

S U M M A R Y
R E P O R T

Center for Home Care Policy & Research

Leveraging Resources for Home- and Community-Based Services in a Time of Fiscal Retrenchment

Information Brokering
for Long-Term Care

*Center for Home Care Policy & Research
Visiting Nurse Service of New York*

FALL 2004

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Funded by the Robert Wood Johnson Foundation

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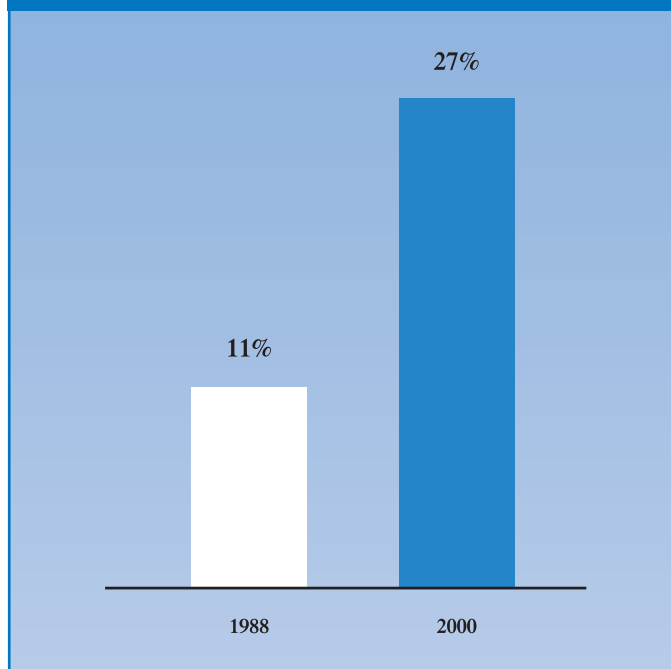
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I. Introduction

Historically, public financing has favored institutional long-term care (LTC) over home- and community-based services (HCBS). Over the last decade, however, publicly funded HCBS have expanded rapidly and changed significantly in response to popular demand and the desire to reduce LTC costs while improving quality of life (see Figure 1). Recent state fiscal crises and resulting budget cuts have hit LTC programs and dollars, raising alarm that progress in redressing the imbalance between institutional care and HCBS will be curtailed.

Figure 1: Percentage of Medicaid Expenditures Directed to HCBS



Source: Kitchener & Harrington, 2001.

Yet the outlook for HCBS is not dismal. Convinced that non-institutional services are a key component of a comprehensive LTC system, many states continue to develop and expand HCBS options. Advocacy groups provide one impetus. Another is the 1999 Supreme Court decision, *Olmstead v. L.C.*, which declared that states must serve disabled people in the most “integrated” community setting appropriate to their needs (O’Hara & Day, 2001). To help states respond to the *Olmstead* decision, the federal government has made available federal “systems change” grants to assist in developing a community-based service

infrastructure. Finally, past budgetary problems have proven that fiscal crisis can sometimes provide a window of opportunity for states to make significant policy advances.

This report offers recommendations on how to promote the provision of effective, appropriate HCBS, even while states grapple with sizeable deficits and continuing fiscal strain. The recommendations are the product of a July 2003 conference focused on the topic “Leveraging Resources for HCBS in a Time of Fiscal Retrenchment.” The conference, convened by the VNSNY Center for Home Care Policy & Research, brought together a group of policymakers and researchers, as well as LTC providers and representatives from national associations and the federal government, to discuss state strategies aimed at sustaining, expanding, and improving HCBS for a growing population of older persons with disabilities. [Note: Appendices A and B contain the list of conference participants and the conference agenda.]

The conference’s objectives were to:

1. Assess available evidence on HCBS access, costs, and benefits
2. Recommend “high leverage” strategies and mechanisms to strengthen HCBS
3. Identify concrete policy-related research and demonstration needs and opportunities

This report is part of the Robert Wood Johnson Foundation-funded project *Information Brokering for Long-Term Care*. The goals of the Information Brokering project are to:

- **Improve dialogue and strengthen links between LTC researchers and policymakers**
- **Bring research to policymakers**
- **Make research more policy-relevant**

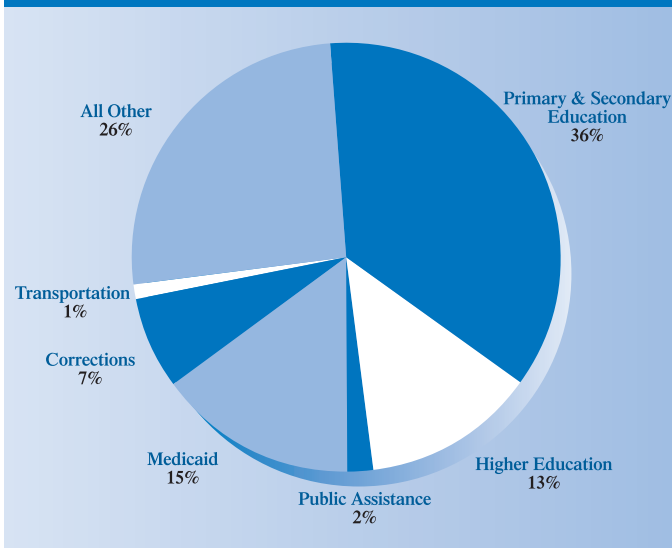
A subsequent conference held in February 2004 addressed issues related to linking housing and LTC services for older adults.

II. The LTC Situation in 2003

The State Budget Crisis

With lagging economies and rising spending, states faced growing budget deficits over the period 2001-2003. Many reluctantly enacted tax increases, while simultaneously implementing substantial budget cuts. Although the situation at the end of 2003 was not nearly as bad as it had been in December 2002, states were again facing budget gaps as they prepared their Fiscal Year (FY) 2005 budgets (Jenny, 2004; Nelson A. Rockefeller Institute of Government, 2004). Medicaid, a primary funder of HCBS, was a prime target for cuts because it accounts for 15 percent of state budgets and is second only to public education at 36 percent (see Figure 2).

Figure 2. Average Distribution of State General Fund Expenditures, 2001



Source: Urban Institute Estimates Prepared for Kaiser Commission for Medicaid and the Uninsured.

