

***Finding Resources for HCBS in Tough Budget Times
to Maximize Community-Based Care:
Case Studies of Three States***

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Over the past two decades, states have developed systems to provide improved service delivery to Medicaid clients in need of long-term care (LTC) services. States have responded to budget pressures and demographic trends in multiple ways. The common thread is a long-term strategy of shifting care delivery from institutional care to lower cost, community-based care.

At all stages of a state's LTC system development, there are significant opportunities for cost-effective improvements in LTC access. The reflections that follow aim to identify LTC resources that could potentially be reallocated to promote greater efficacy and equity in access to services, including specific strategies to tap these potential resources. They draw heavily on the author's experience as a policy maker responsible for LTC development in the state of Colorado.

There are several ways of measuring progress in LTC system development. This paper uses as a measure of transformation, the proportion of LTC expenditures allocated to HCBS. Many LTC researchers have adopted this measure as a comparative measure of state progress. It is used by the MEDSTAT Group for their contract with the Centers for Medicare and Medicaid Services (CMS),¹ by AARP in their *Across the States: Profiles of Long-Term Care 2002*,² and by Kane, Kane and Ladd³ in their landmark review of LTC.

SELECTED STATES

The paper focuses on three states representing a high, medium, and low proportion spent on HCBS (see Appendix 1). Another measure examined in selecting the states was per capita LTC spending.

¹ Eiken and Burwell, "Medicaid HCBS Waiver Expenditures, FY 1995 through FY 2001," The MEDSTAT Group, May 13, 2002.

² Steven Gregory and Mary Jo Gibson, "Across the States: Profiles of Long-Term Care; 2002," Fifth Edition, AARP Public Policy Institute, Washington, D.C., 2003. (Hereinafter referred to as AARP.)

³ Rosalie Kane, Robert Kane and Richard Ladd, "The Heart of Long-Term Care," Oxford University Press, 1998, Chapter 4.

Colorado was selected based on its high reliance on community-based care and on the author's long experience as a policy maker there. Michigan was selected as a state that ranks in the middle in proportion spent on community-based care, and Pennsylvania as a state that ranks low.

The proportion of LTC dollars these states spend on HCBS is inversely correlated with their per capita spending on LTC overall. As can be seen in Table 1, Colorado ranked 5th in proportion spent on HCBS in 2002, and 42nd in per capita spending for LTC. Michigan ranked 34th in proportion spent on HCBS and 27th on per capita spending, and Pennsylvania ranked 40th in proportion spent on HCBS and 4th highest in per capita spending on LTC.

The case studies of the three states identify key structures and strategies that contribute to their vastly different expenditure patterns and show how one state – Colorado – has developed its HCBS system while holding down LTC spending.

Colorado's experience suggests *that in order to shift the balance of LTC services from institutional to lower cost community-based care, LTC needs to be more than a collection of programs*. Waiver programs are necessary, but not sufficient features of a fully developed LTC system. *A fully developed system needs to be a connected system*. As these case studies will demonstrate, the connections in the system, the flows between home, hospitals, nursing facilities, assisted living and other community-based care settings are just as important as having established LTC program options. The Colorado example shows how having community-based service alternatives and a system to facilitate access to them can support consumer choice of community living and lead to greater reliance on community-based care.

Each of the three state examples also reveals opportunities to expand community-based care systems – either by reallocating resources from institutional care to HCBS, or across HCBS programs. The case studies describe changes in system infrastructure, as well as specific strategies and programs, designed to divert clients and reallocate spending. Finally, they identify approaches to targeting – a critical issue in tight budget times.



Table 1: Selected States Characteristics, 2002

State	Expenditures on LTC	LTC Spending/capita	Rank	Proportion Spent on HCBS	Rank
Colorado	\$845,928,300	\$187.69	42	51.1%	5
Michigan	\$2,389,481,098	\$237.76	27	25.6%	34
Pennsylvania	\$5,541,859,959	\$449.28	4	18.4%	40

Sources: Eiken and Burwell, 2002; AARP Report, 2003.

COLORADO

Colorado is a good example of a state with a high proportion of LTC spending devoted to community-based care. The AARP ranking (see Appendix 1) placed Colorado fifth in the nation in 2001. The same report ranked Colorado sixth in the percent of Medicaid clients enrolled in Aged/Disabled Waivers in 1992 (at 1.2%), and third in 1999 (at 3.2%). Data presented by Brian Burwell of the MEDSTAT Group placed Colorado fourth in percent of LTC spending on home care in 2000, behind Oregon, Vermont and Alaska (www.hcbs.org/hcbsdata).

The AARP report also disclosed a continued decline in nursing facility residents for Colorado. From 1996 to 2001, the number of residents in Colorado nursing facilities declined by two percent. Medicaid paid for a relatively small proportion (60.2%) of nursing facility residents in 2001 (ranking 39th in the United States). Medicaid nursing facility expenditures continue to grow, however, at about seven percent per year, driven mostly by nursing and other health care worker costs.

Background

Development of Colorado's community-based LTC system began in the early 1980s and was strengthened in the 1990s. LTC Plans were developed by the Colorado Department of Social Services in 1980 and 1989. Both plans recommended major reforms in program services, delivery systems and administrative structures. *Consolidation of program administration at both the state and local levels*

was key to eliminating program fragmentation and duplication and developing a consistent LTC policy. Administrative restructuring was an essential precursor to changes in delivery systems or programs.

Major portions of the state LTC system were consolidated and became more client and system focused through administrative restructuring. All LTC services were put in the same Department (Social Services) in the 1980s. Administrative responsibility and accountability for LTC programs for children, adults and elderly with physical disabilities were consolidated from three separate units into one division. Responsibility for nursing facilities, HCBS waiver programs, home health services and the state-funded Home Care Allowance and Adult Foster Care programs was placed in the Division of LTC Services. The Division had responsibility for both institutional and community-based care budgets and was encouraged to transition clients and funds from one to the other. Later, the same consolidation occurred with mental health services. The State Mental Hospitals, the capitated mental health services program and the HCBS-Mental Illness waiver program were consolidated into one division. Services for developmental disabilities consistently had been in one division.

Responsibility and accountability were also consolidated at the local level. Colorado always had a single entry point system for developmental disabilities services through its Community Centered Boards. In 1993, Colorado began implementing a single entry point for all LTC services for persons with physical disabilities of all ages. *A person*

applying for Medicaid or state-funded LTC services must access them through one of 25 local single entry point agencies. Care coordinators from these Options for LTC agencies use a single comprehensive client assessment instrument (ULTC-100). Clients are assessed for nursing facilities, HCBS waiver programs including assisted living, the Home Care Allowance program and Adult Foster Care at the same time.⁴ Then, depending on program eligibility, consumers are given a choice of programs to meet their needs.⁵ During the first year of phased implementation of the single entry point system, counties with single entry point agencies experienced 10 percent fewer Medicaid paid nursing facility admissions than counties without single entry points.⁶

HCBS

Colorado has had an aggressive and long-term policy of developing community-based services as alternatives to institutional care. Colorado developed a *personal care voucher program* to help people avoid institutionalization in the late 1970s and *vigorously pursued the HCBS waiver option when it became available*. The Colorado General Assembly authorized a *state-funded Home Care Allowance program* in 1978. The Home Care Allowance program provides monthly voucher payments to Medicaid eligible individuals in need of supports to stay in their own homes. Colorado's Home and Community Based Services for Developmental Disabilities (HCBS-DD) was the second waiver in the country to be approved by the Health Care Financing Administration. Colorado's HCBS-Elderly, Blind and Disabled waiver was the sixth waiver request approved. Colorado currently has nine approved HCBS (Section 1915c)

waivers and three approved community-based care demonstration (Section 1115) waivers (see Table 2). (Note: Two of those 1115 waiver programs are not being implemented).

A major feature of LTC in Colorado has been *home health agency services*. Colorado has encouraged access to skilled home health care as a substitute for skilled nursing care in a nursing facility. Home health care services were originally incorporated in HCBS plans of care and individual cost neutrality calculations. In 1998, the Health Care Financing Administration disallowed home health as a waiver service, but clients could still receive it as a State Plan benefit. Prior authorization of home health agency services by the fiscal agent was eliminated in 1997. Colorado Medicaid spent \$62,825,540 in FY01-02 on home health care. Of that amount, \$50,805,668 (80.9%) was for Long Term Home Health Care. The remaining \$12,019,872 was for acute (defined, at that time, as services for less than 120 days) home health services. Medicaid also had an *extensive Private Duty Nursing program* costing \$15,702,087 in 2002.

