male	1628
Total	4746

Rider 28 Statistics - Ethnicity

American Indian or Alaskan Native	10
Asian or Pacific Islander	20
Black not of Hisp. Origin	593
Hispanic	948
Unknown	121
White not of Hispanic Origin	3054
Totals	4746

Rider 28 Statistics – Living Arrangements

- Adult Foster Care - 33
- Clients alone - 1037
- Assisted Living - 1318
- Client lives with family - 2170
- Client lives with other waiver recipients - 163
- Other - 24

Rider 37/28 Statistics – Length of Stay in NF (3/05 data)

Under one month	141
1-3 month	1323
3-6 months	1266
6 months – 1 year	780
1 year – 3 years	681
3 years – 5 years	182
5 years plus	131
Unknown	265

Financials

- CBA is 77.6% of NF costs on an annualized basis from CMS FY04 372 report
- Low NF occupancy: no backfilling
- Waiver is done on an individual cost cap not the aggregate – therefore, R 28 would be at least cost neutral
- No cost effectiveness study prior to implementation

Financials con't

- NF occupancy flat; has not changed vis a vis R 37/28
- Short stay to "game system" does not appear to be happening
- R 28 clients look like regular CBA clients – and the overall costs are much less than of NF – therefore, if even half the clients would have been in a NF the state breaks even

Financials con't

- Funding transfers occur post hoc
- Periodic reviews determine monies spent on R 37/28 population and a transfer occurs vs. a pre-hoc determination.
- Monies are transferred from NF line item to Waiver line item
- R 37/28 population is factored into NF forecasts for future funding requests to ensure adequate funding for Rider clients

Continued Executive/Legislative Support

- April 2002: Governor Rick Perry Executive Order RP-13
- 2003 Legislative Session: House Bill 2292
- 2005 Legislative Session: House Bill 1867

RP -13

- On April 18, 2002, Governor Perry released his RP-13 on Community Based Alternatives for people with disabilities
- Continued support for the PI Plan, highlighting new areas of importance to include housing and work force issues
- Requires specifically that TDHCA and the HHSA's work on efforts to assure accessible, affordable, and integrated housing
- That the TX Dept of Assistive and Rehabilitation Services, work on employment issues related to individuals with disabilities
- That HHSC and the Texas Workforce Commission coordinate efforts to increase the pool of available community based service workers

RP –13

- HHSC and the HHSA's work to ensure permanency planning for children results in children receiving community placement
- Move forward with the Alternative Family Based Pilot that is referenced in SB 368
- HHSC direct DADS to implement the development of the Selected Essential Services Waiver with existing general revenue
- Continued development and submission of the PI Plan

Supportive Public Policy/Programs

- Relocation Specialists
- Transition Assistance Services
- Housing Voucher Program
- NF Money Follows the Person Transition Teams

Relocation Activities

- Relocation services consist of intense case management to assist NF residents interested in relocating into the community
- Started as a pilot in June 2002 in five sites
- Contractors identified potential NF residents who demonstrated a desire to move into the community

Relocation Activities con't

- Worked w/ILC and AAA Ombudsman
- Performed a transition assessment plan to determine potential for community placement
- Program was expanded in April 2003.
- $1.3 million/annum with GR

Transition Assistance Services

- TLC "morphed" into TAS as a Medicaid funded program in September 2004.
- Services include, but are not limited to:
  - payment of security deposits
  - purchase of essential furnishings
  - payment of moving expenses
  - payment for services to ensure the health and safety of the consumer

TAS con't

- Eligibility: any NF residents who is discharged from the NF into a Medicaid waiver program – September 2004
- $2500 from the overall individual waiver plan of care

Housing Voucher Program

- The Housing Voucher Program (HVP) provides housing opportunities to nursing facility residents interested in section 8 housing
- The Health and Human Services Commission, (HHSC), Texas Department of Housing and Community Affairs (TDHCA), and Texas Department of Aging and Disability Services (DADS) are working in partnership to distribute 35 housing vouchers awarded to TDHCA

Real Choice System Grants

- TX received 5 Real Choice Grants to pilot various aspects
  - Money Follows the Client
  - Creating a More Accessible System
  - Quality Assurance/Improvement for MR waiver
  - Community Integrated Personal Attendant Services (CDS/SRO model)
  - Community Based Treatment Alternatives for Children

Nursing Facility Transition Workgroup

- Transition workgroups provide coordination of services and supports to nursing facility residents needing assistance with their transition
- Local community private-public partnerships in all TX regions (10)

NF Transition Workgroup con't

Workgroups' responsibilities include, but are not limited to the following:

- Develop person-centered transition plans (performed by specialized staff);
- Ensure that client's supports and needs are met using a person-centered approach;
- Explore all sources of supports to ensure all options are considered;
- Coordinate needed services and supports to ensure a successful transition; and
- Identify and address transition barriers.

