APPENDIX A
Descriptions of Eight States that Have Flexible State Budget Policies to Support HCBS

The identification of flexible accounting strategies spans states with fee-for-service programs, partial Medicaid managed care programs, and those with all Medicaid managed LTSS. These states have in common, however, that they have developed intentional state fiscal policies to create budgeting flexibility to manage their LTSS services as if they are a single program, shifting funding as called for between institutional and HCBS services.[42] The following eight states fall into the category of either fee-for-service or hybrid models that include partial Medicaid managed LTSS. Where available the authors have included specific legislative or administrative language authorizing the flexible accounting.

Louisiana

Louisiana uses global budgeting for its entire Medicaid budget, including LTSS. Funding is divided into two large categories, one for administration and one for payments to providers. The provider payments accounts are subdivided into funds for private and public providers. The budget is built from the ground up, program by program, and then it is rolled up into one budget. Once the money is appropriated, it goes into a large account and the Department of Health and Hospitals Medicaid program or the Office of Aging and Adult Services (which operates the Medicaid LTSS services) can move it flexibly between programs as needed; for example, paying for HCBS with savings from reductions in NF utilization.

When funds need to be transferred between programs, it is not a change in the budget; it is only a change in the expenditure. So as LTSS utilization changes, the department does not need to seek permission to transfer funds to pay for services. An economist does monthly forecasts for all programs, budgeting to the bottom line, not to the individual program level. There is one exception to the state's global budget for LTSS: about 15 years ago, parish-owned NFs put up money for an Intergovernmental Transfer program, with the proceeds going into a trust fund. The principal from the trust may only be used for NFs, primarily to rebase rates. Interest can be used for HCBS or other Medicaid uses, but the principal cannot be shifted.

For Louisiana, global budgeting is not a recent innovation: budgets in the state have historically been developed this way. The state also does not delegate many programs to the county, or as they are called in Louisiana, the parish, level. State staffs attribute this to a long precedent, going back to Huey Long, of having funding for many programs determined at the state level, rather than assigned to parishes by formula. No significant parish funding goes to the state to pay for LTSS, although there are local Councils on Aging and some parishes do put money into these organizations. The Councils mainly provide Older Americans Act HCBS, such as meals on wheels and senior centers.

[42] The majority of factual information in these state descriptions is taken from interviews and subsequent personal communications among state staffs and the authors.

Previously, Louisiana used to spend approximately $8 billion in its Medicaid budget, but the amount has dropped after two years of cuts. The state has avoided limiting program eligibility as a budget cutting strategy, but rather has cut provider rates selectively or across-the-board. Sometimes the state has spared certain providers; for example, two years ago LTSS providers were exempted from cuts. State staffs say they are proud that they have not reduced or eliminated HCBS during the current economic downturn, in fact adding HCBS services for 5,000 additional persons in the past two years.[43] They did this by developing a case-mix program for HCBS, based on acuity. This acuity-based allocation system created a budget for each person and did succeed in reducing costs. The state has not seen any increase in the rate of people going into NFs as a result of the change.

However, despite the global structure of the budget, political support to shift funds to "follow the person" has been an ongoing process. According to the state's 2010 MFP Operational Protocol,

> *"Community advocates and the administration have had difficulty securing legislative support for measures that would (1) allow Money Follows the Person to close institutional beds and open waiver opportunities or (2) that would fully consolidate budgeting of long-term care services. MFP legislation for the developmentally disability population failed in the 2004 legislative session, but was enabled on a case-specific basis in the 2006 session.*
>
> *In this session, the legislature approved the closure of specific public and semi-public ICF/DD beds to create additional waiver opportunities that would accommodate persons served in the closing facility. In the 2005 session, legislators signaled their intention toward greater budget consolidation by granting [Office for Citizens with Developmental* Disabilities] *OCDD some flexibility in shifting funds among, but not out of, public ICFs/DD.*
>
> *The following years have resulted in even more flexibility granted to OCDD. The MFP Rebalancing Demonstration provides the program framework and national stage that has aligned support for use of MFP in both the private and public sectors.*[44]

The state has a limited number of slots in its waivers; there are currently 5,428 slots available in two separate waivers for aging and disability, which are 90% to 95% full all of the time. There was an Olmstead suit in 2000 that prompted system changes. In 2001, as a result of a settlement agreement in the 2000 suit, the state set up a personal care program that rapidly grew. It currently serves about 14,000 participants. The program has had an impact on NF

[43] State staffs, Louisiana Department of Health and Hospitals Aging and Adult Services, personal communication, 9-22-11.

[44] Louisiana MFP Operational Protocol, 07/22/10, pp. 16-17. See, retrieved on 12-25-2011 from http://www.dhh.state.la.us/offices/publications/pubs-309/Ph1%20100pct%20Binder1.pdf

utilization and in effect, has resulted in a funding shift. NF utilization in Louisiana has gradually gone down in the last ten years, starting at 30,100 in 2001 and dropping down to about 25,600 NF patients in December 2011.[45] The personal care state plan service had a high benefit level, which contributed to one of the waivers failing the cost-neutrality test, causing problems with CMS. The case-mix system noted earlier restored cost-neutrality.

State staffs acknowledge that their system is not yet fully consumer-directed. They are currently implementing a new waiver with 14 services instead of just the personal care service that was previously provided. The new waiver is more person-centered, allowing a wider choice of services, and includes consumer-directed personal assistance services. The state is also moving to a more evidence-based model. One strategy that has been unsuccessful was an effort to use federal financial participation to fund conversions of their large supply of nursing homes to assisted living. Despite support for the proposal from the state's protection and advocacy organization, CMS denied the state's request to incentivize NFs to convert to assisted living facilities. The state has incentivized reductions in NF beds through other mechanisms, however, including sponsoring private room conversions, a bed buy-back and bed abeyance program, and by encouraging NFs to convert unused capacity to adult day health care.

Changes in Louisiana's LTSS system have come about because of leadership in the department. Current state officials were advocates 20 years ago, and have moved into management positions in the department. This has kept the system moving forward state staffs say, despite legislative pushback that was in part due to assertions by the NF industry that HCBS cost more than NF. State staffs say that they are committed to building an effective and sustainable LTSS system that offers consumers a broad array of choices for HCBS, because they have studied what other states have done and "we know it is the right thing to do."

Massachusetts

Massachusetts has two discrete approaches to budgeting for LTSS services. For its older adult population (over age 65), it uses a true flexible accounting strategy, rooted in program consolidation in one agency, the state Department of Elder Affairs. All services for this population, including LTSS services, are combined into a single budget authority whereby it is "fairly easy" to transfer money between programs.[46] From this account, the Department of Elder Affairs provides all services to persons over age 65, regardless of their setting or qualifying status (for example, a person with a developmental disability who is age 66 will be served by the Department of Elder Affairs). From the state's perspective, state staffs interviewed say this structure is successful; seen as the "best possible way" to budget for LTSS.

[45] American Health Care Association, Research and Data. Retrieved on 12-25-2011 from http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/HISTORICAL_HSNF_OSCAR%20Data%20Report_2001Q4.pdf and http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/PatientCharacteristicsReport_Dec2011.pdf

[46] State staffs, Massachusetts Office of Medicaid, personal communication, 9-20-11.

