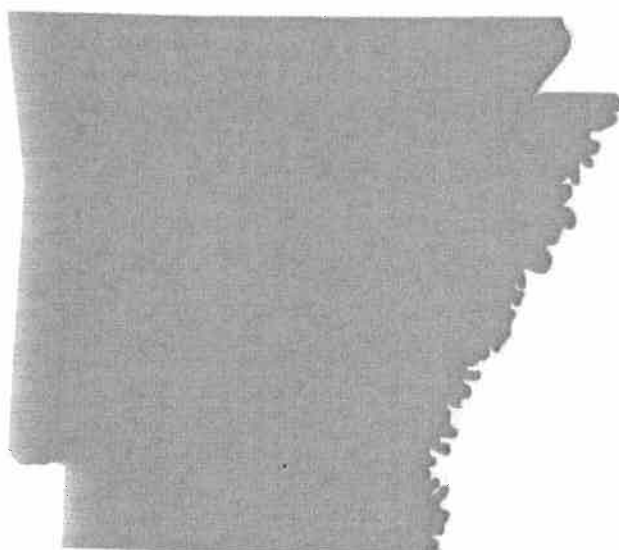


**CHOICES**  
*IN LIVING*

*FOR ARKANSANS WITH  
LONG-TERM CARE NEEDS*



*Arkansas's Long-Term Care System:  
Planning for the Future*



**ARKANSAS  
DEPARTMENT OF  
HUMAN  
SERVICES**

# EXECUTIVE SUMMARY

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Arkansas should rebalance its long-term care (LTC) system by increasing the availability of home and community based services (HCBS). Arkansans overwhelmingly prefer to receive needed LTC services in a community setting. As a result of changing demographics, more Arkansans will need long-term care services. Although nursing homes will continue to play an important role for some individuals with high care needs, for most individuals, HCBS provide a more affordable alternative to nursing home care. Expanding access to HCBS could increase the number of individuals served in their local communities and reduce the rate at which Medicaid long-term care expenditures increase in the future.

While Arkansas has made progress in rebalancing its LTC system, many opportunities for improvement remain. Arkansas still relies more heavily on nursing homes to meet LTC needs than other states; the state also has a high concentration of individuals with low care needs in nursing homes. These low care individuals could be served with HCBS, which would save money and would provide care in the setting that consumers prefer. In terms of Medicaid LTC expenditures, the vast majority of public funds support institutional care options. More than 70% of Medicaid LTC funding is for institutional care in Arkansas, with the remaining 30% spent on HCBS. Nationally, almost 40% of Medicaid LTC expenditures fund HCBS. Arkansas should rebalance its LTC system and expand home care options; doing so would ensure consumer preference, meet legal requirements under the *Olmstead* Supreme Court decision and save money.

# RECOMMENDATIONS

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## **Priority Recommendations Requiring Executive and/or Legislative Action**

1. Increase reimbursement rates for Personal Care, Targeted Case Management and selected ElderChoices services. Incorporate pay for performance standards tied to reimbursement. (See page 27.)
2. Dedicate \$8,000,000 in General Improvement Funds for the development of affordable private (not state government) assisted living facilities. These funds would bring equity into projects in return for a commitment to admit Medicaid residents. (See page 28.)
3. “Repurpose” unused or unoccupied nursing home beds by promoting non-traditional “Home-Style” facilities such as those found in the GreenHouse™ or similar small house models. (See page 28.) Repurposing could assist with efforts to right-size the nursing home industry. (See page 40.)
4. Use a portion of the \$500,000 appropriated to Division of Medical Services for “fast track” to include transition services, case management and other costs for individuals in institutions wishing to return to the community. (See page 29.)
5. Amend ElderChoices and Alternatives 1915 (c) Medicaid waivers to include transition services allowed under current federal regulations. (See page 29.)
6. Create an internal workgroup within DHS to determine which Money Follows the Person Demonstration Services should be incorporated into Medicaid State Plan or waivers. (See pages 29-30.)
7. Restructure the Governor’s Integrated Services Taskforce to advise DHS on the implementation of this plan. (See page 31.)
8. Proceed with piloting SOURCE in four counties. (See page 31.)
9. Develop a DHS strategic plan to meet the home and community based service needs of Arkansans with Traumatic Brain Injuries, including the feasibility of developing a Traumatic Brain Injury Medicaid waiver. (See page 32.)
10. Review long-term care (LTC) Financing options (and organizational system design) to identify models that will enable the state to meet the future increase in demand for LTC services, including global budget, managed care and integrated service models, while improving care coordination and reducing the fragmentation of the LTC system. (See page 32.)

11. Improve the use of technology in the delivery of home and community based services (HCBS). As a part of this initiative, an Information Technology Plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. (Note: 90% federal funding is available for part or all of this recommendation.) (See page 33.)
12. Develop performance standards to measure the progress made in balancing the state's LTC system. (See page 34.)

### **Additional Recommendations**

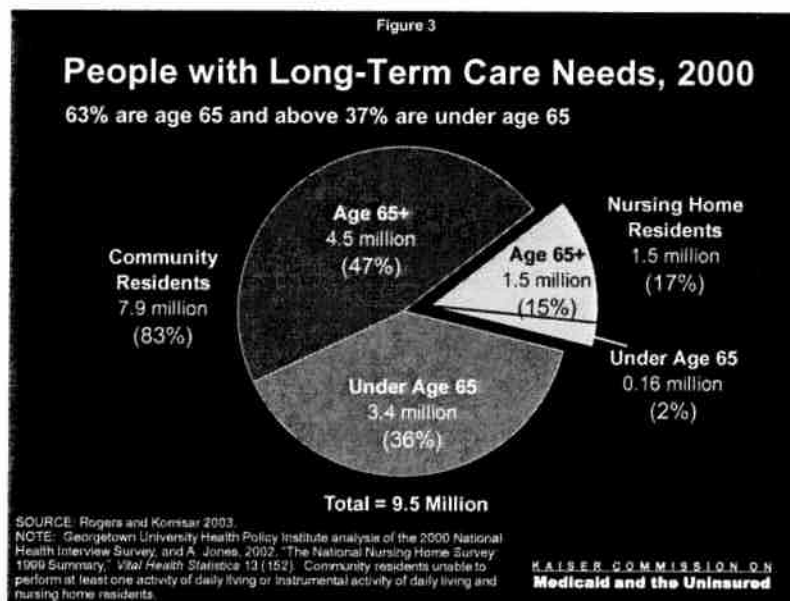
13. Create a work group to address the long-term care application process to ensure consumer choice and timely processing of LTC applications. (See page 34.)
14. Coordinate with Partners in Planning (PIP) to make healthy aging a reality in Arkansas through statewide interdisciplinary coordination and collaboration. (See page 34.)
15. Develop models that integrate acute and chronic care. (See page 35.)
16. Implement Administration on Aging nursing home diversion programs. (See page 36.)
17. Improve access to LTC information and assistance. (See page 36.)
18. Educate consumers and families regarding LTC financing options. (See page 37.)
19. Review Medicaid LTC functional eligibility criteria and procedures. (See page 37.)
20. Improve Hospital Discharge Planning Process. (See page 38.)
21. Enhance support services for informal caregivers. (See page 39.)
22. Increase focus on health promotion and prevention interventions to reduce future need for LTC services. (See page 39.)
23. Support Quality Improvement/Assurance Initiatives. (See page 40.)
24. "Rightsizing" the NH industry/Addressing the Changing role of the NH industry (See page 40.)
25. Explore use of common functional assessment and care planning instruments in order to reduce the completion of duplicative assessments. (See page 41.)

## What is Long-Term Care?

- Services and supports needed when ability to care for self has been reduced by a chronic illness, disability, or aging.<sup>1</sup>
- Long-Term Care (LTC) services usually provided:<sup>2</sup>
  - By family and friends at home;
  - Through home and community based services, such as home health care, personal care, and adult day care;
  - Or in institutional settings, such as nursing homes or residential care facilities

**Long-term care is a variety of services** that includes medical and non-medical care to people who have a chronic illness or disability. LTC helps meet health or personal needs. Most LTC is to assist people with support services such as activities of daily living like dressing, bathing, and using the bathroom. These services and supports can be provided at home, in the community, in assisted living or in nursing homes. It is important to remember that you may need LTC at any age.

You may never need long-term care. This year, about nine million men and women over the age of 65 will need long-term care. By 2020, 12 million older Americans will need LTC. Most will be cared for at home; family and friends are the sole caregivers for 70 percent of the elderly. A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home. About 10 percent of the people who enter a nursing home will stay there five years or more.<sup>3</sup> (Source: <http://www.medicare.gov/longtermcare/static/home.asp>.)



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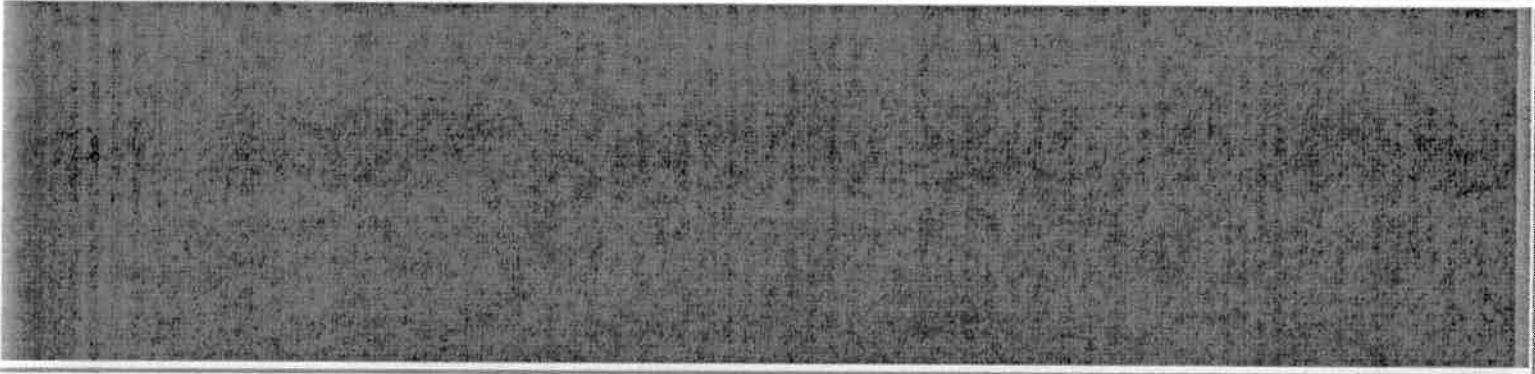
## Introduction

Arkansas has been an innovator in long-term care (LTC) and has a history of success in its efforts to transition individuals from institutional settings to the community. The Arkansas Department of Human Services currently operates a number of programs that provide consumers with home and community based services (HCBS) as alternatives to institutional care. HCBS programs have proven popular with citizens as they provide them with increased choices in how and where they receive LTC services. Not only are HCBS programs preferred by consumers, they also are less expensive than institutional alternatives.

However, work remains. The vast majority, more than 70%, of Arkansas Medicaid LTC expenditures fund institutional care, with the remaining 30% spent on HCBS. "Rebalancing" the LTC system is the goal that drives DHS' LTC planning and policy development efforts. Additionally, Arkansas has a committed corps of consumers and advocates who continue to push the LTC system forward.

*As with all states, Arkansas still has many opportunities for improving our services to older Arkansans and individuals with disabilities.*



- 
- ❖ Older Arkansans and individuals with disabilities must have viable options in how and where they receive quality LTC services.
  - ❖ Changing demographics will result in an increased demand for LTC services.
  - ❖ There is general agreement among Congress, Governors and advocates that the LTC system should be rebalanced.
  - ❖ Not only do Arkansans prefer to remain in the home, but HCBS are less expensive than nursing home care.
  - ❖ HCBS programs work; between 1996 and 2001, Arkansas had a 10% reduction in the number of nursing home residents.
  - ❖ Since implementing the first Medicaid HCBS waiver in 1992, the number of Medicaid recipients in nursing homes has fallen from 14,738 to 12,365 despite a growing population and a large number of unoccupied nursing home beds.
  - ❖ In order to continue making progress towards rebalancing the LTC system, HCBS must be supported and adequately funded.
  - ❖ In response to these challenges, DHS has convened an internal group to plan for the future to meet the LTC needs of Arkansans.

## ELDERCHOICES CASE STUDY: FRANCIS' STORY

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Francis is an 83 year old paraplegic that has been enrolled in ElderChoices, Arkansas's 1915(c) Medicaid waiver that provides in-home and community based care to the elderly, for the past ten years.

Francis remains active in the community and is a consumer representative on the Medicaid waiver Quality Assurance and Quality Improvement (QA/QI) task force.

The average cost to Medicaid for Francis' ElderChoices is care is \$7,458 per year.<sup>1</sup> This amount is significantly less than the average cost to Medicaid for one year in a nursing home in Arkansas, which was \$48,990 in 2006.

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<sup>1</sup> Arkansas Medicaid Claims data, MMIS, Business Objects query.