Barriers to Transition

- Health and Safety
- Medication
- Housing
- Clients w/MR/behavioral health/complex needs
- Lack of services
- Home modifications
- Transportation
- Rural settings: lack of providers/transportation
- Mobility/lack of environmental supports
- Appropriate staffing of relocation specialists

Lessons learned

- Early and continued communication/education/outreach – transform the mind-set as well as the system
- Develop collaborative partnerships and find common goals for continued collaboration among all stakeholders
- Discover all possible interested stakeholders w/non-historically involved community based organizations
- Personality/leadership/political will (find a champion to help build consensus)

Lessons Learned -- continued

- Get your information correct and your message consistent
- Legislative buy-in
- NF provider buy-in and Home Health capacity
- Carpe Diem!

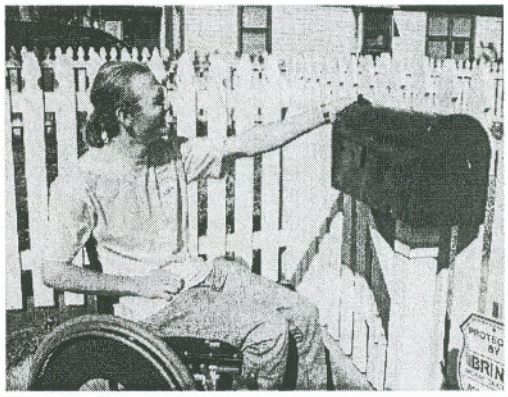
And the beat goes on....

- Follow-up study on factors that make a successful transition
- Is MFP really rebalancing?
- Global budgeting
- Diversion
- Deficit Reduction Act 2005

Contact Information

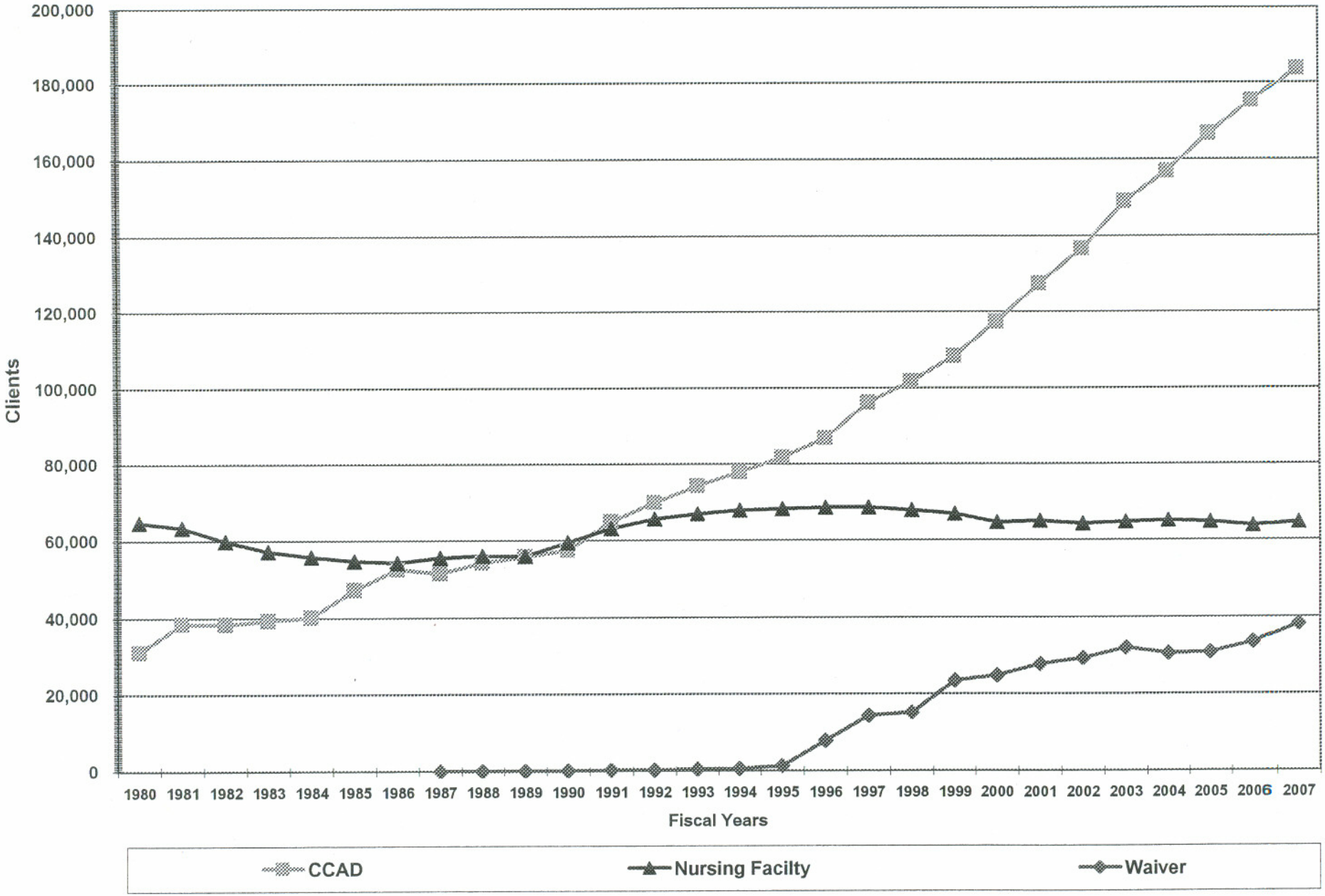
- marc.gold@dads.state.tx.us
- www.dads.state.tx.us
- http://www.dads.state.tx.us/business/pi/