For people with disabilities who are under 65, funding resides in multiple accounts that span four or five departments. It can be difficult for these departments to administer programs with the same flexibility available in the consolidated Department of Elder Affairs. Funding, including funding for waivers, is budgeted in the departments and not at the agency level. The level and availability of services depend on why a person is eligible. If transfers of funds are needed, the state sets up subaccounts and transfers funds from one department to another. Reaching agreements about funding across these departments is a matter of discussion, and as a result these programs have significantly less flexibility to transfer funding between institutional and HCBS accounts than does the Department of Elder Affairs. All LTSS in Massachusetts are provided by the state, with the exception of LTSS in jails, which is administered by the counties.

The Department of Elder Affairs account is commonly referred to as the "Senior Care account," line 4000-0600, and is a population-based account that the state has had in place for nine years. Historically, most of the money in this account was used to fund NFs. Today it includes all services, including the frail elderly waiver, adult foster care, adult day health, crossover claims for the dual-eligible population, Senior Care Options (managed care), Program of All-Inclusive Care for the Elderly (PACE) and NFs.

The Department of Elder Affairs' budget office monitors the Senior Care account weekly, and does day-to-day transactions in the account such as claims processing, as well as tracking to ensure that both program expenditures and population projections are accurate. Although policy changes may impact a specific program, the state does not have an allocation for specific programs within the account. The account is large enough that it has a margin and it usually balances out. As long as the bottom line is under the legislative appropriation, the account is fine. If needed during the last two months of the year, the legislature will authorize transfers between accounts, but this is not typically necessary for the Senior Care account.

When budget reductions have been necessary, the state has identified what it wants to cut; for example, it did not give NFs a Consumer Price Index (CPI) raise. The cut is allocated across accounts that pay for NFs, so the part of the NF-CPI that related to the over-65 population was removed from the 0600 Senior Care account.

The state has found that the Senior Care account provides the flexibility required to purchase services the population needs, as well as giving "everyone a say," including the legislature, the administration and advocates. In particular, both senior advocates and providers like having an account that they can see and can advocate for. Disability advocates in the state are not as happy with having to work with multiple departments and accounts in the under age 65 disability programs.

Michigan

The Michigan Department of Community Health is a large umbrella-like agency that operates public health, LTSS, developmental disabilities, mental illness and substance abuse programs.

The MI Choice program is Michigan's Medicaid 1915(c) HCBS waiver. Twenty agencies, most of them Area Agencies on Aging, administer waiver services. MI Choice offers 18 waiver services, including personal care, homemaker services, respite, adult day care, non-medical transportation, environmental modifications, and NF transition services. The MI Choice program has a lengthy waiting list. In 2005 Michigan added NF transition services to the MI Choice 1915(c) waiver for the elderly and adults with disabilities. Since 2007, the legislature has increased the MI Choice appropriation based upon an estimated number of transitions anticipated.[47]

The state began its transition work with a federal grant in 1999 awarded to four of the state's Independent Living Centers to develop and implement a transition services model. Since that time, the state has adopted systemic changes focused on supporting NF transition and diversion. The Michigan Nursing Facility Transition program is based upon the principle that consumer choice is of paramount importance, and that the funding source should not be a consideration or barrier in planning a transition. To that end, the program operates with maximum flexibility, allowing transition agents to address "every reasonable barrier to transitioning,"[48] including housing, furnishings, home modifications, bad debt, assistive technology and durable medical equipment. In contrast to some state MFP programs (including the California program), in Michigan persons qualify for transition based on their desire to move to the community, not on whether they first meet criteria for MFP support: "After a transition is complete, the state determines whether the individual's transition and first year expenses are eligible for the MFP enhanced Medicaid match rate funding."[49] By means of these policies and by utilizing benchmarks for program outcomes, the state's transition program has grown steadily between fiscal year 2005 – 2011, transitioning a total of 4,898 persons and diverting 963 more from NFs.[50] In its official CMS MFP program, Michigan transitioned 640 persons between 2007-2010 the fifth highest transition amount among the 30 states for whom data was reported.[51] This is substantially better than what most states were able to achieve with their 2007-2010 nursing home transition efforts.[52] The state has experienced a drop of

[47] State staffs, Michigan Department of Community Health Home- and Community-based Services Section, personal communication, 9-21-11.
[48] Speckman-Randall, E., (2011, November), *Michigan's Nursing Facility Transition Program*, Michigan Department of Community Health, Lansing, MI, p. 19. Does not appear to be currently available on line.
[49] Ibid, p. 18.
[50] Ibid.
[51] Speckman-Randall, E., (2010, September), *CMS Operational Protocol Training Conference Call Session 2: MFP Benchmarks*, Michigan Department of Community Health, Lansing, MI. Does not appear to be currently available on line.
[52] From 2007-2010 there were only 11,849, participants nationally in CMS sponsored Money Follows the Persons programs. The figures reported for Michigan's CMS program were 640. Nonetheless these statistics do show the level of effort made in Michigan compared to other states. See Mathematica Policy Research Inc. (2011, October),

1,500,000 Medicaid paid days of NF care between 1999-2011, despite population growth in its senior population during that period.[53]

Michigan no longer institutionalizes people with developmental disabilities; in 2011, the state transitioned the last residents of developmental disability centers to the community. The state also has a Home Help Program that was established in 1995. The program provides in-home services to 50,000 senior and persons with physical disabilities using some 42,000 consumer-directed employees.

On the one hand, Michigan does not do "global budgeting," as there are separate account lines for NFs, the MI Choice waiver program, and the PACE program. On the other hand, the state has a formal policy for the NF budget line to take into account savings associated with the anticipated transitions, and to transfer funds to support the MI Choice waiver program. Funding increases for the MI Choice waiver have been largely dedicated to NF transitions and the budget for the waiver program has received additional funding for each individual transitioned to the community. This has resulted in growth of the MI Choice budget from $123 million in FY 2008 to $229 million in FY 2012. The costs for the MI Choice program are approximately 1/3 the costs of NF care.

According to state staffs, the MI Choice program and its transition services have benefitted from strong leadership in the Department of Community Health, strong advocacy efforts by a coalition of organizations, and strong support in the Michigan legislature. In particular, state leadership successfully made the case within the administration that expanding HCBS programs would be both responsive to consumer and family preferences and would also be cost-effective for the state.

The authority to transfer funds has been repeatedly concretized in Legislative appropriation bills, including the FY 2012 language that supports transitions as a priority and funding transfers (Section 1689, Public Act 63 of 2011).

> *Sec. 1689. (1) Priority in enrolling additional individuals in the Medicaid home- and community-based services waiver program shall be given to those who are currently residing in nursing homes or who are eligible to be admitted to a nursing home if they are not provided home- and community-based services. The department shall use screening and assessment procedures to assure that no additional Medicaid eligible individuals are admitted to nursing homes who would be more appropriately served by the Medicaid home- and community-based services waiver program. It is the intent of the legislature that when an individual is transferred from a nursing home to the home- and community-based services waiver program, the funding to cover that individual's home- and community-based services waiver program costs shall be transferred from the long-term care services line item to the Medicaid home- and community-based services waiver line item. These funds are not available for expenditure until they have*

Money Follows the Person 2010 Annual Evaluation Report Final Report, Princeton, NJ See retrieved on 12-25-2011 from http://www.mathematica-mpr.com/publications/PDFs/health/MFP_2010_annual.pdf see Table III.3

[53] Spreckman-Randall, E., (2011, November), *Michigan's Nursing Facility Transition Program.*

been transferred to another line item in this article under section 393(2) of the management and budget act, 1984 PA 431, 1393.