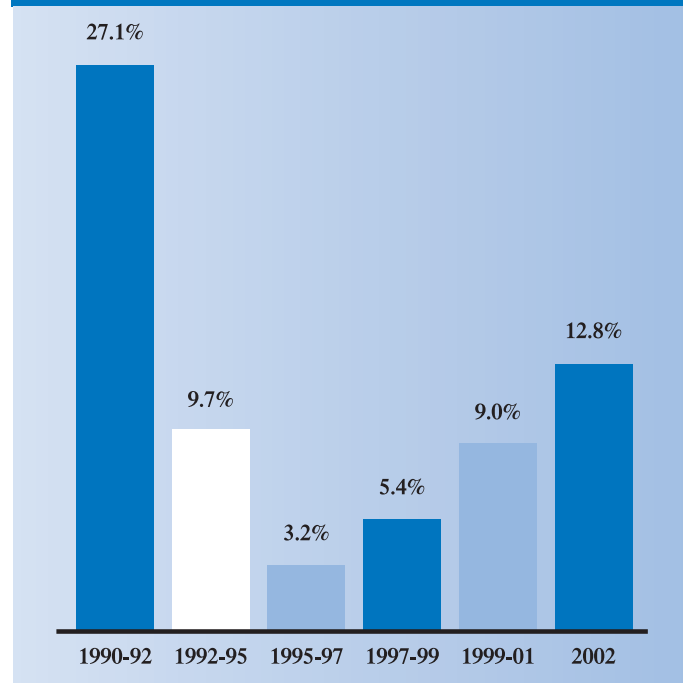
Medicaid spending has grown rapidly in recent years, increasing by nearly 13 percent in 2002 (see Figure 3). Medicaid officials in the fifty states and the District of Columbia cite LTC services among the top four drivers of Medicaid spending, along with pharmacy costs, increased enrollment, and overall health care cost increases (Folz et al., 2003). Because more than half (57%) of Medicaid spending

¹Kaiser Commission on Medicaid and the Uninsured Analysis of CBO Medicaid baseline data. This figure is for federal spending, which parallels state spending.

²Urban Institute estimates, 2002.

growth¹ and 71% of all Medicaid spending² is attributable to expenditures for older adults and people with disabilities, states have looked for cuts for these populations, with a focus on LTC.

Figure 3. Average Annual Medicaid Spending Growth Rates



Source: National Association of State Budget Officers.

Cuts for LTC

For the conference, Williams (2003a, 2003b) prepared an overview of proposed and implemented budget cuts affecting LTC in general and HCBS in particular. Her canvas of multiple reports on state budget actions found that overall states made or proposed an estimated 59 cuts³ to LTC services for the three FYs 2002, 2003, and 2004. These cuts were not confined to states with generous LTC programs but extended to states with all types and levels of expenditure, and their pace appeared to accelerate, with deeper cuts proposed for FY 2004. States were quickest to impose caps or reductions in provider payment, especially payment to nursing facilities. Once these “easier” cuts were exhausted, however, proposals for cuts in eligibility and benefits, primarily for HCBS, emerged. Though there are many ways that states proposed to curtail LTC expenditures, most proposals fell into one of four main categories (see Table 1):

³In this report, each state is counted once per category regardless of how many cuts were made.

1. **Reducing payment rates, especially for nursing homes** - Many states first targeted provider payments. Of all state LTC cuts, the most frequent were payment reductions to nursing homes. (As of the time the conference paper was written, twelve states had enacted cuts and seven had proposed cuts. In addition, two states had reduced HCBS payments and five had proposed cuts.)
2. **Restricting eligibility so that people have to be poorer to qualify for services** - Older adults are eligible to receive Medicaid benefits based on a combination of their income and disability levels. Income eligibility levels are quite low for those not eligible for nursing home services. Proposed restrictions included lowering income eligibility for older adults and people with disabilities. In addition, some states had enacted or proposed restrictions—either higher disability levels or lower incomes—to restrict nursing home services or HCBS. Other states eliminated or proposed to eliminate their medically needy programs.⁴
3. **Reducing or eliminating Medicaid HCBS benefits** - A number of states proposed eliminating or reducing benefits such as personal care services and adult private duty nursing.
4. **Eliminating or restricting Medicaid HCBS waiver programs** - Some states considered eliminating or restricting some of their Medicaid 1915(c) HCBS waiver programs (Medicaid HCBS waiver programs).⁵

Expansion of HCBS

Yet all was not bleak. Continuing their efforts to develop alternatives to nursing homes and to transition older adults and disabled Medicaid enrollees out of nursing homes and into the community, eighteen states enacted and one state proposed waiver expansions or new waivers for FYs 2002-2004.

While the trend is difficult to assess from budget proposals (which do not always include Medicaid waiver activity), it appears that state efforts to expand HCBS programs and Medicaid waivers slowed in FY 2004. Nevertheless, it is possible that even a slower rate of investment in community options, combined with reducing nursing home payment rates and holding overall eligibility steady, might allow at least some states to speed transitions out of nursing homes and enhance services for older adults while at the same time reducing states' budgets.

⁴Medically needy programs allow older adults and people with disabilities who have high medical expenses but income above the Medicaid eligibility level to "spend down" to Medicaid levels (Williams, 2003a, 2003b).

⁵Under the HCBS waiver authority, states can cover additional services (e.g., respite care) and provide Medicaid-covered services without regular Medicaid limitations (e.g., duration) *as long as the services are required to prevent institutionalization*. Waiver programs also differ from regular Medicaid programs in that states can limit services to specific regions and target populations, but are required to establish the number of people they will provide services to in advance (and can create waiting lists). In addition, the average expenditures per beneficiary under the waiver program must be less than or equal to the average expenditures for the regular Medicaid program (O'Keeffe & Wiener, 2004).

Table 1: Number of State Cuts, FYs 2002-2004

	Enacted	Proposed
1. Reducing payment rates:		
Nursing homes	12	7
HCBS	2	5
2. Restricting eligibility so that people have to be poorer to qualify for services:		
Lower eligibility for older adults and people with disabilities	0	5
Lower eligibility for nursing homes and HCBS	1	4
Eliminate medically needy program	2	3
3. Reducing or eliminating Medicaid HCBS benefits	6	6
4. Eliminating or restricting Medicaid HCBS waiver programs	1	5

State Strategies to Increase HCBS Access

Though the goal of most states over the last 25 years has been to increase HCBS, the strategies they have used—and their degree of success—have varied by state. In *State Strategies to Support Community Based Long Term Care*, Miller (2003) reviewed what is known about the factors affecting state variations in HCBS spending and the effectiveness of state strategies employed to expand HCBS access.

Miller’s review found that state variations in Medicaid HCBS spending (both per capita and share of LTC) and use of HCBS reflect, in part, differences in the supply of nursing home beds and community alternatives and, in part, differences in demand related to the demographics of the populations (specifically, percentage of minorities and older adults). In addition, variations in HCBS spending and use are strongly related to differences in state wealth, measured by state per capita income. They also depend on state LTC goals and the policy initiatives pursued to achieve those goals.