- Community Living Exchange Collaborative: ILRU – Jay Klein – Evaluation of Rider 37 (February 2004)

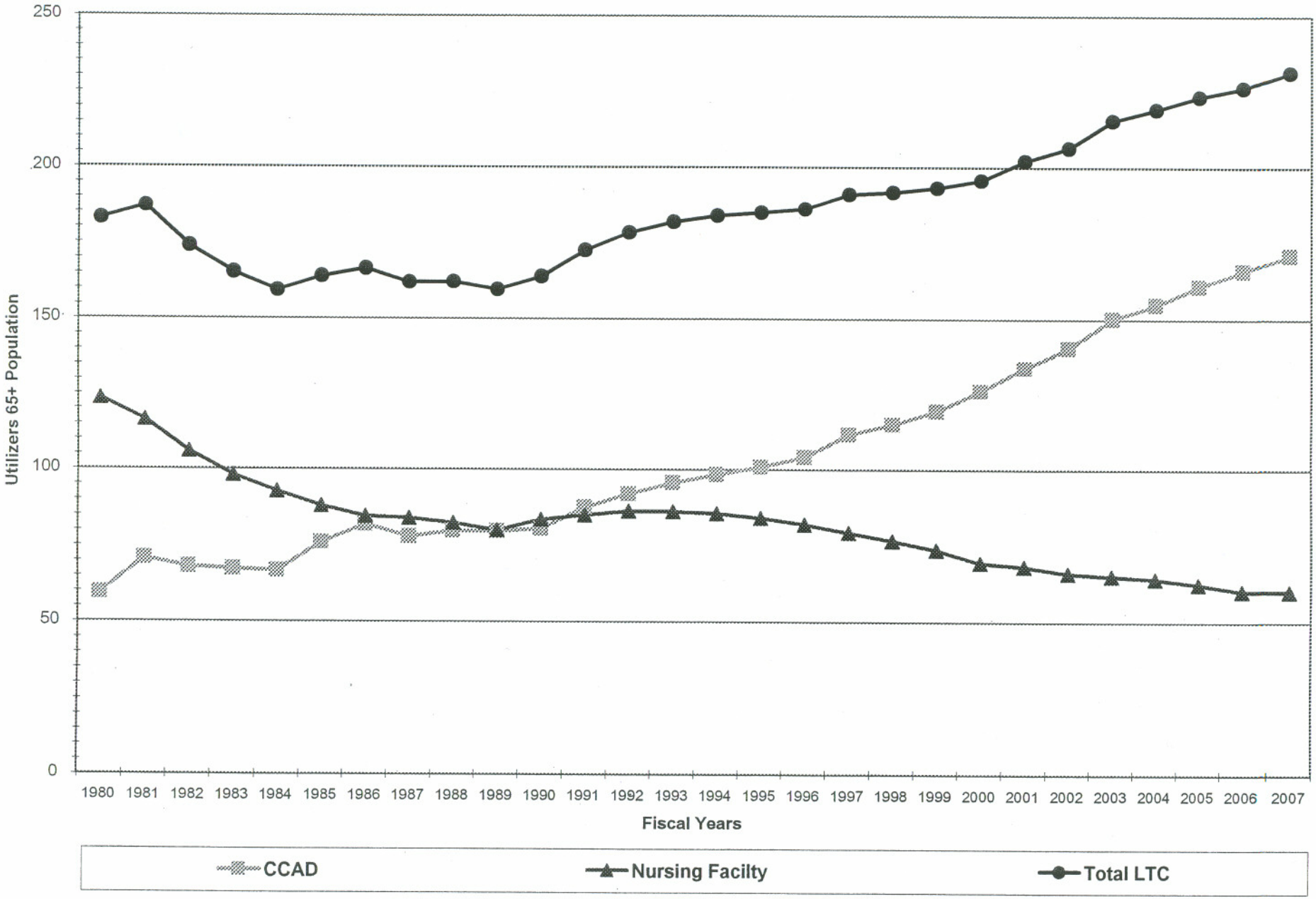


Community Care / Nursing Facility / Waiver Clients

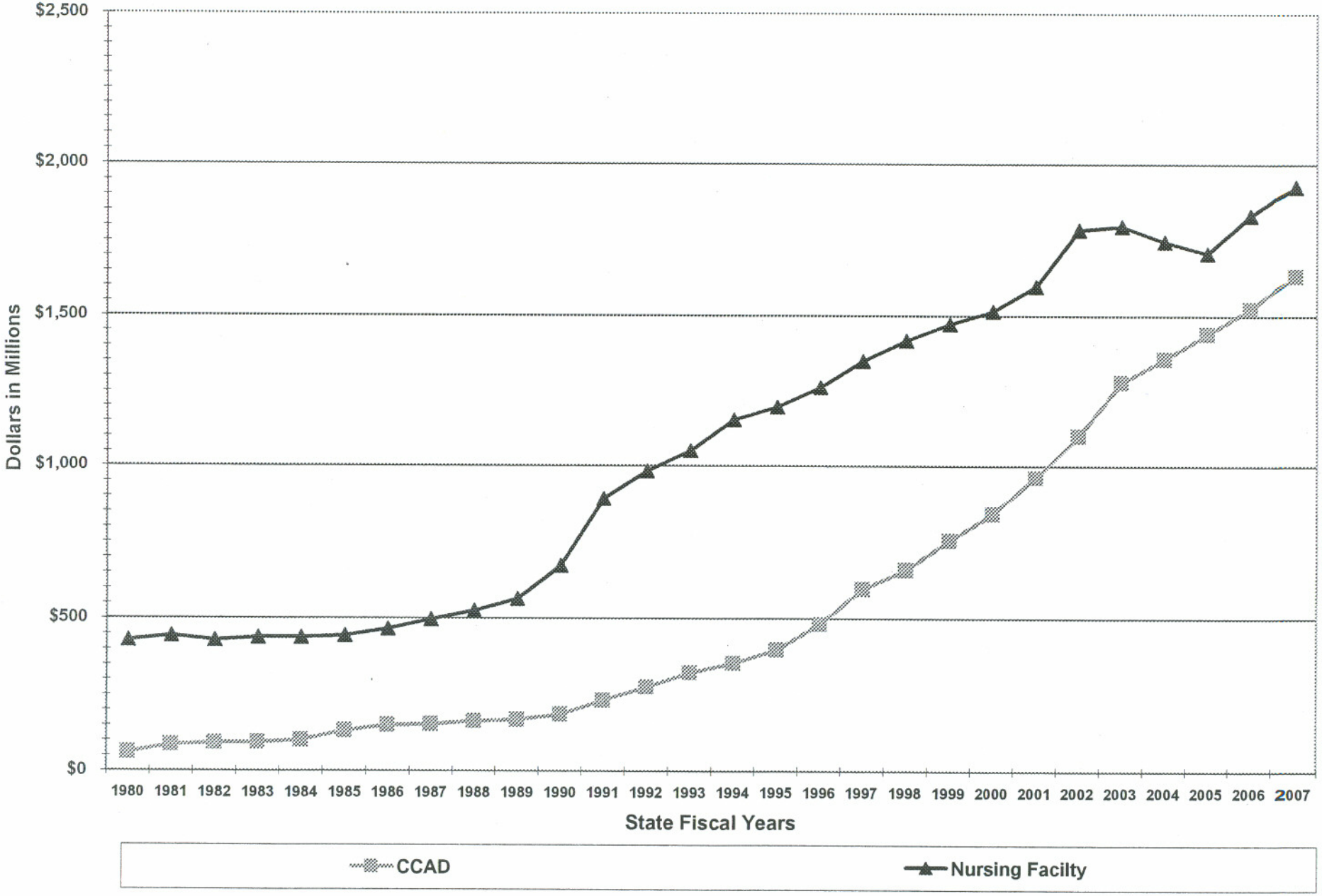
Average Monthly Caseload



Texas LTC Utilizers Per 1,000 75+ Population



Funding Growth for Services
Nursing Facilities and Community Care



INTEREST LIST REDUCTION

Applicants for DADS community-based services may be placed on an interest list because the demand for community-based services and supports often outweighs available resources. Ever since the original Promoting Independence Plan, PIAC's top priority has been full-funding for community-based services and elimination of the interest list. Again, this year's top priority is interest list reduction. PIAC is recommending a ten-year plan to eliminate the current interest list plus any projected demographic growth.

The 79th Texas Legislature (2005) made important progress in serving additional persons from the Medicaid waiver and non-Medicaid community services interest lists. Senate Bill 1 provides $ 97.9 million in general revenue