(2) Within 60 days of the end of each fiscal year, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home- and community-based services waiver program by regions as well as the associated expenditures. The report shall include information regarding the net cost savings from moving individuals from a nursing home to the home- and community-based services waiver program, the number of individuals on waiting lists by region for the program, and the amount of funds transferred during the fiscal year. The report shall also include the number of Medicaid individuals served and the number of days of care for the home- and community-based services waiver program and in nursing homes.

(3) The department shall develop a system to collect and analyze information regarding individuals on the home- and community-based services waiver program waiting list to identify the community supports they receive, including, but not limited to, adult home help, food assistance, and housing assistance services and to determine the extent to which these community supports help individuals remain in their home and avoid entry into a nursing home. The department shall provide a progress report on implementation to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies by June 1 of the current fiscal year.[54]

The legislative language gives state administrators the authority to undertake both NF diversion and transition programs and transfer funds from NF budgets to pay for HCBS services. This authority for flexibility in accounting has existed for almost a decade, and combined with annual reporting requirements, supports the state in its programmatic efforts to provide for the growth of HCBS services.

New Jersey

New Jersey began developing flexible budgeting policies in the late 1990's when it consolidated all LTSS in the Department of Health. The leadership provided by the Commissioner and Deputy Commissioner of Health persuaded the Governor that such a consolidation was necessary to promote effective and efficient LTSS services.[55] The Department of Health was renamed the Department of Health and Senior Services. In 2004 under Governor's Executive Order No. 100, the Health and Senior Services Commissioner was directed to consult with the State Treasurer and prepare an analysis and recommendations for developing a global long-term care

[54] Michigan State Legislature, Act No. 63, Public Acts of 2011, Section 1689. Lansing, MI. See, retrieved on 12-28-11 at http://www.legislature.mi.gov/documents/2011-2012/publicact/pdf/2011-PA-0063.pdf

[55] Reinhard, S., and Fahey, C., (2003, December), *Rebalancing Long-Term Care in New Jersey: From Institutional toward Home and Community Care*, A Report prepared for the Milbank Memorial Fund, New York, NY. See retrieved on 12-25-2011 from http://www.milbank.org/reports/030314newjersey/Rebalancing_Mech.pdf

budgeting process. The intention was to provide the Department of Health and Senior Services with authority and flexibility to move Medicaid recipients to the appropriate level of care and to streamline paperwork and expedite Medicaid eligibility for home care options.

In 2006, the legislature enacted the Independence, Dignity and Choice in Long-Term Care Act. The Act was designed to:

> *"ensure that, in the case of Medicaid-funded long-term care services, 'the money follows the person' to allow maximum flexibility between nursing homes and home- and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State."*[56]

The Act established flexible accounting changes to the LTSS system.

> *"C.30:4D-17.27* ***Duties of commissioner relative to report on budget, management plan.***
>
> *5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:*
> *a. no later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L. 1991, c. 164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and*
> *b. no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L. 1991, c. 164 (C.52:14-19.1), that documents the reallocation of funds to home- and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home- and community-based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.*
>
> *C.30:4D-17.32* ***Inclusion of budget line for Medicaid long-term care expenditures.***
> *10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures*

[56] New Jersey Public Law 2006, Chapter 23. See, retrieved on 12-25-2011 from http://ssl.csg.org/dockets/29cycle/29A/2009adocketbills/1028b01nj.pdf

with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.[57]

Governor Jon Corzine signed the act and in fiscal year 2006 allocated $30 million in state and federal funds to global budgeting to rebalance LTSS. Thereafter, the state budget included a line item dedicated to the global budget initiative.[58] The Department of Health and Senior Services allocated funds to hire a national consultant to assist in the development of a flexible budget projection model and a more effective reimbursement methodology, and formed a global budget workgroup to oversee the work.

The initiative, known as Global Options for Long-Term Care (GO for LTC), has been a multi-year change process to rebalance spending for LTSS by providing a more equitable distribution of public funds between HCBS and NF care. In addition to regular State Plan services, GO provides 14 waiver services to participants who are financially eligible for Medicaid and clinically assessed at a NF level of care. The state developed a new business process for more comprehensive service planning and a coordinated team approach to nursing home transitions. In the first 16 months, the program transitioned 811 nursing home residents to community options. Of these, 306 individuals enrolled in GO, and 505 were transitioned home with either regular State Plan services or no formal services. GO serves persons for an average monthly cost of $1,124 per person, compared to $4,724 per month for nursing home costs, a state savings of $3,600 per person, per month.

The Act also required a progress report to the Governor and the Legislature, including a detailed budget and management plan for implementing the law. However, New Jersey has recently made a policy change in its Medicaid program that may render global budgeting policies moot. In September 2011 the state submitted a comprehensive 1115 waiver, based on a concept paper already approved by CMS, to put its entire state Medicaid program into managed care.[59] Under the comprehensive waiver, all state Medicaid services including LTSS will come under a managed care capitated rate. The capitation rate will differ depending on acuity. Services will be provided by four Health Maintenance Organizations (HMOs), which will be fully at risk for all primary, acute, and LTSS care. Adult day health and NFs will be kept at the same rate for the first year of the managed care contract as the state gains a better understanding of what rates will buy what services. In 2012 there will be a new contract with a new rate system for the plans. Each individual will have his or her own risk-adjusted rate, based on acuity.

ADRCs currently serve as the state's "no wrong door portal" and will continue to do so under the comprehensive waiver, providing front-end information and assistance, assessment screening, financial assessment to understand benefits qualification, and referral for clinical

[57] See, retrieved on 12-25-2011 from ftp://www.njleg.state.nj.us/20062007/PL06/23_.HTM

[58] New Jersey Department of Health and Senior Services, *Independence, Dignity and Choice in Long-Term Care Report, June 21, 2006 – October 1, 2007,* Trenton, NJ, 2007. See, retrieved on 12-27-11 from http://www.state.nj.us/health/senior/documents/ltc_act_report.pdf

[59] State staffs, New Jersey Division of Aging and Community Services, personal communication, 9-29-11.

assessment. The managed care plans will assume responsibility for care management rather than the Area Agency on Aging network, which now performs this function. For the present, the DHSS has retained clinical assessment for NF qualification.

Adult Protective Services (APS) and APS administrative functions are also proposed for federal match in the comprehensive waiver. At least one-third of APS clients are potentially Medicaid-eligible. New Jersey APS is funded at $4 million and has not been increased in years, so this would provide a significant expansion.

