

**Flexible Accounting for Long-Term Care Services:
State Budgeting Practices that Increase Access to
Home- and Community-Based Services**

Recommendations for California

By

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Summary

All states have difficulty finding money for Medicaid programs. However, some have developed flexible accounting practices to make better use of resources by reducing the use of expensive programs and providing programs that cost less on a per-person basis. Flexible accounting consists of budgeting practices and contractual language that incentivize the use of less expensive non-institutional programs and then uses the savings to expand lower-cost services to further reduce the state's use of institutional care going forward.

Flexible accounting helps states use existing funding in ways that better respond to the needs of persons who receive long-term services and supports (LTSS). Traditional accounting practices create budgets based on estimates of how many persons will need a particular type of service or program over the upcoming year. These traditional practices do not take into account the changing needs of the person, tending to assume that programs are unique and persons do not shift back and forth among them. They do not account for the fact that programs with distinct budget line items are interrelated and the state should continually shift persons from expensive to less expensive programs. Traditional accounting practices *in and of themselves* become a barrier to serving persons with the right care at the right time, in the right place. One of the key advantages of flexible accounting is to resolve this impermeability, moving funding into the right account necessary to buy the services that are in demand based on individual needs. As a result, flexible accounting provides the means for a person to move more easily to community care, rather than being locked into expensive institutional care simply because the funding was set by estimate the year before and now requires legislative or state management and budget staff to approve the shift. Furthermore, flexible accounting allows investment in programs that provide more effective care and can save the state money, such as mental health and substance abuse services that reduce acute care and hospital expenditures, and investments in home- and community-based services (HCBS) that can reduce institutional expenditures in nursing facilities (NF) and intermediate care facilities.

The rapidly expanding use of managed care in state Medicaid programs creates a new context for flexible accounting. Approximately 71% of all Medicaid-eligible persons nationally are in a comprehensive managed care plan, a primary care case manager, or a limited benefit plan covering mental health, or substance abuse, or transportation or dental services. The Centers for Medicaid and Medicare Services (CMS) has funded California and 14 other states to create plans for transferring the services of persons who are dually eligible for Medicaid and Medicare from fee-for-service in order to integrate acute, primary, behavioral, and long-term care services. These changes are driving a rapid expansion of Medicaid managed LTSS programs, and raise the question of how flexible accounting is meaningful in a managed care environment that integrates medical care and supportive services.

This report presents various strategies used in Arizona, Hawaii, Louisiana, Massachusetts, Michigan, Minnesota, New Jersey, Pennsylvania, Tennessee, Texas, Washington and Wisconsin. In different ways, these states have made substantial progress in transforming their LTSS systems by developing flexible accounting policies that have reduced NF utilization and captured the savings to support their HCBS programs. Their strategies span the traditional fee-for-service environment, Medicaid managed care systems, and systems that combine a hybrid of both approaches. The authors do not believe that there is one "ideal" model of flexible accounting, but that multiple mechanisms exist, including state-

level fiscal and administrative policies and policies implemented within managed care. A common element found in these states was significant leadership within aging and long-term care departments or agencies; these leaders articulated and documented the benefits of evolving from traditional accounting practices and made changes happen within state administrations.

The purpose of this study was to understand the potential for application of flexible account practices in California's system of LTSS. California currently ranks 15th in the nation in its LTSS system, tied with Arizona, according to a recent national report, *Raising Expectations*, which rated all states in terms of their system performance. In 2009, California spent 53.7% of Medicaid LTSS dollars for HCBS; the remainder was spent on institutional care. However, California's growth in HCBS has come largely without intentional policies to reduce nursing facility (NF) utilization. As in other states, the federal inclusion of nursing facilities as a required Medicaid service acts as a restraint on state efforts to reduce NF expenditures, whereas HCBS are optional services under a state's Medicaid State Plan. Without efforts to reduce institutional spending, growth in the state's HCBS represents growth in real LTSS system costs, which has created strains in the budgeting for HCBS.

This study finds that California has the ability, but not the policy intent, to transfer funds from the most costly to the most cost-effective programs. The state currently has limited methods for understanding and managing trade-offs and costs among LTSS programs. Based on the experiences and outcomes of other states, this report makes recommendations for relevant policies California could adopt. The recommendations are primarily policy changes that are not expensive to implement, but require a substantive and willing rethinking of how LTSS are managed and deliberate planning efforts to redesign their management. The recommendations center around the following themes as developed in the report:

- LTSS should be thought of as one single program that happens to be arbitrarily parceled out among Departments;
- The Health and Human Services Agency needs to improve its leadership capability for managing LTSS;
- The Health and Human Services Agency should be provided more budget authority to transfer funds among Departments;
- Budget practices need to use models that study the interrelationships among programs rather than treat program changes as lists of adjustments to a base budget;
- The state would fiscally benefit from stepped-up efforts to reduce institutional use;
- Managed care contracts need to have language in them that put managed care companies at risk for nursing facility utilization; and
- The state requires a LTSS data system that identifies who gets LTSS services, what their utilization is and what the cost is of the services.

Introduction

Understanding the financing of home- and community-based services (HCBS) is important to states because these services are preferred above nursing home placement by consumers of long-term services and supports (LTSS).¹ A generation of policy work on improving LTSS by state Medicaid agencies, the Centers for Medicare and Medicaid Services (CMS), program advocates and researchers has resulted in insight into the conditions that contribute to effective, high quality HCBS programs.

These are conditions that contribute to such effective, high quality HCBS systems:²

- A belief that persons with physical, mental health, intellectual or developmental disabilities should be offered a choice of services in their home or community rather than being institutionalized;
- A single organizational unit in state government that plans, implements, and operates LTSS programs;
- A single budget with flexibility and authority to spend on varied LTSS based on an individual's needs;
- Services that respond to consumer needs and preferences;
- A single point of entry with a fast, timely and standardized method of assessing financial and functional eligibility and authorizing needed services that is tied to a data system with information about the persons and their utilization;
- A case management system with capacity to provide assistance and oversight for consumers;
- A fair rate setting and contracting process for providers;
- A process for assuring quality oversight throughout the system; and
- A well organized and sophisticated group of consumers, family members, and providers who advocate for the long-term care system.

The general term used to characterize the transformational shift from institutional to home- and community-based care is “rebalancing.” Rebalancing was at the core of the CMS

¹ For example, see <http://www.albanycounty.com/lrc/Newsroom/BuildingANewModelofAging.pdf> and <http://rcilinc.org/advocacy-2/5-reasons-kansas-shouldnt-cut-home-and-community-based-services> Fox-Grage, W., et al. (2006, September) Rebalancing: Ensuring Greater Access to Home- and Community-Based Services, American Association of Retired Persons, Public Policy Institute, Washington, D. C. Retrieved on 12-24-2011 from http://www.aarp.org/health/medicare-insurance/info-2006/fs132_hcbs.html

² It is hard to find a single publication that contains all elements of this list. A close approximation relevant to California is the testimony of Charles Reed, former Assistant Secretary of the Washington State Aging and Adult Services Administration in August of 2010 to the Little Hoover Commission. See Charles Reed, Consultant, Reed Associates; and Former Assistant Secretary, Washington State Aging and Adult Services Administration. August 26, 2010. Testimony to the Little Hoover Commission. Retrieved on 12-24-2011 from <http://www.lhc.ca.gov/studies/agendas/Aug10.html>

innovations in its New Freedom Initiatives program.³ For almost a decade, rebalancing was simply measured by the proportion of a state's LTSS that was spent on institutions vs. the proportion that was spent on HCBS. In 2011, the *Raising Expectations* report, a state scorecard on LTSS produced by the AARP Public Policy Institute, reframed discussions of rebalancing in a more sophisticated way.⁴ The *Raising Expectations* report, colloquially referred to as the *Scorecard*, describes how well states have managed to transform their programs, measures states on 24 indicators organized into four key dimensions, and shows the sophistication that the measurement of effective programs has developed.

Instead of focusing on a single dimension called rebalancing as measured by the % of LTSS paid for in the community, the *Scorecard* examines state performance across four dimensions of LTSS system performance: (1) affordability and access; (2) choice of setting and provider; (3) quality of life and quality of care; and (4) support for family caregivers. The indicators used to measure the concept of rebalancing are now included as indicators in the dimension of "choice of setting and provider." One indicator that was not studied was the degree to which states used flexible accounting to control the flow of funds used to pay for LTSS.