funds ($18.4 million for demographic growth and $79.5 million for interest list reduction) to address the interest lists at DADS. Nevertheless, Tables 5 and 6 demonstrate the on-going need for significant funding to give individuals a choice in receiving services in a community setting.

Interest lists for community-based programs are managed either locally or statewide, depending on the program. The 1915 (c) programs accounted for in this report are:

- Community Based Alternatives (CBA)
- Community Living Assistance and Support Services (CLASS)
- Deaf/Blind with Multiple Disabilities (DBMD)
- Home and Community Services (HCS)
- Medically Dependent Children's Program (MDCP)

DADS was appropriated funds in the 2006-2007 biennium to authorize enrollment for 8,891 individuals in these Medicaid waiver program services. Texas Home Living (TxHmL) and the Consolidated Waiver Program, which is in Bexar County only, do not have independent interest lists. TXHmL offers are made from the HCS interest list; CWP offers are only made when a CWP vacancy is available.

The following tables are from DADS' website and reflect data through June 30, 2006.

TABLE 5

Interest List (IL) Reduction Summary Fiscal Years 2006-2007 (Data through June 30, 2006)						
	CBA	**CLASS**	**DBMD**	**MDCP**	**HCS**	**Total**
Number of Clients on Interest List — Legislative Appropriations Request (LAR) submission (November 2004)	66,787	13,453	18	8,604	26,698	115,560
Total Released/Removed from Interest List	34,286	2,853	34	1,560	2,024	40,757
Enrolled (in program)	*5,977*	*327*	*4*	*92*	*1,205*	*7,605*
In the Pipeline (being processed)	*6,852*	*1,969*	*21*	*751*	*287*	*9,880*
Denied/Declined (to be enrolled)	*21,457*	*557*	*9*	*717*	*532*	*23,272*
Net Remaining from LAR submission *(November 2004)*	32,501	10,600	-16	7,044	24,674	74,803
Percent reduction from 2004 LAR submission	51.3%	21.2%	188.9%	18.1%	7.6%	35.3%
Added to IL since 2004 LAR submission	12,817	4,491	29	3,067	5,724	26,128
Current Interest List — June 30, 2006	45,318	15,091	13	10,111	30,398	100,931*
* Count is duplicated. The unduplicated individual count is 88,864						

Table 6 reflects the amount of time an individual has been on an interest list prior to being offered a "slot" in a specific 1915 (c) waiver program.