On July 1, 2012, the managed care plans will assume responsibility for all waiver services, and all current waiver providers will have to contract with the plans. State staffs report some health plans are open to hiring transitional waiver providers and others have said that they will hire their own. Programs of All-Inclusive Care for the Elderly (PACE) are being phased out over a two-year period; all of the plans will include a similar but not identical range of services as PACE. These services will be available to everyone who is assessed for the level of service, whereas the current PACE program services just 450 persons. PACE may be able to convert to a health home or other model and negotiate a role with the plans, but this outcome is far from certain.

The NFs will also be included under the capitated rate, and will negotiate rates and contract with the health plans. Currently in New Jersey, managed care plans are responsible for the first 30 days of NF care. However, after July 1, 2012 the plans will be at full risk for NF costs and will have no time limit on their responsibility.[60] Behavioral health will be carved out at first, with phased integration because of financial risk. State staffs acknowledge that the waiver ushers in a new era for all of the state's providers.

The request for a Medicaid 1115 waiver to change the New Jersey's Medicaid program was sent to CMS in early September 2011. The state has asked CMS for an expedited review and speculates that the waiver may potentially be approved by June of 2012. It will cover a million lives, and is expected to generate $300 million in savings to the state.

Pennsylvania

Pennsylvania created a fiscal structure as far back as the 1980s that allowed a measure of flexibility in accounting for its LTSS system. The state's funding was organized into three accounts, including a long-term care account that combined their aging waiver, PACE program and NFs; a second account with waivers for people with physical disabilities that had some flexibility; and an account with a third appropriation covering attendant care, including both state and federal funds.

[60] Ibid.

In a decade of work, Pennsylvania has achieved remarkable results in its rebalancing work with LTSS programs. A FY 2000 grant from CMS for the Nursing Home Transition Demonstration Program funded Pennsylvania's Transition to Home (PATH) program until September of 2003. The program began operations in November 2001 in four pilot counties and expanded in 2003 to an additional three counties using state funds. These state funds extended operations into 2004. The state also obtained a 2006 Money Follows the Person demonstration grant. In 2007 the state consolidated its LTSS administrative departments into one Office of Long-Term Living, and this consolidated agency administered the three accounts flexibly to reallocate funds as needed to purchase HCBS.

Determining that transition efforts resulted in cost-savings for the state, the state went on to expand the program statewide and invested $10 million in state general fund in 2008 and $14 million in 2009 into it.[61] Seventy-five agencies participate in delivering transition services, and state general fund dollars are used to provide flexible program aspects that do not fit into categories that can be financed with federal funds. Multiple strategies to address housing have been developed. The state currently has five different waivers that have a line item associated with them that provides funding for transition, and these funds are provided to the state transition program.

In the authors' opinion, Pennsylvania's work has achieved noteworthy results. For each of the last three and a half years, the state has helped approximately 1,600 persons per year leave NFs and move to the community, contributing to an estimated drop of 2,000,000 in the number of Medicaid days paid for by the state and a reduction of 11% in the number of Medicaid NF recipients. State staffs say the transition population mirrors the general NF population in acuity, and roughly 1/3 of all people transitioning do not require any state-funded services following their transition. The state saves an average of $119 per day per transition, or $43,000 per year, for individuals that receive HCBS following the transition. The state estimates their total savings have exceeded over $200 million dollars in NF expenditures.

Pennsylvania ranks 12th in the nation on the *Scorecard*'s dimension of choice of setting and provider. Pennsylvania's MFP program ranked 6th in the nation on the number of persons in transitioned from institutions.[62]

More recently, the state has changed the funding structure for LTSS. For State Fiscal Year 2011-2012, the appropriation for LTSS that included the aging waiver, PACE, and NFs together was divided into three separate accounts. As of July 1, 2011, if funding needs to be moved from NFs to the aging waiver or the PACE program, it will require a supplemental appropriation to make the changes. These supplemental appropriations can only be made at certain times of the year. The state's ability to move funds flexibly so that they "follow the person" will be more difficult.

[61] State staffs, Pennsylvania Department of Aging, Office of Long-Term Living, personal communication, 9-22-11.
[62] Ibid, Mathematica (2011) Table III.3

Texas

Texas staffs say the state is known for originating the "Money Follows the Person" (MFP) strategy in its LTSS system. The state's MFP program was initiated in 2001 when the legislature attached Rider 37 to the appropriations bill, allowing money to be transferred from the NF line item to the HCBS line item to support a person in a NF to transition to a community setting. Since 2001, Texas has transitioned more than 25,000 persons from NFs by means of the MFP policy and the budgeting strategy.[63]

Rider 37 permitted the funding to be transferred quarterly, in bulk, based on changes in utilization and the average cost of services. When someone died, funding for his or her services was permanently left in the HCBS line item, in time expanding funding for community services overall. However, in 2003, with lobbying from the nursing home industry, Rider 28 was passed to amend this process. Subsequently, when a person died, the money was returned back to the NF line. The ongoing transference of appropriated dollars made the process more cumbersome to administer.

In 2005 the legislature enacted a new budget strategy for MFP. The money no longer came from the NF line item based on an individual transition. Access to HCBS through MFP came to function as an entitlement, and the funding level in the legislative appropriation is based on current and forecasted data. The HCBS appropriation has grown over time. If funding is insufficient in the HCBS line to cover services, then money is transferred from NF funding. The Legislative Budget Board administers the transfer based on House Bill 1867 of 2005:[64]

> *AN ACT relating to the transfer of money appropriated to provide care for certain persons in nursing facilities to provide community-based services to those persons. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS: SECTION I: Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.082 to read as follows:*
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> *Sec. 531.082. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services. (b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:*
>
> *(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that*

[63] State staffs, Texas Department of Aging and Disability Services, personal communication, 10-7-11.

[64] Texas State Legislature, *Chapter 531, 79th Legislature, Regular Session, 2005,* Government Code Section 531.082. Austin, TX, 2005. See retrieved on 11-3-2011 from http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0051-0100/sb_87_bill_20110630_chaptered.pdf

subsection among the health and human services agencies and the commission as necessary to comply with this section; or

(2) the commission or a health and human services agency, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that subsection within the agency's budget as necessary to comply with this section.

(c) The commission shall ensure that the amount transferred under this section is redirected by the commission or health and human services agency, as applicable, to one or more community-based programs in the amount necessary to provide community-based services to the person after the person leaves the nursing facility.

Texas NF rates decreased 3% last year. The MFP account is substantial – it had $124 million in funding in the last fiscal year. The number of individuals who are currently accessing community services as a result of MFP is approximately 9,000 persons. For years, the NF population remained at about 65,000; in recent years it began to decline to approximately 56,000 but has now started to increase due to demographic changes, more short stays, a younger disabled population and returning disabled veterans. On average, the HCBS and acute care cost is 65% to 67% of the NF cost.

Texas took advantage of a limited federal offer to implement attendant services to those with incomes up to 300% of Supplemental Security Income (SSI). This has made a significant impact – 140,000 to 150,000 people are served with attendant services.[65] In 2003, the state began a process of re-organization of the health and human services system, consolidating 12 agencies into five, with one of those agencies acting as an umbrella agency for all policy for Medicaid, managed care and other programs. The state currently has strategies for "expedited access" to transition for people with developmental disabilities, and is developing an intensive relocation activity for that population. Texas offers wrap-around services in both the fee-for-service and Medicaid managed care systems and allows a one-time allowance of up to $2,500 under the waiver for setting up a household.