Global Budgeting vs. Flexible Accounting

The use of a single budget has been traditionally referred to as "global budgeting."⁵ In its recent LTSS report, California's Little Hoover Commission included global budgeting in its recommendations for improving LTSS in California and discussed global budgeting at length.⁶

The phrase "global budgeting" has multiple meanings including the use of a statewide cap on Medicaid spending as in Rhode Island's Global Waiver, and the use of "bundled" payments. Given the current multiple meanings of the concept, the authors of this study have decided to reframe the concept in the context of LTSS and call it "flexible accounting" rather than global budgeting. Flexible accounting is conceived to be a broader concept than global budgeting

³ The New Freedom Initiative (NFI) was announced by President George Bush on February 1, 2001 and followed up by Executive Order 13217 on June 18, 2001. Congress supported this major policy change by authorizing the Real Choice System Change program which between 2007 and its inception in FY2001, awarded 314 grants totaling over \$280 million to all fifty States, the District of Columbia, and two territories. For example, 31 "Money Follows the Person" grant awards issued by CMS in 2007. CMS has also sponsored Direct Service Worker grants, Medicaid Infrastructure grants, the Independence Plus program, the Demonstration to Maintain Independence in Employment, and cooperated with the Administration on Aging (AoA) to develop scores of Aging and Disability Resource Centers (ADRCs).

⁴ Reinhard, S., Kassner, E., Houser, A., & Mollica, R., (2011, September), *Raising Expectations: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers*. A report prepared by AARP, The Commonwealth Fund, and The SCAN Foundation, Washington D.C. and New York. Retrieved on 12-24-2011 from <http://www.longtermscorecard.org/>.

⁵ Hendrickson, L. and Reinhard, S. (2004) *Global Budgeting: Promoting Flexible Funding to Support Long-Term Care Choice*. New Brunswick, NJ: Rutgers Center for State Health Policy, Rutgers University, Retrieved on 12-24 -2011 from <http://www.cshp.rutgers.edu/Downloads/4710.pdf>

⁶ Little Hoover Commission, *ibid*, p. 67

including not only the consolidation of LTSS budget accounts in a single budget, but also any accounting or budgeting practice that permits the flexible transfer of funds from one account to another, and any contractual language in managed care contracts that incentivize managed care plans to emphasize HCBS rather than institutional use.

The importance of flexible accounting in discussions of LTSS is that flexible accounting is one solution to the question of “how do you pay for it?” How do you pay for the HCBS services for consumers needing LTSS? In a Medicaid context, one way of paying for the expansion of HCBS services is to reduce institutional use and take the savings from the reduced institutional utilization and use them to expand HCBS. An expansion of the HCBS services will then provide opportunities to divert persons from using institutions, or provide services to help persons leave nursing homes. To accomplish an expansion of HCBS services, institutional savings must first be recognized and transferred to grow the HCBS programs preferred by consumers of LTSS.

To reduce nursing facility (NF) expenditures, 60% of states cut the rates paid to nursing homes or eliminated inflation adjustments in 2011.⁷ While this is an effective short-term answer to controlling institutional expenditures, it fails to impact the demand for nursing home beds. A more effective long-range control is to reduce nursing home demand and use the savings to increase the supply of less expensive alternatives. This is recognized at the federal level in the CMS Money Follows the Person program, which seeks to build HCBS capacity at the expense of nursing home utilization.

Flexible accounting is not about the one-time transfer of funds. Rather, it is the creation of a multi-year process that takes savings from the reduction of institutional use to grow HCBS alternatives to institutional use, which further reduce institutional use. This cycle is repeated over multiple years leading to a permanent reduction in nursing home demand.

Significant financial sums are involved for states that find ways to transfer the savings from institutional to HCBS accounts. For example, the Legislative Budget Board of the State of Texas conducted a 2009 study of the cost savings of its HCBS services and found that they saved the state \$2.6 billion over the period 1999-2007.⁸

Flexible accounting is necessary for efficient state program operation because experience has shown that there are situations where the expansion of lower cost programs can reduce

⁷ “A total of 30 states restricted rates for nursing homes in FY 2011 (24 rate freezes and 6 cuts) and 31 states planned restrictions for FY 2012 (17 states plan to freeze rates and 14 states planned rate cuts). Smith, V. et al. (2011, October), *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012*. A Report Prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. Retrieved on 12-24-2011 from <http://www.kff.org/medicaid/8248.cfm> p. 31

⁸ Legislative Budget Board, (2009, January), *Texas State Government Effectiveness and Efficiency: Selected Issues and Recommendations*, Austin, TX pp. 223-228. The Budget Board took into account that not all persons on waivers would in fact go into nursing homes and based its savings on the analysis that 16 percent of clients with mental retardation or related conditions and 55 percent of aged and disabled clients could have been served in institutional settings.

expenditures in higher cost programs. These situations include the expansion of health homes in primary care practices that reduce hospital inpatient and emergency room use, the provision of mental health and substance abuse services that reduce acute care and state mental health hospital expenditures such as community crisis stabilization beds, and the use of HCBS to reduce institutional expenditures in nursing homes and intermediate care facilities for persons with intellectual and developmental disabilities.⁹

Simply using flexible accounting strategies does not by itself guarantee a state can rebalance its programs. Successfully rebalancing Medicaid programs to emphasize non-institutional services is a complex, multi-year effort and requires a multiplicity of events, such as having a vision or clear policy intent, competent administration to plan and administer changes, and the availability of HCBS and payment practices that encourage community programs. What flexible accounting can achieve is to use lower-cost services to reduce reliance on institutional costs without increasing general fund expense to the state. In other words, flexible accounting is a solution to the question of “how do you pay for it” when trying to implement system improvements.

Medicaid Managed LTSS and Flexible Accounting

The growth of managed care in state Medicaid programs has expanded beyond the use of managed care for health programs for women and children and now encompasses large numbers of the aged and persons with disabilities. Approximately 71% of all Medicaid-eligible persons nationally are in some form of managed care, either a comprehensive managed care plan, a primary care case manager, or a limited benefit plan covering mental health, or substance abuse, or transportation or dental services.¹⁰ Furthermore, CMS has funded 15 states to develop plans for transferring the services of persons who are dually eligible for Medicaid and Medicare, colloquially referred to as “duals” or “dual eligibles” from fee-for-

⁹ This savings emphasis on the reduction in acute care institutional costs is found throughout current Medicare initiatives. For examples, see the expansive Medicare programs implementing the Affordable Health Care Act such as the Medicare Shared Savings Program (MSSP). See the MSSP final rules retrieved on 12-24-2011, from <https://www.cms.gov/sharedsavingsprogram/>. E.g. see also the Pioneer ACOs and the Community Care Transitions Program. See also Meyer, H. (2011, March) A New Care Paradigm Slashes Hospital Use and Nursing Home Stays for the Elderly and the Physically and Mentally Disabled, *Health Affairs*, 30, no.3:412-415. For a California discussion of these cost tradeoffs, see Mollica, R. & Hendrickson, L. (2009, November), Home- and Community-Based Long-Term Care: Recommendations to Improve Access for Californians, A Report prepared for California Community Choices, California Health and Human Services Agency, Sacramento, CA. pp. 149-160. Retrieved on 1-15-2012 from http://www.hcbs.org/files/162/8057/FINANCE_REPORT_FINAL.pdf

¹⁰ For documentation of the 71%, see Medicaid and CHIP Payment and Access Commission (MACPAC) (2011, June), *The Evolution of Managed Care in Medicaid*, Washington, D.C. retrieved on 10-3-2011 from <http://www.macpac.gov/reports>. See also, Iglehart, J. (2011, September), *Desperately Seeking Savings: States Shift More Medicaid Enrollees to Managed Care*, *Health Affairs*, 30, no.9: 1627-1629. Not available on line except through purchase. See, retrieved on 3-2-2011, <http://content.healthaffairs.org/content/30/9/1627.abstract?rss=1>.

service to managed care in order to integrate acute, primary, behavioral, and long-term care services.¹¹

In a managed care environment that integrates medical care and supportive services, flexible accounting acquires new meanings since funds for institutional and HCBS programs are already comingled when transferred as capitation rates to a managed care entity. The question becomes, what can a state Medicaid unit do in a managed care environment to ensure that rebalancing continues to be pursued and that HCBS are used instead of more costly institutional services? What does “rebalancing” mean when HCBS are a rate cell in a per member per month (PMPM) capitation payment?

This report first considers the experience of other states in developing flexible accounting procedures and contracting language, then discusses California’s procedures and makes recommendations for improving California capability to use flexible accounting.

Flexible Accounting in Twelve States

This report first looks at selected states with flexible accounting practices and examines how related policies have been realized in these states. The states selected for review were: Louisiana, Massachusetts, Michigan, Pennsylvania, New Jersey, Texas, Washington, and Wisconsin.¹² In addition, to reflect the changes that are occurring as states rapidly shift to managed care programs, we included a review of states with high Medicaid managed care penetration in order to examine strategies they use to reduce utilization of institutional services and emphasize HCBS through managed care policies. Those states selected are: Arizona, Hawaii, and Tennessee – all states that have almost all Medicaid-eligible persons in managed care programs – as well as Minnesota, which has a rich managed care history and has about two-thirds of its Medicaid enrollees in comprehensive risk-based managed care programs.