State strategies to promote HCBS can be categorized into several types:

1. Expanding public and private funding sources and revenues flowing to HCBS –

- Increasing federal dollars by:
 - Establishing Medicaid HCBS waiver programs and increasing waiver slots
 - Expanding functional and financial eligibility for Medicaid HCBS waiver programs
- Expanding public LTC resources by using “state-only” dollars to supplement Medicaid
- Encouraging the growth of private LTC insurance
- Mobilizing private dollars to support affordable assisted living

Medicaid HCBS Waiver Programs Have Been a Key Mechanism for Expansion

Between 1992 and 2000 the number of states with Medicaid HCBS waiver programs serving older adults with or without disabilities increased from 40 to 49, with the District of Columbia also implementing a waiver program over this period. The number of participants increased from 152,839 to 407,219 while expenditures grew from \$0.6 to \$2.8 billion.

2. Changing payment and regulatory policies to encourage HCBS –

- Shifting from cost-based to prospective nursing home payment allows money to be redirected to HCBS
- Paying for HCBS in residential alternatives to nursing homes (e.g., assisted living facilities)

Payment System Changes

- By 2000, all states but three used prospective payment for nursing homes (compared to only 17 in 1990).
- In 2002, 41 states had approval to provide Medicaid services in residential settings such as assisted living and board and care homes allowing approximately 102,000 individuals to receive services paid for by Medicaid in residential care settings.

3. Limiting institutional growth –

- Regulating institutional bed supply (e.g., through certificate of need (CON) and/or bed moratoria)
- Using state dollars for nursing home bed “buyouts” and/or conversions

Constraining Institutional Growth

- The use of regulations to constrain institutional growth is a longstanding strategy that continues to be employed.
- In terms of bed supply, 31 states reduced bed supply but 18 states and the District of Columbia increased bed supply (and one state saw no change).

4. Combining the above approaches in capitated managed LTC plans that aim to increase access to a wider range of services while providing financial incentives to limit institutional care –

- Encouraging the growth of plans that integrate funding to cover primary/acute and LTC services
- Developing programs and plans that capitate LTC only while promoting coordination with acute/primary care providers

Capitated Managed LTC Plans in 2003

- 230,000 older adults were covered under capitated managed LTC plans.
- 21 states had at least one Program of All-inclusive Care for the Elderly (PACE) or pre-PACE site, with a total of 10,000 enrollees.
- Four social HMO (SHMO) sites were operational.
- Programs for dually eligible older adults were operational in five states: Arizona, Minnesota, New York, Texas, and Wisconsin.

Empirical research in the field does not single out one specific strategy as the most effective way to increase HCBS access or service use. In general, Miller found policies with the greatest impact expanded a variety of public and private funding sources and revenues for HCBS. States increased capacity through the use of Medicaid HCBS waiver programs, as well as Medicaid-funded home health and personal care services. In some states the use of state-only dollars was significant. The preponderance of evidence shows that Medicaid and/or state-only spending on HCBS is positively correlated with Medicare home health spending, thus suggesting that the use of state dollars is a complement to rather than a substitute for federal dollars. Finally, limiting institutional growth by moderating nursing home bed supply has been shown to be somewhat effective, but more so when combined with other strategies.

Miller concluded from her review of the field that mechanisms to address fiscal resource issues are critical to expanding HCBS. In addition to continued funding for federal Systems Change Grants for Community Living, she identified the Federal Matching Assistance Percentage (FMAP) as a potentially important mechanism to support HCBS expansion. A change in the FMAP formula that provides greater support to states with greater demand for LTC could assist states in their efforts to support HCBS.

Impact and Cost-Effectiveness of HCBS

Several key questions related to costs, benefits, and strategies for efficient service provision logically follow from the assessment of state initiatives to expand HCBS. In *The Cost-*

Effectiveness of Home- and Community-Based Long-Term Care Services, Grabowski (2003) reviewed the evidence on:

- Whether HCBS expansion leads to lower aggregate LTC spending
- What benefits HCBS provide to clients and caregivers
- How, given societal preferences for HCBS, such services can be provided most efficiently

Grabowski cautioned that there really has been no research on HCBS cost-effectiveness per se, largely because the task is so complex due to the wide range of outcomes that would have to be defined and quantified in order to answer this question. Some evaluations have focused on program costs, others on client and caregiver outcomes, while a few have jointly analyzed costs and outcomes. In addition, some evaluations have compared HCBS costs and outcomes relative to institutional care while others have compared various models of HCBS.

Evaluations of early HCBS demonstrations such as Channeling found that HCBS did not lower overall spending on LTC but did increase client and informal caregiver welfare. Grabowski noted that such evaluations provided important information on the costs and effectiveness of individual programs relative to the status quo but are less relevant now given the new generation of HCBS programs, which have different mixes of services available and new benchmarks to compare them to. In addition, the recent policy focus is not so much on justifying HCBS relative to institutional care but rather on finding ways to target and provide HCBS more efficiently.

Current evidence on costs, benefits, and strategies for a more efficient HCBS delivery system can be drawn from studies of:

1. Medicaid HCBS Waiver Programs
2. Consumer-Directed Care
3. Capitated Managed LTC Plans
4. Medicare Home Health

Medicaid HCBS Waiver Programs:

Studies show that greater HCBS spending is associated with lower aggregate Medicaid LTC expenditures. However, these studies have a variety of methodological weaknesses including how states were selected for study, unmeasured state and time

varying factors, and the fact that the states pursued packages of options that went beyond simply liberalizing HCBS coverage. For example, states also employed policies of nursing home diversion (e.g., preadmission screening), global budgeting, and other factors in an effort to control costs; thus, expenditure impacts are not simply the result of HCBS expansion.

Consumer-Directed Care:

Programs that give more control to clients have emerged as a vehicle for enhancing consumer satisfaction while providing HCBS more efficiently. Quasi-experimental evidence from one program in California found greater client satisfaction without a decrease in safety or an increase in unmet needs. Evidence from the rigorous evaluation of “cash and counseling” demonstrations in Arkansas, Florida, and New Jersey showed better client outcomes and satisfaction. Preliminary data on costs indicated higher expenditures for the consumer-directed group due to the fact that many members of the agency-directed group did not access the paid care for which they were eligible while members of the consumer-directed group generally accessed all of the care for which they were eligible (Grabowski, in press).

Capitated Managed LTC Plans:

A number of such programs have been evaluated, including PACE, SHMOs, the Arizona Long Term Care System (ALTCS), Texas Star+Plus, and the Minnesota Senior Options Program. The preponderance of evidence has shown that the integration of acute and LTC services through managed care and the use of capitation payments can lower costs and improve or at least achieve comparable outcomes to the fee for service system. The evidence, nevertheless, is based on quasi-experimental study designs that may not assess comparable populations or fully account for favorable selection into capitated managed LTC plans.