Colorado has historically spent proportionately large amounts on home health care compared to other states. The state ranked sixth in the nation in the percent of Medicaid clients age 65 and over receiving home health services in 2001.⁷ Colorado spent \$931.77 per recipient for home health in 1999. This was eighth highest in the nation, and is much greater than Michigan (\$379.53) or Pennsylvania (\$383.06).⁸

Several proposals have been made to substitute more personal care services for home health nurse and aide services but those proposals were not implemented. Based on the experience of other states, there are large cost-benefit opportunities for substitution of lower cost services in Colorado. According to some estimates the amount saved through this substitution could be up to \$5 million per year.⁹

⁴ Home health services, whether for acute or long-term care, were exempted from the single point of entry requirement. However, this exemption was removed in 2003.

⁵ The Options for LTC agencies are paid on a per person per year basis for persons choosing a community care program. No payments are made for clients admitted to a nursing facility.

⁶ Colorado Department of Social Services, "LTC Single Entry Point System, Annual Report," 1994.

⁷ AARP, p. 226.

⁸ Eiken and Burwell, Medicaid HCBS Waiver Expenditures, FY 1995 through FY 2001, The MEDSTAT Group, May 13, 2002.

⁹ Personal Communication with Department staff.

Table 2: Medicaid HCBS Waiver Programs in Colorado, FY2002

Waiver Program	Number Served*	Waiting List	HCBS Costs/Person	Total Medicaid Cost/ HCBS Client	Institutional Costs/Person Comparison
Aged, Blind & Disabled	15,157	None	\$5,726	\$13,431	\$29,817
Persons Living with AIDS	112	None	NF-\$6,147 Hosp-\$8,760	\$23,643	\$25,404
Brain Injury	384	None	\$16,828	\$26,505	\$15,973
Children's Extensive Supports	243	Yes	\$10,071	\$30,939	\$114,487
Major Mental Illness	1,923	Yes	\$6,786	\$14,385	\$39,106
Developmentally Disabled	3,780	Yes	\$48,917	\$53,488	\$125,560
Children's Habilitative Residential Program	280	None	\$30,657	\$43,029	\$114,487
Supported Living Services (DD)	2,974	Yes	\$11,586	\$17,311	\$114,487
Children's HCBS	630	Yes	**	**	**

*Unduplicated recipients.

**Information not available.

Source: Colorado Department of Health Care Policy and Financing, HCFA 372 Reports, 2002.

Colorado does not have Personal Care as an optional Medicaid service. The issue has been considered several times, but making personal care a blanket statewide program was always determined to be too costly and uncontrollable. Targeting personal care services to clients most in need through waiver programs has been the chosen strategy.

Institutional Care

The Colorado nursing facility population and ICF-MR population have certainly been affected by the community care alternatives described above. When the HCBS-Elderly/Disabled waiver program was implemented in 1983, there were about 10,000 Medicaid clients in nursing facilities. Approximately the same number of clients (10,200) resided in nursing facilities in 1999, despite a 4.3 percent annual increase in the population age 85 and over. *Since 1999, the number of Medicaid clients in nursing facilities has declined by five percent, from 10,200 to*

9,800 in 2002.¹⁰

In 1983, Colorado provided care for about 4,000 individuals with mental retardation or developmental disabilities in four Regional Centers (ICF-MRs). In the last 20 years, three of those Regional Centers have been closed and the fourth has been downsized considerably, with plans for its eventual closure. Most of those clients have been transferred to eight-person group homes, independent apartments or family residences. Only 120 individuals with developmental disabilities remained in the institution in 2002, costing \$19 million.

Finding Resources for Community-Based Services

Colorado has substituted federal Medicaid matching funds for state LTC expenditures on several occasions. *The process, known as "refinancing," is one of converting a formerly*

¹⁰ Department of Health Care Policy and Financing, Annual Nursing Facility Census Report, 2002.

state-only funded program into a Medicaid program for Medicaid eligible clients. One of the largest of these refinancing efforts involved converting state-funded Residential Child Care Facilities into Medicaid providers of mental health rehabilitation services called Residential Treatment Centers. The vast majority of the residents were Medicaid eligible foster care children. In the initial year of the program (1995), approximately \$16 million in federal funds were substituted for state funds. In the current fiscal year, the program draws about \$30 million in federal funds.

There were also many children with developmental disabilities, as well some with mental health needs, in the Residential Child Care Facilities. The state obtained an HCBS *waiver to provide these children developmental and habilitation services*. This program, the Children's Habilitative Residential Program, currently serves about 280 individuals with federal matching funds paying \$8.6 million (half) of the annual cost of care.

In addition, Colorado implemented an *HCBS-Mental Illness waiver* in 1997. The waiver program was approved as an alternative to nursing facility care by CMS, not as an alternative to an Institution for Mental Disease, which Medicaid does not pay for. Colorado initiated this waiver program because it lost a lawsuit that had challenged the State's limitation of its Aged/Disabled waiver program to persons with physical illnesses. The plaintiff, a person with a mental illness who had been in a nursing facility paid by Medicaid, wanted access to the HCBS waiver program, as had other nursing facility residents. The State lost the court challenge. Consequently, it decided to request and implement a separate waiver for persons with mental illness in order to involve the clinical and programmatic expertise of the mental health system in providing this service. CMS approved the waiver in 1996. There are now almost 2,000 persons being served, using Medicaid matching funds, in this program.

Colorado is also a leader in *consumer-directed care*. The State applied for a Section 1115 waiver to allow persons receiving Medicaid home health agency services and/or Medicaid waiver program personal care services

to hire and manage their own direct care providers (attendants). This was the *first effort by a state to move beyond consumer-direction of personal care services to include home health agency services as well*. The State needed an *exemption from the state nurse practices act and a federal Section 1115 waiver*. The waiver was approved in 2001 and the program began enrolling its first group of clients in Fall 2002. The program expects to save the State expenditures but was not conditioned on that provision. It will certainly meet the budget neutrality requirements. Its purpose was to facilitate personal autonomy and to demonstrate the feasibility of such a program. Savings similar to or greater than the Robert Wood Johnson Foundation funded Cash and Counseling Demonstration programs (Arkansas, Florida, New Jersey) are expected, but have not been estimated.

The Colorado Department of Health Care Policy and Financing began a *Deinstitutionalization Pilot Project* in July 1997. The purpose was *to demonstrate the feasibility of deinstitutionalizing Medicaid clients from nursing facilities to the community through intensive case management activities by three (of 25) single entry point agencies*. The premise was that a number of clients in nursing facilities would choose to receive care in community settings if they received more assistance from case managers in relocating. While there were about 1,000 clients per year that were already being transferred from nursing facilities to HCBS, this program targeted the more difficult to place.

During the first year of the program, 119 clients were contacted and assessed. Of these, 68 individuals were relocated to community settings. Family support and case management services were significant determinants of successful relocation, but age and functional limitations were not. Many of the deinstitutionalized clients had come from hospitals to nursing facilities (62%). Nursing facility staff were the most frequent source of referrals (48%). Most clients (64%) were *relocated to assisted living facilities*. Clients reported significant improvement in their health status and overall satisfaction with their living

status. During the first year, 10 clients (15%) returned to the nursing facility. The Department saved \$347,361 during the first (start-up) year of the program. This calculation was based on actual client days after subtracting administrative costs.

The second year, after expanding to additional counties, 83 clients were deinstitutionalized. In the third year, 80 clients were transitioned. One of the key features of the program was *direct payment for assessments and care planning, and payments for community relocations (sometimes referred to as a bounty payment)*.¹¹

Colorado also addressed another LTC system problem common to most states. Over 40 percent of nursing home admissions were discharges directly from hospitals. Most of these clients had not yet established Medicaid eligibility and consequently, the single entry point agencies could not develop community living alternatives for them. Colorado developed a “*Fast Track*” *eligibility process to give priority in eligibility determination to persons being discharged from hospitals. With this Fast Track Medicaid eligibility, plans of care could be developed with HCBS or other Medicaid services.* This facilitated the diversion of clients from nursing facilities.

Responses to Budget Shortfalls

Colorado has made *deep and serious cuts in its Medicaid program in order to operate within the state budget.* The economic recession and prior permanent tax rate cuts caused revenue shortfalls exceeding \$900 million or about 14 percent of the state budget in FY 02-03. The Colorado Constitution mandates an annually balanced budget and requires any tax increase to go to a vote of the people, thus extensive and rapid program budget cuts were implemented. The first round of budget cuts began July 1, 2002 at the beginning of FY 2002-03, to comply with a four percent reduction in General Funds

mandated by the Governor. With the 50/50 match in federal Medicaid funds, this amounted to an eight percent reduction in Medicaid program funds.