The identification of states that use flexible accounting was aided by the authors’ previous work and general knowledge of state LTSS programs; however, two formal search procedures were also done. First, the operational protocols submitted by 30 states to the CMS Money Follows the Person Demonstration Program (MFP) were examined. An explicit purpose of the MFP program is to “Eliminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-

¹¹ Kaiser Commission on Medicaid and the Uninsured, (2011, August), *Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS*, Washington, D.C. Retrieved on 11-3-2011 from <http://www.kff.org/medicaid/upload/8215.pdf> See also <http://www.integratedcareresourcecenter.com/>

¹² The authors chose not to study Oregon because it has been so well studied before. However, it has had consolidated administrative and budgeting for LTSS since the early 1980s.

term services in the settings of their choice.”¹³ Since one of the four stated purposes of the Federal MFP program considered the flexibility of state budgeting, we evaluated the states’ responses to see if flexibility issues were addressed.

The second step in the identification of which states had flexible accounting practices was to review current literature. One recent study by AARP was found that had a table showing which states had some accounting flexibility to transfer funds among LTSS.¹⁴

This search pattern identified 14 states that were said to have used or considered flexible accounting in their LTSS. The authors selected eight states to further research based on where flexible accounting appeared to be clearly used in a systematic way. The review of the states is primarily based on interviews with Medicaid and budget staffs in these states.¹⁵

In addition to these eight states, the authors selected four additional states with experience in operating Medicaid managed care plans. Three states were selected because they have the highest percent of Medicaid enrollees in comprehensive risk-based managed care: Hawaii (97%), Tennessee (94%), and Arizona (90%).¹⁶ Minnesota was also selected because it has a long managed care history, was the highest ranking state on the *Scorecard*, and had 63% of its Medicaid population in a comprehensive risk-based managed care plan.¹⁷

A look at how states with Medicaid LTSS managed care plans structure their LTSS is illuminating. These states are different from other states with managed care programs in that all four have put managed care plans at risk by including NF care as part of the benefit package and have not “carved” it out or do not “pass through” the NF payment. In a “carve out” or “pass through” arrangement, persons are disenrolled from the managed care plan when the person enters a NF and the facility receives a fee-for-service payment for the person.¹⁸ Mirroring state-level

¹³ The grant application is available at, retrieved on 12-24-2011 from <http://www.grants.gov/search/search.do?mode=VIEW&oppld=56091> see p. 5, and p. 8

¹⁴ AARP Public Policy Institute, (2011, January), *Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports*, American Association of Retired Persons, Washington, D.C. Retrieved on 11-3-2011 from <http://www.aarp.org/health/health-care-reform/info-10-2010/health-panel-10201.html> See Table 1 for information on current state flexible accounting practices.

¹⁵ The exception is Arizona, a state whose managed care program is well documented. Arizona information was derived from literature, rather than an interview with state budget staffs. Calls were first made to the Money Follows the Person project directors and then interviews were either held with them or with other state staff that the authors were referred to. There is no one position title to that has information about how a state uses flexible accounting. We ended up talking with four persons who directed Aging and/or LTSS Services, one deputy budget director, a director of strategic planning and two senior policy persons in aging services in addition to MFP directors. In states with managed care program, interviews were also held with contract officers responsible for the managed care contracts.

¹⁶ Medicaid and CHIP Payment and Access Commission (MACPAC). (2011, June), *The Evolution of Managed Care in Medicaid*. Washington, D.C., 2011. Retrieved on 12-24-2011 from <http://www.macpac.gov/reports> p. 13

¹⁷ Ibid. Medicaid and CHIP Payment and Access Commission (MACPAC), Table 9

¹⁸ There appear to be no readily available data describing the degree to which nursing home and LTSS are “carved out” of managed care contracts in state Medicaid programs such as they are in California. However, the work of CMS and its State Demonstrations to Integrate Care for Dual Eligible Individuals Project will invoke substantial

policies that create incentives to use cost-effective HCBS instead of more expensive and less desirable NF services, these managed care programs have intentional policies to incentivize HCBS.¹⁹

Data on the results of interviewing staffs in these states show there is no one best way of achieving flexible accounting. The ability to transfer funds between large and complex program areas is historically developed over time and depends on the ability of influential administrators to obtain cooperation and agreement from program, budget and legislative staffs. At the state level, different approaches can be employed to achieve flexible accounting. For example, placing all LTSS funds in one department, in one account, gives a single department the authority to shift funds across programs as necessary. Another option, albeit more complicated, involves shifting funds across multiple departments operating multiple LTSS programs, with authority granted by a control agency.

Three main topics emerged from our interviews:

A. State Leadership

Interviews with officials in study states revealed the key role of leadership. It was evident from the interviews that all of the states with intentional fiscal policies to emphasize HCBS had influential leaders who understood the impact of HCBS spending on costs for other LTSS. State staffs interviewed specifically identified individuals by name that were credited with creating more flexible accounting practices.²⁰

B. State-level Fiscal and Administrative Policies

The following state-level and administrative policies were identified:

- NF and HCBS funds are combined into a single budget account;
- State statutes are passed that specify the circumstances under which NF funds can be shifted to HCBS accounts;
- Administrative rules are promulgated that specify the circumstances under which NF funds can be shifted to HCBS accounts;

managed care innovations in the care of persons who are dually eligible for Medicare and Medicaid. See, retrieved on 12-24-2011 <http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/>

¹⁹ For similar practices in Massachusetts's managed care programs, see Summer, L. (2011, October), *Examining Medicaid Managed Long-Term Services and Support Programs: Key Issues to Consider*, An issue brief prepared for the Kaiser Commission on Medicaid and the Uninsured, Washington, D.C. See p 16. Also see pages 6 reference to New Mexico coLTs program and Table 1 on page 7. Retrieved on 1-15-2012 from <http://www.kff.org/medicaid/8243.cfm>

²⁰ For an emphasis on leadership in the context of California long-term service and supports programs see, The Little Hoover Commission, (2010, April), *A Long-Term Strategy for Long-Term Care*, Report #205, Sacramento, CA. Retrieved on 12-14-2011 from <http://www.lhc.ca.gov/studies/205/report205.html>

- Administrative consolidation, whereby one administrative unit has responsibility for all LTSS, or all persons with certain characteristics such as those 65 years of age;
- Specialized units that span multiple departments are used such as a caseload forecasting council;
- One administrator maintains responsibility for multiple offices spanning two departments, and
- HCBS is conceptualized to be an entitlement if a person is already in a NF.

C. Policies Implemented within Medicaid LTSS Managed Care

State-level fiscal and administrative policies developed primarily in the fee-for-service environment are relevant in systems that incorporate elements of both fee-for-service and managed care. Policies that control the utilization of NF services and encourage HCBS within managed LTSS systems are also important and are becoming more so as many states develop plans for integrating medical and supportive services for dual eligibles and shift their systems toward managed LTSS. Policies developed to promote HCBS services in a fee-for-service environment find parallels in a managed care environment: nursing home diversion projects, nursing home transition projects, timely assessment, timely development of care plans, and care coordination.

The following managed care policies were identified:

- Performance requirements about HCBS use including the timely completion of assessments, the timely completion of care plans, and the timely commencement of services;
- The use of a blended rate that puts the managed care plan at risk if NF utilization exceeds the historical experience used to set the rate;
- The use of a blended rate that contains savings for the plan if current year NF utilization is lower than the historical experience used to set the rate;
- A drop in the rate received by the managed care plan if a person enters a NF;
- Contractual requirements to put on a NF transition project e.g. reproducing an MFP program in the context of managed care;
- The use of a higher per member per month (PMPM) rate for persons needing HCBS services;
- Contractual requirements for care coordination, and
- Contractual requirements to put on a NF diversion program by working with hospitals.

Summary Points about States Studied

Figure 1: Examples of Key State Leadership

State	Leadership Accomplishment
WA	A strong Washington state long-term care official successfully argued that to level the playing field between NF and HCBS, HCBS should be forecast “as if” they are an entitlement. This policy became a foundational principle of the state’s high-performing LTSS system.
MI	A small group of Michigan state officials became proponents of expanding NF transitions and using a "Money Follows the Person" budget strategy. They worked closely within the administration and with the state Budget Office to create broad support for this funding approach. This policy was most recently reauthorized by the legislature in the department's budget bill in 2011 with the expectation that anyone who wishes to transition from a NF to HCBS have access to the necessary supports and services.
TX	Leadership in Texas developed the original Money Follows the Person (MFP) approach of transferring funding from the NF line to the HCBS line to enable persons to transition to community settings. This leadership has been maintained since the program’s inception and has provided policy continuity, allowing the state to continue to develop and maintain successful MFP flexible budgeting approaches through several policy iterations. Texas has transferred more than 25,000 people from NFs by means of these policies.
TN	Strong leadership by an Assistant Commissioner emphasized attentiveness to stakeholder input and drove the state’s vision toward innovation and far-reaching reforms within the development of the CHOICES managed LTSS program. Tennessee is gaining an average of 1% of rebalancing <i>every month</i> by means of this program.
LA	Leadership in the Louisiana LTSS system comes from current state officials who were advocates in the system and have moved into state government, bringing a change in culture and an emphasis in developing best practices in LTSS.
NJ	New Jersey had strong leadership from a Commissioner and Deputy Commissioner of the Health Department that consolidated all LTSS. Legislative and Departmental leadership created the state’s global budget for long-term care and the forecasting methodology to manage the programs in one cost analysis.