Medicare Home Health:

The adoption of a new payment system by Medicare for home health services enabled the study of whether payment incentives can be effective in controlling use of home health services. Home care utilization declined significantly under the Interim Payment System (IPS) that was adopted before the new full Prospective Payment System (PPS) was put into place. The IPS showed no systematic negative impact on quality of care or the outcomes of beneficiaries with selected conditions such as stroke, chronic obstructive pulmonary disease (COPD), heart failure, hip fracture, and diabetes. In addition, there was no evidence of cost shifting to Medicaid. A full evaluation of the PPS is still underway, but an analysis of the National Home Health Prospective Payment Demonstration shows similar results to the IPS study: less home health care use and no change in beneficiary health outcomes.

In recapping his review of the literature, Grabowski pointed out that research on HCBS costs and benefits has been constrained by the methodological and practical difficulties of evaluating real life programs implemented in very different state-specific contexts. He observed that the jury is still out on whether expanding HCBS decreases or increases overall LTC spending. There is also not definitive evidence on the impact of capitated managed LTC, payment changes, or consumer-directed care, although accumulating data suggest that all are promising mechanisms for limiting costs and improving outcomes. He concluded that in general HCBS provide benefits to enrollees, that some approaches appear more beneficial than others, and that prudent policymakers should continue to experiment with and evaluate innovative models designed to improve a wide range of beneficiary outcomes and increase the efficiency of the HCBS delivery system.

Case Studies: Lessons Learned

In Milne’s *Reflections of a Former State Policymaker on What Three States Have and Have Not Done to Maximize Community-Based Care* (2003), he focused on three states—Colorado, Michigan and Pennsylvania—that devote very different shares of LTC dollars to HCBS (see Table 2).

He described the strategies these three states have adopted to expand HCBS access and promote cost-effective use of services, as well as targets of opportunity where future policy changes could be expected to produce positive results. Areas of opportunity include:

- Identifying additional resources in order to expand HCBS, including finding ways to substitute federal for state funding
- Reallocating resources from existing institutional care expenditures to less expensive HCBS programs
- Removing barriers to information and access, intervening with “choice” information at crisis points, and targeting HCBS to people at highest risk of institutionalization in order to reduce overall LTC spending
- Developing the system infrastructure needed to divert clients to community living (thus allowing resource reallocation to take place). Steps for creating a LTC infrastructure include:
 1. Undertaking administrative consolidation at the state level
 2. Consolidating responsibility and authority at the local level by creating “single entry point agencies” that consumers contact for information, referral, and access to all LTC services
 3. Establishing a comprehensive pre-admission review that includes a standard client assessment form to determine the need for “nursing home level of care” and a timely client assessment and eligibility process
 4. Supporting the development of residential alternatives to nursing homes

Table 2. Comparison of Selected State LTC Expenditures, 2001		
	Medicaid LTC Expenditures Allocated to HCBS	LTC Spending Per Capita
Colorado	51.1%	\$173.93
Michigan	25.6%	\$238.72
Pennsylvania	18.4%	\$416.18

Source: Gregory & Gibson, 2003.

COLORADO

In Colorado, consolidation of program administration at both the state and local levels was key to eliminating program fragmentation and duplication and to developing a consistent LTC policy.

- Virtually all LTC services—including nursing facilities, Medicaid HCBS waiver programs, home health services, and the state-funded Home Care Allowance and Adult Foster Care programs—reside in the state’s Division of Long Term Care Services, which is responsible for both institutional and community-based care budgets.
- A person applying for Medicaid or state-funded LTC services must access them through one of 25 local single entry point agencies.
- Expansion of HCBS use has resulted from aggressive pursuit of Medicaid waivers plus heavy reliance on home health agency services in the absence of an optional personal care benefit.
- With an exemption from the state Nurse Practices Act, as well as a federal Section 1115⁶ waiver, consumer-directed care options now extend to both personal care and home health agency services.
- The fiscal crisis of FY 2002-2003 led to cuts in home health payment rates and efforts to substitute HCBS personal care services for home health services—a policy that had been recommended in prior years but not implemented.

⁶1115 Waiver Research and Demonstration Projects include budget-neutral research, pilots and demonstrations to “expand managed care to include HMOs, partially capitated systems, primary care case managers, or other variations.” 1115 waivers allow for “provision of services which are not otherwise matchable, allows for the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program.” Retrieved from: <http://www.cms.hhs.gov/medicaid/1115/default.asp>

MICHIGAN

Michigan has a strong foundation of HCBS programs that could provide the basis for the development of a more comprehensive LTC system. However, two limitations in Michigan are:

1. Lack of a seamless system to access information and no single entry point to access services
2. Limited residential alternatives to institutional care, due in part to the state's decision not to use Medicaid to pay for services in assisted living facilities

A 2000 Department of Community Health report entitled Michigan's Long-term Care Work Group Report and Recommendations developed a plan to create an organized LTC system. To achieve this goal the Department subsequently made three main recommendations:

1. Develop comprehensive assessment for all LTC services.
2. Implement a prior authorization process for select programs.
3. Offer a continuum of services.

Given its strong managed care history, Michigan may consider integrating its acute and LTC services under a capitated managed LTC plan in the future.

PENNSYLVANIA

Pennsylvania's LTC system currently relies heavily on institutional care. In addition to the limits on consumer choice, the Pennsylvania system is one of the most expensive in the

United States. The Pennsylvania Intra-Governmental Council on LTC convened a Barriers Elimination Work Group to identify the barriers impeding change and to recommend ways to improve access to a LTC system with more HCBS options. The Work Group recommended that Pennsylvania institute processes to:

1. Provide easily accessible information and referrals for all LTC services
2. Create a single application form for all LTC services
3. Expedite Medicaid financial applications, including providing assistance to consumers with the application itself and offering additional case management services
4. Use statewide functional eligibility criteria
5. Increase access to assisted living programs, including providing clear rules about assisted living and ensuring adequate payment levels and quality assurance systems
6. Target individuals most at risk of nursing home placement in order to reallocate, and not add to, LTC expenditures

Discussion

Each of the conference papers evoked lively discussion. Comments on the current fiscal environment emphasized four main themes:

1. **HCBS and other LTC cuts need to be viewed in the context of overall state budget priorities and trends in state revenues and deficits.** Cuts proposed for FY 2004 appeared deeper than those implemented in FY 2002 and FY 2003, and an improving economy in FY 2004 could mitigate their severity. On the other

hand, state economies may recover more slowly than the national economy, and states may face continuing pressure to cut spending, raise taxes, or both.