## **Arkansas's Long-Term Care System: Planning for the Future**

### I. DEMOGRAPHICS AND UTILIZATION:

Nationally, it has been estimated that almost 10 million Americans have LTC needs.<sup>4</sup> Although older adults constitute the majority of users of Medicaid LTC services, individuals under age 65 with a disability are also major users of the LTC

system.<sup>5</sup> Coming demographic changes will result in an increase in the demand for LTC services. Specifically, from 2000 to 2020, the population of Arkansans 65 or older and 85 or older will increase by nearly 40%.<sup>6</sup>

**Table 1. Age Distributions for Arkansas, 2000 and 2020**

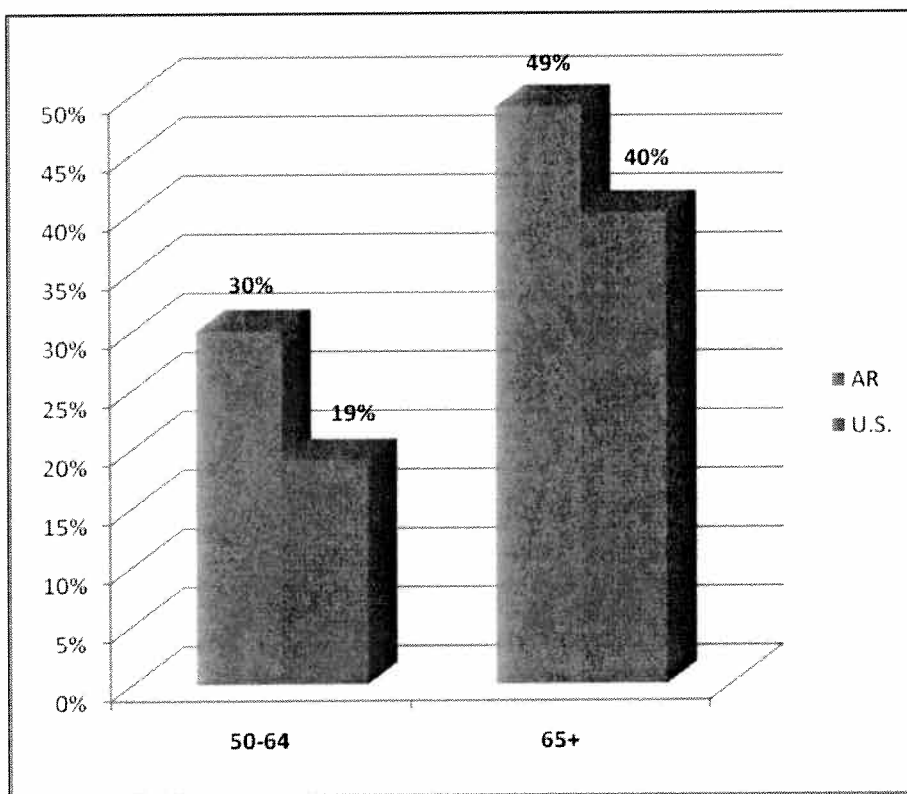
Age Group	Census 2000		Projection 2020		2000 - 2020 Change	
	Number	Percent	Number	Percent	Total	
	Total	Total	Total	Total	Number	Percent
Total	2,673,400	100.0	3,060,219	100.0	386,819	14.5
0-4	181,585	6.8	201,970	6.6	20,385	11.2
5-9	187,224	7.0	203,460	6.6	16,236	8.7
10-14	192,935	7.2	207,306	6.8	14,371	7.4
15-19	198,765	7.4	205,031	6.7	6,266	3.2
20-24	181,598	6.8	185,737	6.1	4,139	2.3
25-29	176,674	6.6	178,659	5.8	1,985	1.1
30-34	176,171	6.6	180,776	5.9	4,605	2.6
35-39	200,340	7.5	191,138	6.2	-9,202	-4.6
40-44	197,787	7.4	189,333	6.2	-8,454	-4.3
45-49	181,913	6.8	186,860	6.1	4,947	2.7
50-54	167,606	6.3	186,277	6.1	18,671	11.1
55-59	39,393	5.2	208,558	6.8	69,165	49.6
60-64	117,390	4.4	204,086	6.7	86,696	73.9
65-69	105,175	3.9	174,655	5.7	69,480	66.1
70-74	93,159	3.5	140,081	4.6	46,922	50.4
75-79	76,517	2.9	93,516	3.1	16,999	22.2
80-84	52,676	2.0	58,047	1.9	5,371	10.2
85+	46,492	1.7	64,729	2.1	18,237	39.2

Source: Arkansas 2020 Report, citing U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

In addition to demographic changes associated with the graying of the baby boom generation, disability rates, another important predictor of the need for LTC services, are higher than the national average for Arkansans of all ages.<sup>7</sup> In fact, nearly 50% of Arkansans age 65 or older has at least one disability, compared to 40% of Americans age 65 or older; further, 30% of Arkansans age 50-64 has at least one disability compared to the national average of 19%.<sup>8</sup>

While the prevalence rates of any disability among elderly people have recently been on the decline<sup>9</sup>, current obesity trends suggest that the obesity epidemic could “reverse the decline in disability rates, resulting in higher demand for health care in old age”.<sup>10</sup> Despite the conflicting projections regarding future disability rates<sup>11</sup>, the sheer growth in the older population will cause the number of disabled older Americans to “soar in coming decades”.<sup>12</sup>

**Chart 1: Disability Rates for Selected Age Groups, U.S. and AR, 2005**



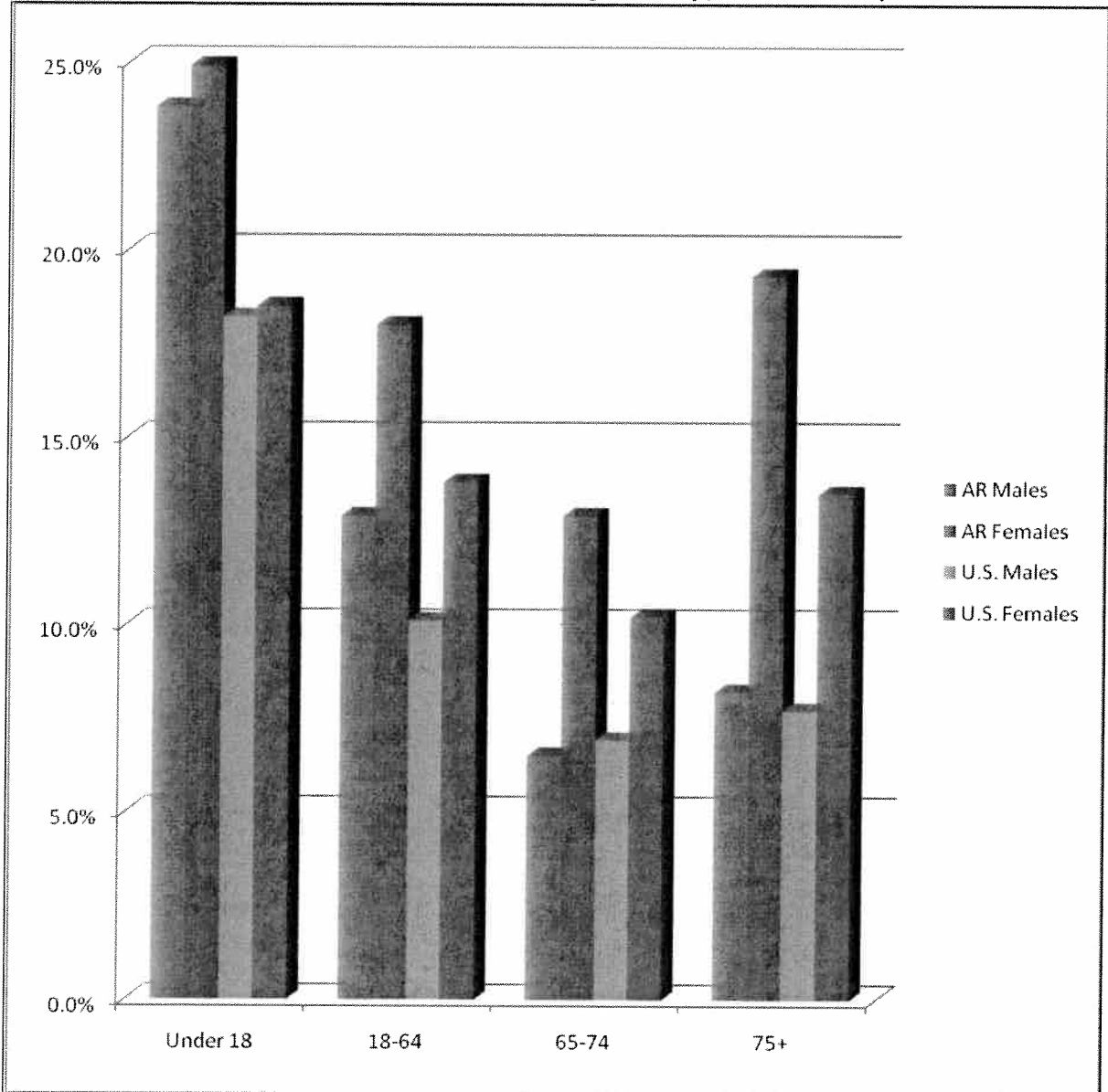
Source: Houser A, Fox-Grage W, Gibson MJ, "Across the States: Profiles of Care and Independent Living", AARP, Seventh Edition, 2006.

Note: This definition of disability is met if any one of the following five disabilities is present: sensory, physical, mobility, self-care, cognitive/mental.

Medicaid is the primary public financing mechanism for LTC services. It is the primary payer for low-income Arkansans as well as individuals that become impoverished as a result of paying for needed LTC services.

Arkansas's poverty rates are higher than the national average for all age groups.<sup>13</sup> In fact, according to SFY 2005 data, 75% of all nursing home residents in Arkansas were eligible for Medicaid.<sup>14</sup>

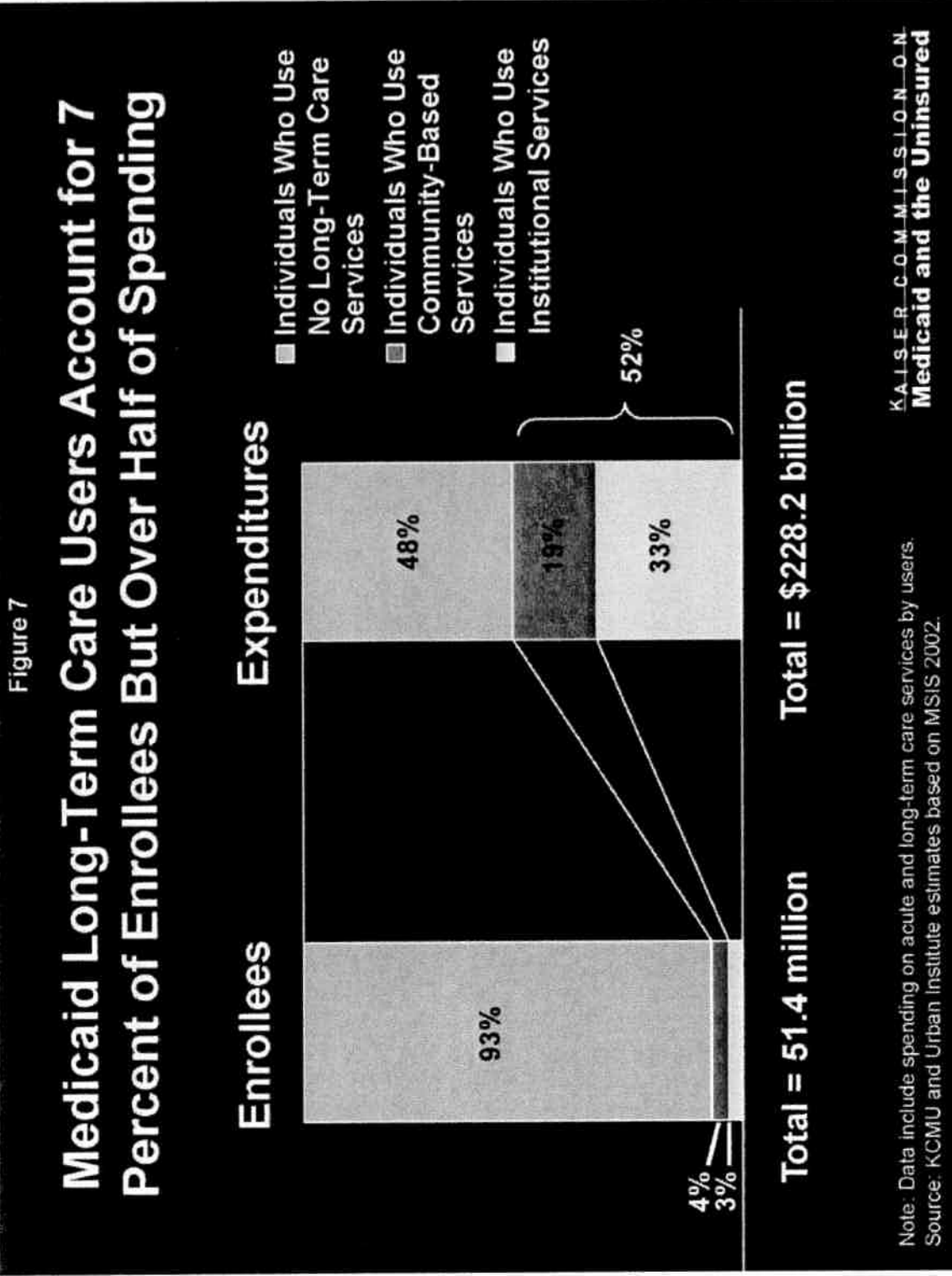
**Chart 2: Poverty Rates by Gender and Age Group, U.S. and AR, 2006**



Source: Baer D, "State Handbook of Economic, Demographic & Fiscal Indicators, AARP, Seventh Edition, 2008.