Figure 2: State-Level Fiscal and Administrative Policies

Mechanism	Description	Used By
Consolidated Caseload Forecasting	The Washington State Caseload Commission conducts monthly forecasts of all LTSS programs, including NF and HCBS, which are accepted by the legislature as the legitimate basis for the budget appropriation for LTSS. The Council’s deliberations can take into account the impact of lowering or raising the caseload of one program on other programs and funding can be set accordingly	WA
Consolidated LTSS Administration	Consolidated department or agency responsible for the administration and fiscal management of LTSS programs. WA and PA have full consolidation of the state LTSS system; MA consolidates administration for all services for those over 65 (including seniors with any type of disability). TX consolidated 12 health and human services Commissions and Departments into 5 Departments agencies and created an umbrella agency to oversee the five. Consolidation increases administrative flexibility to transfer funds and grow or stunt programs.	WA PA MA TX
Risk Modeling Across Programs	WA has a sophisticated risk modeling system across programs that helps the state understand the cost drivers in the system and how spending in one program affects costs in another in order to make the most cost-effective investments. This is a budgeting device that takes into account the impact of programs on one another.	WA
Single Appropriation and Account for NF and HCBS	Both institutional and HCBS services are appropriated in a single account and funds may be used flexibly as called for. TN and LA have a single large appropriation that can be used flexibly without restriction. WI appropriates NF and its managed Family Care program that provides HCBS as one single appropriation, allowing seamless transfers between them. MA has a single Senior Care Account that incorporates both NF and HCBS for everyone over age 65.	TN LA WI MA
Ability to Transfer Funds from NF Line to HCBS Line	Authority to transfer funds between the NF line and the HCBS line. MI has used this practice for years; it was most recently formalized in Section 1689 of the state’s 2011 appropriations bill. PA had one consolidated account for three programs (aging waivers, PACE program and NF accounts) with flexibility to transfer between them as needed (this policy has now been changed). TX began its Money Follows the Person policy with Rider 37, transferring funds quarterly based on individual transitions. Now TX uses a dedicated budget line item for HCBS services under MFP and if funding is insufficient in the HCBS line, funds are transferred from the NF line.	MI PA TX
Entitlement for HCBS	WA forecasts HCBS “as if” they are an entitlement for everyone in the LTSS system. TX provides access to HCBS through MFP as an entitlement, and if the dedicated budget line item has been exhausted, it then transfers funds from the NF line to cover the entitlement.	WA TX

Figure 2: State-Level Fiscal and Administrative Policies

Mechanism	Description	Used By
Transition Allowance	Although specific numbers are unknown, it is likely that all states that have a nursing home transition program (approximately 40) use a transition allowance to help a person leave a NF. Such transition assistance is useful in lowering NF utilization. In the authors' point of view, states should use such allowances regardless of what kind of MFP program a state has or does not have. Transition allowances should not be limited to persons in a state MFP program.	
Global Budget Line Item	The NJ global budgeting initiative, as passed by the Legislature in 2008, called for a single budget model for all LTSS, and required that a budget and management plan be periodically submitted to the Governor and legislature, documenting the reallocation of funds to HCBS from NF. For State fiscal years 2008 through 2013, the 2008 Act calls for funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care (state dollars only), plus the percentage anticipated for programs and persons eligible for federal matching dollars, to be reallocated to HCBS.	NJ
One Administrator	PA developed an outstanding LTSS program. One policy it used was to have one administrator supervise multiple offices in two different Departments.	PA

Figure 3: Policies Implemented within Medicaid Managed Care

Mechanism	Description	Used By
Managed Care Organization (MCO) Responsible for Both NF and HCBS Under Blended Capitation Rate with Full Risk and Full Profit	The principal mechanism for discouraging utilization of NF and encouraging the utilization of HCBS is that the MCO is at full risk for costs, and also may keep savings it creates by serving members with more cost-effective HCBS. MN and TN use this mechanism. This may also be the method utilized by NJ under its new comprehensive 1115 managed care waiver. WI uses this mechanism in its Medicaid managed LTSS Family Care program. A "blended" rate is used wherein the capitation rate the plan receives contains funds for both HCBS and NFs based on historical utilization.	MN TN NJ WI

Figure 3: Policies Implemented within Medicaid Managed Care

Mechanism	Description	Used By
MCO Responsible for Both NF and HCBS Under Blended Capitation Rate with Risk and Profit Sharing with State	Under these mechanisms, MCOs are responsible for both NF and HCBS, and there are different formulas for how much risk the plans have and how much profit they may keep as a result of better management of NF utilization. See state descriptions for details about each state’s risk and profit-sharing approach.	HI AZ TN
HCBS Available as an Entitlement (Enrollment Not Capped) for NF Level	Although enrollment in HCBS is capped in these managed systems, the caps do not apply to any person who is leaving a NF or meets NF level of care; those persons may receive HCBS despite the cap. In TN, persons transitioning from a NF to the community are exempt from the waiver enrollment caps. In WI, enrollment in the Family Care program to receive HCBS is not capped for anyone leaving a NF. The TX STAR+PLUS managed program is even broader – if a person’s income is below SSI, HCBS are an entitlement if they are coming in from the community; MFP is available for those in a NF.	TN WI TX
Higher Rate for HCBS Services	MN provides a case-mix adjusted PMPM rate for individuals who meet the eligibility criteria for HCBS which is higher than the PMPM used with the non-HCBS eligible population.	MN
Transition Allowance Benefit	At the discretion of the managed care plan, TN allows plan members transitioning from a NF to access a one-time allowance of \$2,000 for expenses to set up a household.	TN
Requiring Plans to Work with Consumers who Want to Transition	MN expects plans to work with consumers to transition to the setting of their choice. HI requires plans to put on their own Money Follows the Person transition program. WI’s Medicaid managed LTSS Family Care program is required to assist consumers with services to ensure they can live where they prefer. TN MCOs may transition eligible members from a NF to the community through either the CHOICES managed care program or through the statewide MFP demonstration project. TX has a state-run MFP program outside of managed care, and the operation of this program is coordinated with STAR+PLUS plans. Texas also requires its STAR+PLUS managed care plan to provide transition assistance through what are called STAR+PLUS Support Units (SPSU) that are responsible for helping persons transitioning from nursing homes. For example plans are obligated to assist the NF applicant/member who wants to return to the community by providing information and referrals to possible resources in the community. Individuals who leave a nursing home can be eligible for STAR+PLUS waiver services.	MN HI WI TN TX

Figure 3: Policies Implemented within Medicaid Managed Care

Mechanism	Description	Used By
Performance Measure Requiring Service Timelines for Sentinel Events	TN has strict performance measures with associated liquidated damage penalties for missing service timeline requirements for sentinel events, such as enrollment in HCBS, assessment, service planning and commencement of services. AZ has similar performance measures to reinforce timelines for service delivery. TX requires STAR+PLUS plans to develop a long-term services plan within 30 days for new enrollees.	TN AZ TX
Performance Measure with Penalty for NF Utilization	TX introduces some risk to their program through a performance measure that requires plans to pay a penalty when a person enters a NF. TX also requires the plan to pay 4 months of NF costs.	TX

States Studied and Scorecard Rankings

Figure 4 below shows how the twelve states studied ranked in the *Scorecard* with the overall ranking of the states as well as their ranking on each of the four dimensions that comprise the overall ranking. Across all four dimensions the 12 states scored best, on average, on the dimension measuring Choice of Setting and Provider. A look at the measurement indicators used in the *Scorecard* shows that the Choice of Setting and Provider contains seven measurement indicators. Four of these indicators directly measure the use of HCBS in the state. These indicators are:

- The proportion of Medicaid LTSS spending that pays for HCBS;
- The proportion of new Medicaid LTSS beneficiaries who receive HCBS;
- The number of assisted living and residential care units per 1,000 population age 65 plus; and
- The proportion of long-stay nursing home residents who have low care needs.

It is reasonable to find that these 12 states do better on indicators that directly measure how well states are “rebalancing” their LTSS programs because of their commitment to flexible accounting.²¹ Again, simply using flexible accounting strategies per se does not by itself guarantee a state will rebalance its programs. Successfully rebalancing Medicaid programs to emphasize non-institutional services is complex and requires a multiplicity of events such as having a vision or clear policy intent, competent administration to plan and administer changes, the availability of HCBS, payment practices that encourage community programs, and a multi-year effort to rebalance.