State staffs say they have learned that the MFP policy to allow for institutional relocation is not sufficient on its own – prevention and diversion are vital to allow an individual to retain community housing and social support systems. The state has a limited diversion program, which is being expanded slightly, and has also built diversion into its Medicaid managed care program, called STAR+PLUS.

[65] State staffs, Texas Department of Aging and Disability Services, personal communication, 10-7-11.

who live within a service area and is voluntary for children under the age of 21 who are receiving SSI. NFs and Intermediate Care Facilities for individuals with developmental disabilities (ICFs) are carved out of STAR+PLUS. For those with dual eligibility, STAR+PLUS does not change the way that they receive acute or primary care services through their choice of Medicare-funded services.

The state uses performance measures to control the utilization of NFs by managed care plans. The plans are assigned a penalty when persons who are enrolled in the plans enter or return to a NF. The plans are also responsible for four months of the cost of the stay in the NF before the person is disenrolled. As part of the plan benefits, if a person's income is below the SSI level, then HCBS waiver services are an entitlement; they do not have to be on an "interest list" to wait for services nor have to rely on MFP to relocate from an institution to receive services. As such, STAR+PLUS serves as an effective NF diversion program.

Washington

Washington began development of its high-performing LTSS system during a budget crisis in the early 1980's, when it discovered that different programs and departments were using different methods of forecasting the caseloads of similar programs. Out of this awareness, the Caseload Forecast Council was established to make monthly forecasts of all entitlement caseloads, including NFs. State aging officials successfully argued that to level the playing field between NF and HCBS, HCBS should be forecast "as if" they are an entitlement.[66]

The Caseload Forecast Council conducts a monthly process of forecasting and adjustment, and its recommendations result in a per-capita appropriation for all LTSS that is presented to policymakers as a related, unified whole. The state has an explicit goal of reducing NF beds over time while increasing HCBS, and while there is the potential that the legislature could argue with forecasts, in fact, it does not.

In the same timeframe, responsibility for both NF and HCBS were consolidated into an Aging and Disability Services Administration, which has the authority to transfer funds among its accounts. The end result is a self-correcting system where funds can be moved to buy services that are needed through a continuous process of forecasting and adjustment, tracking both the NF and HCBS side and efficiently moving funds between them. The consolidation also contributed to the ability to create a single point of access for LTSS, and taken together, the consolidation, the forecasting and the single point of access are the core elements that undergird the system. In 2002 the developmental disability system was added to the Aging and Disability Services Administration; in 2010 mental health and substance abuse services, including state mental health hospitals, were also added. These recent additions have resulted in growing pains for the state as different program staff learn to work together.

[66] State staffs, Washington Department of Social and Health Services/Aging and Disability Services Administration, personal communication, 10-4-11.

Washington has an evolving Medicaid managed care footprint, having recently proposed to include seniors and people with disabilities in managed care. However, the state also has a healthy fee-for-service system. As in other states, budget reductions are driving an increasing focus on managed care. Selected as one of the 15 states to receive a design contract to develop plans to integrate medical and supportive services for dual eligibles from CMS, the state is currently grappling with how to maintain the best features of its LTSS system in a managed environment for those who are dually eligible for Medicare and Medicaid.[67] One of the key questions is how to marry the financial systems that have worked in the past into a duals demonstration, including how to keep caseload control over NF utilization. Another prominent issue is how developmental, behavioral health and substance abuse services will be purchased in the future.

The state currently provides HCBS to persons with high medical costs in community settings, but traditionally has not paid attention to managing medical costs. State staffs interviewed say they are using their duals demonstration to look at the problem of managing high cost persons. They also feel that significant improvements can be made through better utilization of substance abuse treatment. The dual eligible pilot process will be driven by task forces and will prominently include the topics of benefits, outcomes, and financing.

One of the state's strengths is a sophisticated system of risk modeling across programs. The Aging and Disability Services Administration developed this in conjunction with the state's Health Care Authority, which has responsibility for Medicaid purchasing and purchasing for other state health programs, and which operates an all-payer claims database. The duals project will pull Medicare claims data into their model. The state is likely not ready to pursue full risk-based capitation; rather it is interested in developing hybrid models to test over a four- to five-year period to support multiple incremental steps to transition its system.

Wisconsin

Wisconsin's system of LTSS spans multiple programs, including a large fee-for-service nursing home population, a "legacy" system of HCBS waivers administered by counties and tribal governments, and a state-level program of Medicaid managed LTSS, called Family Care. The state's fee-for-service nursing home population is reimbursed through a case-mix methodology using the Resource Utilization Groups Version III (RUG-III), which takes into account three acuity levels that are reflected in the rate. The rate setting is done "in-house" by the Center for Health Systems Research and Analysis (CHSRA), located at the University of Wisconsin.[68]

The state began rebalancing efforts in 1981 by placing a moratorium on the construction of new nursing home beds and launching a county-operated system of HCBS called the

[67] Ibid.
[68] State staffs, Wisconsin Health Services, personal communication, 10-7-11.

Community Options Program (COP) and the Community Options Program Waiver (COP-Waiver). Historically, these "legacy" waivers have been capped and have experienced long waitlists, although waivers to facilitate nursing home relocation were not capped; anyone who wanted to transition from a nursing home could receive a waiver. Counties provided a significant contribution, approximately $100 million in county funds, to the funding of the programs.

As a result of these long-standing programs, the state has a robust array of HCBS services and providers, along with strong state policy direction in support of consumer choice. The state's NF utilization has gone down over the last 20 years. For example in December 2001 Wisconsin's NF population was 38,430 and in December 2011 it was 29,794.[69]

In 1998, Wisconsin adopted the Family Care program, a state-administered system of Medicaid managed LTSS. In 2006, Family Care was expanded throughout the state, although not in every county, with the intention of eliminating waiting lists for HCBS over the following five years. There are five managed care plans that participate in Family Care. Counties agreeing to implement the program work with the plans to transition the existing COP-Waiver enrollees onto Family Care. The state also established Aging and Disability Resource Centers (ADRCs) to provide front-end single-entry point assistance and referral and to do the function eligibility assessment for the program.

Since Family Care began, counties have experienced gradual but significant reductions of waitlists. In the initial year of Family Care implementation, the state required the counties to continue their funding levels through a maintenance of effort (MOE) requirement. The MOE is stepped down over five years to a level of 22% of the community aid block grant. So over time, the county share of cost is reduced by 60%, with the state investing more resources as well as getting better utilization that reduces costs.[70] The county risk for future growth of HCBS is also reduced.

State staffs say a small percentage of those in Family Care are in NFs, and NF utilization is built into the Family Care capitation rate. Even within counties administering Family Care, some residents in NFs remain in fee-for-service. For those persons, the managed care organization pays the NF the fee-for-service rate.

Wisconsin has policies that discourage the utilization of NF services in their managed LTSS program through both fiscal incentives and performance measures. Fiscal incentives are achieved through the blended capitation rate, which is based on prior year utilization of acute care, HCBS and NF services. Plans save money in the current year when they reduce NF utilization because their current rate contains funding for their higher historical NF utilization.