### Chart 3: Why focus on LTC needs?

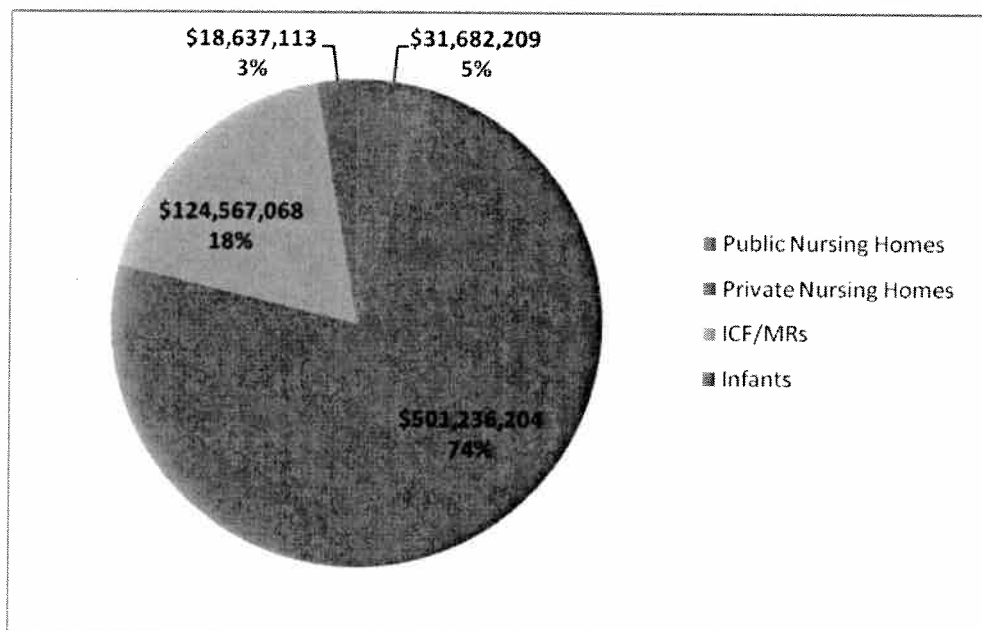
Long-Term Care users are high cost Medicaid beneficiaries. Although they comprise only 7% of total enrollees, they account for 52% of all Medicaid expenditures.



Arkansas Medicaid expenditures for LTC institutions in SFY 2007 totaled \$678,694,143, which accounts for 20.5% of overall spending by the Arkansas Medicaid program.<sup>15</sup> This amount includes spending on both nursing homes and ICF-MRs, but does not include money spent to support HCBS programs.

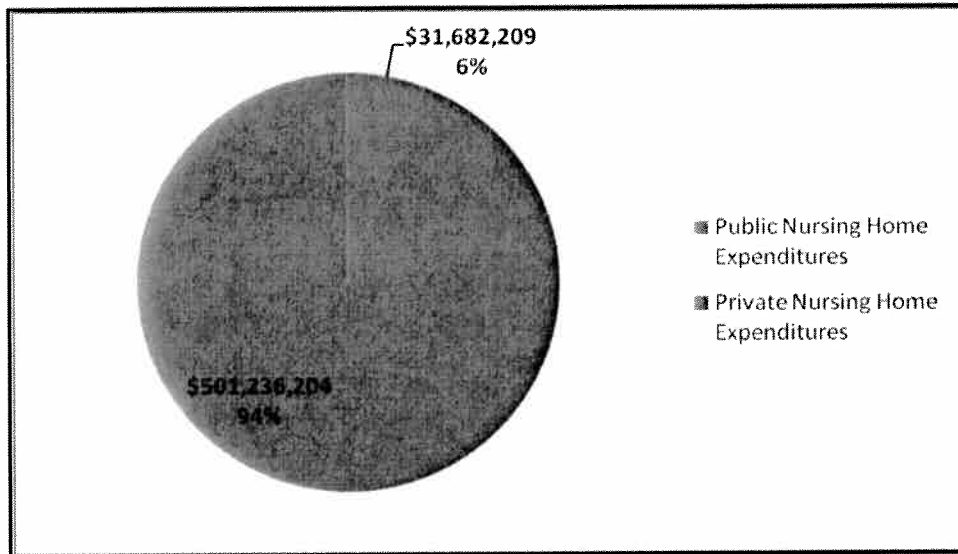
Arkansas Medicaid Nursing home expenditures for SFY 2007 totaled \$532,918,413, which accounts for 79% of Arkansas Medicaid LTC expenditures.<sup>16</sup> Nursing home expenditures comprised 15% of all Arkansas Medicaid spending in SFY 2007.<sup>17</sup>

**Chart 4:  
Arkansas Medicaid LTC Expenditures, SFY 2007**



Source: AR DHS, Division of Medical Services, Long-Term Care Medicaid Factsheet, based on Medicaid Claims Data from MMIS system.

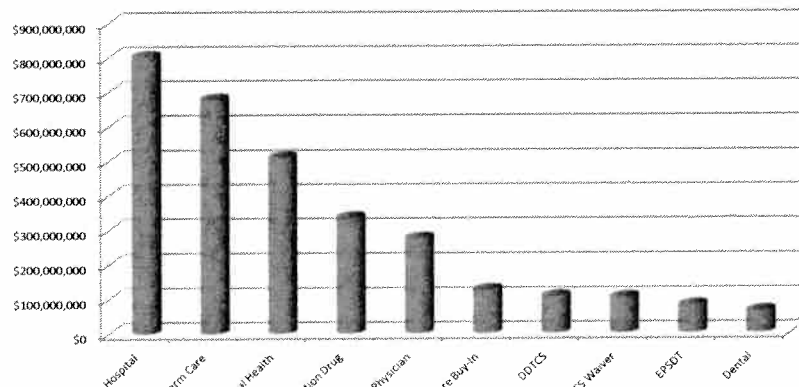
**Chart 5:**  
**Arkansas Medicaid Nursing Home Expenditures, SFY 2007**



Source: AR DHS, Division of Medical Services, Long-Term Care Medicaid Factsheet, based on Medicaid Claims Data from MMIS system.

**Chart 6:**

**Arkansas Medicaid Top 10 Most Expensive Service Types in SFY 2007 for Recipients of All Ages**



Source: Arkansas Medicaid Claims Data, MMIS, Business Objects queries based on Medicaid Factsheets for SFY 2007.  
 Note: All program and service definitions are taken from Medicaid Factsheets.

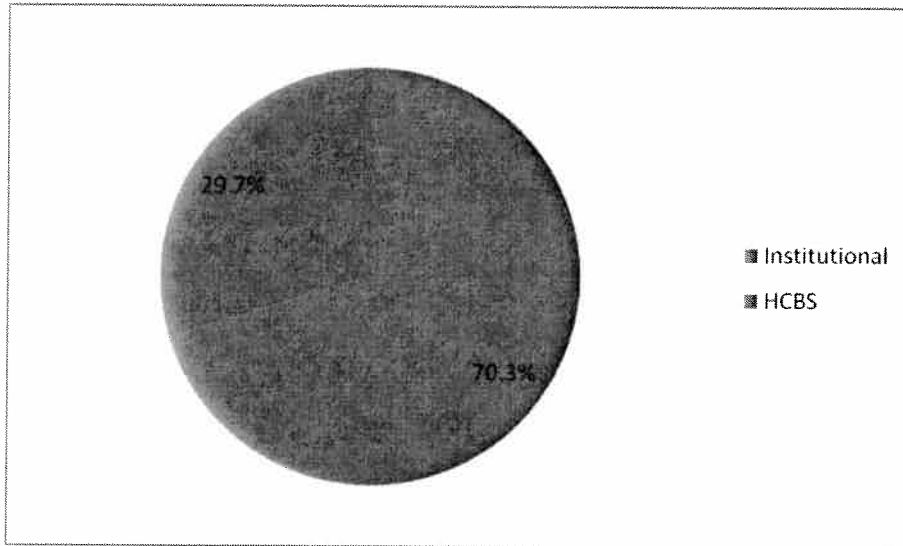


When HCBS services are included in calculations of LTC expenditures, 32% of the total 2006 Arkansas Medicaid budget was dedicated to long-term care services.<sup>18</sup> Of Arkansas's long term care expenditures in FFY 2006, 70.3% was spent on institutional care services, while 29.7% supported home and community based services (HCBS).<sup>19</sup>

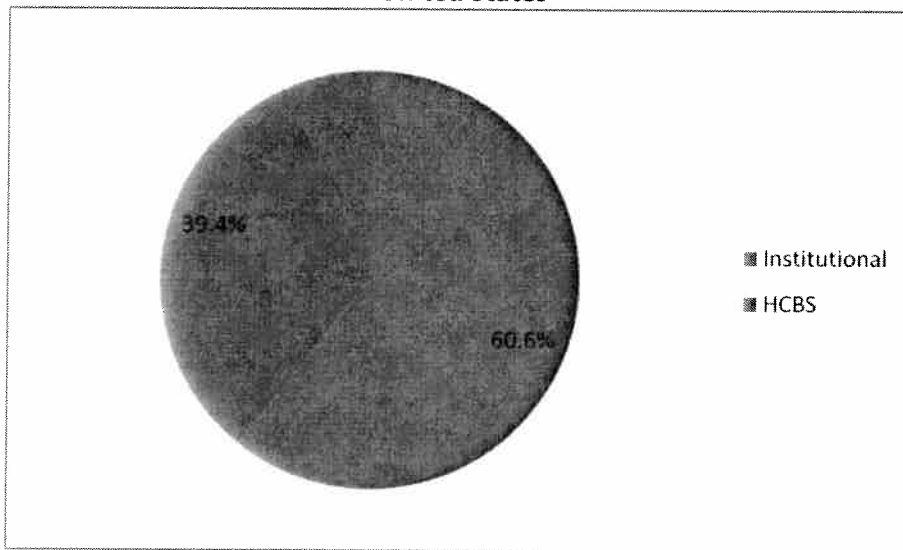
Nationally in FFY 2006, long-term care expenditures accounted for 33.2% of total U.S. Medicaid spending. Of national long-term care expenditures in FFY 2006, institutional expenditures comprised 61% of overall LTC spending with the remaining 39% spent on home and community based services.<sup>20</sup>

**Charts 7&8: Distribution of Medicaid LTC Expenditures Institutional vs. Community Based Services, 2006**

**Arkansas**



**United States**



Source: Burwell B, Sredl K, Eiken S, "Medicaid Long Term Care Expenditures in FY 2006", Thomson Medstat.

## II. BACKGROUND INFORMATION ON REBALANCING LTC:

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Most people strongly prefer home and community based services to institutional care options.<sup>21</sup> Home and community based services (HCBS) consist of a wide variety of medical and social services and include services such as home health, personal care, homemaker services, adult day care, respite care and assisted living.