²¹ For example, compare the overall scores vs. scores on the Choice of Setting and Provider for Arizona, New Jersey, Texas, Massachusetts, and Louisiana.

Figure 4: States Studied and Their Scorecard Rankings by Dimension

State	Overall Ranking	Affordability and Access	Choice of Setting and Provider (Indicator of Rebalancing)	Quality of Life and Quality of Care	Support for Family Caregivers
Minnesota	1	4	3	4	4
Washington	2	6	2	18	2
Hawaii	4	14	20	3	10
Wisconsin	5	16	11	9	17
Arizona	15	39	18	26	3
New Jersey	22	10	34	28	21
Texas	28	20	19	42	19
Massachusetts	30	17	14	34	39
Michigan	31	37	15	21	33
Pennsylvania	39	47	12	22	46
Louisiana	43	18	46	46	36
Tennessee	45	42	47	48	26

Flexible Accounting in California’s Budgeting Practices for Long-term Services and Supports

According to the *LTSS Scorecard*, California’s LTSS system performance ranks at 15th in the nation, tied with Arizona. This ranking is due in large part to the state’s performance in the domains of affordability and access as well as choice of setting and provider. California spends 53.7% of Medicaid LTSS funding on HCBS, which places it sixth in the nation on the *Scorecard’s* rankings, which is due in large part to the In-Home Supportive Services (IHSS) program. Much of California’s HCBS expenditures are in the state’s In-Home Supportive Services (IHSS) program: the Governor’s budget for 2012-13 proposes spending \$1.4 billion in state general fund revenue, contributing to California having the nation’s largest personal care services program.²² The strength of the IHSS program and the savings it generates because of institutional costs that are avoided are an established feature of California’s LTSS system.

In theory, a good way of studying flexible accounting in California would be to identify all accounts and expenditures associated with LTSS and inquire about what transfer mechanisms and authorities are necessary to transfer funds in and out of the each account. However, this is

²² See the Governor’s Budget Summary for 2012-2013. Retrieved on 1-13-2012, from <http://www.ebudget.ca.gov/pdf/BudgetSummary/FullBudgetSummary.pdf>, p. 120.

impractical given the administrative organization of LTSS services in the state. The last study that documented each LTSS program in California was done in 2006 by the Legislative Analyst's Office (LAO).²³ As shown in Appendix C, the 2006 LAO study found 32 programs in eight Departments. In 2006, these eight departments were:

- Aging
- Developmental Services
- Health Care Services
- Mental Health
- Public Health
- Rehabilitation
- Social Services
- Veterans Affairs

Collectively, in 2006, public agencies in California spent approximately \$13.8 billion dollars in state, federal and local funds on these 32 programs. Conducting interviews with all departments with LTSS programs has the dual difficulty of identifying who to talk with about multiple programs and gaining their cooperation in releasing budget-related information. In an era when state programs are continually cut and providers and advocates have initiated numerous lawsuits, these barriers make a "count the caseload and dollars" approach to a study of flexible accounting difficult. Staffs are willing to be interviewed, but obtaining meaningful quantitative information is difficult if the information is not already published. The difficulty is demonstrated by the fact that the LAO has not repeated its study since 2006.²⁴

In lieu of a more quantitative approach to studying the amount of current budget flexibility in California, the authors reviewed budget documents, interviewed staffs, and prepared a summary of what emerged from the review of budget documents and interviews.²⁵

What the authors found was that a review of California budget documents is also not a practicable way of studying flexible accounting in LTSS. The Governor's Budget pages contain summaries of issues and high-level department budget amounts.²⁶ In May and November of each year, the departments publish what are called "Estimates". These are more helpful

²³ See Legislative Analyst's Office, (2006, February), *Improving Long-Term Care*, A section in the Analysis of the 2006-07 Budget Bill, Sacramento, CA. pages C-17 ff. Retrieved on 11-3-2011 from http://www.lao.ca.gov/analysis_2006/health_ss/healthss_anl06.pdf#page=17

²⁴ When interviewed, LAO staff said they have had requests to repeat the 2006 study, but that there are real difficulties in obtaining caseloads and costs on thirty programs from multiple departments.

²⁵ 13 staffs from California agencies were interviewed, including the California Health and Human Services Agency and the Departments of Finance, Aging, Veterans Affairs, and Health Care Services, as well as the Senate Office of Research and the Legislative Analyst's Office. The main questions asked were about budget flexibility and how funds were currently transferred. Who could transfer what?

²⁶ For example, the Governor's 2012 Enacted Budget for the Health and Human Services Agency. See retrieved on 11-3-2011 from <http://www.ebudget.ca.gov/pdf/Enacted/BudgetSummary/HealthandHumanServices.pdf>

documents because they include more detailed information.²⁷ But while the Estimates are excellent in describing what policy changes are affecting the base budget, only high-level program information is presented on the base budget itself. It is hard to use these reports to identify program caseloads and what is being spent on specific LTSS.

The California budgeting documents do contain extensive information on the sources of funding. The legislature allocates appropriations by funds.²⁸ Detailed information by Department by fund, including fund transfers, is presented in numerous budget documents.²⁹ However, what is missing from all budget documents is information showing specific programs, what their caseloads and expenditures are and how they have changed in recent years. In other words, the budget documents work well for accountants who track what account the legislature appropriated money to and what transfers were made among accounts. However, if you wish to understand expenditures and how many persons received what services, then, except for the analysis of specific policy changes that affect the base budget, the budget documents are not especially useful.³⁰

What emerges from the interviews and review of documents is a picture of considerable flexibility at the department level and less flexibility if transfers involve shifts of funds across departments.

Departments have the authority to transfer funds within their programs to the extent that the Budget Act does not identify specific elements in the program. For example, the proposed budget for the Department of Health Care Services (DHCS), the state's Medicaid agency, contained approximately \$42.5 billion dollars for FY 2011-2012. The majority of this money was contained in "program element" code 20.10 Medical Care Services (Medi-Cal). DHCS has the authority to transfer funds within account 20.10 to the extent that the Budget Act does not specify how they shall be spent.

DHCS also has a program element code 20.25, Children's Medical Services. A transfer between 20.10 and 20.25 would require permission from the Department of Finance. In this case, DHCS cannot transfer funds without approval because the specific program elements are identified in the Budget Act. For many departments, the Budget Act only identifies expenditures at the program level and does not drill down to the more detailed levels. For these departments, funds can be moved around within a program without approval. But although this description is

²⁷ For example, policy changes are analyzed in detail and the budget assumptions by program are published. For example see, retrieved on 11-3-2011 from http://www.dhcs.ca.gov/dataandstats/reports/mceestimates/Documents/2011_May_Estimate/M11_Assumptions_Tab.pdf

²⁸ For example, see, retrieved on 11-3-2011 from http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_0051-0100/sb_87_bill_20110630_chaptered.pdf

²⁹ For example see, retrieved on 11-3-2011 from <http://www.ebudget.ca.gov/pdf/GovernorsBudget/4000/4260RWA.pdf>

³⁰ The Department of Aging has "program narratives" which provide some information. See, retrieved on 11-3-2011 from http://www.aging.ca.gov/stats/facts_and_program_narratives_2011.asp

accurate in a general sense, there are restrictions on transfer of capital outlay and limits on amounts that can be transferred, as well as circumstances under which legislative review occurs.³¹

The California Health and Human Services Agency has the administrative authority over the large human services departments. However, the Agency does not have the authority to transfer funds across departments. This authority is exercised by the Department of Finance. As seen in the examples of other states, another type of flexibility is created when states use administrative functions for activities that span programs. In California, there are apparently no administrative bodies that meet regularly to coordinate activities of related programs in different departments. There do not appear to be routine budgeting discussions across the eight departments on how changes in one LTSS services will impact changes in other services. In other words, there is no coordinated budgeting across related programs. Administrative units in smaller departments do not have the authority or staff to coordinate budgeting and caseload projections across larger departments, and fiscal staffs in the larger departments perceive they are tasked with extensive responsibilities already.³² The result appears to be that in California there is no equivalent of the Washington Caseload Forecast Council or the Pennsylvania practice of combining related programs under an administration that reports to one department.³³

Rather than analyzing groups of similar programs together, California has a budgeting tradition of analyzing, department by department, discrete specific policy changes, hundreds of them a year, and projecting their fiscal impact on the department's base budget. California human services budgeting practices do not appear to study groups of interrelated programs. For example, when budget staffs propose budget cuts to LTSS programs, they typically assume that all money spent on the program will be saved and they do not project the continued fiscal impact of increased utilization in other programs.³⁴ For example, what is the impact of changes in mental health programs on substance abuse treatment expenditures, acute and psychiatric hospital expenditures, case management programs, pharmaceutical expenditures, and emergency medical services and how do funds get efficiently transferred across departments and accounts to concretize these impacts?

