

THE LUCAS GROUP

**South Carolina Department of
Health and Human Services:
Strategic Vision/Plan for
Rebalancing Long Term Care**

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About The Lucas Group

Our Government Solutions team has proven Medicaid experts who have delivered exceptional results across the country in moving Medicaid to sustainable growth paths, while at the same time improving the quality of care. Our staff is committed to producing strategies that meet our clients' needs to improve the efficiency of Medicaid and provide relief from mounting program expenses. We are also committed to simultaneously enhancing service delivery for Medicaid beneficiaries while upgrading quality with definable benchmarks for outcomes.

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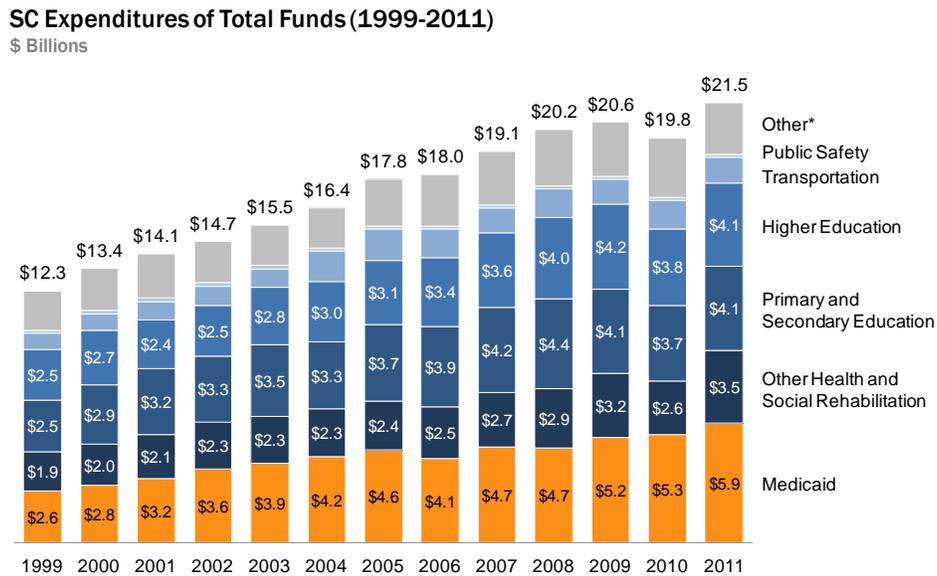
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Executive Summary

In 2009, Medicaid, a state and federal joint health insurance system for the poor and disabled, became the largest state program in South Carolina's total state budget. In 2011, Medicaid accounted for \$5.9 billion in total state expenditures, or 27% of the overall \$21.5 billion total state budget. To put into perspective the size of the program, the other large state expenditures included Higher Education (\$4.1 billion, or 19% of the budget), Primary and Secondary Education (\$4.1 billion, or 19%) and Transportation (\$1.3 billion, or 6%).

What's more alarming about Medicaid is that the program's growth is 53% greater than the growth of the budget as a whole. Between 1999 and 2011, Medicaid has grown at an average annual rate of 7.2%, while South Carolina's budget increased at a 4.7% rate.

Figure 1



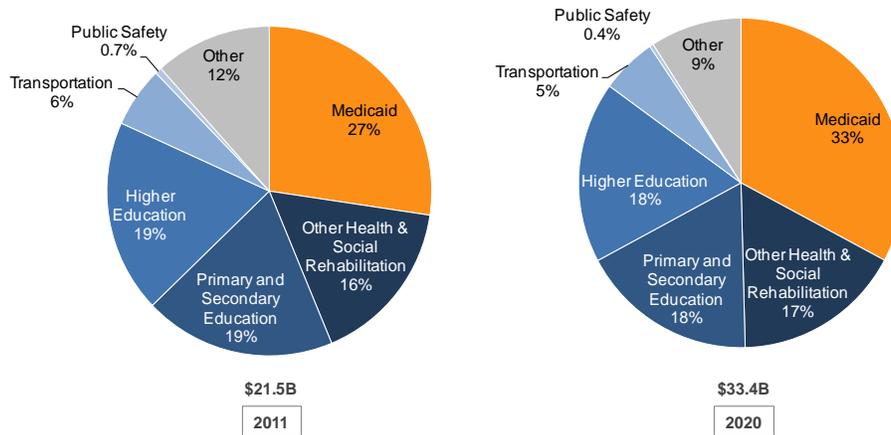
*Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Correctional; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Aid to Subdivisions
Source: SC Budget and Control Board; Lucas Group analysis

Statewide, Medicaid's growth is on an unsustainable path. On its current track, Medicaid will grow to represent 33% of South Carolina's total budget by 2020, with the program expenditures reaching over \$33 billion.