Arkansas has been an innovator in the provision of (HCBS) as alternatives to institutional care<sup>22</sup>. In fact, in 2003, there were 12.29 Medicaid HCBS participants per 1,000 population; a rate substantially higher than the national average of 8.82.<sup>23</sup>

### **Federal Initiatives**

Historically, the Medicaid program has focused LTC supports on services provided by institutions, as was the norm in 1965, when the Medicaid program originated.<sup>24</sup> Consequentially, the Medicaid statute included nursing home services among mandatory benefits. Not until 1981, did Congress authorize states to provide HCBS through waiver and demonstration projects.<sup>25</sup> This has resulted in an

institutional bias in the Medicaid program.<sup>26</sup>

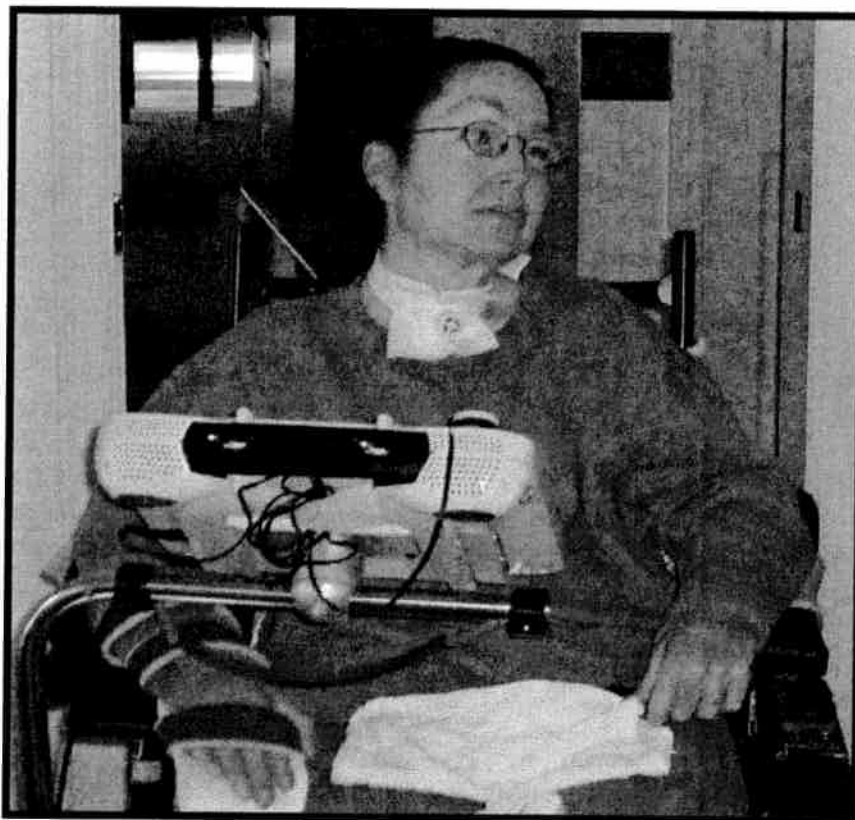
Recently, however, initiatives have been undertaken in order to “rebalance” the LTC delivery system. One such initiative is the New Freedom Initiative, which President Bush launched in February of 2001.<sup>27</sup> The aim of the New Freedom Initiative is to “remove barriers to community living for people of all ages with disabilities and long term illnesses” and is designed to support states’ in their efforts to comply with the Supreme Court’s 1999 decision in *Olmstead v. L.C.*<sup>28</sup> In *Olmstead*, the Court ruled that the Americans with Disabilities Act required states to provide programs and services “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.”<sup>29</sup>

The federal government, through the Centers for Medicare and Medicaid Services, has provided funding opportunities for programs to assist with rebalancing efforts through a number of grant programs including the Money Follows the Person Demonstration Grants and the Real Choice Systems Change Grants.<sup>30</sup> Additionally, the Deficit Reduction Act of 2005 (DRA) made several significant changes to LTC Medicaid policies; specifically, the DRA allows states more flexibility to provide HCBS and consumer direction programs without a waiver.<sup>31</sup>

## ALTERNATIVES CASE STUDY: TINA'S STORY

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Tina is 38 years old and has right hemiparesis due to a brain stem aneurysm she suffered in 1999. She lived in the state nursing home, the Arkansas Health Center, for more than 5 years, where she received skilled care.



Tina moved out of the nursing home in early December, 2004, and spent Christmas in her own home. She directs her own care through the Alternatives for Physical Disabilities program, a 1915(c) consumer-directed Medicaid waiver, and makes decisions about where and how she will live. For years, Tina was told by many professionals that she would always require skilled nursing home care and would never be able to live successfully in the community. Tina's response to them now — just wait until they hear she takes the van by herself to go shopping!

The average cost to Medicaid per month for Tina's stay in the Arkansas Health Center was \$10,950; under the Alternatives waiver, the average cost to Medicaid per month is \$2,772. Tina's diversion from the institutional setting to the Alternatives program has saved the state Medicaid program \$343,476 over the last three and a half years.

## II. OVERVIEW OF CURRENT REBALANCING EFFORTS:

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Nursing home transition and diversion programs are one strategy states have employed to begin rebalancing the LTC system.<sup>32</sup> Formal nursing home transition programs were first initiated with federal support in the late 1990s; prior to this time, only a few states administered nursing home transition projects.<sup>33</sup> However, since the late 1990s, several federal initiatives including the Real Choice Systems Change grants and the Money Follows the Person Rebalancing Initiative have supported the development of nursing home transition programs.

### Other States' Initiatives

States have responded to the increased grant opportunities to rebalance the LTC system by increasing available HCBS. Some examples of initiatives used to that end in other states include: pre-admission counseling programs (Maine); global budget for all LTC services (Oregon and Washington); and enacting legislation that added HCBS as an entitlement under the Medicaid program (select counties in Wisconsin where the Family Care program is available).<sup>34</sup> Other states have used the Minimum Data Set (MDS) to guide their rebalancing efforts. For example, New Jersey and Wyoming have used the MDS to identify nursing home residents that have indicated a preference for returning to the community.<sup>35</sup> Vermont and Pennsylvania have used a combination of MDS domains to identify

candidates for transition.<sup>36</sup> Georgia uses MDS data to run an algorithm that takes into account an individual's desire to leave, their length of stay and impairment level; candidates for transition are thereby identified.<sup>37</sup>

### Nursing Home Transition and Diversion Efforts in Arkansas:

Arkansas has been an innovator in the area of LTC and has had success in its efforts to transition individuals from institutional settings to the community.<sup>38</sup> Arkansas has had experience with nursing home transition programs; specifically, the Division of Aging and Adult Services administered a CMS funded transition program, Passages, from 1998-2000. Under Passages, candidates for transition were identified by analysis of Minimum Data Set (MDS) assessments; 111 Arkansans were successfully transitioned from the nursing home to the community under this program.<sup>39</sup>

More recently, Arkansas has been awarded a Money Follows the Person Rebalancing Demonstration Project, under which the state will transition 305 individuals from institutional settings to the community. Additionally, another nursing home initiative, AR Home, a 1915(a)(c) Medicaid Waiver, was recently submitted to CMS. Under AR Home, a Prepaid Health Plan would work to transition individuals out of nursing homes back into the community.

In developing criteria for nursing home transition programs, the following characteristics are frequently used to identify possible candidates for transition: resident preference; functional status and resource use/nursing home cost (RUG Groups); and length of stay in the facility prior to proposed transition.<sup>40</sup> Arkansas's recent acquisition and analysis of MDS data will provide information necessary to identify candidates for participation in the state's transition efforts, including Money Follows the Person. An improved understanding of the nursing home population will inform policy for improving nursing home diversion and transition efforts in Arkansas.



In addition to transition efforts, nursing home diversion efforts also play an important role in rebalancing the LTC system. In fact, researchers have concluded those states who are most successful at helping individuals remain in the community do not operate nursing home transition and diversion programs in isolation; rather, they employ a multi-pronged effort to “increase the capacity for community-based care, to inform consumers about options for care, and to assist consumers as they make choices about care.”<sup>41</sup> Arkansas was recently awarded a nursing home diversion grant from the Administration on Aging that is currently being piloted in two counties.

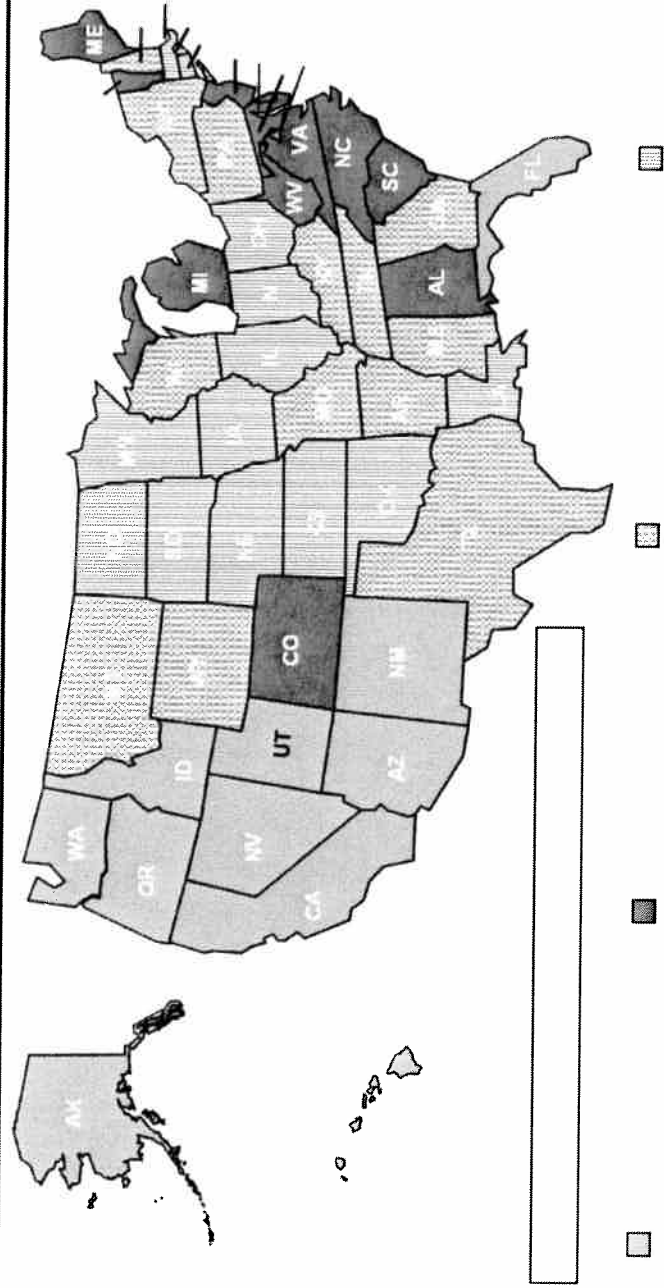
The following table lists a number of nursing home diversion strategies that have proven successful in other states. The table (see Table 2) has been modified from its original version<sup>42</sup> to indicate whether Arkansas and other selected states have similar initiatives underway.

TABLE 2: STRATEGIES TO PROMOTE NURSING HOME DIVERSION

	AR	OR	WA	ME	NJ	PA
Percent of Medicaid LTC Spending for HCBS, FY 06	29.7	71.6	60.6	52.5	34.1	27.7
<b>Expediting program eligibility determinations</b>						
Expedited Medicaid financial eligibility determination	Triage Pilot		*			*
Self-declarations of financial circumstances accepted initially	Triage Pilot		*			*
Established timeframes for initial functional assessments	*		*	*	*	*
Use of provisional plans of care	*					*
<b>Ensuring that HCBS providers are willing and able to provide immediate care</b>						
Payment assured for those with "presumptive eligibility"	Triage Pilot		*			*
Consumer option to hire independent providers	*			*		*
Nurse Practice Acts or delegation programs allow less skilled providers to deliver services	*	*	*	*		
<b>Developing procedures to track and manage placements</b>						
Mandated nursing home pre-admission assessment for <i>all</i> individuals		*		*		
Requirements for hospitals or nursing homes to inform Medicaid of admissions	*		*	*		
Initial Medicaid nursing facility certifications for limited time periods		*		*	*	*
Case managers continue to monitor community placements for a period after diversion or transition (Indiana)	*					
<b>Assuring that financing arrangements support community based care</b>						
One budget for all LTC services		*	*			
Waiting list priority for diversion or transition (Vermont, Indiana)	* DD/ACS only					
<b>Providing support to maintain or obtain community residences</b>						
Use state funds to help finance moves or home modifications	*		*		*	*
Home maintenance allowance for Medicaid beneficiaries in institutions, likely to return to the community			*	*	*	*
<b>Informing people about options for care</b>						
Publicity campaigns	*		*		*	*
Training with hospital discharge planners				*	*	*

Note: Chart as presented in "Strategies to Keep Consumers Needing Long-Term Care in the Community and Out of Nursing Facilities", Laura Summer, Kaiser Commission on Medicaid and the Uninsured. Information for states other than Arkansas as presented in 2005 report. Arkansas column added and Arkansas information is current. Source of expenditure data: Burwell B, Eiken S, Sredl K, Thomson Healthcare, "Medicaid Long Term Care Expenditures in 2006".

In Arkansas, 41-49 of every 1,000 individuals age 65 or over resides in a nursing facility. This is higher than the national average.