These kinds of analyses can be done by health care organizations. For instance, in its response to the Request for Information related to the Dual Eligible Pilot Project, the Health Plan of San

³¹ A fuller description of transfer procedures is provided in Control Section 26 of the final 2011-2012 budget summary. See p. 760 ff. retrieved on 10-2-2011 from

http://www.documents.dgs.ca.gov/osp/GovernorsBudget/pdf/Governors_Budget_2011-2012.pdf

³² For example, the Fiscal staff in the Department of Health Care Services reviews approximately 300 policy changes a year.

³³ See the website of the Washington Council at, retrieved on 10-3-2011 from <http://www.cfc.wa.gov/>

³⁴ This is generally true with the exceptions that reductions in service to persons with developmental disabilities are usually accompanied by the recognition that expenditures of the Department of Developmental Services might increase, and sometimes an undocumented cost offset will be added to a savings estimate such as in the 2011 savings estimates of eliminating the Adult Day Health Care program.

Mateo wrote, “The proposed model will produce cost savings in areas beyond long term institutional care. For example, we anticipate reductions in hospital admissions and ER visits through appropriate care coordination, social services supports, care transitions planning, targeting of the highest risk consumers, and through enhanced clinical care in long term care facilities. Provision of appropriate coordinated care support to primary care physicians for their most complex patients will also help reduce costly inpatient admissions and ED visits.”³⁵ In contrast, the state lacks information about programs and costs, how they interact with one another and how this interaction can result in cost-savings and reduced utilization of institutional care. Such analysis does not appear to be done even episodically by California’s large human services departments.

Medicaid Managed Care in California

California’s current Medicaid managed care environment employs three managed care models covering 4.5 million Medi-Cal beneficiaries in 30 counties: the Two-Plan model, the Geographic Managed Care (GMC) model, and the County Operated Health Systems (COHS) model. In the 14 counties that use the two-plan model, the DHCS contracts with a “Local Initiative” which is a coalition of local government, community groups and health care providers and one or more private insurance plans. These health plans then compete for Medi-Cal enrollees.³⁶ In the two counties, Sacramento and San Diego, that use the GMC model, DHCS contracts with commercial plans and there is no cap on the total number of plans that could serve the population.³⁷ In the 14 counties that use the COHS model, DHCS contracts with a health plan created by the County Board of Supervisors with input from local government, health care providers, community groups, and beneficiaries. In COHS counties, all enrollees are in the same managed care plan and managed care enrollment is mandatory for all Medi-Cal recipients living in COHS counties, including persons dually eligible for Medicare and Medicaid.³⁸

Plans bear limited financial risk for enrolled individuals who are placed in long-term care institutions, such as nursing facilities. In Two-Plan and GMC counties, plans are not responsible for the costs of long-term institutional placement past the first month after the month of admission. Plans in these counties are actually required to *disenroll* beneficiaries who have been in an institution for more than one month after the month of admission. The COHS work by getting two kinds of rates. They get one rate for persons who are NF eligible, as defined by DHCS, and another rate for persons who are not NF eligible. The plans pay the nursing facilities

³⁵ See the June 1, 2011 application letter from the Health Plan of Sam Mateo (HPSM), retrieved on 12-24-2011 from <http://www.dhcs.ca.gov/provgovpart/Documents/Health%20Plan%20of%20San%20Mateo%20RFI.pdf>

³⁶ The Two-Plan model is in use in 14 counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.

³⁷ The GMC model is in use in Sacramento and San Diego counties.

³⁸ Medi-Cal beneficiaries are enrolled in six COHS health plans in 14 counties (Marin, Mendocino, Merced, Monterey, Napa, Orange, San Mateo, San Luis Obispo, Santa Barbara, Santa Cruz, Solano, Sonoma, Ventura, and Yolo. See the DHCS managed care website at <http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx> for more data on California’s managed care plans.

for NF stays. This is a “pass through” – that is, the nursing homes get the Medicaid fee-for-service rate. Because of this, plans do not incur a financial penalty when an individual is institutionalized under any of California’s three managed care models. There is little or no monetary incentive for the plans to provide enrollees with non-required services that will prevent institutionalization. Two California health plans, CalOptima in Orange County and the Health Plan of San Mateo, have adopted innovative approaches and provide additional services;³⁹ however, in general lacking the risk for institutional costs, California’s health plans have very little incentive to develop and provide HCBS to prevent institutionalization.

Concluding Comments

While California is unique in geography and size, the state can benefit from the experiences of other states, which have crafted intentional policies to incentivize HCBS and to reduce reliance on institutional services. State systems are moving rapidly in the direction of managed care, but the best practices of effective LTSS systems can be implemented and remain relevant in either a fee-for-service or a managed care environment. Fiscal strategies that enable states to have better information, management and control, and to achieve good outcomes still matter and create a more coherent and efficient program than random budget cuts, episodic lawsuits, and a budget system designed to benefit state accountants.

California and other states have the difficult task of managing popular programs with substantial demand for them in a time of shrinking resources. States are understandably looking to managed care practices to save money. The same strategies that state policy makers and advocates used for years to promote HCBS within Medicaid fee-for-service programs can also be used in a managed care context. The use of blended rates that put plans at risk for NF utilization, requirements for timely assessment and care planning, performance measures that discourage institutional use, priorities placed on helping persons leave institutions, and plan requirements for diversion and transition programs are mainly developed from fee-for-service experience.

Recommendations for California

The following recommendations are selected based on practices found in states that have implemented some form of flexible accounting. California policymakers can use these

³⁹ For a description of CalOptima see, retrieved on 12-24-2011 from <http://www.dhcs.ca.gov/provgovpart/Documents/CalOptima%20PowerPoint.pdf> see also the Health Plan of San Mateo’s comments on risk responsibility, retrieved on 12-24-2011 from <http://www.dhcs.ca.gov/provgovpart/Documents/Health%20Plan%20of%20San%20Mateo%20RFI.pdf>

recommendations to strengthen LTSS programs, both now and as the aging population grows in the future. The recommendations are primarily policy changes that are not expensive to implement, but do require a substantive and willing rethinking of how LTSS are managed and deliberate planning efforts to redesign their management.

For example, initiating risk modeling across all LTSS programs and services requires a better integration of existing data sources and establishing uniform reporting of assessment and expenditure data for both fee-for-service and managed care program. The CaMRI experience shows this can be a formidable task in California.⁴⁰ Other states have found solutions for these challenges. For example, Colorado uses a Statewide Data Analytics Contractor to support its accountable care organizations. In contrast, with exception of the one-time CaMRI project, California officials have made no efforts to even hire a contractor to integrate LTSS data, let alone integrate the State's Medicaid data with Medicare data.

However, there are positive and practical actions that California decision makers can take, specifically:

- 1) ***Develop a LTSS leadership position at the California Health and Human Services Agency***, with responsibility and focus at the agency level for all LTSS programs in California. The Little Hoover Commission has recommended this step, and the experience of other states has demonstrated the importance of leadership and deep understanding of LTSS within state government.⁴¹ When you have 32 programs that span eight departments, it is unrealistic to think that they can be managed at a departmental level especially when changes in one program ripple through to others in unforeseen ways.
- 2) ***Invest the California Health and Human Services Agency with authority to seamlessly transfer funds between LTSS accounts*** in order to move funds as individual's needs change and to invest in the most cost-effective and needed services. In addition to the developed capacity to analyze discrete policy changes, what is additionally needed are budgeting models that span multiple departments and programs and contain

⁴⁰ A 2011 report from The SCAN Foundation analyzes at length the complexities and obstacles of integrating data about California LTSS programs. Such integration needs to exist before this group of related programs can be managed effectively. The SCAN Foundation, (2011, November), *CaMRI -- Studying Recipients of Long-Term Care Services and Supports: A Case Study in Assembling Medicaid and Medicare Claims and Assessment Data in California*, Sacramento, CA. Retrieved on 12-24-2011 from http://www.thescanfoundation.org/sites/default/files/CaMRI_Data_Case_Study_Report.pdf

⁴¹ In April 2011, The Little Hoover Commission published a 143-page report that dissected the problems in the status of long-term services and supports programs in California. Among other recommendations, recommended the appointment of an "identifiable leader" at the Health and Human Services Agency who would be responsible for long-term services and supports. The Little Hoover Commission, (2011, April), *A Long-Term Strategy for Long-Term Care*, Sacramento, CA. see pp. 64 ff. Retrieved on 12-23-2011 from <http://www.lhc.ca.gov/studies/205/Report205.pdf> .

mechanisms to follow the flow of caseload across programs and transfer funds among programs.