TABLE 6

Time on Interest List by Program Percentage of overall population (Data through June 30, 2006)					
TIME	**CBA**	**CLASS**	**DBMD**	**MDCP**	**HCS**
0 to 1 year	51.0%	20.8%	69.2%	24.1%	17.8%
1-2 Years	26.3%	18.7%	30.8%	23.6%	15.1%
2-3 years	13.4%	18.8%	0.0%	24.0%	14.3%
3-4 years	9.3%	18.6%	0.0%	20.6%	13.4%
4-5 years	0.0%	10.9%	0.0%	7.7%	12.6%
5 years +	0.0%	12.4%	0.0%	0.0%	26.8%

TEXAS Department of Human Services

Rider 28 Client Demographics

Data Effective Date: May 31, 2006

Description: Demographic information about currently active Rider 28 Clients. Rider 28 clients are those individuals who have an 'Enrolled From' code 12 entered in SAS on or after September 1, 2003, AND who has not previously been identified as a Rider 37 client.

Living Arrangement	Client Count
COMMUNITY - ADULT FOSTER CARE	36
COMMUNITY - ALONE	1,100
COMMUNITY - ALTERNATIVE. LIVING/RES. CARE	1,413
COMMUNITY - W/FAMILY	2,256
COMMUNITY - W/OTHER WAIVER PARTICIPANTS	162
ICF/MR - COMMUNITY	2
OTHER	31
Total	**5,000**

Note: The "OTHER" category includes those clients with a null living arragement or a living arrangement of Nursing Facility.

Service Group	Client Count
CBA	4,737
CLASS	38
COMMUNITY CARE	2
MEDICALLY DEPENDENT CHILDREN PROGRAM	162
STAR+PLUS	61
Total	**5,000**

Age Group	Client Count
0 - 9	115
10 - 17	54
100 +	12
18 - 20	8
21	8
22 - 44	364
45 - 64	1,322
65 - 69	451
70 - 74	520
75 - 79	622
80 - 84	650
85 - 89	514
90 - 94	281
95 - 99	79
Total	**5,000**

Region	Client Count
00	6
01	201
02	377
03	1,510
04	634
05	264
06	196
07	365
08	579
09	162
10	47
11	659
Total	**5,000**

Gender	Client Count
FEMALE	3,256
MALE	1,743
UNKNOWN	1
Total	**5,000**

Ethnicity	Client Count
AMERICAN INDIAN OR ALASKAN NATIVE	13
ASIAN OR PACIFIC ISLANDER	18
BLACK- NOT OF HISP. ORIGIN	628
HISPANIC	985
UNKNOWN	146
WHITE- NOT OF HISP. ORIGIN	3,210
Total	**5,000**

Reducing Institutional Capacity: Indiana Notes

Web site: http://www.in.gov/fssa/elderly/options/

Presenter—Steve Smith, Director, Director, Indiana Family & Social Services Administration's Division of Aging[5]

- Indiana spends about 77% of its aging budget on nursing homes, which are operating at around 80% capacity.
- As MBA, director Smith approaches this as a business problem, talking to facilities about how they can change their business model to better address the demand for community-based care.
    - Business pipeline—defining customer, thinking about future growth
    - New sources of revenue—from offering new services
    - Using capital efficiently—getting providers to see services as portfolio, rather than silo
    - Achieve rate of return with rebalancing—how to make new services profitable
- In addition to existing facilities, the department is also seeking potential new entrants to LTC service provision--growing in assisted living, adult day, adult foster care. May be opportunities for entrepreneurship—including for women, minority groups. Reaching out to diverse groups.
- Reducing the oversupply of beds through assistance with closure or conversion
    - Facilities wanting to close or convert must go through a proposal process that includes a transition plan.
    - Contract with AAAs or other third party to validate transition plan.
    - 3 milestones to meet before full payment—approved transition, closure, successful transition
    - Pay $25,000 for occupied Medicaid/dual certified bed; $10,000 for unoccupied Medicaid/dual certified bed. Also, $15,000 for real estate portion.
    - Most proposals thus far are closures.
    - Moratorium on new bed development. Considering allowing bed trading for facilities that want to upgrade quality.

[5] The following notes on Smith's presentation were written by Jennifer Farnham, based on notes taken at the meeting.