2. **Distinguishing between proposed and implemented cuts is difficult because laws and regulations are moving targets.** Moreover, even cuts that have been put in place can be rescinded quickly in response to pressure from providers and/or consumer advocates.
3. **Although some changes appear draconian, proposed cuts are sometimes exaggerated for political purposes.** Proposals for drastic cuts can be a political strategy used to arouse support for less drastic measures.
4. **A budget crisis can be used to gain support for program changes that would not be politically palatable in times of fiscal plenty.** In order to take advantage of crisis, however, state policymakers must have their “ducks and data in a row,” meaning that policy proposals have to be designed in advance, well documented, and ready for implementation.

Discussion of strategies for expanding HCBS capacity focused on two main sets of issues:

1. **Are constraints on nursing home capacity actually an effective way of freeing up resources for HCBS?** Conference participants pointed out that CON regulations might constrain nursing home bed growth without constraining nursing home expenditures, especially if the costs of caring for current nursing home residents continue to escalate. If the main impact of CON is on beds but not on overall institutional expenditures, then there will not be real “savings” to be redirected to HCBS. Furthermore, given the vagaries of the political process, it is not clear that savings from holding down nursing home expenditures will necessarily be redirected to HCBS. These observations led to a discussion of the pros and cons of tying HCBS expansion to the availability of dollars “freed up” from the nursing home sector and to the kinds of positive incentives that could be offered to nursing facilities to engage them in efforts to transition people into the community and to develop service-enriched housing options as alternatives to traditional nursing home care.
2. **How might changes in the FMAP support HCBS expansion?** Conference participants expressed a good deal of interest in Miller’s suggestion of building on

the precedent established by the Jobs Growth and Tax Relief Reconciliation Act of 2003, which included changes to the FMAP to provide budgetary relief to the states for FY 2003 and FY 2004. The National Governors Association, for example, recommended increases in the FMAP tied to implementation of the Olmstead decision. There was discussion of increases to support Medicaid room and board for individuals leaving institutions or HCBS for people with serious mental health problems. Another strategy discussed was to amend the FMAP so that it would account for state level variations in demand for LTC by reflecting variations in the proportion of older adults or minority populations in states—two measures related to the prevalence of disabled people requiring HCBS. Several participants, however, voiced a cautionary note suggesting that individual state efforts to increase their number of Medicaid waiver slots approved by CMS might be more successful in the context of the federal deficit than a broader initiative to change the FMAP formula.

Discussion of Grabowski’s paper focused on the strengths, weaknesses, and findings of specific program evaluations highlighted in his literature review. Conference participants underscored the difficulties inherent in trying to produce a policy-relevant synthesis of HCBS research studies that focus on different populations, payment methods, and delivery organizations embedded in diverse political and fiscal contexts. For example, some questioned how useful it was to include Medicare home health, which is intended as a post-acute care benefit, in the category of HCBS, which are generally construed as LTC.

The dilemma is that on the one hand policymakers want to discern general trends and to sort out strategies that work from those that do not, while on the other hand they want to learn specific program details applicable to their own program settings. In this regard, the policymakers at the conference found Milne’s case studies of Colorado, Michigan, and Pennsylvania to be particularly useful, especially because they went beyond the “usual suspects” to describe states that do not often appear in the LTC literature.

In summing up a rich and subtle discussion, the group agreed on the following four points:

1. Evidence shows that the level of public funding, the supply of services and providers, the nature of

- incentives, and the use of targeting all make a difference in promoting the rational use of HCBS.
2. Politics, data, and the ability to mobilize data when the political climate is ripe make a difference in access to HCBS.
 3. Political leadership and politicians' knowledge of LTC affect the range of a state's politically viable LTC options.
 4. Questions about what incentives will most affect key LTC actors and what targeting tools can translate into better outcomes for specific states are still being answered.

III. High Leverage Strategies for HCBS

After conference participants discussed the papers and case studies, they broke into small groups charged with proposing broad strategies and "high leverage" mechanisms to further rebalance the LTC system. Upon reconvening, the groups recommended that states embrace four interconnected strategies in order for HCBS to thrive in a period of severe fiscal strain. The four strategies could be implemented individually; however, the conference participants observed that each recommendation would make the others stronger and the success of one (e.g., the consolidation of state LTC administration) would make the success of another (e.g., pooling financial resources) all the more likely.

Recommendations

1. Consolidate state LTC administration.

Conference participants recommended that states consolidate LTC administration by bringing together all LTC programs and managing them as one portfolio. Evidence from states that currently "manage across the system" shows that central administration of LTC allows for increased control over policy priorities, program dollars (the total LTC "budget") and program choices. It also allows for better control over who gets into the system (single point of entry). In turn, central control and a single point of entry promote efficiency and lend consistency to systems that otherwise tend to be highly fragmented.

2. Pool financial resources. Along with consolidating LTC administration, the group recommended combining LTC resources and minimizing categorical

constraints to the maximum extent possible within the scope of state authority and discretion. While this would be a major undertaking, it should be a high priority because pooling of dollars enhances flexibility and maximizes resources available to support a wide range of service options. Furthermore, pooling resources facilitates the service integration, trade-offs, and reallocation necessary to achieve desired outcomes.

Depending on federal and state legal, regulatory, and political constraints, the group recommended that states pool LTC resources across one or more system components:

- Settings (institutional, residential, and HCBS)
- Payers (Medicaid, state-only dollars, Medicare, Administration on Aging, and out-of-pocket)
- Programs (waivers, optional, and mandatory Medicaid benefits)
- Geographical entities (state, regional, and local)

Once dollars are pooled they can be allocated through a variety of mechanisms, including population-based regional budgets, capitated managed LTC plans, and cash/service budgets at the individual level.

3. Target dollars and services. The conference participants recommended that states implement "targeting" techniques to strengthen the ability of LTC systems to allocate resources based on explicit criteria designed to promote efficiency and effectiveness. Targeting could take the form of developing individual or population-based budgets or service packages "titrated" to risk. Titrating resources to risks was defined as allocating dollars, services, or other supports according to people's risk of incurring poor outcomes in the absence of such services and to the probable benefits associated with their receipt of effective care. The group agreed that the ultimate goal should be to distribute resources to promote the best outcomes at the right cost for the most people. However, given the great variation in individual needs and preferences, the relative dearth of evidence on which HCBS interventions work best for whom, and the importance of individual choice,

the group recommended creating dollar budgets as opposed to discrete service packages. In either case, in order to determine the appropriate level of resources to be allocated a uniform comprehensive assessment would need to be administered, ideally, at a single point of entry into the LTC system.