- 3) ***Initiate Risk Modeling across all LTSS programs and services***, similar to Washington State's risk modeling system (see details, p. 36). This should be initiated both inside and outside managed care. A coordinated budget and model of LTSS will provide the state with data that will help policymakers understand the impacts of spending or spending reductions in one account on savings and costs to another account. Not only does California need a tool to understand the most cost-effective investments in LTSS, it also needs the tools to understand the risks of budget reductions. How many times does the State have to lose in Federal courts before it realizes it needs better tools to understand the programs it is attempting to cut? This function should be organizationally located within the California Health and Human Services Agency.
- 4) ***Continue strategic consolidations of LTSS programs***, begun in California this year with the consolidation of the Department of Mental Health and the Department of Alcohol and Drug Programs within the Department of Health Care Services. All consolidations should be designed with maximum flexibility to transfer funds between different types of programs and services in order to respond to consumer needs, including preference of setting.
- 5) ***Regularly report on progress toward rebalancing funds from institutional services to HCBS***, similar to the report required in New Jersey's global budgeting initiative. This report should document the shift both inside and outside of managed care initiatives. It would memorialize the progress of system change initiatives and document California's progress toward implementation of the Supreme Court's Olmstead decision. The ability to efficiently report even this information is dependent upon improvements in data systems and recognition that rebalancing is both a fee-for-service and a managed care responsibility.
- 6) ***Create an entitlement to a wrap-around array of HCBS services to anyone in a NF***. This type of entitlement has been used in Washington and Texas and has been documented to contribute to cost-effectiveness in both states; it reduces NF utilization and is responsive to consumer choice of setting and service. California has done this with its assisted living waiver, but should expand the concept.
- 7) ***Offer a one-time Transition Allowance for costs of transition from an institutional setting for anyone wishing to leave***, covering costs including first and last month's rent, utility deposits, kitchen appliances, furniture and basic household items. Texas, a state similar in size to California, offers a \$2,500 allowance for these costs. The Transition Allowance should be offered both inside and outside of managed care programs and not be limited to participation in the state's Money Follows the Person program. Any one at any time should be able to get this aid regardless of what program or eligibility group they are within.

- 8) ***Under all managed care plans, including the dual eligible pilots that are being developed, give MCOs responsibility for both NF and HCBS services, and adopt a blended rate covering NFs as well as home- and community services with as much risk as feasible.*** This should be enacted for all managed care contracts including those for whom NF services are currently carved out.
- 9) ***Under all managed care plans, including the dual eligible pilots, exempt persons transitioning from NFs, or people who meet a NF level-of-care requirement, from enrollment caps for HCBS.*** Tennessee, Wisconsin and Texas offer this as a cost-effective alternative within their managed care plans. California should offer HCBS to persons at a NF level-of-care as an entitlement under all managed care plans.
- 10) ***Under all managed care plans, including the dual eligible pilots, require MCOs to provide transition services,*** including assistance in securing housing and transportation.
- 11) ***Build requirements into managed care contracts that the plans are responsible for working with hospitals and other agencies to create and operate NF diversion programs.***
- 12) ***Under all managed care plans, including the dual eligible pilots, implement performance measures on timelines for sentinel events,*** similar to those incorporated in Texas and the Tennessee CHOICES program (see details, p. 34 and p. 45). Such events should include admission rates to NFs, NF transition goals, and the timely assessment and implementation of service plans for HCBS services.
- 13) ***Create a data system for managing LTSS programs with data on assessment and program utilization for all persons using LTSS. The assessment information needs to contain data on all types of disability, including physical, mental health, intellectual and developmental disabilities.*** On the one hand, when this idea has been raised in the past, the objection was that it will cost money to build this information system. On the other hand, not having a data management system for \$13 billion dollars spent on LTSS programs is also costly. For example, in 2011, the Governor directed the closure of the Adult Day Health Care (ADHC) program. To find out the characteristics of the persons using ADHC services, the Department supervising the elimination of ADHC first reviewed 8,000 ADHC care plans by hand because the plans were not computerized, and then paid \$12.8 million to a private vendor to assess 15,000 ADHC recipients. The Department also paid managed care companies to assess thousands more. These expenditures of thousands of hours of staff time and millions of dollars are wasteful and inefficient data patches that occur because the state has not built a LTSS data system.

APPENDIX A

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

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

Louisiana

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

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

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

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

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

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

“Community advocates and the administration have had difficulty securing legislative support for measures that would (1) allow Money Follows the Person to close institutional beds and open waiver opportunities or (2) that would fully consolidate budgeting of long-term care services. MFP legislation for the developmentally disability population failed in the 2004 legislative session, but was enabled on a case-specific basis in the 2006 session.

In this session, the legislature approved the closure of specific public and semi-public ICF/DD beds to create additional waiver opportunities that would accommodate persons served in the closing facility. In the 2005 session, legislators signaled their intention toward greater budget consolidation by granting [Office for Citizens with Developmental Disabilities] OCDD some flexibility in shifting funds among, but not out of, public ICFs/DD.

The following years have resulted in even more flexibility granted to OCDD. The MFP Rebalancing Demonstration provides the program framework and national stage that has aligned support for use of MFP in both the private and public sectors.⁴⁴

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

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

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

utilization and in effect, has resulted in a funding shift. NF utilization in Louisiana has gradually gone down in the last ten years, starting at 30,100 in 2001 and dropping down to about 25,600 NF patients in December 2011.⁴⁵ The personal care state plan service had a high benefit level, which contributed to one of the waivers failing the cost-neutrality test, causing problems with CMS. The case-mix system noted earlier restored cost-neutrality.

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

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

Massachusetts

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

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

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

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

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

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

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

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

Michigan

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

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

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

⁴⁷ State staffs, Michigan Department of Community Health Home- and Community-based Services Section, personal communication, 9-21-11.

⁴⁸ Speckman-Randall, E., (2011, November), *Michigan's Nursing Facility Transition Program*, Michigan Department of Community Health, Lansing, MI, p. 19. Does not appear to be currently available on line.

⁴⁹ Ibid, p. 18.

⁵⁰ Ibid.

⁵¹ Speckman-Randall, E., (2010, September), *CMS Operational Protocol Training Conference Call Session 2: MFP Benchmarks*, Michigan Department of Community Health, Lansing, MI. Does not appear to be currently available on line.

⁵² From 2007-2010 there were only 11,849, participants nationally in CMS sponsored Money Follows the Persons programs. The figures reported for Michigan's CMS program were 640. Nonetheless these statistics do show the level of effort made in Michigan compared to other states. See Mathematica Policy Research Inc. (2011, October),

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

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

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

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

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

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

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

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

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

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

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

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

New Jersey

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

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

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

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

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

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

The Act established flexible accounting changes to the LTSS system.

“C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

- a. no later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L. 1991, c. 164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and*
- b. no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L. 1991, c. 164 (C.52:14-19.1), that documents the reallocation of funds to home- and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home- and community-based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.*

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.

10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Pennsylvania

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

⁶⁰ Ibid.

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

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

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

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

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

⁶¹ State staffs, Pennsylvania Department of Aging, Office of Long-Term Living, personal communication, 9-22-11.

⁶² Ibid, Mathematica (2011) Table III.3

Texas

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

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

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

AN ACT relating to the transfer of money appropriated to provide care for certain persons in nursing facilities to provide community-based services to those persons. BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS: SECTION I: Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.082 to read as follows:

Sec. 531.082. TRANSFER OF MONEY FOR COMMUNITY-BASED SERVICES. (a) The commission shall quantify the amount of money appropriated by the legislature that would have been spent during the remainder of a state fiscal biennium to care for a person who lives in a nursing facility but who is leaving that facility before the end of the biennium to live in the community with the assistance of community-based services. (b) Notwithstanding any other state law and to the maximum extent allowed by federal law, the executive commissioner shall direct, as appropriate:

(1) the comptroller, at the time the person described by Subsection (a) leaves the nursing facility, to transfer an amount not to exceed the amount quantified under that

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

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

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

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

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

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

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

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

STAR+PLUS provides health care, acute and long-term services through contracted health plans. In March 2012, all major urban, extra-urban and suburban counties will be included under STAR+PLUS. STAR+PLUS combines traditional health care and LTSS, such as providing help in the home with daily activities, home modifications, respite care and personal assistance. Service coordination is a feature of STAR+PLUS. Enrollment is required for most Medicaid recipients

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

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

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

Washington

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

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

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

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

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

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

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

Wisconsin

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

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

⁶⁷ Ibid.

⁶⁸ State staffs, Wisconsin Health Services, personal communication, 10-7-11.