Colorado *quickly cut provider reimbursement rates,* and also used the desperate budget situation as justification to streamline and tighten its community care system and programs. The program reductions reflected the practical and political considerations existing in Colorado and were guided by comparisons of relative program expenditures in other states. *Home health agency services received the biggest cuts along with several other community-based care programs.*

The Colorado LTC system had evolved with home health agency services being a large part of long term supports, both in proportion of clients served and in payment rates. In 1999, Colorado ranked sixth in the nation, with 9.2 percent of Medicaid clients aged 65 and over receiving home health services.¹² Colorado ranked fifth in the nation in home health aide hourly wages at \$10.02 per hour. Colorado also ranked fifth in the nation in per capita home health spending at \$16.53 per capita.¹³ In 2002, the average hourly wage rate for Licensed Practical Nurses ranked seventh and the average hourly wage rate for home health aides ranked fourth.¹⁴

After passage of the 1997 Medicare reform law (OBRA 97), which sharply contracted Medicare payments for home health, *home health agencies in Colorado responded by rapidly increasing the amount of services provided for each Medicaid home health client. Medicaid home health expenditures roughly doubled in four years.*

This issue provided the impetus for the Department of Health Care Policy and Financing to *focus program controls on home health utilization and to expand the scope of administrative responsibility of the single entry point system to include prior authorization of long term (greater than 120 days) home health agency services.* There had been a proposal to

¹¹ Colorado Department of Health Care Policy and Financing, “The Deinstitutionalization Pilot Project; Evaluation and Status Report,” November, 1998. Joan Bell, Project Director.

¹² AARP, p. 226.

¹³ AARP, p. 238.

¹⁴ AARP, p. 244

include home health services in the scope of control of single entry point agencies when they were formed in 1993. The proposal was rejected at that time because of concern with the already large scope of these new agencies and their inexperience in “medical model” home health.

The very rapid expansion of the home health budget resurfaced the issue and the decision was made to require the same service planning and service authorization for long term home health services as for the rest of HCBS. *Home health care utilization control was finally incorporated into the local agency’s responsibility for LTC.* The single entry point agencies now control the service authorization function for both long-term home health care and HCBS personal care. *The substitution of lower cost personal care for home health nursing and nurse aide services is now happening.*

An audit of the HCBS Elderly/Disabled waiver program and the Home Health program conducted by the Colorado Legislative Audit Committee staff also provided direction for the budget and program reductions. The Legislative auditors focused on *high cost clients in the HCBS program.* Many of these clients are very frail, ventilator-dependent or have quadriplegia. When the cost of HCBS services were combined with the costs of home health services, there were about 770 clients whose annual Medicaid expenditures exceeded \$50,000 per year. These identified clients were not exceeding the waiver program individual budget neutrality comparison because that comparison only counts waiver program service costs. But when home health agency services were added, the costs for these individuals exceeded nursing home costs and costs for some individuals exceeded \$100,000 per year.¹⁵ *This audit provided further impetus for policies to control home health utilization and cut rates.*

The following is a comprehensive list of LTC program reductions enacted in the past two years in Colorado. The first set occurred in the spring of 2002 and were implemented through

rule and other administrative changes. The Legislative session was ending and there was not time for changes in the law.

1. *Home Health rates were reduced by five percent, generating expected savings of \$7,745,634. [This rate cut was later rescinded and replaced with the elimination of home health therapies after negotiations with sit-in protesters—providers, advocates and persons with disabilities.]*
2. *Maximum reimbursement for long term home health was set at \$211 per day. It was later returned to \$227 per day.*
3. *Private duty nursing rates were reduced by five percent, generating expected savings of \$709,163.*
4. *Stricter admission/continued stay criteria were applied to Private Duty Nursing, resulting in \$775,538 savings in the first year.*
5. *Home Health Therapies were limited to acute care clients only (eliminated for LTC clients, except for Early Periodic Screening Diagnosis and Treatment (EPSDT) children).*
6. *The threshold score on the ULTC-100 LTC client assessment instrument (nursing home level of care) was raised from 20 to 25 points. The fiscal impact was not stated separately.*
7. *Lowering the HCBS-Elderly/Disabled waiver program slots to the July 1, 2002 level (i.e., creating a waiting list) was discussed. Savings were expected of \$5,474,272. Combined savings for this new waiver program ceiling and raising the threshold (number 6 above) was estimated at \$8,584,244. [This has not been implemented. The waiver program remains open to new clients.]*
8. *Home Health costs were added to HCBS costs and Home Care Allowance program costs for nursing facility cost comparison purposes in the HCBS program.*
9. *The Department changed the definition of acute home health care from “less than 120 days” to “less than 60 days.”*

¹⁵ Office of the State Auditor, “Home and Community Based Services and Home Health Performance Audit,” Denver, CO, Colorado State Auditor, June 2001, p.7.

10. The Department now *requires home health clients to pass the LTC screen* in order to receive long term (greater than 60 days) home health care.
11. *Single Entry Point Agencies became responsible for authorizing services for all adult long term home health clients.*
12. Home Care Allowance Program admissions were frozen, providing savings estimated at \$5,551,643.
13. Department rules changed so that *nursing facility rate changes* will be made 10 months after the close of the cost reporting period, instead of the usual two month lag period. This delay of eight additional months was estimated to generate a one-time saving of about \$5 million.

Items 1 – 5 above are examples of cuts *focused on the relatively high expenditures on home health agency services*. Items 8-11 above are examples of *program reform measures to tighten the administration of the community care programs*. These reforms were not perceived as necessary or critical until budget cuts forced severe program reductions and restructuring of the single entry point agency controls.

In the spring of 2003, several more LTC program changes were made, some requiring legislation.

1. The Legal Immigrant optional Medicaid eligibility group was eliminated by legislation. Implementation is *currently stayed* by court order.
2. The *Medicaid pharmacy benefit* for an individual was *limited* to eight prescription drugs at a time. Prescriptions above that number needed special authorization. Savings of \$6.6 million per year were estimated. The program impacted 7,432 clients, of whom a disproportionate share were clients in LTC. [This program was *later rescinded* after a headline Denver Post newspaper story about physicians encountering incredibly long waits on the telephone (e.g. 45 minutes) to receive drug prescription authorizations.

- Physicians had not been consulted during the development of this program.]
3. The *Administrative Incentive Payment for Nursing Facilities* was *eliminated*. Savings were estimated at \$1.6 million.
 4. The LTC client assessment form (ULTC-100) is required to be completed by the nursing facility on the date of admission. [Backdating of prior authorizations is disallowed.]
 5. *Monthly (instead of quarterly) receipt of HCBS services is required to remain in the HCBS program.*
 6. Monthly Home Care Allowance *voucher payments were reduced*. Savings are estimated at \$1.2 million in 2002-03.
 7. The LTC *client assessment instrument (ULTC-100) was revised and the benefit eligibility criteria were tightened*. The new instrument focuses on functional need for unskilled services. This program change targeted those receiving minimal HCBS services in order to remain Medicaid eligible. Many of these clients were Medicaid funded transplant recipients needing anti-rejection medications. This provision was adopted instead of a lower waiver program cap and waiting lists.
 8. Children's Extensive Support Waiver Program was eliminated and merged into Children's HCBS waiver program. No slots were lost in this administrative simplification.
 9. *Home Health payment units were changed from a visit (2 ½ hours) to ½ hour increment units* to enable payment for smaller amounts. Home health aides are paid a weighted amount of \$31.66 for the first hour per day, then \$9.46 for ½ hour increments after that.

The State's policy of *program and payment reductions in Colorado fell disproportionately on HCBS*. Colorado Medicaid has always paid nursing facilities very well. Colorado ranked 14th in the nation in payments at \$102 per day in

1998.¹⁶ The one-time \$5 million reduction in payments (i.e., postponement in cost adjustments) in 2002 amounted to a 1.3 percent reduction in nursing facility expenditures. The \$1.6 million cut in incentive payments in 2003 is a 0.4 percent reduction. The nursing facility reimbursement system is in state law and no rate cut law changes were proposed in 2002 or 2003.

Rate or expenditure cuts comparable to those for community-based care are not currently being considered for Medicaid nursing facility services. The next step being pursued is to develop a nursing facility provider tax system to draw down more federal funds for nursing facility services. A specific provider tax will be imposed that will generate additional state revenue that can then be matched with federal funds for Medicaid nursing facility expenditures. This refinancing effort is expected to bring in about \$15 million in new federal funds to offset State fund expenditures.

In the short run, *Colorado's ranking in proportion of state spending on community care is likely to fall with the Department's budget cuts falling disproportionately on community care. In the long run, the state is positioned to exercise greater control over nursing home admissions and community care utilization.* Beginning July 1, 2003, single entry point agencies are doing prior authorization and utilization review for *all* LTC services. This includes nursing facilities, all adult long term home health clients, and HCBS programs. This is another step in consolidating authority and control of LTC resources in local agencies. This will give the state greater control over resource allocation in the future.