4. **Promote consumer empowerment.** Conference participants strongly endorsed the current movement towards consumer empowerment. Empowering consumers can take many forms, ranging from allowing people an increased voice in care decisions to granting ultimate control over their own services and/or service budgets. The most comprehensive form of consumer empowerment—and the ultimate goal recommended by the group—was to pool financial resources and design LTC benefits so that the dollars would follow the person. For *real* empowerment to occur, the group agreed that consumers must have the responsibility for deciding among a meaningful range of choices. For *maximum* empowerment to occur, the recommendation was that consumers be granted responsibility for a full spectrum of care and not just for selected parts. For empowerment to work “*on the ground*,” the conference participants recommended that states provide consumers (including both the recipients of LTC and their informal care givers) with information and decision making assistance to enable them to understand the choices available. Furthermore, because genuine empowerment requires real options, the group agreed that there is a national imperative to expand the supply of affordable, accessible housing and supportive service alternatives, including assisted living and other service-enriched housing arrangements.

Rationale

The small groups generated a three-fold rationale for their recommended strategies:

1. **LTC consolidation is necessary for any real change.** The fragmented nature of the current LTC system prevents states from creating a unified, rational LTC policy. In this highly fragmented system, LTC issues get lost and/or tackled simultaneously in different administrative and program offices. Duplication of services, increased administrative costs, confusion, and minimal satisfaction

by consumers are all problems that exist because of this fragmentation. Organization does matter. Streamlining programs and reallocating resources at all levels will permit a real LTC system to develop, as opposed to the “system” of sundry programs, services, and administrators that currently exists.

2. **Increased efficiency and effectiveness will result.** Central management should improve the environment and support available to assess the LTC needs of the population and to identify the key components of an efficient and effective LTC system that meets the needs of the population. Pooling LTC resources, reducing the points of entry into the system, and developing explicit criteria for targeting dollars and/or services should make the LTC system more equitable by increasing the likelihood that people with similar circumstances will be treated similarly. It should also make the system less confusing to consumers, providers, and the public at large. Along with improved communication and increased accountability, a streamlined system should allow current resources to be harnessed and used more efficiently and effectively.
3. **Flexibility will increase and more choices will become available.** Consolidated management and resource allocation should foster policies that promote the development of new, underdeveloped LTC alternatives. Increased use of individual and/or population-based LTC budgets in the place of narrowly categorical LTC benefits should encourage the supply of non-traditional HCBS and service-enriched housing arrangements. In short, well thought out reallocation should provide more real choices in the form of more options and greater flexibility to choose among types of services, locations, and providers of care. Moreover, the flexibility to use public dollars for a range of HCBS should increase choices for all consumers of LTC, not just those who can afford to purchase LTC privately. The bottom line will be increased consumer satisfaction and better outcomes.

Obstacles

The small groups identified a host of significant obstacles that stand in the way of achieving the fundamental changes embodied in the four recommendations. These obstacles

range from the political (e.g., lack of consensus on the goals of LTC and lack of political interest in services that are neither heroic nor curative) to the practical (e.g., how can LTC risks and benefits be accurately measured and how should risk-adjusted individual or population budgets be constructed). While formidable, the barriers are not necessarily insurmountable, and conference participants expressed optimism that many states can make significant incremental progress in overcoming them.

1. Intra-governmental turf wars are one major obstacle to consolidating LTC administration and resources.

Historical rivalries between agencies, as well as resistance to change within agencies, often make it difficult to dismantle bureaucratic barriers. As one policymaker put it, “getting groups in the same room is not sufficient.” There must be a well-conceived plan and a mechanism for achieving a common vision of LTC among key executives in charge of the respective governmental entities. When competition or conflict is the result of differing legislative mandates or regulations, achieving the vision may require carefully designed plans to change state laws or obtain waivers from federal regulations. Even in circumstances where bureaus, agencies, or programs are consolidated, there must be careful attention to educating and obtaining buy-in from frontline bureaucrats and case managers and to designing performance measures that demonstrate movement (or lack of movement) toward desired change.

2. Provider opposition is another major obstacle.

States will improve their chances of achieving significant LTC change if they can bring powerful provider groups to the table with some expectation of reduced uncertainty, increased benefit, or a degree of influence over the revamping of the system. To this end, states should avoid framing reallocation issues as a “zero sum” game in which nursing facility owners, home health agencies, or any other established provider group inevitably will lose. Instead, they should focus on designing incentives that acknowledge sunk costs and encourage existing entities to “morph” into new forms, downsize, or else exit the market. In general, “provider pushback” can be expected against policies promoting consumer empowerment. Both provider education and provider incentives will be needed to overcome organizational

maintenance concerns and professional bias that undermine willingness to cede greater choice and responsibility to individual consumers and consumer groups.

3. Lack of consumer support can be an obstacle to change, especially when consumers perceive any changes in the current system as a way of limiting services (rationing) or choice of providers.

The general public, advocacy groups, and policy-makers need to understand that rationing—often hidden—occurs every day across all programs and that making allocation criteria explicit should increase equity (the chance that people in like circumstances will be treated equally). While requiring a “single point of entry” to the LTC system may sound restrictive, it can be justified on the grounds that it will improve the clarity of information available to consumers and the range of choices that can be considered before a LTC decision is made. As noted above, it should also increase equity as the allocation process is made more explicit. Finally, targeting and titration, which are abstract terms that nevertheless conjure up visions of rationing, require careful explanation but can offer great appeal to LTC consumers when they come in the form of cash/service budgets that allow consumers to choose the specific services and supports for which the dollars are spent. Nevertheless, consumers and their advocates will rightly be concerned that the level of cash/service budgets funded by a state be sufficient to cover necessary care because, otherwise, choices may be so limited as to be meaningless.

4. Financial concerns and public accountability constitute a special barrier to the use of cash/service budgets as a means to pool individual LTC dollars and achieve consumer empowerment.

On the one hand, as implied above, consumers may fear that adoption of a LTC cash benefit will serve as a convenient mechanism for capping LTC costs and a screen for reducing service entitlements. On the other hand, prudent fiscal managers may worry about substitution or “crowd out,” which occurs to the extent that cash benefits are claimed in circumstances where families could have provided care themselves or paid privately for care. In addition, consumer empowerment strategies based on

cash benefits frequently raise the twin specters of poor, unmonitored quality of care or outright fraud and abuse. While positive evidence from the recent Cash and Counseling demonstrations should counter such concerns, the legacy of long-ago scandals associated with the use of personal care vouchers and “co-signed” checks lingers in some states.