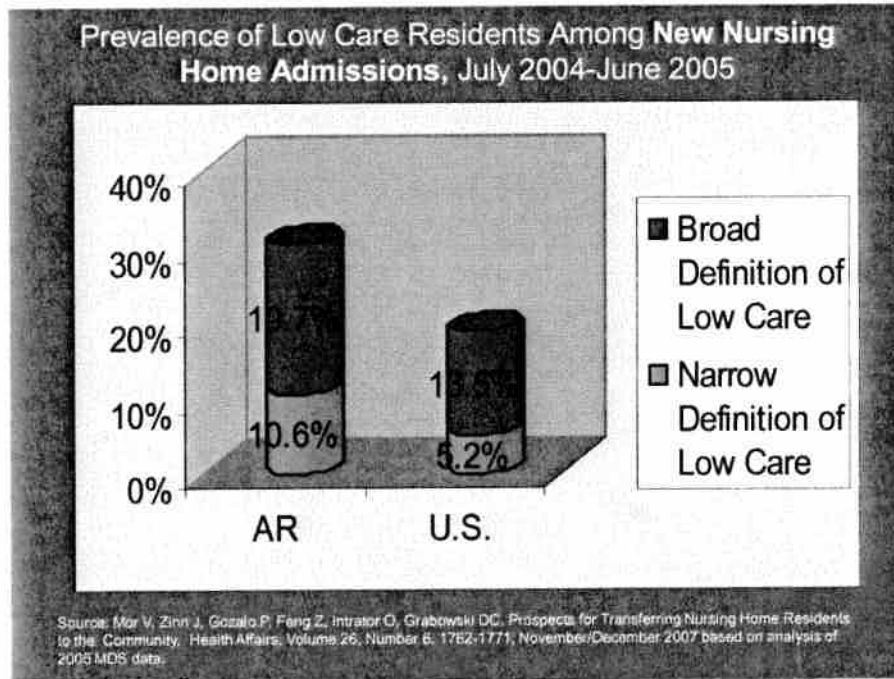
#### IV. IDENTIFYING LOW CARE NH RESIDENTS AS PART OF ARKANSAS'S NH TRANSITION STRATEGY:

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Researchers have concluded that a significant percentage of nursing facility residents could be treated in lower levels of care.<sup>43</sup> According to a recent paper published in *Health Affairs*, Arkansas has a higher than average prevalence rate of low care nursing home residents.<sup>44</sup> Specifically, among the long-stay nursing home population, 9.1% residents of Arkansas's nursing homes meet the narrow definition of

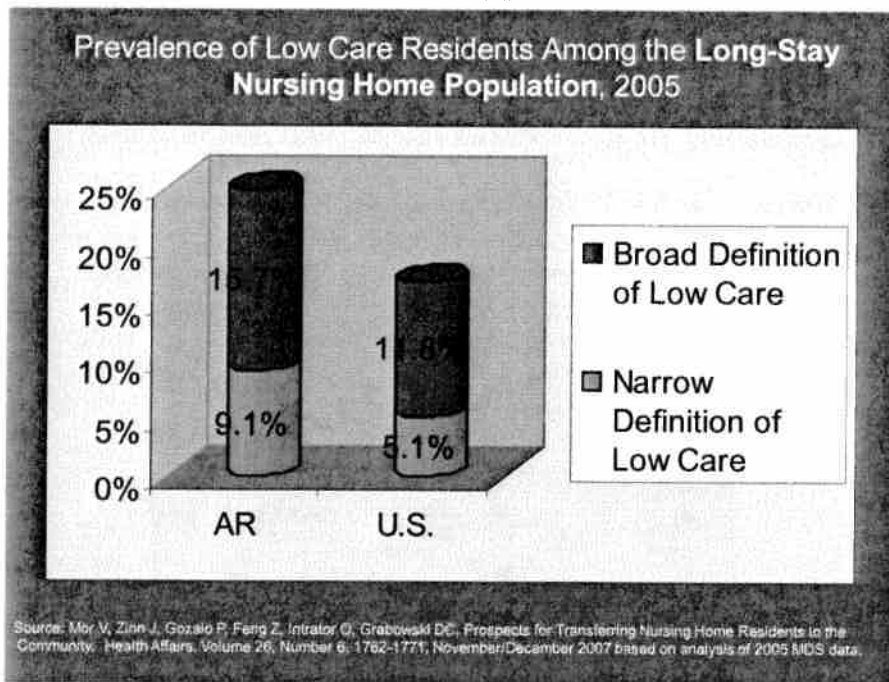
low care, while 15.7% meet the broader criteria for low care; the national average is 5.1% and 11.8%, respectively. Among new admissions, 10.6% and 19.7% of Arkansas's nursing home population meets the narrow and broad definitions of low care; nationally, 5.2% and 13.5% of new admissions are for low care residents.<sup>45</sup>

**Chart 10:**





**Chart 11:**



**Arkansas MDS Study Data:**

In studying LTC issues, the AR DHS Division of Aging and Adult Services (DAAS) analyzed a prevalence sample of calendar year 2007 Arkansas Medicaid nursing home resident assessments from the Centers for Medicare and Medicaid Services (CMS) Minimum Data Set (MDS) national data repository. The MDS is the federally-mandated assessment conducted for all residents of Medicare/Medicaid-certified nursing facilities upon admission and at least quarterly thereafter<sup>46</sup>.

The Health Affairs “narrow” definition<sup>47</sup> used by several states, including Michigan and Louisiana,<sup>48</sup> to define “low-care” residents in nursing homes was applied to the sample data, which was comprised of 12,399 unique individuals identified as Medicaid per diem residents from each resident’s assessment selected for

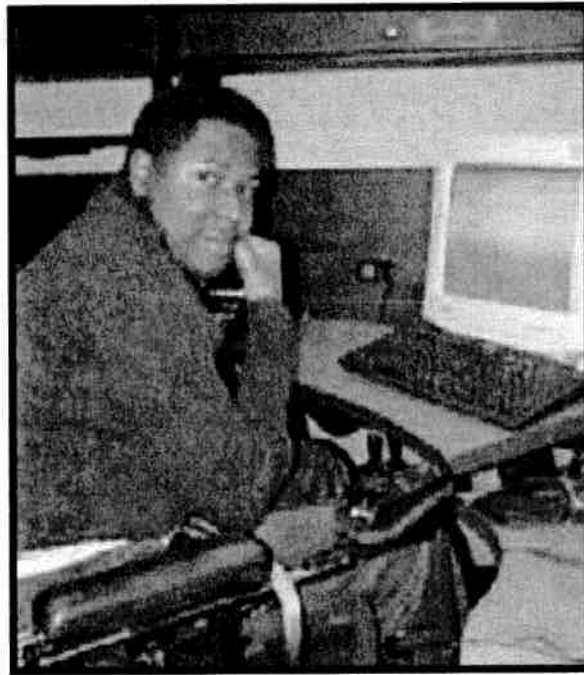
analysis. The analysis showed that during calendar year 2007, an estimated 10.7% of Medicaid per-diem residents were classified as low-care. It is important to note, however, that the low care residents identified were not in need of care. They may have required some assistance in bathing or performing some activities of daily living. However, they did not have major medical problems such as cognitive or functional problems, as identified from their assessment data.

During the calendar year, \$560M was spent on behalf of Medicaid beneficiaries treated in the nursing home. Projecting the percentage of low-care Medicaid residents to actual calendar year 2007 expenditures, it is estimated that as much as \$59M could have been spent on low-care care residents at the nursing facility.

## INDEPENDENT CHOICES CASE STUDY: FRANKLIN'S STORY

Franklin suffered a spinal cord injury at age 16, which resulted in quadriplegia. However, despite this disability, Franklin works full-time at Acxiom. Franklin enjoys his work, is good at it, and inspires his co-workers. He is known for his abilities, rather than his disabilities.

Franklin's disability qualified him for Medicaid personal care services and he enrolled in Arkansas's Cash & Counseling program, Independent Choices, in 1998. Franklin uses the Independent Choices program because it gives him the flexibility that he needs; his attendant helps him get ready for work and drives him to and from the office. Working and the services he receives from Independent Choices have enabled him to lead a normal life. He is married and has two children. He and his family live in a nice home in Little Rock and he bought a van, which is equipped with a wheelchair lift.



The services that Franklin has received over the past ten years have cost Medicaid, on average, \$9,964 a year. Many others with quadriplegia reside in the state's nursing homes. In comparison, the average cost to Arkansas Medicaid for a year in a nursing home is \$48,990.<sup>1</sup>

<sup>1</sup>Source: Arkansas Medicaid Claims Data, Business Objects query. "Nursing Home Gainers Far Outpace Losers in 2006", [arkansasbusiness.com](http://arkansasbusiness.com), February 26, 2007. Available from: <http://arkansasbusiness.com/printable.asp?aid=96895>

V. POLICY RECOMMENDATIONS FOR REBALANCING LTC IN ARKANSAS

The following recommendations are based on a literature review and from a review of the LTC plans of several other states.<sup>49</sup>

1. **Increase reimbursement rates for Personal Care, Targeted Case Management and selected ElderChoices Services. Incorporate pay for performance standards tied to reimbursement.**

There has not been a rate increase for Home Delivered Meals and Targeted Case Management in 16 and 18 years, respectively. All of the aforementioned services, with the exception of Targeted Case Management, are dependent on minimum wage workers; the upcoming federal minimum wage increases will adversely affect these services. The requested Medicaid rate increases will barely cover the increase in wages for minimum wage workers and will not offset the rising costs of gas and food, which impact the cost of providing these services. See table below for additional information on the proposed rate increases.

**MEDICAID SERVICE RATES — Current and Requested**

SERVICE TYPE	Current Rate	Requested Rate	Estimated Cost of Increase	Date Rate Set
Targeted Case Management	\$17.00/hr	\$45.00/hr	\$2,756,325	1990
Home Delivered Meals	\$4.97/meal	\$7.03/meal	\$2,073,779	1992
Personal Care	\$14.56/hr ②	\$16.76/hr	\$9,247,542	2004
Homemaker	\$14.56/hr ②	\$16.76/hr	\$2,638,454	2004
Adult Companion	\$14.56/hr ②	\$16.76/hr	\$630,320	2004
In-Home Respite	\$14.56/hr ②	\$16.76/hr	\$1,522,286	2004
Agency Attendant Care	\$14.56/hr ②	\$16.76/hr	\$498,894	2007
<b>Estimated Total Cost of Increase (Federal and State) = \$19,363,555</b>				
<b>► Estimated Total Arkansas General Revenue = \$5,264,963 ◀</b>				
<p>☐ = Services dependent on minimum wage workers                  ☐ = Service rate has not been increased in 16-18 years.                  ② = Rate includes a 72-cent increase requested from CMS, but not yet approved.                  ► State Match Rate = 27.19% ◀</p>				

**2. Dedicate \$8 million in General Improvement Funds for the development of private affordable assisted living facilities. These funds would bring equity into projects in return for a commitment to admit Medicaid residents.**

The availability of residential alternatives to nursing home care is critical to the success of nursing home transition and diversion efforts.<sup>50</sup> Arkansas has experience in developing affordable assisted living; the State received funding from the Robert Wood Johnson Foundation in 2001 to develop a model of affordable assisted living under the *Coming Home* program. Lessons learned from this project should inform Arkansas's future efforts to support additional affordable assisted living facilities.

Identify tax credits and other financing mechanisms (such as grants, low interest financing, revolving loan funds, bonds or loan guarantee programs) to leverage additional public and private resources in order to accelerate the development of affordable assisted living facilities<sup>51</sup> in combination with General Improvement Funds to provide private facilities an incentive to accept Medicaid patients who would otherwise seek nursing home care.

**3. "Repurpose" unused or unoccupied nursing home beds by promoting non-traditional "Home Style" facilities such as those found in the GreenHouse™ or similar small house models.**

Arkansas's Home Style facilities, which are the emphasis of both the Greenhouse™ and similar small house models, encourage the creation of residential style facilities with small numbers of residents per facility, private rooms, and an emphasis on making the facility appear and function as a true home. This could be performed in a number of ways, including:

- Requiring that unused beds be "turned back" as a means of financing the additional costs of Home Style facilities.
- Allowing providers to utilize unused beds only for facilities that incorporate home-style principles and physical plants.
- Require facilities that want to add beds or build a new facility to "turn back" unused beds. If this is adopted, however, it would not apply to replacement facilities nor would it apply when a significant unmet bed need existed; i.e., it should not apply in a manner as to create or exacerbate need.

Next steps:

- i. Determine the optimum number of beds in light of increased HCBS versus factors that could increase bed need.
- ii. Explore the ability to "re-purpose" unused beds as a means to finance or encourage the construction and operation of Home-Style facilities.

- 4. Use a portion of the \$500,000 appropriated to the AR DHS Division of Medical Services for “fast track” to include transition services, case management and other costs for individuals in institutions wishing to return to the community.**

Individuals often encounter the LTC system due to a fall or other crisis. For hospitals, the easiest discharge is to a nursing home. Once stabilized these individuals may be able to return to the community. AR DHS has the ability to “fast track” some clients ready for discharge from a hospital. However, for those already in a nursing home, discharge may present more obstacles, especially when the resident does not have a home to which to return. Funds are needed to pay utility and rent deposits, buy basic furniture, house hold items, etc. Medicaid case management is limited. Using the existing AR DHS funds could greatly facilitate transitions back to the community.