MICHIGAN

Michigan is near the middle of states in the proportion of its LTC expenditures allocated to community care. It is a large state with a large Medicaid program and a large LTC population. In 2001, Michigan spent \$2.4 billion, of a total Medicaid budget of \$7.6 billion, on LTC services. In 2001, Michigan allocated 25.6% of its LTC expenditures to HCBS, ranking 34th in

¹⁶ AARP, p. 25.

the nation (see Appendix 1).¹⁷ Michigan ranked 21st in the number of Medicaid clients enrolled in Aged/Disabled waiver programs in 1999.¹⁸ Michigan also ranked in the middle, or 27th at \$238.72, in per capita LTC spending in 2001. Medicaid expenditures for nursing facility care grew at 8.4 percent and 2.2 percent in 2001 and 2002 respectively, after a major increase of 34 percent in 2000.

LTC Programs and Services

Michigan's LTC programs are housed in the Michigan Department of Community Health. Most LTC policy and programs are located in the Bureau of Medicaid Policy and Quality Assurance, Medical Services Administration. The Bureau encompasses nine Medicaid State Plan services, and the Section 1915(c) HCBS-Aged/Disabled waiver program. The Office of Services to the Aging operated three state-funded programs.¹⁹

In 2002 Michigan Medicaid paid for 28,130 clients in nursing facilities, at an average cost of \$51,806 per FTE to total \$1.45 billion. Michigan has one remaining ICF-MR with about 220 residents who are there because their plan of service calls for that level of care. There is no waiting list to receive community living services and supports.

The 2002 census for Michigan's Medicaid-funded *personal care program* was approximately 4,300 people at a given point in time, while the census for its *extensive Home Help Program* was approximately 38,000. The Home Help Program is a consumer directed program, in which the consumer arranges for his or her own care provider with assistance from a care manager if needed. Michigan's *home health and private duty nursing programs*, with a census of 5,720 and 309 persons, respectively,

¹⁷ The MEDSTAT Group ranked Michigan 33rd in the nation, at 23.4 percent, in proportion of LTC spending on community care (Eiken and Burwell).

¹⁸ AARP, p. 226.

¹⁹ Michigan also operates two MR/DD waiver programs through another Department.

were relatively small compared to the Home Help Program.²⁰

Michigan served another 12,639 unduplicated persons at an HCBS cost of \$4,907 per person and a total Medicaid cost of \$18,331 per person through its Aged/Disabled waiver program (MI Choice). This compared to \$20,164 for nursing facility care and \$5,308 for other Medicaid services to nursing facility residents. Total Medicaid costs for each unduplicated HCBS waiver client were \$18,331 and total Medicaid costs for each unduplicated nursing facility client were \$25,472 (see Table 3).²¹

The number of unduplicated clients served in the Michigan Aged/Disabled waiver program in 2001 (12,639) was less than the number served in the Colorado HCBS Aged/Disabled waiver program (15,157), although Michigan's population is more than twice as large.²²

In contrast, Michigan paid for roughly three times the number of nursing facility residents as Colorado. Colorado has demonstrated that over one-half of its nursing facility-eligible Medicaid clients can be served safely and at less cost in the community.

If Michigan were to reduce its number of nursing facility residents by just 10 percent, it could realize significant savings – in the range, perhaps, of \$30 million per year.²³ If it could serve half of its nursing facility eligible population in the community, it might realize three times the savings. This is a large potential pool of net resources that in theory could be freed up for reallocation to other purposes.

Michigan has a strong foundation for making progress to a more balanced LTC system. It has an Aged/Disabled waiver program, home health, a consumer-directed personal care program and three state-funded community care programs (care management program, respite services and physical disability services). But without a system to allow and facilitate the diversion of clients to community-based care, this huge potential for resource reallocation will be difficult to realize.

Making a System for LTC

After an 18 month planning process, the state Department of Community Health issued a LTC plan in June 2000, entitled *Michigan's LTC Work Group Report and Recommendations*.²⁴

Table 3: Medicaid HCBS Waiver Programs in Michigan, FY 2002

Waiver Program	Number Served*	Waiting List	HCBS Cost per Person	Total Medicaid Cost per HCBS Client	Avg. Institutional Cost per Person Comparison
Elderly/Disabled (MI Choice)	12,639	None	\$4,907	\$13,424	\$25,472
Habilitation Supports	8,159	None	\$43,218	\$10,079	\$86,502
Children's Waiver	420	< 700	\$9,857	\$45,871	\$85,747

* Unduplicated recipients.

Source: Michigan Department of Community Health, HCFA 372 Reports, 2002.

²⁰ Michigan Department of Community Health, "LTC Programs Status and Recommendations; A Working Paper," June 2003. (Hereinafter referred to as LTC Programs.)

²¹ Michigan Department of Community Health, HCFA 372 Report, 2001.

²² Michigan's total population in 2002 was 10.05 million and its population 65 and older was 1.2 million. Colorado's total population in 2002 was 4.5

million and its population 65 and older was approximately 435 thousand.

²³ 2800 nursing home residents x \$25,472 total Medicaid costs for nursing facility residents (HCFA 372 estimate) minus 2800 x \$14,447 total Medicaid costs for HCBS waiver clients = \$31 million.

²⁴ "Michigan's LTC Work Group Report and Recommendations," Michigan Department of Community Health, June 2000. (Hereinafter referred to as Michigan's LTC Work Group.)

The Report and Recommendations provide an excellent plan for LTC system development in Michigan.

The report concludes that *Michigan needs an organized system of LTC*. It observes that:

Michigan's current LTC system does not focus enough on prevention and early intervention, is not consumer driven, lacks a clear point of entry and has limited choices. Existing services are not integrated into coordinated systems of care. There are no incentives for planning and use of private resources, and dual public funding streams (Medicaid and Medicare) create confusion and impede efficiency.²⁵

Several state reports have observed that accessing LTC in Michigan is difficult, confusing and fraught with many wrong doors and referrals to other service providers. *There is no system for easy access to information and supportive services*. State plan services and the Home Help Program are accessed through the Family Independence Agency, which has over 100 offices throughout Michigan's 83 counties. The Family Independence Agency also determines financial eligibility for Medicaid services. The Office of Services to the Aging administers a variety of services for seniors through 16 regional Area Agencies on Aging. Office of Services to the Aging include care management and respite services. Fourteen of the Area Agencies on Aging, along with seven other agencies, make up 21 waiver agents that administer the MI Choice waiver program for the elderly and disabled.²⁶ Sorting out this confusing array of entry portals is difficult for consumers, especially if they are in a crisis. Individuals seeking LTC need to know what the available services are, what they need, and whether they are eligible for a particular service before they make a LTC decision. Many

families determine this to be too difficult and find it easier to contact a nursing facility instead.

According to a 2003 working paper issued by the Department of Community Health, Michigan needs to put in place several critical tools of a LTC access system. These include:

- a *client assessment* instrument that includes medical/functional eligibility criteria that define the nursing facility level of care
- a *prior authorization* process for LTC services (e.g., nursing facility, HCBS, and Program of All Inclusive Care for the Elderly (PACE))
- a *continuum* of services for LTC.²⁷

The working paper concludes that in order to be effective in "implementing a continuum of LTC," the assessment instrument must be a *comprehensive LTC assessment instrument, covering all LTC programs*. It should assess needs and program eligibility for the range of programs, including: nursing facilities, HCBS, assisted living, home help and personal care services. Such an assessment instrument would have clearly defined nursing facility level of care criteria, which are missing from the current system. (The only authorization currently required for nursing home admission is a physician's signature.) The level of care criteria would be designed to control nursing facility admission by establishing a threshold of need and directing individuals to lower level services when appropriate. The level of care criteria also would define whether an individual is eligible for, and must be given a choice of, HCBS care.

The second infrastructure component recommended for managing Michigan's LTC services is a *prior authorization process* for Medicaid payment of a nursing facility, HCBS and PACE.

Michigan is one of the few remaining states that does not have an assessment-based pre-approval process for the Medicaid payment for nursing facility admissions and HCBS waiver enrollment. A pre-approval process would serve to verify that the nursing facility level of care

²⁵ Ibid, p. 3.

²⁶ Personal correspondence from Joseph Baumann and LTC staff, Michigan Department of Community Health, September 22, 2003.