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

As a result of these long-standing programs, the state has a robust array of HCBS services and providers, along with strong state policy direction in support of consumer choice. The state’s NF utilization has gone down over the last 20 years. For example in December 2001 Wisconsin’s NF population was 38,430 and in December 2011 it was 29,794.⁶⁹

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B

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

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

Arizona

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

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

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

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

In addition to the capitation rate methodology, AHCCCS also uses a performance measure with its contractors. AHCCCS medical policy requires that services for HCBS members are initiated within 30 days of enrollment, based on a personal visit and thorough assessment of service needs by a case manager. The reporting of this measurement assesses the percentage of newly placed ALTCS members who received specific HCBS services within 30 days of enrollment, overall and by the contractor. The minimum performance standard on this measurement is 92%; while the AHCCCS goal was 98% in 2011.⁷³ Contractors are publicly rated, their performance is publicly critiqued by the state assessors, and corrective action plans are required of contractors that do not meet minimum standards.

Hawaii

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

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

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

⁷³ See retrieved on 3-11-2011 from

<http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS-HCBS-2011.pdf>

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

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

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

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

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

Minnesota

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

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

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

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

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

Minnesota began enrolling seniors (including dual eligibles) into managed care in the early 1980s; however long-term care was initially not included. The state transitioned that original program to a new Medicaid managed LTSS program called Minnesota Senior Care Plus (MSC+) in 2005.⁷⁷ MSC+ serves Medicaid-eligible seniors, or those who are Medicaid eligible and also enrolled in fee-for-service Medicare Parts A and B. The MSC+ program operates in all of the state's 87 counties and serves about 25% of the state's senior managed care population.

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

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

⁷⁶ State staffs, Minnesota Aging and Adult Services, personal communication, 11-18-11.

⁷⁷ Parker, P. (March, 2009), *Managed Care Programs, Where are We Now? MSHO, MSC+, SNBC and MnDHO*, see retrieved on 12-27-11 from http://www.dhs.state.mn.us/main/groups/aging/documents/pub/dhs16_144535.pdf

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

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

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

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

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

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

Tennessee

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

In 2008, as a result of a broad stakeholder process, the legislature passed the Long-Term Care Community Choices Act to reorganize and rebalance the state's long-term care services. In 2010 the state launched CHOICES in Long-Term Care within its TennCare managed care program. The CHOICES program restructured long-term care service delivery by integrating NF and HCBS services for seniors and adults with physical disabilities into the existing Medicaid managed care delivery system. People who were already TennCare recipients remained with their existing plan, which became responsible for their LTSS services and provided continuity of care. Those new to TennCare and CHOICES have a choice between two MCOs in each region of the state. To qualify for CHOICES, persons are required to meet a nursing home level of care and to qualify for Medicaid LTSS. The program gives each eligible member the choice to receive either NF or HCBS. HCBS may be provided as long as the plan can safely address the person's needs in the community and as long as each individual's care does not exceed the cost of the NF. Enrollment in Medicaid managed care is mandatory. In Tennessee the annualized cost of Medicaid NF care is \$55,000 and the average annualized cost of HCBS is approximately \$19,000.⁸²

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

⁸⁰ Ibid.

⁸¹ Gordon, D., Killingsworth, P., Long, W. (2010, August), TennCare Oversight Committee Presentation. See, retrieved on 12/27/11 from <http://www.tennicare.org/PDFs/tenncare082410.pdf>

⁸² State staffs, Tennessee Long-Term Care Strategic Planning and Program Implementation, Bureau of TennCare, personal communication, 11-22-11.

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

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

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

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

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

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

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

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

The model provides the state with significant flexibility to make changes: all aspects of the contracts are reviewed every six months and updated as needed to meet the needs of the state and the MCOs. Two years ago the state was serving 17% of persons with HCBS; now the rate of HCBS is 31%. As a result of the new program, the state is seeing an average increase of nearly 1% of rebalancing within its long-term care system every month.⁸⁴ A recent study by the Center for Business and Economic Research at the University of Tennessee, Knoxville found that 95% of enrollees in TennCare expressed satisfaction with the program, a 34-point increase from the program's first year of 1994.⁸⁵

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

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

Appendix C
California Legislative Analyst’s Office: Many State-Funded Programs Provide Long-Term Care Services⁸⁶

Many State-Funded Programs Provide Long-Term Care Services				
2005-06 (In Millions)				
Program	Department	Total Cost	Services	Clients
Institutional Care				
Nursing facilities/Intermediate Care Facilities (ICF)—fee-for service	Medi-Cal/ Health Services	\$3,001	Continuous skilled nursing and supportive care in private, licensed facilities.	Medi-Cal eligible elderly, disabled, or needy.
State Hospitals	Mental Health	\$888	State institutions.	Mental health patients.
Developmental Centers	Developmental Services	\$708	State institutions.	Developmentally disabled.
ICF—Developmentally Disabled	Medi-Cal/ Health Services	\$374	Private, licensed health facilities.	Medi-Cal eligible developmentally disabled.
Nursing Facilities—managed care	Medi-Cal/ Health Services	\$254	Long-term care provided by County Organized Health Systems in an institutional setting.	Medi-Cal eligible elderly, disabled, or needy.
Veterans' Homes-Nursing facilities and ICFs	Veterans Affairs	\$57	State institutions.	Elderly or disabled veterans.
Veterans' Homes-residential	Veterans Affairs	\$50	State institutions.	Elderly or disabled veterans.

⁸⁶ Legislative Analyst’s Office, (2006, February), *Improving Long-Term Care*, Sacramento, CA. Figure 1 Retrieved on 12-24-2011 from http://www.lao.ca.gov/analysis_2006/health_ss/hss_02_anl06.html. This 2006 report is the latest that summarizes all California long-term care programs across departments, although some programs have been eliminated since this writing.

Program	Department	Total Cost	Services	Clients
Community-Based Care				
In-Home Supportive Services	Social Services	\$3,811	Personal care and case management services coordinated by county welfare departments, to allow persons to remain in their homes.	Low income, elderly, blind, or disabled.
Regional Centers	Developmental Services	\$2,932	Includes day programs, community care facilities, and support services.	Developmentally disabled and residing in own home, home of a relative, or in community care facilities.
SSI/SSP Nonmedical out-of-home	Social Services	\$498	Cash grant for residential care (generally, grants used for Residential Care Facilities).	Elderly or disabled, as eligible according to income and assets.
Adult Day Health Care	Medi-Cal/Aging	\$418	Health, therapeutic, and social services on a less than 24 hour basis.	Elderly or younger disabled adults.
Nutrition services	Aging	\$148	Congregate or home-delivered nutritional meals.	Elderly.
EPSDT³ shift nursing	Medi-Cal/Health Services	\$147	In-home private duty.	Medi-Cal eligible under age 21.
Supportive services	Aging	\$85	Programs authorized by the Older Americans Act, including case management and transportation.	Elderly.
Program of All-Inclusive Care for the Elderly	Health Services	\$83	Full range of care, including adult day health, case management, personal care, provided on a capitated basis.	Elderly.

Program	Department	Total Cost	Services	Clients
Community-Based Care				
Family Caregiver Support Program	Aging	\$36	Respite, day care, and transportation to assist caregivers.	Caregivers for elderly or grandparents raising grandchildren.
Nursing Facility Subacute Waiver	Medi-Cal/ Health Services	\$33	Home- and community-based alternative to nursing facility subacute care.	Medi-Cal eligible, physically disabled meeting nursing facility subacute care criteria for 180 days.
Conditional Release Program	Mental Health	\$22	Assessment, treatment, and supervision.	Judicially committed.
AIDS Waiver	Medi-Cal/ Health Services	\$20	Alternative to nursing facility or hospital care.	Medi-Cal eligible with HIV infection or AIDS.
Nursing Facility A/B Waiver	Medi-Cal/ Health Services	\$16	Alternative to nursing facility level A or B.	Medi-Cal eligible, physically disabled meeting nursing facility A or B care criteria for 365 days.
Alzheimer's Day Care Resource Centers	Aging	\$14	Day care.	Persons with Alzheimer's or other dementia, and their caregivers.
In-Home Medical Care Waiver	Medi-Cal/ Health Services	\$14	Alternative to care in an acute hospital.	Medi-Cal eligible, severely disabled requiring care in an acute hospital for 90 days.
Independent Living Centers	Rehabilitation	\$13	Grants for a full range of services.	Disabled.
Caregiver Resource Centers	Mental Health	\$12	Nonprofit resource centers.	Caregivers of brain-impaired adults.
Long-Term Care Ombudsman	Aging	\$11	Advocates for rights of residents in 24-hour long-term care facilities.	Elderly.

Program	Department	Total Cost	Services	Clients
Community-Based Care				
Traumatic Brain Injury project (TBI)	Mental Health	\$1	Hospital and community-based services to help retain independence.	Adults with TBI, caused as a result of an external force to the head.
Senior Companion Program	Aging	\$1	Companionship and transportation services.	Elderly.
Respite care	Aging	— ^b	Temporary or periodic services to relieve primary and unpaid caregivers.	Elderly or disabled, and their caregivers.
^a Early and Periodic Screening, Diagnosis and Treatment program.				
^b Amount is less than \$1 million.				