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[69] See American Health Care Association, Research and Data, retrieved on 12-25-2011 from http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/HISTORICAL_HSNF_OSCAR%20Data%20Report_2001Q4.pdf and http://www.ahcancal.org/research_data/oscar_data/NursingFacilityPatientCharacteristics/PatientCharacteristicsReport_Dec2011.pdf

[70] State staffs, Wisconsin Health Services, personal communication, 10-7-11.

Conversely, plans are at risk if NF utilization is higher in the current year than the historical level of utilization assumed in the plan's capitation rate for the current year. The state obtains savings because their NF utilization is reduced in future years.

The state has also set performance measures for the plans that require that they work with consumers to enable them to live where they want. Like the legacy waiver system, Family Care has an entitlement for services for every person who wants to leave a NF. Due to budget pressures, as of July 1, 2011, enrollment in Family Care is capped, but there are exceptions to the cap and one exception is for persons leaving a NF.

Wisconsin has a formal policy of flexible budgeting to support its LTSS program. The NF and Family Care budgets are in one single appropriation. The state picks up changes in utilization when people transition from a NF through a system of projections, and then funds the shift from NF to Family Care. Language regulating fund transfers in the Medicaid program provides statutory authority to transfer funds between accounts:

> *"…Notwithstanding s. 20.002 (1), the department may transfer from this appropriation account to the appropriation account under sub. (5) (kc) funds in the amount of and for the purposes specified in s. 46.485. Notwithstanding ss. 20.001 (3) (b) and 20.002 (1), the department may credit or deposit into this appropriation account and may transfer between fiscal years funds that it transfers from the appropriation account under sub. (5) (kc) for the purposes specified in s. 46.485 (3r). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation account to the appropriation account under sub. (7) (bd) funds in the amount and for the purposes specified in s. 49.45 (6v)."*[71]

The approval of the state budget office is required for these intra-department transfers within the appropriation; however, approval is pro forma because on average the HCBS costs are lower. The funding for legacy waivers works in a similar way.

[71] Wisconsin State Legislature, *Chapter 20, Statutes of 2011,* Annual Budget Appropriation Section 20.435(4) (b) GPR. See retrieved on from 11-15-2011 from https://docs.legis.wisconsin.gov/statutes/statutes/20/V/435//4/b

APPENDIX B
Overview of Four States that Incentivize HCBS in Medicaid Managed Care Programs

Three of the four states selected for review, Arizona, Hawaii, and Tennessee, serve almost all Medicaid-eligible persons in managed care programs. The fourth state, Minnesota, has about two-thirds of its Medicaid enrollees in comprehensive risk-based managed care programs. Their methodology is an example of flexible accounting in a managed care context; utilizing a blended capitation rate that puts contractors at risk for both institutional and HCBS. A capitation rate works like a single large account comprising separate funding streams and states can build incentives into the contractual language to encourage the spending from the account on HCBS services.

Arizona

In 1982, Arizona was the last state to adopt a Medicaid program, and the first to create a Medicaid managed care system. The Arizona Health Care Cost Containment System (AHCCCS) was created in 1988 to cover acute care and limited post-hospital NF coverage. The Arizona Long-Term Care system (ALTCS) followed in 1989 to provide managed LTSS coverage. Arizona also has a State Children's Health Insurance Program, KidsCare.

AHCCCS uses a combination of rate structure and performance indicators to stress the importance of HCBS within its ALTCS program. AHCCCS actuaries create a managed care rate for both nursing facilities and HCBS services and then the managed care contractors get a blended rate for both services based on assumptions about the number of months of NF care and the number of months of HCBS services that their plan enrollees will experience based on historical utilization patterns. "After the end of the contract year, AHCCCS will compare the *actual* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long-term care capitation rate for that year. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage."[72]

Conversely, if the contractor places more persons in HCBS services than budgeted for, the contractor will have in effect made a profit on the blended rate, since the rate assumes a higher NF utilization level. If the amount saved is less than 1% nothing happens. If the amount is greater than 1% then the state will do a 50-50 split with the contractor on the amount of money saved by using higher HCBS.

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[72] Arizona Health Care Cost Containment System (AHCCCS) (2011, January), *Arizona Long Term Care System (ALTCS) Elderly & Physically Disabled(E/Pd) Contract For Contractors,* Phoenix, AZ p. 79 Retrieved on 11-3-2011 from http://www.azahcccs.gov/commercial/Downloads/Solicitations/BiddersLibrary/YH12-0001/General/General_SectionA_F_YH12-0001_1_31_11FINALCLEAN.pdf For all RFP related documents see, retrieved on 11-3-2011 http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH12-0001.aspx

In addition to the capitation rate methodology, AHCCCS also uses a performance measure with its contractors. AHCCCS medical policy requires that services for HCBS members are initiated within 30 days of enrollment, based on a personal visit and thorough assessment of service needs by a case manager. The reporting of this measurement assesses the percentage of newly placed ALTCS members who received specific HCBS services within 30 days of enrollment, overall and by the contractor. The minimum performance standard on this measurement is 92%; while the AHCCCS goal was 98% in 2011.[73] Contractors are publicly rated, their performance is publicly critiqued by the state assessors, and corrective action plans are required of contractors that do not meet minimum standards.

Hawaii

In February 2009, Hawaii shifted its Medicaid program to managed care through an 1115 managed care waiver. The state's QUEST program serves Medicaid-eligible persons who are well, and the QUEST Expanded Access (QExA) program covers those who are aged, blind or have other disabilities. Four of the state's five existing waivers were rolled up into managed care; the developmental disability waiver was not included. Persons with developmental disabilities receive their health care through the managed program but still receive HCBS through a separate waiver. Services for persons with serious mental illnesses were partially included in managed care. The state's waiting list for HCBS waivers stood at about 500 persons in 2009 and the managed approach provided services to all of those people, clearing the waiting list.

Prior to the changeover, Hawaii's efforts to reduce NF utilization were primarily focused on diversion. However, with the launch of the QExA program, rebalancing spending between NF and HCBS became an explicit goal.[74] The state started with three rates, based on assessment: plans received the lowest rate for primary and acute care for those living in the community. A second and higher rate-level covered people assessed as needing HCBS, and the highest rate was paid for those in NFs. The state applied further adjustments based on age, gender and geography, so the ultimate rate was a complex formula. To disincentivize utilization of NF, a plan that moved a person from the community to a NF received a penalty whereby it was reimbursed only at the HCBS rate for a one-year period after the move. The plan was required to pay the difference in the cost of care. In addition, the plan would be paid at the HCBS rate immediately for anyone discharged from a NF and into HCBS.

This system was intended to reduce NF utilization and shift resources to HCBS; however, according to state staffs, it did not have the intended effect. Plans were afraid of receiving the penalty if they moved people from NFs and the placement in the community subsequently failed. Consequently, the plans kept people who were residing in nursing homes where they

[73] See retrieved on 3-11-2011 from http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS-HCBS-2011.pdf

[74] State staffs, Hawaii Department of Human Services, Med-QUEST Division, personal communication, 11-2-11.

were as long as possible. In addition, they were incentivized to over-assess people as requiring HCBS in order to secure the higher HCBS rate. This problem was compounded by an increased workload for eligibility staff that resulted in delays in implementing rate changes when a person moved from one location to another.