²⁷ LTC Programs, p. i.

criteria have been met and that all other requirements for Medicaid payment are in place, including the Pre-Admission Screening Annual Resident Review (PASARR) process/decision. A pre-approval process would also ensure that the state can attest to informed choice, assuring that individuals are aware that they can access HCBS instead of the nursing facility if they so choose.²⁸

The third critical component recommended for Michigan's LTC system is a set of *local level single entry point agencies* to provide information and referral, service access (assessment and level of care determination), case management, client monitoring, and quality management. Michigan does not have an "...identifiable point of access for LTC services, no care management across programs and settings, and no continuum of care exists." The report also points out that *the fragmented system*, "... makes utilization redirection very difficult at the state level."²⁹

It is extremely difficult to estimate the client impact and fiscal impact of establishing a single access system to LTC options. Colorado reported 10 percent fewer admissions to nursing facilities in counties with single entry point systems compared to counties without single entry points. While the situation in Michigan is different, an impact of a similar amount would mean that Michigan Medicaid would pay for 135 fewer admissions per month into nursing facilities.

The other major impediment to greater choices of community living in Michigan is the lack of assisted living as an alternative to nursing facility care. Families seeking residential care services on the State LTC web site cannot find assisted living. Assisted living is not a covered benefit. "Currently, individuals can receive Medicaid financed supports and services in any setting except licensed Adult Foster Care homes and licensed Homes for the Aged."³⁰ Michigan's LTC Programs report concludes, "Most states that have significantly changed utilization and cost patterns to more HCBS have incorporated assisted living and/or

adult foster care settings as a means for providing the necessary housing."³¹ Colorado found assisted living to be an essential component of its deinstitutionalization project. The new Michigan Nursing Facilities Transitions grant project, funded by CMS, includes provisions for assistance in the area of accessing and developing housing options. *Changing the rules to allow Medicaid payment for selected services in assisted living facilities would make these residential services more realistic alternatives to nursing facility care.*

While one of the many recommendations of the LTC Work Group Report was for a capitated, managed LTC system, the policy consideration is on indefinite hold. *In the longer term, Michigan may want to re-consider a policy of integrating acute and LTC services in managed care organizations.* The rationale is that integration of acute and LTC benefits and Medicare and Medicaid financing in an HMO would reduce confusion for clients, offer incentives for providing preventive care and for maintaining individuals in community settings. With Michigan's strong history of managed care, this would seem to be a next logical step. From a budget perspective, most states take a five percent discount when capitating LTC services. Five percent of current Medicaid LTC spending in Michigan is over \$119 million.

The Fiscal Situation

Like other states, Michigan is enduring serious budget shortfalls. The MI Choice waiver program for the elderly and disabled has operated with a reduced budget for the last two years. In 2001, the program spent approximately \$144 million; in 2002, the budget was \$126 million; and for 2003 the budget is about \$100 million. Other LTC programs have experienced flat or increased funding. The state is again forced to plan for a substantial reduction in its LTC budget for FY 2004.³²

²⁸ LTC Programs, pp. 6-7.

²⁹ LTC Programs, p. 2.

³⁰ Michigan's LTC Work Group, p. 26.

³¹ LTC Programs, Attachment 6.

³² Personal correspondence from Joseph Baumann and LTC staff, Michigan Department of Community Health, September 22, 2003.

PENNSYLVANIA

Pennsylvania is an example of a state that spends a low proportion of its LTC dollars on HCBS but is working on improving that balance and giving consumers greater choices. Pennsylvania spends 18.4 percent of its LTC expenditures on HCBS. AARP ranked Pennsylvania 40th in the nation in 2001. The MEDSTAT Group report, using slightly different definitions, ranked Pennsylvania 43rd, with 15 percent of LTC expenditures allocated to HCBS in 2000.³³

Pennsylvania spends a high amount per capita on LTC. In 2001 it ranked 4th highest in the nation in per capita expenditures for LTC, spending \$416.18 per person (see Appendix 2). The state has a strong financial commitment to LTC, using State Lottery funding and Tobacco Lawsuit Settlement funding to supplement state general funds. Pennsylvania, however, could spend far less money on LTC if it could diminish its reliance on institutional care.

Demographics drive LTC planning and budgeting in Pennsylvania. Persons age 65 years and over are 15.6 percent of the total population, second only to Florida. (People 65+ comprise 12.3% of Michigan's population and 9.6 % of Colorado's.) The elderly population in Pennsylvania is one of the fastest growing in the nation. The population aged 85 and over grew by 38.3 percent from 1990 to 2000, ranking seventh highest in the nation. The number of persons aged 85 and over with two or more limitations in activities of daily living is projected to increase 22 percent by 2010.³⁴

Administration

Several state agencies share responsibility for administration of LTC services for the elderly and persons with disabilities in Pennsylvania. The Department of Public

Welfare (DPW) administers the Medicaid program and ten of the HCBS waiver programs. The Department of Aging administers the HCBS program for the elderly and the Older Americans Act programs. The Department of Aging also houses the Intra-Governmental Council on LTC.

The Council was established in 1986 to study Pennsylvania's LTC system and to provide options and recommendations to the Governor, the General Assembly and state administrators on consumer access, financing and ways to streamline the LTC system so that it is more responsive to the needs of consumers and their families. The Department of Health is responsible for licensure and certification of nursing facilities and home health agencies.³⁵

County Assistance Offices in each of the 67 counties are responsible for Medicaid financial eligibility determination. A new *on-line financial eligibility system* for health care coverage, food stamps and cash assistance called COMPASS became operational in 2002. COMPASS became available for LTC eligibility in 2003. The *system provides a single application for a wide variety of programs*, including health care coverage, LTC services, cash assistance, and food stamps. COMPASS is available in hard copy through County Assistance Offices or on-line through the state web site (www.longtermcare.pa.us).³⁶

The 52 Area Agencies on Aging are responsible for services assessment, preadmission screening and level of care determination for persons applying for nursing facility care, or Medicaid or state-funded HCBS. The Area Agencies on Aging use the Comprehensive Options Assessment form to conduct all client assessments and to determine the need for services. Case managers assess a person's physical and cognitive functioning, limitations in activities of daily living, and instrumental activities of daily living, availability of supports, physical environment, and social participation.

The 46 County Offices of Mental Retardation are responsible for client assessment, case management and service delivery for persons with mental retardation

³³ Eiken and Burwell.

³⁴ Carol O'Shaughnessy, Ron Weissert, Julie Stone, Sidath Panangala, Meridith Walters, "A CRS Review of 10 States: Home and Community-Based Services-States Seek to Change the Face of Long-Term Care: Pennsylvania," Congressional Research Service, CRS web, April 1, 2003, p. 6. (Hereinafter referred to as CRS Report).

³⁵ CRS Report, p. 13.

³⁶ CRS Report, p. 16.

across the state.³⁷

Institutional LTC

The number of nursing homes and nursing home beds in Pennsylvania has decreased substantially since 1998. The nursing home occupancy rate is 88.2 percent, higher than the national average of 80.8 percent. *As a share of LTC spending, nursing home spending increased from 63 percent to 72 percent from FY 1990 to 2001.* Pennsylvania Medicaid spent \$5.5 billion on nursing facility services in FY 2002.³⁸

During the same time period, Medicaid spending for ICF-MRs decreased from 29 percent to 9.5 percent of Medicaid spending.³⁹ *Pennsylvania has made an extensive transformation in its system of services for people with developmental disabilities.* Pennsylvania spent about \$1.6 billion on services for persons with developmental disabilities in 2000, of which 72 percent was for community-based care.⁴⁰

HCBS

The state's largest waiver program is the Consolidated Mental Retardation program. The largest waiver program for the elderly is the Pennsylvania Department of Aging (PDA) waiver program (see Table 4). Pennsylvania also has *especially strong state-funded HCBS programs for persons who do not meet the Medicaid resource and income eligibility criteria.* The Options Program provides services to persons who have incomes greater than the Medicaid income standard of 300% of the federal Supplemental Security Income (SSI) payment level. The *Bridge Program* provides services to persons who cannot meet the Medicaid resource criteria of assets less than \$2,000.

The Options Program, begun in 1972, is financed through the Pennsylvania State Lottery. It provides client assessment, case management and pre-admission screening for persons age 18

and over applying for nursing home care, and for SSI recipients applying for a personal care home. Financial eligibility rules incorporate cost-sharing criteria. Participants with incomes below 125 percent of the federal poverty level are not required to pay for services. Participants with incomes between 125 percent and 300 percent of the federal poverty level pay on a sliding fee scale. Participants above 300 percent of the federal poverty level pay the full cost. This program does not consider financial resources for program eligibility and consequently covers many people. Over 91,000 individuals were served at an average cost of \$1,983 per person in 2001-02.

The Bridge Program, implemented in January 2002, is financed with State tobacco settlement funds. The Bridge Program is for persons age 60 and over, who meet the Medicaid income eligibility requirements, but can have up to \$40,000 in assets. Program services are similar to the Pennsylvania Department of Aging (Elderly) waiver program. Each participant is required to pay 50 percent of the cost of direct services received. *This cost-sharing system is the "bridge." It allows persons with resources above the allowed amount to spend down until they qualify for Medicaid coverage.* About 200 individuals were covered in 2001-02.⁴¹

In 2000, Pennsylvania served 58,771 persons meeting the nursing facility level of care criteria. Of those, 54,208 were nursing facility residents and only 4,563 were in HCBS. The numbers served by the PDA waiver in 2001-2002 had increased to 9,309 as shown in Table 4. Thus Pennsylvania, like Michigan, could realize substantial savings if it could reduce the actual number of people served in nursing facilities and shift their care to the community.