Reducing Institutional Capacity: Minnesota Materials

Online materials

Minnesota Department of Human Services. (2006, July 19). *Bulletin: Nursing Facility Policy Changes in 2006 Legislation.* Available at: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_059224 [pp. 8-14 included in meeting packet]

Minnesota Department of Human Services. (2006, June). Status of Long-Term Care in Minnesota 2005: A Report to the Minnesota Legislature. Available at: http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs_id_059536.pdf

Printed materials:

Minnesota Nursing Facility Rates & Policy Division Presentation (4 pages)

Held, R. (2006, September 13). Minnesota Strategies: Nursing Facility Rightsizing

Minnesota Strategies
Nursing Facility Rightsizing

Money Follows the Person
Robert Held
September 13, 2006

Goal

Minnesota's goal is to re-balance LTC – to shift the location where LTC is provided and where the funding goes, from institutions to home and community settings.

Historical Context

- 1970s - Certificate of Need
- Recognition that Minnesota is extremely overbedded (91.2 beds per 1000 in 1987)
- Early 1980s –
  - CON repealed, Moratorium on new nursing home beds enacted
  - Pre-admission screening
  - Funding for HCBS

Historical Context

- 2001 - Long-Term Care Task Force
  - Gaps analysis
  - Community Services Service Development Grants
  - Enhanced PAS - LTC Consultation
  - Refinements to HCBS programs

Bed Closure Incentives

- 2000 – Layaway
- 2001 to 2003 Planned Closure
- 2004 Planned Closure Incentive re-instated
- 2005 – Single Bed Incentive
- 2006 – Planned Closure Incentive increased

Layaway

- Allows facility to remove beds from active service without permanently losing the bed
- Bed must remain in layaway for at least one year
- Layaway for up to 5 years, then it's gone permanently

Layaway Benefits

- Property rate reallocation (would average about **$12** per resident day if half of beds are put in layaway)
- No surcharge or licensure fees – about $3000 per year
- Bed holds
- Getting used to operating with fewer beds
- Benefits apply also if bed is de-licensed

Layaway Policy Issues

- Fiscal note
  - ➢We want to shift care, but, if you close beds, the fixed costs remain
  - ➢If you close an entire facility, residents are relocated
  - ➢Where are the savings?
  - ➢Fewer beds leads to diversions

Planned Closure

- Goal is to close obsolete beds in overbedded areas
- Layers on top of layaway
- Permanent de-licensure of beds, or of entire nursing facility
- Must coordinate with local planning
- Subject to department approval
- Closure remains voluntary, but approval expires after 18 months if not acted on

Planned Closure - Benefits

- Planned closure rate adjustment =
  - ➢# beds closed
  - ➢Times $2080 / bed (PCRA Factor)
  - ➢Divided by # beds receiving rate adjustment times 365
  - ➢= **$5.70** per resident day if half of beds are closed

Planned Closure – Policy Issues

- Fiscal note - What is the purpose of planned closure?
  - ➢to bring about closures, or
  - ➢to ease a transition that will occur anyhow?
- Did the incentive work
  - ➢Goal was to close 5040 beds
  - ➢Approvals granted for 4900 beds
- Were there savings?

Planned Closure Incentive Reinstated

- Negotiated - PCRA Factor conditioned on no added cost to the state
- Determined by formula, considering
  - ➢Case load savings
  - ➢Increased HCBS costs
  - ➢Loss of surcharge revenue
  - ➢PCRA Factor limited to $2080

Single Bed Incentive

- Layers on top of layaway and planned closure
- Added incentive when the closure of a bed results in creation of a new single bed room
- Single bed incentive (per resident day payment rate increase =
  - 20%
  - Times number of new singles
  - Divided by number of active beds on 7/1/2005
  - Would average about **$13** per resident day if half of beds are closed

Nursing Facility Rates & Policy Division

Planned Closure Incentive Increased

- PCRA Factor no longer limited to $2080
- Negotiated subject to no added cost to the state, cumulatively
- Very complex to implement
- Transparency vs. negotiation

Nursing Facility Rates & Policy Division

What is the right strategy?

- Build HCBS,
- Relocate nursing home residents, or
- Downsize the nursing home industry?

ALL THREE!