- 5. Amend Medicaid waivers for ElderChoices and Alternatives 1915(c) Medicaid waivers to include transition services allowed under current federal regulations.**

CMS policy changes since 2002 have increased flexibility under Medicaid HCBS waivers to support states’ nursing home transition efforts by allowing states to bill certain community transition services. In order for a state to take advantage of this funding option, the state must amend its waiver(s) to add community transition services. These services are only available to individuals moving from a Medicaid funded institution to a home or apartment; the service is not available to support individuals moving to community residential settings, such as group homes and assisted living facilities. Under the community transition services option, Medicaid can pay for services such as: security deposits; essential furnishings and moving expenses; utility deposits; and services necessary for the health and safety of the resident including pest eradication and allergen control.<sup>52</sup>

Arkansas should take advantage of this flexible funding option by amending its HCBS waivers to add transition services in order to further strengthen nursing home transition programs underway in the state.

- 6. Create an internal AR DHS workgroup to determine which Money Follows the Person Demonstration Services to incorporate into Medicaid State Plan or Waivers.**

Money Follows the Person is a federal grant that supports rebalancing by giving individuals a choice in where they live and receive services. Its goal is to transition 305 individuals from institutions back into the community. The grant is funding and testing eight demonstration services for the next twelve months. (See table on following page for listing of the MFP demonstration services.) If demonstration services are continued, Arkansas must add them to the Medicaid State Plan or Waivers.

**Table 4: MONEY FOLLOWS THE PERSON (MFP)  
DEMONSTRATION SERVICES**

<p><b>Service</b></p>
<p><b>24 Hour Helpline:</b> 800-toll free telephone access to nurse triage, care advice and support to callers with any health related concerns.</p>
<p><b>In Home Monitoring Technology:</b></p> <ol style="list-style-type: none"> <li>1. 24/7 personal monitoring system, using sensory technology, that identifies developing health problems and alerts for potential emergencies. The system can detect prolonged inactivity, extreme temperature changes and captures this into a web-based program accessible by family or care professionals. This may also work in conjunction with Personal Emergency Response units, if needed.</li> <li>2. Medication Monitoring Device: The device stores pre-set dosages in a programmed unit. It plugs into phone line and self checks nightly. Device is programmed for dosage times, delivers meds with an auditory and visual reminder, and has features (depending on the type of unit) to include rotation floor to remove med cup if not taken in established time frame, notification of failure to acknowledge taking meds, so that intervention can be taken earlier to prevent potentially negative health concerns.</li> </ol>
<p><b>Telemedicine:</b> The practice of health care delivery, diagnosis, consultation, treatment transfer of medical data or exchange of medical education information by means of audio, video, or data communications. Includes components of Tele-health and Tele-Rehabilitation.</p>
<p><b>Community Transition Services:</b> Items, goods, or services necessary to allow an individual residing within an institution to transfer into a community setting. Includes environmental modifications, assistive devices, deposits, essential furniture, appliances and household items in addition to goods or services deemed appropriate for transition activities.</p>
<p><b>Supported Living:</b> This is an array of individually tailored services and activities to enable individuals to reside successfully in their own homes, or in an alternative living setting. Delivered over a 24 hour period in a protected supervised environment on a short-term basis.</p>
<p><b>24 Hour Emergency (Attendant) Care:</b> The provision of assistance to a medically stable and/or physically disabled person to accomplish those tasks of daily living that the individual is unable to complete independently. May be agency or self-direction status. Time limited (short-term) status. Includes companion, transportation, errands, incidental housekeeping.</p>
<p><b>Intense Transition Management:</b> The provision of assistance in obtaining services or benefits, beyond the scope of existing case management activities currently reimbursed by Medicaid. Includes acting on behalf of the clients to resolve identified barriers to needed services or resources, such completion of applications and paperwork, attending meetings/hearings on behalf of client, inspection of services or goods, crisis intervention, setting up banking services and other related activities.</p>
<p><b>Therapeutic Interventions: (****Still In Development****)</b> Will include additional assessments (nutrition and depression, initially) and identification of high risk needs. Intervention (dietician consultation or mental health consultation) will be implemented with post assessments to determine impact.</p>

**7. Restructure the Governor’s Integrated Services Taskforce to advise AR DHS on the implementation of this plan.**

The Governor’s Integrated Taskforce (GIST) was formed to assist the State in developing an *Olmstead* Plan. The *Olmstead* Plan has been completed, with the majority of the priority recommendations achieved and action steps in progress. The GIST has helped guide AR DHS in development of System Change Grants and the Money Follows the Person demonstration. Because the Department has a major planning process underway for mental health (System of Care) and because services for individuals with developmental disabilities tend to be different than those for the elderly and adults with physical disabilities, it is recommended that the GIST is restructured to focus on the elderly and adults with physical disabilities. Further, it is recommended that the GIST advise AR DHS on the implementation of this plan and other issues related to the elderly and adults with physical disabilities.

**8. Proceed with piloting SOURCE in four counties.**

SOURCE, Service Options Using Resources in Community Environments, establishes a design of Enhanced Case Management to improve the health outcomes of targeted populations. In Arkansas, the SOURCE program proposal will target the following groups:

- persons aged 65 and older who participate in the ElderChoices HCBS Medicaid waiver program;
- individuals aged 21 through 64 who participate in the Alternatives for Adults with Physical Disabilities HCBS Medicaid waiver program;
- persons aged 18 and older who participate in the IndependentChoices Cash and Counseling Demonstration waiver program;
- individuals receiving SSI benefits based on a physical disability as determined by the Social Security Administration and have a level of care need for personal care as defined by the Arkansas Medicaid Personal Care program.

SOURCE is a case management model that provides the framework to manage the care of consumers across all lines of service, diagnosis or disability through a cost-effective, comprehensive managed care model. SOURCE is distinguished from other programs by the linkage of primary medical care to community services, through a Primary Care Physician/Case Manager team and approach.

The Arkansas proposal will be piloted in 4 counties in northwest Arkansas and is tentatively scheduled for implementation 1-1-09, pending approval by CMS.

**9. Develop an AR DHS strategic plan to meet the HCBS needs of Arkansans with Traumatic Brain Injuries (TBI), including the feasibility of developing a TBI Medicaid Waiver.**

Often labeled as “the silent epidemic”, there is a heightening awareness, at the state and national levels, of the increasing numbers of individuals who have suffered TBI, in part due to the Iraq war. While spinal cord injuries are estimated to occur at a rate of 5 per 100,000 persons each year, TBI occurs at a rate of 200 per 100,000 persons each year. Evidence suggests there is a huge gap in critical services needed to maximize recovery from TBI, such as secondary or sub-acute rehabilitative care. Challenges in providing necessary TBI services include the length of recovery time and lack of reimbursement for specialized care options. The number of individuals with TBI living in LTC institutions, due to the lack of necessary services, is growing. A TBI specific waiver would assist individuals in their recovery efforts and help them develop strategies enabling them to live with their ongoing disabilities in a less restrictive setting. Traditional nursing homes are not trained to deal with the unique impairments associated with TBI and frequently encounter behavior problems potentially endangering to themselves or other residents. Individuals with TBI often tend to be younger than the average nursing home resident, creating another disparity of the typical nursing home population. Arkansas’s TBI waiver would offer rehabilitative and supported employment directed services to allow these individuals to make a more complete recovery and remain productive citizens earning wages, paying taxes, and exerting choices in how they live their lives.

**10. Review LTC financing options and organizational system design to identify models that will enable the state to meet the future increase in the demand for LTC services, including a global budget, managed care and integrated service models.**

With the aging of the baby boom generation, LTC expenditures are projected to increase dramatically. Thus, the state should explore new funding models that will enable the state to provide choice-driven, cost-effective and quality LTC services to improve care coordination and reduce the fragmentation of the LTC system.<sup>53</sup>

*Next steps:*

- i. Explore possibility of creating a global budget for LTC as done in Washington and Oregon.
- ii. Consider use of Medicaid Managed LTC plans.
- iii. Examine LTC organizational, structural and systems issues in order to improve care coordination and reduce fragmentation of LTC system through use of an integrated model.



**11. Improve the use of technology in the delivery of HCBS. As part of this initiative, an Information Technology plan, which will facilitate access to HCBS and support quality improvement and quality assurance activities, will be developed and funded. (Note: 90% of federal funding is available for part or all of this recommendation.)**

Telehealth, one promising use of technology, has been defined by the U.S Health Resources and Services Administration as “the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.”<sup>54</sup> As many as 44 states provide some type of Medicaid reimbursement for Telehealth services.<sup>55</sup> Providing telehealth services in the home has the potential to reduce Medicaid spending.<sup>56</sup> Additionally, telehealth allows states to provide services to individuals in less restrictive settings and supports “aging in place” initiatives.

Health Information Exchange (HIE) is concerned with the exchange of clinical information across providers and care settings to improve care coordination. In theory, improved access to complete clinical data for patients across the health care system should lead to improved clinical decisions, clinical outcomes, less duplication of services and lower health care costs.

Greater use of technology, such as document management software, could improve operations within AR DHS. AR DHS plans to develop and implement automated, web-based processes that include common applications, common assessment tools, and plans of care. AR DHS will decide whether to adapt existing tools within the state or develop and implement Arkansas-specific tools. Those involved in the planning phase will also provide input on how best to prepare, train, and equip agency staff, providers, participants, and applicants for the switch to IT systems. The current plan is to create all of these IT solutions through enhancements to the MMIS or through systems that interface seamlessly with the MMIS in order to use 90/10 enhanced funding. AR DHS will develop and submit to CMS an Advanced Planning Document (APD) for development and implementation of these systems.

*Next steps:*

- i. Collaborate with the Arkansas Regional Quality Initiative (RQI) Health Information Exchange (HIE), a collaborative group of Arkansas health insurers including Arkansas Medicaid, and other stakeholders to explore increasing the number of Medicaid programs that reimburse telehealth services.
- ii. Consider increasing use of electronic document solutions to enhance efficiency in AR DHS program operations.

**12. Develop performance standards to measure the progress made in balancing the state's LTC system.**

In 2007, Arkansas was one of ten states awarded a State Profile grant from the Centers for Medicare & Medicaid Services (CMS). The grant will support Arkansas's efforts to assess its LTC system. Under the grant, stakeholder input on identifying service gaps in the LTC system will be gathered through a series of Strength, Weakness, Opportunity, Threats (SWOT) analyses, which will be conducted with different populations that are consumers of LTC services. In addition to the stakeholder assessment activities, a group of national experts on LTC will conduct an evaluation of the system; will analyze the feasibility of Arkansas adopting LTC reforms that have proven successful in other states; and will develop policy recommendations suggesting changes that will improve the balance of the LTC system in the state. Another goal of the State Profile grant is for CMS, with the assistance of a National Balancing Indicator Contractor, to develop a set of national balancing indicators to measure balancing of LTC services across and among the states.

**13. Create a work group to address the LTC application process to ensure consumer choice and timely processing of applications.**

Navigating the application process for Medicaid HCBS Waivers is a maze through which many frail older individuals and families cannot find their way. The process is complex and necessitates the collection of numerous documents such as bank statements. It can take over 45 days to complete. Arkansas has added several HCBS Waivers, which have improved care in the community. However, expanded choices have created confusion among consumers, professionals, and even AR DHS staff that process applications ranging from family planning to food stamps to HCBS waivers. The Work Group would be comprised of consumers, advocates, DAAS, Department of County Operations (DCO), providers and other interested parties.

**14. Coordinate with Partners in Planning (PIP) to make healthy aging a reality in Arkansas through statewide interdisciplinary coordination and collaboration.**

PIP is a partnership between UAMS' Reynolds Institute on Aging, the Arkansas Department of Health's Center for Health Improvement, AARP and DAAS within DHS that is committed to working together to make healthy aging a reality in Arkansas through statewide interdisciplinary coordination and collaboration. It has four goals that support and enhance the efforts of this plan: (1) older Adults will have a choice in how and where they receive quality LTC services and supports; (2) older Adults will experience optimal health; (3) older adults will have livable communities; and (4) increase the availability of a qualified and committed workforce serving older adults. AR DHS will work with PIP to achieve goals that parallel or expand upon AR DHS' vision for LTC in Arkansas.

**15. Develop models that integrate acute and chronic care.**

The Centers for Medicare and Medicaid Services (CMS) estimates there are 6.2 million people in the U.S. that are eligible for both Medicare and Medicaid. Many in this group have complex medical and chronic care needs that require lengthy stays in a variety of long-term settings.

Those who qualify for both Medicare and Medicaid – the dual eligibles– are the most vulnerable of Medicare beneficiaries. They are more likely to be female, live in a nursing home, have a serious disease or chronic condition, suffer from serious functional limitations, have less access to a regular source of care or preventive services, and make greater use of emergency room services.<sup>57</sup> Because Medicaid and Medicare are fundamentally different (see chart below), states face a challenge in integrating care. However, to achieve optimal health outcomes and control cost, Arkansas should explore options for integration.