Efforts to Reallocate LTC Resources

Pennsylvania has adopted several strategies to improve the balance in their LTC system. One of those strategies is the *Nursing Home Participation Review Program.* Pennsylvania

³⁷ CRS Report, p. 13.

³⁸ Eiken and Burwell.

³⁹ CRS Report, p. 35.

⁴⁰ CRS Report, p. 26.

⁴¹ Pennsylvania Intra-Governmental Council on Long Term Care, LTC in Pennsylvania Briefing, (Harrisburg, PA, Intra-Governmental Council on Long Term Care, April 2002), p. 10.

Table 4: Pennsylvania HCBS Selected Waiver Programs (SFY 2001-02)

Waiver Program	Number Served	Waiting List	HCBS Costs/Person	Total Medicaid Costs/Person	Institutional Costs/Person Comparison
Elderly (PDA)	9,309	None	\$8,136	\$12,909	\$44,000
Attendant Care	1,804	None	\$26,500	*	\$38,059
Independence	452	None	\$18,234	*	\$42,116
AIDS	78	None	*	*	\$14,000
Commcare/TBI	22	None	\$117,697	*	\$146,740
Consolidated/MR	13,614	Yes	\$54,538	\$60,077	\$100,280
Person/Family Directed	6,218	Yes	\$7,105	\$11,367	\$120,701
OBRA/DD/Early Intervention	377	None	\$39,633	*	\$129,949
Elwin (Deaf and Blind)	42	None	*	*	*
Michael Dallas (Tech. Dependent)	57	None	*	*	*

*Information not available.

Source: Pennsylvania Department of Public Welfare, HCFA 372 Reports, 2002.

had a Certificate of Need program until it was allowed to lapse in 1996.

After the number of nursing homes and beds began to rise, the Department of Public Welfare adopted a Medicaid Participation Review Program in 1998. *Nursing facilities wanting to participate in Medicaid must be reviewed and approved for the need for facilities and beds by Medicaid.*

The main objective of the review process is to "...respond to consumers' desire to age in place by redirecting limited state resources from higher-cost, less preferable institutional settings to more cost-effective HCBS, through encouraging the development of other components of the array of LTC services."⁴² The number of Medicaid nursing facility beds has decreased from 90,800 in 1998 to 89,500 in 2000.⁴³

The other main strategy for providing LTC choices for consumers is implementing a series of Medicaid HCBS waiver programs. Pennsylvania now has 11 Medicaid Section 1915 (c) waivers. The Pennsylvania Department of Aging implemented its Section 1915 (c) waiver program for persons age 60 and over in January

1999. This implementation date of 1999 is very late compared to most other states. Many states began their first waiver programs in the early or mid-1980s. Colorado began its first two large waiver programs in 1983 and Michigan began its first waiver program in 1994. Pennsylvania spent \$54 million on its Aging waiver program in 2001.

According to state officials, the number of Medicaid patient days in nursing homes has been reduced and the number of Medicaid certified beds has been reduced by two percent.⁴⁴

Pennsylvania has made substantial progress in decreasing the number and size of its residential facilities for persons with mental retardation or developmental disabilities. In 1990, 46.7 percent of its residents were in facilities for six persons or less. In 2000, 67.8 percent of residents were living in these small facilities, ranking Pennsylvania 25th in the nation.⁴⁵ The State's 1997 Multi-Year Plan recommends further reducing the use of larger

⁴² LTC in Pennsylvania, Briefing Book, p. 15.

⁴³ Personal correspondence from James Pezzuti and Daniel McGuire, State of Pennsylvania, September 11, 2003.

⁴⁴ LTC in Pennsylvania, Briefing Book, p. 14.

⁴⁵ David Braddock, et al. "Disability at the Dawn of the 21st Century and the State of the States." American Association on Mental Retardation, Washington, D.C., 2002.

facilities and proposes specific targets for doing so.⁴⁶

Pennsylvania operates *three waivers for persons with mental retardation or developmental disabilities*. The Consolidated Waiver for Individuals with Mental Retardation is the largest waiver program in Pennsylvania, both in terms of expenditures and in number of persons served. This program provides a comprehensive range of services for persons age 3 and older. These services include: residential and day habilitation, prevocational services, supported employment, transportation, respite care, private duty nursing, specialized therapies, and permanency planning for children and youth. Program expenditures were \$714 million in 2001. The second waiver program is the *Person/Family Directed waiver program*. This program provides similar services to the same population as the Consolidated waiver program but emphasizes consumer/family directed care. The program cost cap is \$21,225 per year. The third waiver program is the OBRA waiver program. It targets persons with developmental disabilities and is an alternative to nursing home care. Services include: service coordination, assistance with daily living, respite care, environmental adaptations, assistive technology or specialized medical equipment, therapies, prevocational services, and supported employment.

Expenditures for institutional care have declined as a percent of LTC expenditures during the last decade. Spending for institutional care was 92.2 percent of total LTC spending in 1990, dropping to 81.6 percent in 2001. This decrease came from a 14.8 percent decrease in spending for ICF-MRs. *Nursing home spending actually grew by 196.7 percent over this period*. This was greater than the overall increase in Medicaid spending of 182.3 percent. During this same time period, *expenditures for HCBS waiver programs grew by 627.3 percent*.⁴⁷

Eliminating Barriers to Progress

Pennsylvania has done a thorough job of analyzing the barriers to reducing its reliance on institutional care and giving consumers improved choices of living in the community. The Pennsylvania Intra-Governmental Council on LTC convened a work group to analyze the barriers to increasing HCBS and make recommendations to remedy those problems. The work group was composed of consumers, providers and program administrators from the affected state departments. Their work focused primarily on programs for persons with physical disabilities.⁴⁸

The 22 barriers and recommendations developed by the Barriers Elimination Work Group make an excellent blue print for reforms necessary to improve the LTC system in Pennsylvania. With the extreme demographic pressure facing Pennsylvania, the Commonwealth is seeking to provide LTC in a lower-cost manner. The report states, “The costs of financing a LTC system that primarily relies on nursing home care for a rapidly increasing group of people will be prohibitive.”⁴⁹ This reliance on institutional care places Pennsylvania fourth highest in the nation in spending per capita on LTC at \$416.18.

Several of the barriers and recommendations identified by the Barriers Elimination Work Group could have substantial impacts on shifting the balance to community-based care. The Work Group reported the barriers in priority order. Their *highest priorities were to improve aspects of the client access system to support more choices of community-based care*.

Barrier 1: *The process for determining eligibility and starting services takes too long.* The Work Group characterizes this barrier as the highest priority to resolve. This procedural barrier means that HCBS is not truly an alternative to nursing facility care. Slow eligibility determination is particularly problematic for persons being discharged from a hospital. Without Medicaid eligibility, a

⁴⁶ Pennsylvania Office of Mental Retardation, “A Multi-Year Plan,” 1997.

⁴⁷ CRS Report, p. 35.

⁴⁸ Pennsylvania Intra-Governmental Council on LTC, Home and Community-Based Services Barriers Elimination Work Group, March 2002.

⁴⁹ Ibid, p. 3.

community-based plan of services cannot be implemented because community providers will not accept the financial risk for providing services without a payment source.⁵⁰ *CMS has recently changed rules to permit “presumptive eligibility” for HCBS services and will allow federal matching funds for case management services for those persons.*

The Pennsylvania Work Group also recommends that (Medicaid) financial eligibility applications be expedited. Several states have addressed this problem by setting performance deadlines. Colorado requires that a client functional assessment be completed within 24 hours for someone being discharged from a hospital and within 48 hours for someone living in the community. Similar performance standards could be set in Pennsylvania. The Work Group further recommends that Pennsylvania adopt the interim presumptive eligibility provisions recently made available by CMS.

Barriers 2 - 6 concern *obtaining information about and applying for community-based services*. The report states that consumers do not have enough information about: HCBS, their particular program needs, how to access support programs, and the complexities of the Medicaid application. In addition, functional eligibility determinations do not have clear criteria and take too long.

The Work Group makes several recommendations to address the barriers. These include: using a *single application form for all LTC services*, providing *easily accessible information and referral* for services, providing personnel to assist consumers in completing the Medicaid application form, using formal *statewide functional eligibility criteria*, and *expediting functional eligibility decisions*.