Nursing Facility Rates & Policy Division

Minnesota / US Comparison - Number of beds

- Minnesota
  - 1987 – 48,307
  - 1995 – 47,181
  - 2003 – 39,530
  - 2005 – 37,182
- Average annual change '98 to '03 = **-1.37%**
- US
  - 1995 – 1,751,302
  - 2003 – 1,756,699
- Average annual change '98 to '03 = **+0.03%**

Nursing Facility Rates & Policy Division

Minnesota / US Comparison – Beds per 1000 age 65+

- Minnesota
  - 1987 – 91.2
  - 1995 – 82.0
  - 2003 – 64.2
  - 2005 – 59.3
- Average annual change '98 to '03 = **-2.24%**
- US
  - 1995 – 51.9
  - 2003 – 48.9
- Average annual change '98 to '03 = **-0.66%**

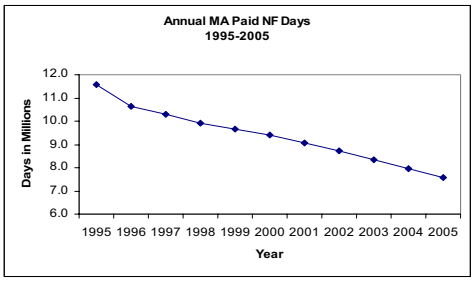
Nursing Facility Rates & Policy Division

Minnesota / US Comparison – Beds per 1000 age 85+

- Minnesota
  - 1987 – 745.3
  - 1995 – 611.4
  - 2003 – 407.7
  - 2005 – 365.4
- Average annual change '98 to '03 = **-3.68%**
- US
  - 1995 – 475.8
  - 2003 – 372.3
- Average annual change '98 to '03 = **-2.69%**

Nursing Facility Rates & Policy Division

Nursing Home Days



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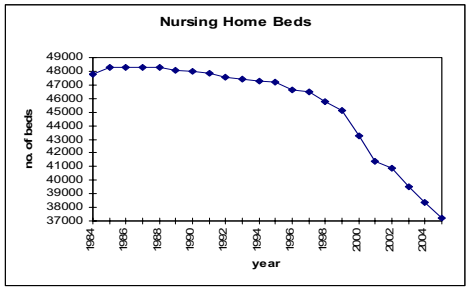
NH Beds in Minnesota



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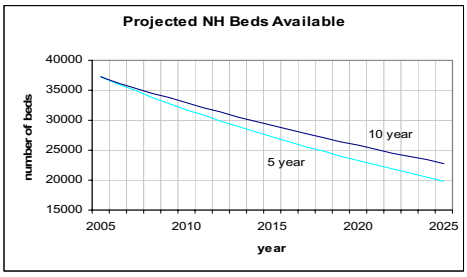
Trend in Number of NH Beds



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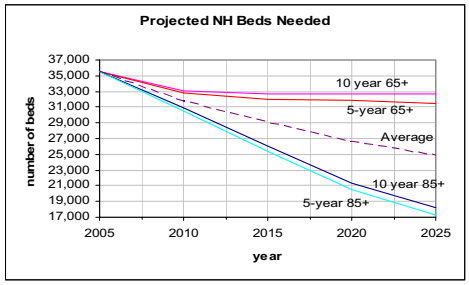
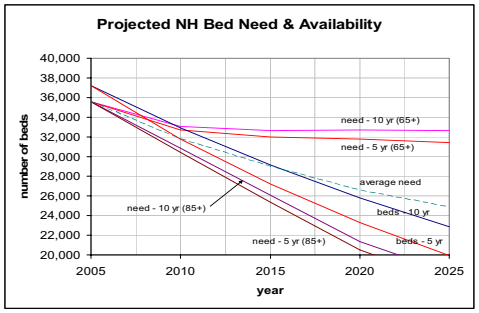
Trend in Need for NH Beds



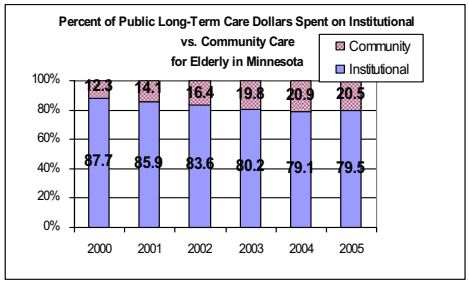
Nursing Facility Rates & Policy Division

Projected Need and Availability



Nursing Facility Rates & Policy Division

Rebalancing



Nursing Facility Rates & Policy Division