### Differences in Acute Versus Long-Term Care

<b>Acute Care</b>	<b>Dimensions</b>	<b>Long-Term Care</b>
Acute Illness	Demand Source	Chronic Illness
Diagnosis	Critical Source	Function
Hospital/Outpatient	Site	Nursing Home-Home
Sharply Delineated	Boundaries	Fuzzy
Cure	Desired Outcomes	Maintenance
Professionals	Caregivers	Family Members
Physician Directed	Professional Roles	Physician is absent- other turf is disputed
Interventionist	Styles of Care	Maintenance
High	Technology	Low
Dynamic Science	Intellectual Basis	Pre-paradigmatic
Intensity	Cost Drivers	Duration
Medicare	Primary Public Payer	Medicaid

Source: Bruce C. Vladeck, 1994

## 16. Implement Administration on Aging Nursing Home Diversion Programs

Arkansas was awarded a \$500,000 nursing home diversion grant from the Administration on Aging (AoA) in 2007. Under this project, two of the state's Area Agencies on Aging are providing HCBS to 150 non-Medicaid eligible Arkansans at imminent risk of nursing home placement and spend-down to Medicaid. This program builds on Arkansas's successful Independent Choices Cash & Counseling model and provides consumers with the ability to use flexible service dollars to meet their long-term care needs. Arkansas is currently applying for additional funding from AoA to expand this program and plans to sustain it beyond the grant period to provide Arkansans with an additional option regarding how and where they receive needed LTC services.

## 17. Improve Access to LTC Information and Assistance

In order to support informed decision-making and to enhance individual choices, information and assistance must be provided to enable individuals to plan for their own LTC needs.

*Next steps:*

- i. Expand Choices in Living publicity campaign to educate the public on the importance of planning for LTC needs and to increase awareness of available services and supports.
- ii. Add link to Medicare Nursing Home Compare website to DAAS website as a source of information on nursing home quality.



## **18. Educate consumers and families regarding LTC financing options**

Education campaigns on the importance of planning for future needs may reduce reliance on Medicaid as a provider of LTC services, particularly for individuals with higher incomes. In 2007, Arkansas enacted Act 99, which created a Long Term Care Partnership program. The program is intended to encourage the purchase of LTC insurance and to strengthen consumer protection provisions with respect to LTC insurance policies. Additional initiatives designed to promote personal and family planning and preparedness for future LTC needs include the following:

- i. Outreach efforts to promote the AR LTC Partnership program.
- ii. Encourage use of financing mechanisms such as affordable reverse mortgages that allow individuals to remain in their homes and pay for care with private resources.
- iii. Explore a Medicaid Managed Care Program.
- iv. Explore potential role of social insurance.

## **19. Review Medicaid LTC functional eligibility criteria and procedures. Develop a process to designate Medicaid beneficiaries in nursing facilities as either long or short stay residents with periodic reassessments by an independent party. Require reassessments for individuals originally certified as short stay residents.<sup>58</sup>**

New Jersey, which has one of the largest nursing home transition programs in the country,<sup>59</sup> has implemented this strategy. In New Jersey, all short-term residents are certified for a six month or less stay in the nursing home; during this period counselors work with the “short-stay” residents to develop a community relocation plan. Another option is to require reassessment after the initial certification period; both of these efforts are aimed at ensuring that short-term nursing stays do not evolve into long-term stays.<sup>60</sup>

*Next steps:*

- i. Revise Arkansas’s LTC assessment process to designate all Medicaid recipients in nursing homes as either short stay or long stay residents.
- ii. Require periodic reassessments after the initial certification period.

## 20. Improve Hospital Discharge Planning Process

Coordinating HCBS in terms of authorizing coverage and services can be a complicated and time-consuming process; admission to a nursing home, however, is perceived to be a “quick, safe discharge for the hospital.”<sup>61</sup> Thus, outreach and education for hospital discharge planners regarding the array of available HCBS should be developed to improve the hospital discharge planning process in order to decrease the bias in favor of discharge to nursing facilities.

Another difficulty in using the hospital discharge process to divert institutional placements is associated with the lengthiness of the Medicaid eligibility process. Thus, timely eligibility determinations are critical for successful community placements.<sup>62</sup> Presumptive eligibility programs, which have been implemented in a number of states including Arkansas, address this challenge by shifting the cost of caring for individuals who may not ultimately qualify for Medicaid services from individual HCBS providers to the state.<sup>63</sup>

### *Next steps:*

- iii. Apply for the 2008 Real Choice Systems Change grant, which offers funding to support the development and implementation of a person-centered hospital discharge planning model
- iv. Improve education efforts targeted at discharge planners regarding available HCBS
- v. Expand Options Counseling program to include hospitals
- vi. Increase efforts to identify individuals discharged to a nursing facility that are short-stay clients and provide follow up assistance to ensure that they do not become long-stay residents.



## 21. Enhance support services for informal caregivers

Informal caregivers play an integral role in the LTC system. A 2004 report by AARP and the National Alliance for Caregiving estimated that approximately 44 million men and women in the United States provided unpaid care to a family member, neighbor or friend.<sup>64</sup> The one year economic value of services provided by informal caregivers was estimated to be \$306 billion.<sup>65</sup> Additionally, the same report found that two-thirds of caregivers needed more help with, or information concerning, activities and commonly faced issues.<sup>66</sup>

*Next steps*<sup>67</sup>:

- i. Integrate caregiver support information and services into Choices in Living Resource Center;
  - o Explore grant opportunities to provide caregiver training programs;
- ii. Include caregiver support services into each consumer's plan of care;
- iii. Expand scope and extent of supplemental services available to caregivers;
- iv. Authorize the use of direct funding to allow informal caregivers to purchase respite or supplemental services.<sup>68</sup>

## 22. Increase focus on health promotion and prevention interventions to reduce future need for LTC services

In 2003, over 1.7 million cases of seven common chronic diseases were reported in Arkansas; of all states in the U.S., Arkansas reported the third-highest number of chronic diseases per capita.<sup>69</sup> The economic impact of chronic diseases on the state in 2003 totaled \$13.9 billion in annual costs.<sup>70</sup> It is projected that the chronic diseases will increase dramatically in the next twenty years, unless improvements in preventing and managing chronic diseases are made.<sup>71</sup> Further, unintentional injuries such as falls, should be addressed through education and interventions. The Centers for Disease Control estimates that nearly one third of individuals age 65 and older experience a fall each year; the total direct cost for falls among older adults in 2000 was estimated at \$19 billion.<sup>72</sup> With the coming demographic increase in the number of older Americans, the cost of falls is expected to reach \$43.8 billion by 2020.<sup>73</sup>

*Next steps:*

- vii. Disseminate information on falls and disability prevention (CDC information through Choices in Living Resource Center).
- viii. Implementation of Chronic Care Management Programs such as SOURCE (Service Options Using Resources in Community Environments) as used in Georgia.

### 23. Support Quality Improvement/Assurance Initiatives

The quality of LTC services is an ongoing concern. In fact, mandated use of the Minimum Data Set (MDS) stemmed from Congressional concerns regarding the quality of care provided in nursing homes.<sup>74</sup> In response, Congress mandated the use of the Resident Assessment Instrument (RAI) in the Nursing Home Reform Act, part of The Omnibus Budget Reconciliation Act of 1987 (OBRA-87).<sup>75</sup> Before the Congressional mandate requiring MDS assessment in the OBRA 87 reforms, quality of care data on nursing homes was only available in aggregate form.<sup>76</sup> More recently, quality outcomes for HCBS have been integrated into LTC quality improvement and assurance efforts.<sup>77</sup>

*Possible next steps:*

- i. Build upon current efforts of Arkansas Foundation for Medical Care (AFMC) to improve national nursing home quality indicators.
- ii. Provide incentives for quality care rather than only assessing penalties for poor care.
- iii. Increased staffing requirements.
- iv. Improved training/education.
- v. Support the development of Greenhouse and/or Eden models.

### 24. “Rightsize” and Address the Changing Role of the Nursing Home Industry

Arkansas’s nursing home occupancy rate for 2006 was 72.7%, which was among the lowest in the country.<sup>78</sup> Arkansas’s low nursing home occupancy rate indicates a need for a “rightsizing” of the state’s nursing home industry. Several states (including Indiana, Michigan, Minnesota, Nebraska, North Dakota, New York and Wisconsin) have begun exploring options to reduce the number of certified nursing home beds as part of a comprehensive plan to rebalance their LTC systems. Common “rightsizing” approaches include converting existing nursing facility beds to assisted living units, offering providers a premium or one-time payment as an incentive to close beds or facilities. As a part of this process, other states have made efforts to include nursing home providers in systems change activities designed to provide increased consumer choice and an expanded array of HCBS, which are preferred by consumers.<sup>79</sup>

*Next steps:*

- i. Review Medicaid reimbursement methodology to determine cost, if any, of paying for vacant beds.
- ii. Evaluate LTC reimbursement rates/methodologies; consider use of a case mix reimbursement rate structure/tiered reimbursement rates based on level of care needed (to create disincentives for serving low care residents and incentives for serving high care residents).



**25. Explore the use of common functional assessments and care planning instruments in order to reduce the completion of duplicative assessments.**

Several states have begun to address the duplicative screening and assessment processes used in their LTC systems.<sup>80</sup> *InterRAI*, an organization comprised of researchers in over 20 countries<sup>81</sup>, has developed a series of common instruments including: MDS 2.0 (for nursing home services); RAI-AL (assisted living); RAI-HC (home care services); RAI-AC (acute care services); RAI-MH (mental health services); RAI-PAC (post-acute care services) that can be used as care planning and assessment instruments for LTC services.<sup>82</sup>

*Next step:*

- i. Consider use of *InterRAI* assessments and care planning instruments for LTC services (except DD services).<sup>83</sup>

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## CONCLUSION

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Arkansas has been an innovator in the area of LTC and has had success in efforts to transition individuals from institutional settings to the community by providing a wide array of HCBS.<sup>84</sup> In order to continue this trend and to retain its reputation as an innovator in LTC rebalancing efforts, nursing home transition and diversion programs should be strengthened. Additionally, a strategic plan to meet the current and future long-term care needs of Arkansans should be developed. Planning for future LTC needs is essential; LTC expenditures already account for almost one-third of total Medicaid expenditures. With the aging of the baby-boom generation, the demand for long-term care will only increase. LTC planning and policy development efforts should embrace the philosophy of rebalancing and ensure compliance with the Supreme Court's *Olmstead* decision by providing Arkansans with additional choices regarding how and where they receive needed LTC services.

## APPENDIX 1: SUMMARY OF PROGRAMS SERVING OLDER ARKANSANS AND ADULTS AND WITH PHYSICAL DISABILITIES

### HCBS PROGRAMS

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Even while these planning efforts are underway, Arkansas is devoting tens of millions of new dollars to HCBS. These programs provide citizens a choice of how and where they receive LTC services. Not only do citizens prefer to remain in the home, the services are less expensive.

Moreover, these programs work. **Between 1996 and 2001 Arkansas saw a 10% reduction in the number of nursing home residents.**

**www.ARGetCare.org** a web based statewide listing of services for older adults and people with disabilities. The Website's Self-Assessment Tool can help clarify one's needs or those of a loved one. The Learn About pages describe types of services that might meet those needs. If an individual already knows what they are looking for, AR-GetCare contains the most comprehensive and up-to-date listing of resources anywhere in Arkansas. One can search for services by location, special needs such as wheelchair accessibility, and other criteria. The site also contains checklists that can help one to choose the provider that best meets their needs. A "Housing Registry" is being added to the site.

**Choices in Living** is a virtual Aging and Disability Resource Center (ADRC) that provides information and assistance to connect consumers with the services and supports they need. A call center is staffed with experts on a wide range of services and corresponding programmatic and financial eligibility requirements. In addition to information, the Center can authorize the immediate start of services through a triage system. Individuals may also receive face to face help to apply for services in their homes through partner organizations at the local level.

**Options Counseling Act 516** of 2007 requires all nursing homes to notify AR DHS of all admissions within 24 hours, regardless of payment source. Consumers are mailed a packet of material on HCBS and provided the **Choices in Living ADRC** toll free number. In-home visits may also be made by registered nurses to help determine which programs may provide care in the home.

The **Direct Service Worker Registry (DSW)** is a customized internet based system designed to match the needs of in-home consumers, regardless of income, directing their own personal care with individual personal care providers. Subject to availability, the DSW Registry offers consumers with a referral, listing the names of potential personal care providers, as well as detailed information regarding availability, expected wages, services provided, contact information and more. There is no charge for the service.

## HCBS PROGRAMS

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**Personal Care** is an in-home care program that assists over 16,000 Arkansans of all ages maintain their independence by helping with activities of daily living such as bathing, grooming and eating. (Medicaid State Plan Service).

**PACE** (Program for All-inclusive Care for the Elderly) combines Medicare and Medicaid funding to better meet the unique needs of older Arkansans by improving their health and providing a range of HCBS. A hospital and Area Agency on Aging have teamed up to create the state's first PACE project (Medicaid State Plan Service).

**IndependentChoices** gives 2,000 older Arkansans and individuals with physical disabilities control over their lives by allowing them to self-direct their Medicaid Personal Care. This program received the Council of State Government's 2003 Innovation in State Government Award (Medicaid 1115 Demonstration waiver recently transferred to a Medicaid State Plan Service).