In response, the state reassessed and changed its rate-setting methodology. Since July 1, 2010, the state has utilized a blended capitation rate that is based on encounter data. Rates are based on forecasted trends, and plans are reimbursed at the same rate for each person, whether they reside in a NF or in the community. Thus, when plans are successful in moving persons out of NFs, they experience savings. The plans negotiate contracts with NFs directly; the state does not get involved in NF rates except to require that they are acuity-based. State staffs report that this system has made a huge impact. They are seeing transitions from NFs take place, and NF rates are lower under the new arrangement. The managed care plans did not object to the change to a blended rate.

The state limits the plans to a 7% administrative rate. It has also designed a risk-sharing agreement with the plans. If the plans realize more than a 3% profit, the overage is split with the state; but if the plans experience more than a 5% loss, the state shares the cost.[75] State staffs said that they were originally worried about securing adequate HCBS providers, but found that the marketplace produced new providers. As a budget cutting measure, the rates were cut by 3% in 2011. At this time, the state has not had to implement its risk-sharing agreement with the plans.

The plans are required as part of their contract to administer the state's MFP program, the Going Home Plus program. Plans are paying for the care coordination. The transition services were included in their blended capitation rate when the MFP program was included in QExA in October 2010. They do not use any community-based providers of transition services. There are performance measures in the contracts that allow the state to provide incentives; however, the blended rate appears to be achieving the state's goals, and no incentives have been deemed necessary. The state is now working on ways to refine its methods of monitoring quality of care.

Minnesota

Minnesota's system of LTSS is the highest ranked in the nation, scoring in the top decile of the LTSS Scorecard on all measures; affordability and access, choice of setting and provider, quality of life and quality of care, and support for family caregivers. The majority of the state's services are provided through a long-standing managed care system.

The state initiated its managed care approach in 1983. In the early 1990s a demonstration grant from the Robert Wood Johnson Foundation helped refine the model. In 2007 state leadership made a decision that NF beds would be reduced and HCBS expanded. In 2007 the state

[75] State staffs, Hawaii Department of Human Services, Med-QUEST Division, personal communication, 11-17-11.

legislature expanded managed care statewide.[76] The state now uses managed care to serve over 535,000 participants through eight local non-profit managed health plans. The state has one large managed care system for families and children who are Medicaid-eligible, which also includes Minnesota Care, the State Children's Health Insurance Program. To address seniors and people with disabilities, the state currently has three managed care programs for special needs populations. In 2011, these programs served 48,250 seniors and 5,860 people with disabilities. State staffs attribute system benefits to their managed care model:

- Increased access, including transportation to medical appointments and other services;
- Flexibility in paying providers;
- Special initiatives to increase primary and preventive care;
- More help for members, including interpreter services;
- 24/7 nurse lines;
- Cultural competency and health literacy programs;
- Additional care coordination;
- Navigation assistance;
- Assessment and tailored care planning;
- Increased oversight, accountability and quality assurance across multiple services and provider types.

Minnesota began enrolling seniors (including dual eligibles) into managed care in the early 1980s; however long-term care was initially not included. The state transitioned that original program to a new Medicaid managed LTSS program called Minnesota Senior Care Plus (MSC+) in 2005.[77] MSC+ serves Medicaid-eligible seniors, or those who are Medicaid eligible and also enrolled in fee-for-service Medicare Parts A and B. The MSC+ program operates in all of the state's 87 counties and serves about 25% of the state's senior managed care population.

Mandatory enrollment of seniors is required under a statewide 1915(b) waiver. The program serves people in all care settings; about 40% of members are served with LTSS in community settings and 20% are residents in NFs. The program includes most state plan services, personal care and all Elderly Waiver services as well as 180 days of NF services. Nursing home members remain enrolled for all other services after the 180 days NF benefit is exhausted. MSC+ does not include Medicare services or Part D pharmacy benefits – members must enroll in a separate Medicare Part D plan for access to most drugs. State staffs believe that the MSC+ program aligns incentives and cost efficiencies and coordinates health services with state plan HCBS and NF services under the same care management system.

Minnesota Senior Health Options (MSHO) has operated under a 1915(a)(c) waiver since 1997 and provides integrated Medicare/Medicaid Special Needs Plans as a voluntary alternative to MSC+ for dually eligible seniors. Persons enrolled in MSHO receive their Medicare services

[76] State staffs, Minnesota Aging and Adult Services, personal communication, 11-18-11.
[77] Parker, P. (March, 2009), *Managed Care Programs, Where are We Now? MSHO, MSC+, SNBC and MnDHO*, see retrieved on 12-27-11 from http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_144535.pdf

through a Special Needs Plan (SNP). The program is available statewide in all 87 counties and the same managed care organizations participate in both MSC+ and MSHO. MSHO includes all Medicaid state plan services, personal care, 180 days of NF services, Elderly Waiver services, and all Medicare services including Part D pharmacy services. The program enrolls persons in all settings. Members receive annual risk assessments, care plans and care coordination across benefits; plans contract with counties, community-based care coordination agencies, clinics and care systems to provide individual care coordination. About 75% of Medicaid enrolled seniors in managed care participate in MSHO.

The third managed care program is called Special Needs Basic Care (SNBC), a voluntary Medicaid program for persons with disabilities who are ages 18-64. SNBC operates in 78 of Minnesota's 87 counties. SNBC contracts with five of the health plans that participate in the senior programs, and serves about 6,000 people with all types of disabilities in all settings. Three of the five health plans are also SNPs and can integrate Medicare and Medicaid services, including Part D for enrollees who choose to enroll in the SNP. About 41% of the participants meet the state's long-term care criteria, and about 30% meet the criteria for a primary diagnosis of mental illness. The program includes up to 100 days of NF and home health and all mental health services, including mental health case management. Members receive annual risk assessments, care plans and navigation or care coordination across benefits. Program data indicate that members of SNBC have more access to primary and preventive care than those who are in the state's fee-for-service system.[78] The program enrolls both dually and non-dually eligible participants. It was designed in collaboration with a Disability Managed Care stakeholder group and operates under a 1915(a) state plan for voluntary managed care programs. Like the MSHO program, SNBC contracts with counties, care systems and a variety of community-based providers for services. As a cost-saving measure, beginning January 1, 2012, people with disabilities under age 65 who are in the Medicaid fee-for-service program will be asked to enroll in a SNBC health plan, but if they prefer they may choose not to enroll and stay in fee-for-service.

The state's managed care rates are set based on either fee-for-service and/or managed care program history, depending on which data is appropriate, available and most up-to-date. (Since there is no longer a fee-for-service base appropriate or relevant to seniors, rates for seniors in MSHO and MSC+ are based on plan costs. SNBC rates, however, are still based on fee-for-service data.)[79] All of the managed care programs have contract language that governs how the state pays for NF services, as well as some language on rates the plans must pay nursing homes. Basically, the plans must pay Medicaid rates to NFs unless they have a contract for a negotiated rate between the facility and the plan. The MSHO program also requires plans to be responsible for Medicare NF days, through their contract with CMS. The state does not govern MSHO Medicare provider payment rates.