5. **Ambiguity and disagreements about the responsibilities of informal caregivers are yet another obstacle standing in the way of achieving more unified, explicit LTC policy.** Legally, eligibility for Medicaid LTC benefits is not affected by the availability of unpaid family caregivers; however, the availability of family support is almost universally considered on a case-by-case basis as part of the care planning process and the formation of individual service plans. Taking account of informal supports enables states to stretch limited public resources and reach larger numbers of needy individuals, even though in some cases it amounts to penalizing families who are willing to provide care themselves. Conference participants recommended that the equity issues related to family caregiving be considered further under the category of targeting LTC dollars and services. They also noted that lack of adequate information and support services for family caregivers constitutes, in itself, an impediment to effective consumer empowerment.
6. **The shortage of homecare workers was cited as a current barrier to many strategies aimed at expanding the supply of HCBS.** While not a panacea, state policies that allow payments to family caregivers are one option for expanding the supply of service providers. This approach has been used successfully by some states, especially in rural areas. The use of cash/service budgets, recommended above, would allow for payment of family caregivers. Conference participants noted that states encounter “pushback” when they curtail services provided by paid family caregivers, as families come to expect a certain level of income.
7. **The lack of sufficient and sufficiently accessible research-based information is a serious disadvantage to proponents of LTC reform.** A major limitation for each of the recommendations is that there is not a robust evidence base to build a foundation for

change. LTC decisions are and must be made every day with whatever minimal information policymakers can find, but actual research-based information is not readily available in a useable form. Researchers must increase their ability to synthesize and distribute existing research while at the same time creating a research agenda that will increase the amount of policy-relevant research going forward. Poor state data systems and the inability to track people over time and across service settings must be rectified. The states’ capacity to profile who uses LTC, who might use it, and what consequences changes in the system will make over time needs to be improved. (Appendix C summarizes the group’s recommendations for future research.)

IV. Conclusions

Six main conclusions emerged from the final plenary session of the conference:

1. **Change requires increased awareness of the benefits of LTC.** Because LTC is usually overshadowed by acute care, the public must be made aware of why LTC is a good thing and why investing in LTC is necessary for both the good of society in general and identifiable individuals and their families. Building public awareness is a long-term undertaking, and a number of conference participants argued that building support for LTC in the future may require using new terminology and showing how access to HCBS protects people from the adverse consequences of unmet needs.
2. **Strong state leadership is necessary to make substantial change.** None of the recommendations made by the group are minor. All are interconnected and require consolidation at multiple levels. Conference participants felt that only substantial change would have a real impact and that such change requires strong champions. Champions are needed to increase awareness of the benefits of LTC, to publicize LTC performance gaps, to promote awareness of necessary policy changes, and to make sure that policy recommendations are followed through. Strong leadership is also necessary to promote accountability and facilitate control, which in turn should foster greater integration of policies and programs.

3. **Mechanisms should be developed to collect and publicize examples of where LTC is working and how others can replicate these examples and bring them to scale.** Despite interstate variation on many factors affecting LTC policy (e.g., fiscal environment, political culture, and provider supply), conference participants stressed that states could and should be learning from each other. Good policy work often goes unnoticed, so that one state cannot readily learn from the successes of others and “the wheel is reinvented” over and over again. More work needs to be done to find out exactly how the states that are making beneficial changes are executing them (e.g., the drafting of legislation and regulations), and more effort needs to be invested in sharing information across states.
4. **A large expenditure of political “capital” will be required to surmount turf wars and create a strong leadership base.** Politics determines how much policy reform an individual state can achieve at any given time. Much LTC policy—especially current funding arrangements—reflects the interests of political constituencies. Proposals to significantly change the status quo often create new “winners” and “losers,” and the losers are likely to mount considerable opposition. Leaders need to be willing to put a lot at stake, because LTC reform is a large and sensitive issue where even incremental change can be difficult to achieve.
5. **The complex relationship of housing and LTC must be addressed if people are to have real choice in receiving HCBS.** A number of issues related to service-enriched housing were raised, including how to pay for residential alternatives to institutional care, the diverse nature of so-called assisted living arrangements, the role of the private for-profit sector, and the difficulty of formulating rational regulation in this area. [Note: A subsequent Information Brokering for Long-Term Care conference held in February 2004 focused solely on the issues related to linking housing and supportive services for older adults.]
6. **The formulation of LTC strategies must be conducted in the context of the larger health and social system.** HCBS is part of a larger LTC system, which in turn is embedded in the larger health care system. The fact that LTC is bifurcated into HCBS

and institutional services is a major problem in implementing effective LTC policy. Participants expressed the sentiment that vilifying institutional providers is dysfunctional and that the nursing home industry must somehow be made part of the solution rather than the problem. They emphasized the importance of looking at LTC as a system rather than as discrete, opposing, programs and sectors. Thinking about the interface between LTC and the acute care system is also important because a good deal of LTC decision making takes place while people are in an acute care setting. In addition, in order to be effective, the LTC system needs to include and/or connect to social services (e.g., financial planning and social work) because health and social services issues are often intertwined for people who are chronically ill and disabled. Finally, the implications and consequences of ethnic, racial, and cultural diversity among both the LTC population and the LTC workforce must be fully considered if LTC is to be made more responsive and effective.

V. References

- Folz, C., Friedenzohn, I., DeFrancesco, L., Konig, M., Hallman, L., & Alberga, J. (2003). State of the states: Bridging the health coverage gap. *Academy Health*. Retrieved from: <http://www.statecoverage.net/pdf/stateofstates2003.pdf>
- Grabowksi, D. (2003). *The cost-effectiveness of home and community-based long-term care services: Review and synthesis of the most recent evidence* (Conference Paper). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Grabowksi, D. (in press). *The cost-effectiveness of home and community-based long-term care services: Review and synthesis of the most recent evidence* (Policy Brief). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Gregory, S., & Gibson, M.J. (2003). *Across the states 2002: Profiles of long-term care* (5th ed.). Washington, DC: AARP Public Policy Institute.
- Jenny, N.W. (2004). State tax revenue growth gains momentum: Preliminary January-March quarterly data. *Institute State Fiscal News*, 4(3), Retrieved from: http://stateandlocalgateway.rockinst.org/fiscal_pub/state_news/sn_reports/SFN_4-3.pdf
- Kitchener, M., & Harrington, C. (2001). *Medicaid 1915(c) home and community based waivers: Program data, 1992-1999* (Working Paper). San Francisco, CA: University of California at San Francisco.
- Miller, N. (2003). *State strategies to support community based long-term care* (Conference Paper). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Milne, D. (2003). *Reflections of a former state policymaker on what three states have and have not done to maximize community-based care: Finding resources for HCBS in tough budget times* (Conference Paper). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Nelson A. Rockefeller Institute of Government. (2004, February). *A sluggish year: Fiscal year 2003 tax revenue summary* (State Fiscal Brief No. 70). Retrieved from: http://www.rockinst.org/publications/state_fiscal_briefs.htm
- O'Hara, A., & Day, S. (2001). *Olmstead and supportive housing: A vision for the future*. Washington, DC: Center for Health Care Strategies, Inc.
- O'Keefe, J., & Wiener, J. (2004). *Public funding for long-term services for older people in residential care settings* (Conference Paper). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Williams, C. (2003a). *An overview of recent state HCBS budget cuts* (Conference Paper). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York.
- Williams, C. (2003b). *An overview of recent state HCBS budget cuts* (Policy Brief No. 16). New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York. Retrieved from: <http://www.vnsny.org/research/publications/pdf/No16Williams.pdf>

VI. Acknowledgements

This report was prepared as part of the *Information Brokering for Long-Term Care* project funded by the Robert Wood Johnson Foundation.