Several of these barriers are the same as those identified in Michigan. Pennsylvania has plenty of funding and plenty of programs, but needs the LTC system infrastructure in place to provide the mechanisms of a system to give individuals real choices of community living.

Area Agencies on Aging in Pennsylvania already provide a limited single entry point for LTC services for persons age 18 and over with physical disabilities. Area agencies provide client assessments and level of care determination for HCBS programs and state-funded community care programs. They also perform pre-admission screening for persons of all ages seeking admission to a nursing facility.⁵¹

An initiative by the Pennsylvania Department of Public Welfare to establish Community Resource Centers for Persons with Disabilities, which provide eligibility assessment, program eligibility determinations, individualized service plan development, service brokering, client monitoring, emergency response, nursing home transition services, and quality management for younger persons with disabilities, has been put on hold.

Barriers 11 - 13 highlight the need for affordable community housing and supervised living and reveal the institutional bias in the current programs. Lack of access to an assisted living service is the same barrier that exists in Michigan.

Medicaid will not pay for shelter and food costs through an HCBS program but will pay those costs for nursing home residents. Consequently, most states have developed assisted living programs in their HCBS programs where Medicaid pays for the support services and the individuals SSI check pays for shelter and food. However, under Pennsylvania law, *an individual may not be nursing home eligible and live in an assisted living residence or a personal care home. This law forecloses aging in place and preempts an individual’s choice of residence.* Over 30 states have assisted living certification laws and have extensive, successful experience with caring for nursing home eligibles in assisted living facilities. In Colorado, over 1,500 HCBS-Elderly/Disabled Adult clients live in assisted living facilities. This is about 15 percent of the Medicaid nursing home program population. In addition, Colorado found that residential care was essential to its program of transitioning clients from a nursing facility to community

⁵⁰ Pennsylvania Intra-Governmental Council on LTC, Home and Community-Based Services Barriers Elimination Work Group, March 2002.

⁵¹ CRS Report, p. 47.

living. Over 60 percent of the residents transitioned needed assisted living in order to return to the community.

Pennsylvania can expand its assisted living services. Well-designed assisted living could provide an appropriate substitute for some nursing home residents. It could provide the residency and supervision that many clients need to be able to remain in the community. Of course, allowing clients to remain in their own homes (i.e., aging in place) is a preferred, less costly alternative, but for some individuals that is not the best option. Having *clear rules about assisted living, sufficient payment levels, person-centered quality assurance systems and case manager monitoring should go a long way to establishing this service as a viable alternative to nursing facility care.*⁵²

Opportunities to Reallocate Resources

Pennsylvania has extensive opportunities to expand its HCBS programs. Because the Aging waiver program was only recently implemented (1999), it has a great deal of room to grow. To do this expansion in tight budget times, *the program must be closely focused on targeting individuals most at-risk of nursing home placement in order to reallocate, not add to, LTC expenditures.* Pennsylvania has a superb structure of state-funded programs to complement its Aging waiver program. It can better afford to target its waiver programs to those most in need, because there are safety net programs to fall back on.

The other long run strategy Pennsylvania could adopt is integrating acute and LTC and Medicare and Medicaid financing in Health Maintenance Organizations. These delivery systems have strong financial incentives to maintain individuals in preferred, community settings.

⁵²Robert Mollica, "State Assisted Living Policy: 1998," National Academy for State Health Policy, Portland, Maine, 1998; and David Stevenson, Christopher Murtaugh, Penny Feldman and Mia Oberlink, "Expanding Publicly Financed Assisted Living and Other Residential Alternatives for Disabled Older Persons: Issues and Options," Center for Home Care Policy and Research, Visiting Nurse Service of New York, Fall/Winter 2000.

LESSONS FROM EXPERIENCE

In examining the LTC systems in each of these three states, resources that can be tapped for expanding community-based care have been identified, several opportunities for reallocating existing resources have been highlighted, and the importance of having systems or mechanisms to change the flows of clients and funding has been emphasized.

Identifying Resources

There are several examples of identifying resources to be used for expanding HCBS in the state case studies. One that Colorado and other states have used extensively is finding *ways to substitute federal funds for state funding (refinancing).* Each state has opportunities for acquiring federal funds to substitute for state funded programs. Currently, only three states have HCBS-Mental Illness waiver programs. These programs can be used to substitute federal funding for state funded mental health programs.

Reallocating Resources

Another approach is to *identify Medicaid funds that can be reallocated from existing expenditures on institutional care to less expensive community-based care.* Colorado provides for over one-half of its nursing facility level of care clients in HCBS waiver programs. If Michigan could serve half of its nursing facility level of care population in the community by transitioning some 8,500 clients to community living, it possibly could save as much as \$100 million per year. If Pennsylvania could serve one-half of its nursing facility level of care population in the community, nearly 25,000 individuals would be transitioned to community living, with a potential savings of \$890 million per year.

System Infrastructure Needed to Reallocate Resources

One of the main lessons from the Colorado case study is that the *system infrastructure necessary to do the resource reallocation must be in place for the reallocation to happen.* A

system to facilitate the diversion of clients to community living is needed. Michigan is a good example of a state needing stronger systems for directing client and resource flows to community care. Pennsylvania is in a similar situation. Each lacks strong mechanisms to facilitate client choice of community living.

The Oregon and Colorado HCBS and single entry point systems were formed in tight budget times. Other states could take advantage of the current budget crisis to strengthen their LTC systems. Colorado is finding that the current budget crisis is forcing the hard policy choices needed to install additional system management and control systems for LTC.

Several steps will facilitate developing the appropriate infrastructure. One is *administrative consolidation at the state level*. This means bringing together all of the LTC programs (at least for a single client population) under one roof. This makes that organizational unit responsible and accountable for the whole LTC budget for that population and for consistent state policy. This empowers that organizational unit to promote the substitution of lower cost services for higher cost services within its own budget allocation.

The second important step in creating a LTC system infrastructure is *consolidation of responsibility and authority at the local level*. *Single entry point agencies* provide a local organization that consumers can contact for information and referral and access to all LTC services.

The third step is to establish a *comprehensive pre-admission review process and provide the tools to make this process effective*. *Single entry point agencies must have client assessment instruments with criteria that determine nursing home level of care*. These objective criteria are necessary for controlling utilization of nursing facility and HCBS services. When the pre-admission review process was implemented in Colorado, nursing facility admissions decreased from 400 to 300 per month. If the assessment instrument is comprehensive (i.e. encompassing all LTC programs and services) the consumer will not have to endure another assessment to access a different service. *In addition, the client assessment and eligibility determination process*

must be timely enough in order to make community-based services a real alternative to a nursing facility.

The fourth step raises the “the chicken or the egg” question. Does a state need an array of community services as alternatives to nursing facilities first, before it has a system to direct people there? The answer is that both are needed. Constructing a system to divert or transition clients from nursing facilities to community living is a waste of resources if the programs and services they need are not there. One of the lessons of Colorado, Oregon and many other states is that *residential alternatives are a critical part of the community services system*. Many individuals being discharged from hospitals or nursing facilities need the supervision and availability of services that residential care provides. Some consumers, particularly individuals being discharged from nursing facilities or hospitals or those with mental or cognitive impairments, require residential supports. Assisted living should be designed to fill that need.

Specific Strategies

Several specific strategies and programs to reallocate resources to HCBS have been identified in these three states. For many states, the most readily available technique is *refinancing*. This is the substitution of federal Medicaid dollars for state funds. Colorado provided examples of refinancing of a state plan service in using Medicaid rehabilitation services to pay for mental health services for foster care children in Residential Treatment centers. Colorado also provided examples of refinancing of state funded services through waiver programs for children with developmental disabilities in Residential Treatment Centers and for persons with mental illness through an HCBS-Mental Illness waiver program.

Another strategy is to *substitute lower cost services for higher cost services* in LTC. Colorado began substituting HCBS personal care services for State Plan home health services in response to rapid increases in the home health budget and the current State budget crisis.

Of course, the greatest opportunity for substituting lower cost services for most states is

to substitute community-based care for institutional care. *The three states in these case studies have been very successful in achieving this for their client populations with developmental disabilities.* They have transitioned almost all of their ICF-MR populations to community living, closing expensive facilities in the process. The states have done less well in transitioning their nursing facility populations to community living. But the examples of Colorado (and Oregon, and Washington, and Vermont) suggest that over half of the existing nursing facility level of care Medicaid clients could be safely served in the community at far less cost.

LTC system infrastructure is needed to allow this substitution to happen. If given an equal choice, most consumers will choose to receive services in their own homes or another non-institutional setting rather than a nursing facility. *Interventions of choice information and alternative service plans need to be made at the “crisis time”* when an individual is being discharged from a hospital or otherwise contemplating a decision about nursing facility placement. Systems need to be set up to inform individuals residing in nursing facilities of their options of community living as well.