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[78] Parker, P., (9-16-2010), *MN Special Needs Managed Care Programs Overview and Update.* See, retrieved on 12-27-11 from http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_152887.pdf

[79] State staffs, Minnesota Senior Health Options, Department of Human Services, personal communication, 12-20-11.

The contracts with plans are designed with incentives that support what the state sees as the appropriate level of NF utilization. Up front, all members are screened for risk of NF placement. Members who are assessed as at risk then qualify for a higher HCBS payment rate. The state also builds into the contracts the utilization levels it thinks are an accurate reflection of need for NF services. If the plans can utilize lower rates of NF, they can keep the savings. It they utilize higher than the specified levels, they are at risk for the higher costs. These mechanisms have resulted in an average length of NF stay over four years of about 150 days total; since 2004 the use of HCBS grew by 48% and NF utilization declined by 22%.[80]

Tennessee

Tennessee's managed Medicaid program, TennCare, began in 1994. At the beginning, long-term care was carved out and it offered few options for HCBS. In 1999 the state was spending over 99% of LTSS funding on NFs, and less than 1% on HCBS. Over the next decade the state expanded services to 6,000 people through a HCBS waiver, but by 2009 it was still spending less than 10% of its long-term care funding on HCBS.[81]

In 2008, as a result of a broad stakeholder process, the legislature passed the Long-Term Care Community Choices Act to reorganize and rebalance the state's long-term care services. In 2010 the state launched CHOICES in Long-Term Care within its TennCare managed care program. The CHOICES program restructured long-term care service delivery by integrating NF and HCBS services for seniors and adults with physical disabilities into the existing Medicaid managed care delivery system. People who were already TennCare recipients remained with their existing plan, which became responsible for their LTSS services and provided continuity of care. Those new to TennCare and CHOICES have a choice between two MCOs in each region of the state. To qualify for CHOICES, persons are required to meet a nursing home level of care and to qualify for Medicaid LTSS. The program gives each eligible member the choice to receive either NF or HCBS. HCBS may be provided as long as the plan can safely address the person's needs in the community and as long as each individual's care does not exceed the cost of the NF. Enrollment in Medicaid managed care is mandatory. In Tennessee the annualized cost of Medicaid NF care is $55,000 and the average annualized cost of HCBS is approximately $19,000.[82]

The CHOICES program included the state's HCBS waiver services and added additional community-based residential alternatives and consumer-directed options to the service mix. It also streamlined access. The program integrates medical, behavioral, and LTSS within two

[80] Ibid.
[81] Gordon, D., Killingsworth, P., Long, W. (2010, August), TennCare Oversight Committee Presentation. See, retrieved on 12/27/11 from http://www.tenncare.org/PDFs/tenncare082410.pdf
[82] State staffs, Tennessee Long-Term Care Strategic Planning and Program Implementation, Bureau of TennCare, personal communication, 11-22-11.

managed care companies located in each of the state's three regions. The CHOICES program currently serves 30,800 persons.

In creating the program, the state amended contracts with existing plans that were selected in a competitive bidding process. The state sets a blended capitation rate that covers all physical, behavioral services and LTSS, including NF services. This flat rate is the same for those who are dually eligible as for others. The rate incorporates assumptions about how many people will use NFs, for how long; and how many will use HCBS, and for how long. The blended rate is an incentive to the plans to encourage HCBS. In the first year, the plans are at full risk for all services, including NF services, regardless of profit or loss. There is no time limit on their risk; they remain fully responsible for costs for the duration of stay. After year one, if a plan manages better than the assumptions, it will make a profit, which it retains. The state does go back and do a retrospective analysis to understand what happened during the past year. This analysis informs the actuarial process that will determine the capitation rates. There is no retroactive recouping for the plans, and no risk corridor to limit their liability.[83]

State staffs say that their actuarial studies have been very accurate. Overall, if NF utilization goes down, the state is able to serve more people with the same number of dollars. Until 2013, the plans are required to contract with all currently certified NFs. The state sets the rates of reimbursement for both NFs and HCBS, and also determines the level of care required to access both services. There are also enhanced training and technical assistance requirements for long-term care providers who contract with the plans. The plans have stringent prompt pay requirements to pay claims to providers within a specified time period.

The state also has strict penalties if the plans miss deadlines on sentinel events. For new enrollees who wish to receive HCBS, the plans have a ten-day requirement to do a home visit, an assessment, create a plan of care, and commence services. There are some services, such as home modifications, pest abatement and assistive technology, that have a longer timeframe. For persons in NFs, the plans have 30 days to visit, make an assessment for HCBS services, and create a plan of care. State staffs report that, for the most part, the plans are meeting the timeline requirements, and so far penalties have been rarely used but they are available.

The state caps the number of new individuals who may participate. The program's enrollment target has increased by almost 47% since March of 2010, entirely by redirecting existing state long-term care funding. Persons who are currently residing in NF are exempt from the cap, and if eligible, may access HCBS at any time. The CHOICES program has eliminated the state's waiting list for HCBS.

[83] A "risk corridor" is a commonly used term in financial negotiations such as Medicaid reimbursement changes and capitation contracts with managed care companies. It is an agreement for managing risk over a multi-year period in which gains and/or losses to either party are phased in over a multi-year period. The "risk corridor" concept caps gains and/or losses to specified amounts, which change each year.

The plans are required to administer the state's MFP program, as well a diversion program. The state requires the plans to work with the recipient on transition activities, including housing, social activities, and integration into the community. As needed, the MCOs may authorize a one-time allowance for members transitioning out of a NF. The allowance of $2,000 per member may be used for expenses such as first month's rent, utility deposits, kitchen appliances, furniture, and basic household items. In response to the requirements and incentives, the plans have focused on developing robust NF transition programs. Plans are also developing separate and distinct programs with hospital discharge planners.

State staffs attribute the successful design and implementation of CHOICES to strong leadership from an Assistant Commissioner, who provided the vision for the program. The program was designed to take advantage of competitive market forces to get the best possible services for residents with the best use of state dollars.

The model provides the state with significant flexibility to make changes: all aspects of the contracts are reviewed every six months and updated as needed to meet the needs of the state and the MCOs. Two years ago the state was serving 17% of persons with HCBS; now the rate of HCBS is 31%. As a result of the new program, the state is seeing an average increase of nearly 1% of rebalancing within its long-term care system every month.[84] A recent study by the Center for Business and Economic Research at the University of Tennessee, Knoxville found that 95% of enrollees in TennCare expressed satisfaction with the program, a 34-point increase from the program's first year of 1994.[85]

[84] State staffs, Tennessee Long-Term Care Strategic Planning and Program Implementation, Bureau of TennCare, personal communication, 11-22-11.

[85] Center for Business and Economic Research at the University of Tennessee, (2011, November), The Impact of TennCare: *A Survey of Recipients, 2011*. Knoxville, TN. Retrieved on 12-25-2011 from http://cber.bus.utk.edu/tncare/tncare11.pdf p. 15.