We would like to give special thanks to the authors of the conference papers, our reviewers, the conference participants, and the Robert Wood Johnson Foundation. In addition we would like to thank our project staff, including Chris Murtaugh, Mia Oberlink, Pamela Nadash, Michal Gursen, and Alexis Stern.

Center for Home Care Policy & Research

The Center for Home Care Policy & Research conducts scientifically rigorous research to promote the delivery of high quality, cost-effective care in the home and community and to support informed decision making by policymakers, payers, managers, practitioners, and consumers of home- and community-based services.

The Center for Home Care Policy & Research was founded in 1993 and has a close relationship with its parent agency, the Visiting Nurse Service of New York, the largest nonprofit home care agency in the United States.

Appendix A

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<u>Federal Policymakers/Representatives from National Associations</u>	8
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Appendix B

INFORMATION BROKERING FOR LONG-TERM CARE (a project supported by the Robert Wood Johnson Foundation)

LEVERAGING RESOURCES FOR HOME- AND COMMUNITY- BASED SERVICES (HCBS) IN A TIME OF FISCAL RETRENCHMENT

CONFERENCE AGENDA

Thursday – July 18, 2003

- 3:00 p.m. – 3:15 p.m. Introduction: Purpose of the Conference: Penny Feldman**
- To assess current research-based evidence on HCBS
 - To identify & prioritize the most promising state strategies & mechanisms for enhancing HCBS access, efficiency and effectiveness
 - To outline associated political & practical issues involved in implementing these strategies
 - To identify related information needs and opportunities for research and demonstrations to support HCBS
- 3:15 p.m. – 3:45 p.m. Review of the Evidence on State Strategies to Increase HCBS Access: Nancy Miller**
- What are the main state strategies for increasing access?
 - What are the main “drivers” of access?
 - What policy levers appear to be the most effective?
- 3:45 p.m. – 4:15 p.m. Review of the Evidence on Impact and Cost-Effectiveness of HCBS: David Grabowski**
- How strong is the evidence on HCBS costs, beneficiary outcomes, cost-effectiveness?
 - What are the most promising strategies for enhancing HCBS efficiency and effectiveness?
- 4:15 p.m. – 5:00 p.m. Discussion of Evidence: Emergent Themes, Issues, Lessons**
- What crosscutting themes emerge from the evidence?
 - What are the unresolved questions that policymakers have about these mechanisms?
 - What other mechanisms/strategies need to be addressed through research and synthesis?
- 5:00 p.m. – 5:15 p.m. Break**
- 5:15 p.m. – 5:30 p.m. Overview of State LTC Budget Cuts: Enacted and Proposed**
- Are the data consistent with the experience and information of the assembled experts?
 - What modifications are needed to make the information useful to LTC decision makers?

- 5:30 p.m. – 6:30 p.m. Panel: The State Budget Crisis: Disaster or Opportunity? A View from the States: Chris Gianopoulous, Maine; Gregory Vadner, Missouri; Chuck Wilhelm, Wisconsin**
Discussant: Diane Braunstein, National Governors Association
- What LTC cuts have been enacted/proposed in your state and why?
 - What initiatives, if any, have been curtailed?
 - What new initiatives or opportunities have emerged—or might emerge—that are consistent with the current fiscal situation?
 - What, if any, national reform would be most helpful to your state?

6:30 p.m. – 7:15 p.m. Reception

7:15 p.m. Dinner

Friday – July 19, 2003

8:00 a.m. – 8:30 a.m. Breakfast

8:30 a.m. – 9:00 a.m. Overview: Case Studies of Colorado, Michigan, Pennsylvania: Dann Milne

9:00 a.m. – 10:30 a.m. Shifting the Balance between Institutional and Home- and Community-Based Services

- What is the most useful set of organizing principles that can assist policymakers in thinking about “rebalancing” strategies, mechanisms and options?
- Which strategies and mechanisms appear to have been most successful in Colorado, Michigan, and Pennsylvania? Why? Which have been least successful and why? Which are most generalizable to other states?
- Which of these would you single out as most important in an era of fiscal retrenchment?

10:30 a.m. – 10:45 a.m. Break

10:45 a.m. – 12:15 p.m. Concurrent Breakout Sessions

Meeting participants will break into small groups. Each group will focus on a broad strategy and related “high leverage” mechanisms for “rebalancing.”

- What are the “high leverage” mechanisms within this broad strategy?
- What are the main political issues that affect their feasibility?
- What are the main practical issues that affect their feasibility?
- What are the potential benefits? Potential negative/perverse/unintended consequences?
- What are the additional information needs?
- Would you recommend a demonstration to test out your recommended approach/mechanisms? What would the demonstration look like?

12:15 p.m. – 1:00 p.m. Lunch

1:00 p.m. – 2:00 p.m. Report back

The small groups will report back on their groups’ findings, and areas of similarity and disagreement will be discussed.

2:00 p.m. – 3:30 p.m. Summary and conclusions

Meeting participants will formulate their priorities, recommendations and “cautions.”

Appendix C

Recommendations for Further Research

- 1) Identify the most effective strategies for managing across the whole system
- 2) Determine how administration changes impact services and costs
- 3) Experiment with different ways to dismantle program barriers and pool resources
- 4) Develop knowledge/data/tools in order to define service packages or budgets
- 5) Support additional demonstration and research on capitated managed LTC plans and initiatives to “cash out” the nursing home benefit
- 6) Create evidence-based algorithms to match budgets/service packages to the likelihood of risks and benefits
- 7) Create and test new:
 - Decision making mechanisms
 - Risk indicators
 - Outcome measures
 - Uniform assessment tools
- 8) Seek evidence on existing consumer-directed programs (specifically addressing concerns with leakage, abuse, and clinical outcomes)
- 9) Look for ways to strengthen outcome measures and predictive models to support consumer-directed programs