**Alternatives Waiver** provides helps over 1,000 adults with physical disabilities to avoid institutionalization by allowing them to hire and manage their own attendants and modify their homes to make them accessible for wheelchairs (Medicaid 1915(c) Waiver).

**ElderChoices** provides helps over 5,500 older Arkansans avoid institutionalization by providing a range of HCBS: Companion, Respite, Home Delivered Meals, Personal Emergency Response Systems, Chore, and Homemaker (Medicaid 1915(c) Waiver).

**Adult Family Homes**, also known as Adult Foster Care, is being added to **ElderChoices**.

**Assisted Living** is a combination of services and housing that provides an alternative to institutionalization. DAAS has worked with the Arkansas Finance Development Authority and local entities to create innovative methods to develop and build affordable assisted living (Medicaid 1915(c) Waiver).

**Nursing Home Diversion Grant** In collaboration with two of the State's Area Agencies on Aging (AAAs) AR is expanding service delivery options available through the AAAs, thereby providing Arkansans with increased consumer-directed LTC service options. The project is aimed at individuals not eligible for Medicaid, but at risk of entering a nursing home with the goal of keeping them in the community (AoA Grant).

**ARHome**, a waiver pending with CMS will allow Medicaid beneficiaries living in nursing homes an option to "cash out" their nursing home care and return to the community. It builds on Arkansas' success with IndependentChoices. Combines a Pre-paid Health Plan with services (Medicaid 1915(a)(c) Waivers).

## HCBS PROGRAMS

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**Money Follows the Person** is a \$21 million grant with the following objectives: A) Rebalance the LTC support system so that individuals have a choice of where they live and receive services; B) Transition 305 individuals from institutions back into the community. C) Promote a strategic approach to implement a system that provides person centered, appropriate, needs based, quality of care/quality of life services and a quality management strategy that ensures the provision of, and improvement of, such services in both the home and community-based settings (CMS Grant).

**AR SOURCE** (Service Options Using Resources in Community Environments) demonstration is scheduled for launch in January 2009. SOURCE is a model of voluntary acute and chronic care coordination. The goals of SOURCE are: Reducing inappropriate emergency room use, multiple hospitalizations, and nursing facility placement caused by preventable health complications, by promoting self-care and informal supports; maintaining health and function and slowing the decline that can result from chronic conditions; and eliminating service delivery fragmentation through managed care principles, outcome-based management, and relief from programmatic constraints, using a model that is replicable in a variety of environments.

The goals are met by: Active involvement of primary care physicians (PCPs) in coordinating services; Enhanced case management, including the power to authorize and change HCBS services; Communication and cooperation between the PCPs and the case managers; Use of interdisciplinary teams, each led by a medical director, to review cases; Accountability from HCBS providers through selective contracting and review of performance on outcome measures; and Expedited access to HCBS services (Medicaid State Plan Service).

Planning is under way for a **Traumatic Brain Injury Waiver**.

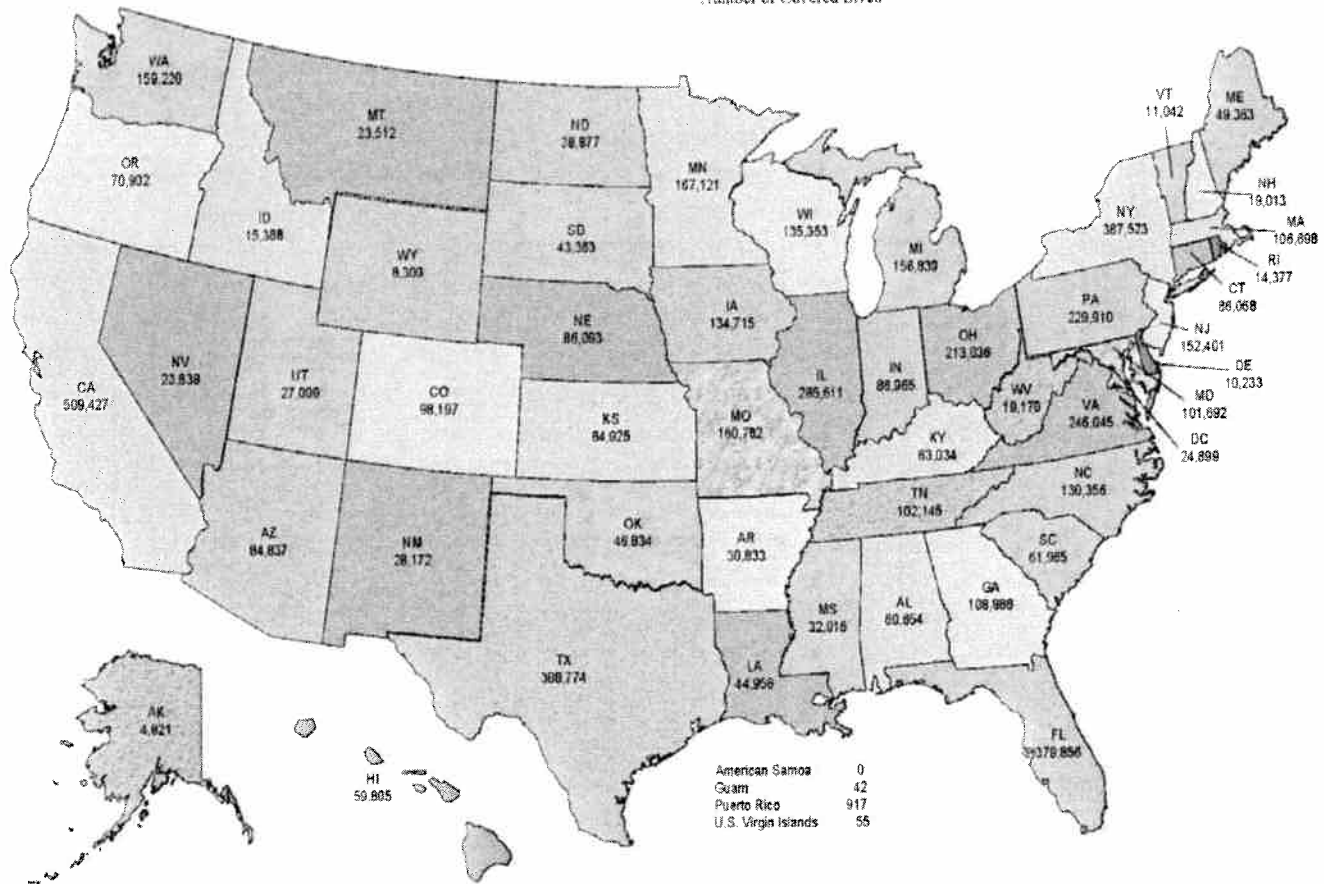


## APPENDIX 2: LONG-TERM CARE INSURANCE STATUS

### Long-Term Care Insurance Experience Report

2006 Form C by State

Number of Covered Lives



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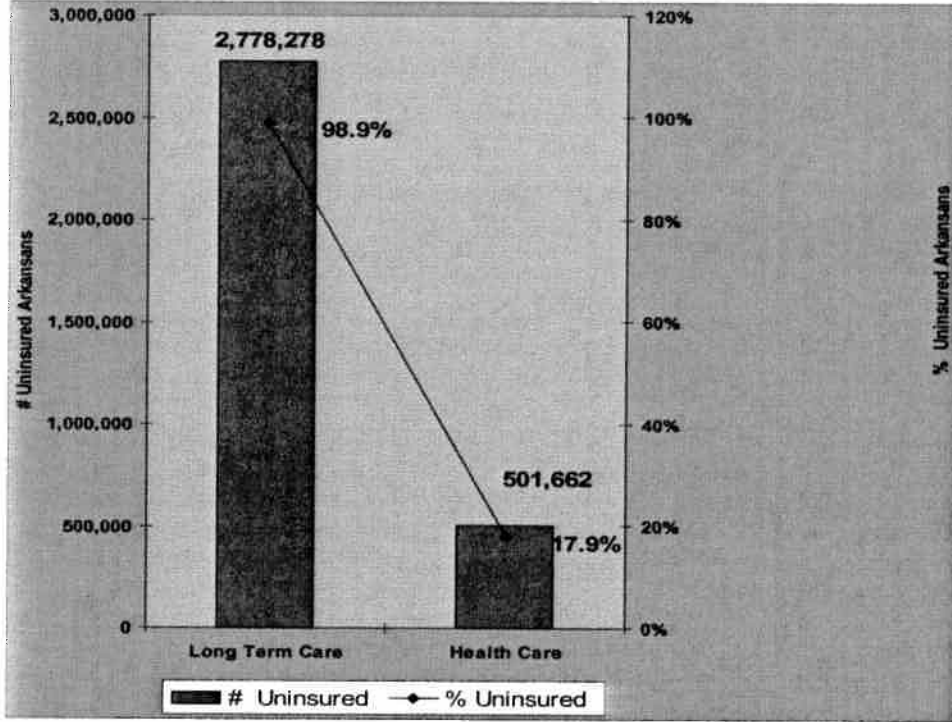
Source: National Association of Insurance Commissioners, "Long-Term Care Insurance Experience Report", 2006.

- ❖ **40 million: Number of Americans uninsured for health care**
- ❖ **250 million: Number of Americans uninsured for long-term care**

Nationally, in 2006, 5,614,852 Americans were insured for LTC. Among the states, Arkansas ranks 38<sup>th</sup> in the number of covered lives, with 30,833 covered within the state. Only 1% of Arkansans are insured for LTC, the remaining 99% have no insurance coverage for LTC expenses.

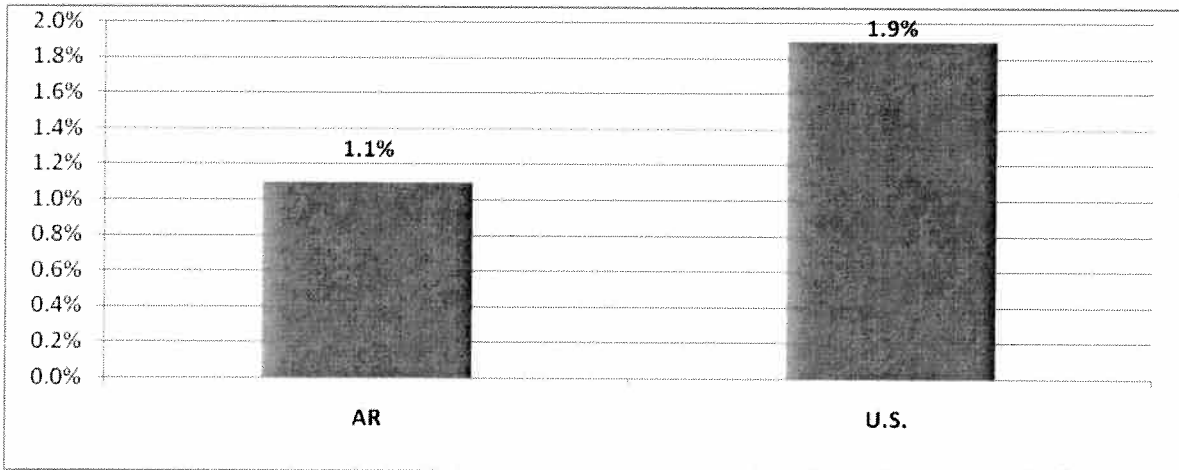
## APPENDIX 3: LONG-TERM CARE INSURANCE STATUS

**Number and Percentage of Uninsured Arkansans (LTC Insurance v. Health Insurance), 2006**



Data Sources: Health Insurance Data: Kaiser Family Foundation, State Health Facts, "Health Insurance of the Total Population, States (2005-2006), U.S., 2006", Urban Institute and Kaiser Commission on Medicaid and the Uninsured, estimates based on the Census Bureau's March 2006 and 2007 Current Population Survey (CPS: Annual Social and Economic Supplements). Available from: <http://www.statehealthfacts.org/comparebar.jsp?ind=125&cat=3>; LTC data: National Association of Insurance Commissioners, "Long-Term Care Insurance Experience Report, "Number of Covered Lives", 2006.

**Percent with LTC Insurance Policies, AR and U.S., 2006**



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<sup>82</sup> North Carolina Institute of Medicine, "A Care Plan for North Carolina: Final Report". Durham, NC, January 2001. Available from: <http://www.nciom.org/lcfinal.pdf>. Accessed 4/20/08.

<sup>83</sup> Note: there is currently no InterRAI assessment for DD; additionally, the PASSR assessment is federally mandated for individuals with DD to determine eligibility for nursing facility care. Source: North Carolina Institute of Medicine, "A Care Plan for North Carolina: Final Report". Durham, NC, January 2001.

<sup>84</sup> Arkansas Department of Health and Human Services, Division of Aging and Adult Services, "Services for Persons Who Are Aging". Available from: <http://www.arkansas.gov/dhhs/sgAging.html>. Accessed 10/20/06.