In many cases, this means *removing barriers to information and access.* This will require establishing specific programs, such as a nursing facility deinstitutionalization program or a fast track eligibility program. These are the system infrastructure mechanisms needed to accomplish diversion and transitions from nursing facilities to community living.

Another specific substitution strategy being widely pursued is *consumer-directed care.* The substitution is a consumer-directed attendant (hired, trained and directed by the LTC program participant) for an agency-directed worker. The primary purpose of consumer/family directed care is to give the consumer greater autonomy and independence, but tapping into non-traditional labor markets will likely lower the cost.

Targeting

The fundamental question in developing LTC systems to facilitate choices of community

living in tight budget times is a targeting question. The issue is one of accomplishing the diversion of clients to community care while at the same time lowering the Medicaid paid nursing facility census. Spector, Reschovsky and Cohen⁵³ estimate that approximately 15 percent of nursing facility residents could be diverted to lower levels of care. Targeting community programs to those individuals in institutions or at-imminent-risk of nursing facility placement is the best approach.

Several targeting strategies are available. Colorado has chosen not to have an optional Medicaid personal care program but instead to provide personal care only through waiver programs in the belief that such care can be better managed and controlled through the waiver mechanism. It has successfully diverted clients from nursing facilities by implementing a *nursing facility client assessment and prior authorization process.*

Colorado also adopted a *Most-in-Need screen* for applicants to its HCBS-Elderly/Disabled waiver program. Three specific functional indicators were selected. Deficiencies in these activities of daily living (bathing, mobility and confusion) were most correlated with nursing home admissions. By adding this screen to the usual client assessment, the state focused the program on diverting those individuals most at-risk of nursing facility admission. The screen slowed the growth of the HCBS program, but did not increase nursing home admissions.

The State of Vermont takes a different approach on targeting and HCBS resource allocation. Vermont has a *“prioritization” process for waiver program slots*, which accords highest priority to:

1. Residents in nursing homes needing waiver services to be discharged to a home and community setting

⁵³William D. Spector, James D. Reschovsky, and Joel W. Cohen, “Appropriate Placement of Nursing Home Residents in Lower Levels of Care.” Milbank Quarterly, 1996, Volume 74, No. 1, pp. 139-160.

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2. Patients in a hospital needing waiver services in order to be discharged to community care
 3. Persons who are at risk of significant harm unless they receive waiver services
 4. Persons who are at-risk of moving to a more restrictive setting unless waiver services are provided

This approach to targeting at-risk clients has allowed Vermont to make a rapid and substantial shift in LTC resource allocation within a fixed budget. Targeting has allowed it to transition clients from nursing facilities to community care and close two nursing facilities. The money to finance the expansion of HCBS has been reallocated from the nursing facility budget line.

The other targeting approach being encouraged by CMS and adopted by several states is to develop *nursing facility transition programs*. CMS has given program development grants to many states to design and develop programs that identify clients in nursing facilities, educate them about their options and assist them in relocating to community living. The Colorado Deinstitutionalization Project mentioned earlier is a good example. The savings for these transitions can be roughly estimated as the difference in nursing facility cost vs. HCBS program costs. *This targeting protocol eliminates concerns over the “out-of-the-woodwork” phenomenon because all of these clients are at 100 percent risk of being in a nursing home.*

Many opportunities exist for states at all levels of system development to identify and reallocate resources to provide greater choices for community living. Many models and tools already exist to help states in rebalancing efforts. Given the current fiscal climate, many states may find that the balance of political will is shifting to allow them to undertake reforms which were not acceptable when budgets were expanding.

Appendix 1
Allocation of Medicaid LTC Expenditures
Between Nursing Facilities, ICF-MRs, and HCBS, 2001

State	HCBS Expenditures	Rank	ICF-MR Expenditures	NF Expenditures
New Mexico	55.1%	1	4.5%	40.4%
Vermont	55.0%	2	0.9%	44.1%
Alaska	54.2%	3	0%	45.8%
Wyoming	52.0%	4	13.2%	34.9%
Colorado	51.1%	5	2.1%	46.8%
Washington	47.8%	6	9.2%	43.0%
Oregon	47.7%	7	1.1%	51.3%
Minnesota	41.6%	8	11.4%	47.0%
New Hampshire	40.9%	9	0.6%	58.5%
California	40.4%	10	8.3%	51.3%
Maine	40.1%	11	10.9%	49.0%
Rhode Island	40.1%	11	1.7%	58.2%
Utah	39.1%	12	22.5%	38.4%
Montana	38.4%	13	9.9%	51.6%
Kansas	38.2%	14	7.8%	54.0%
North Carolina	37.3%	15	19.6%	43.0%
New York	36.5%	16	16.0%	47.5%
West Virginia	35.8%	17	9.0%	55.2%
Wisconsin	35.7%	18	11.3%	53.0%
Oklahoma	33.4%	19	14.1%	52.6%
Massachusetts	33.3%	20	8.6%	58.1%
Connecticut	31.9%	21	12.5%	55.6%
South Carolina	31.2%	22	21.4%	47.4%
Idaho	30.2%	23	23.7%	46.1%
Kentucky	29.5%	24	10.1%	60.4%
Texas	29.2%	25	22.0%	48.8%
Virginia	29.1%	26	18.6%	52.3%
Maryland	28.8%	27	5.5%	65.7%
Arkansas	28.0%	28	14.9%	57.1%
Nebraska	27.8%	29	8.3%	63.9%
Delaware	27.5%	30	15.8%	56.7%
Missouri	26.9%	31	11.0%	62.1%
South Dakota	26.5%	32	7.8%	65.6%
Hawaii	25.7%	33	3.8%	70.5%
Michigan	25.6%	34	1.3%	73.1%
Nevada	25.3%	35	17.8%	56.9%
Florida	24.7%	36	11.0%	64.3%
Iowa	23.7%	37	26.8%	49.4%
Alabama	20.7%	38	6.7%	72.6%
Georgia	20.6%	39	10.2%	69.2%
North Dakota	20.6%	39	19.2%	60.2%
Arizona	18.4%	40	0%	81.6%
Pennsylvania	18.4%	40	9.5%	72.0%
New Jersey	18.1%	41	13.2%	68.7%
Tennessee	15.4%	42	19.4%	65.2%
Ohio	14.9%	43	21.6%	63.5%
Indiana	14.7%	44	22.7%	62.6%
Illinois	14.4%	45	26.4%	59.2%
Louisiana	9.7%	46	21.2%	69.1%
Mississippi	9.3%	47	26.4%	64.4%
Dist. of Columbia	6.4%	48	30.8%	62.8%

Source: Steven Gregory and Mary Jo Gibson, "Across the States: Profiles of Long-Term Care; 2002, Fifth Edition, AARP Public Policy Institute, Washington, D.C., 2003.

Appendix 2 LTC Spending Per Capita, 2001

State	Amount	Rank
New York	\$708.49	1
Connecticut	\$537.70	2
District of Columbia	\$442.98	3
Pennsylvania	\$416.18	4
Rhode Island	\$396.52	5
North Dakota	\$396.17	6
Minnesota	\$385.35	7
Massachusetts	\$384.14	8
New Jersey	\$376.26	9
Louisiana	\$375.60	10
Nebraska	\$337.78	11
Wisconsin	\$335.59	12
Kansas	\$329.25	13
Ohio	\$320.32	14
Maine	\$319.62	15
South Dakota	\$312.93	16
Vermont	\$310.93	17
Oregon	\$304.81	18
Missouri	\$297.99	19
West Virginia	\$294.92	20
New Hampshire	\$284.65	21
Iowa	\$258.57	22
North Carolina	\$248.87	23
Alaska	\$246.64	24
Delaware	\$244.86	25
Arkansas	\$240.42	26

State	Amount	Rank
Michigan	\$238.72	27
Washington	\$238.41	28
Montana	\$238.27	29
Oklahoma	\$234.41	30
Kentucky	\$230.06	31
Wyoming	\$228.34	32
Mississippi	\$225.96	33
New Mexico	\$224.33	34
Indiana	\$213.73	35
Tennessee	\$209.55	36
Alabama	\$207.76	37
Illinois	\$202.96	38
Maryland	\$197.42	39
Idaho	\$195.25	40
South Carolina	\$194.13	41
Colorado	\$173.93	42
Hawaii	\$171.72	43
Florida	\$161.52	44
Texas	\$154.20	45
California	\$146.83	46
Virginia	\$140.48	47
Georgia	\$131.13	48
Utah	\$106.05	49
Nevada	\$77.02	50
Arizona	*	*

*Information not available.

Source: Steven Gregory and Mary Jo Gibson, "Across the States: Profiles of Long-Term Care; 2002," Fifth Edition, AARP Public Policy Institute, Washington, D.C., 2003.