Figure 2

SC Expenditures of Total Funds Forecast (2011-2020)

% of Total



Note: 2020 estimates based on slightly different growth rates than used on previous slide, resulting in modified forecast numbers
 *Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Transportation
 Source: SC Budget and Control Board; Lucas Group analysis

The policy implications of this are clear, in that South Carolina has four choices available to mitigate the impact of its largest state budget cost driver growing at such a substantial rate:

1. Increase taxes on residents and employers to offset growth;
2. Cut other fundamental state programs, such as education and public safety, to accommodate Medicaid increases;
3. Reduce Medicaid provider rates, nursing home permit days and continue to grow waiting lists for services to hold spending in check; or
4. Reform Medicaid to bring efficiency to the program and keep growth within appropriate budgetary constraints.

In the most recent budget, South Carolina achieved savings through reducing Medicaid provider rates, a reduction in nursing home permit days, and a cut in certain programs. While this certainly helped the state close a significant budget gap at a difficult time, the long-term impact of repeating this strategy is less viable. At a certain point, some medical providers may no longer accept Medicaid recipients and quality of care will suffer, particularly for those providers for whom Medicaid makes the majority of their business. Many of these same providers also accept other forms of insurance, such as Medicare and this situation could have a substantial impact on the entire health care system.

The South Carolina Department of Health and Human Services (SCDHHS) believes that the fourth approach is the right solution for the citizens of the state. Ultimately, the future of Medicaid in South Carolina depends on the state's ability to deliver quality care in the most efficient manner.

Furthermore, when possible, the state should present services in a manner that empowers beneficiaries to make good, cost-effective decisions about their care.

This report begins the process of bringing evolutionary reform to one aspect of Medicaid – the state’s long term care (LTC) system. Long term care is an array of services, ranging from home and community-based services to nursing homes, for frail seniors and disabled adults.

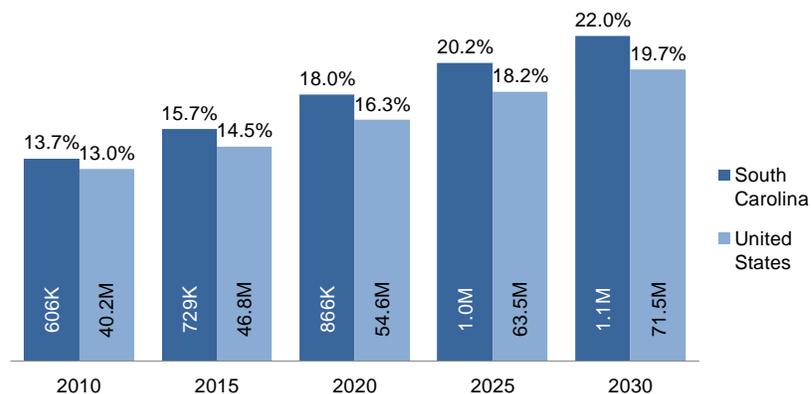
Demands on the Long Term Care System

Like all states nationally, South Carolina faces a significant demographic shift coming in the next two decades. As Baby Boomers age, retire and ultimately need long term care services, this major influx of new seniors will place a major, new demand on the Medicaid long term care (LTC) system.

South Carolina faces a greater aging demographic, based on Census Bureau estimates. Currently, 13.7% of the state’s population is aged 65 or older, while the national average is 13%. At the same time, the number of seniors in South Carolina as a percentage of total state population is expected to grow by 60% over the next two decades, while nationally, that growth is expected to be 51%.

Figure 3

Population 65+ Years Old in South Carolina vs. U.S. (2010-2030)
% of Total Population

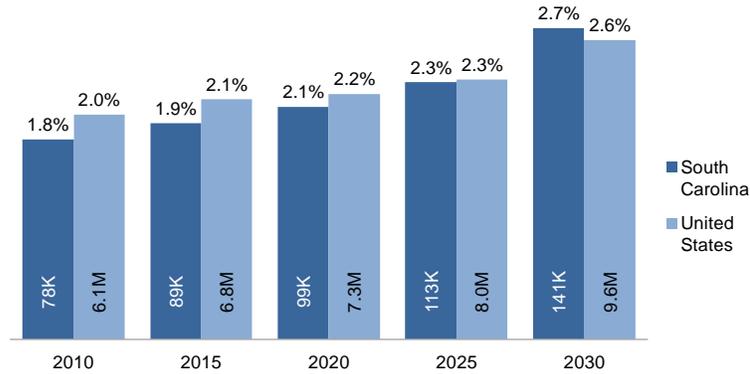


Source: U.S. Census Bureau

Of even greater concern for the LTC system is the number of seniors age 85 and older. These are the most likely citizens who need care in a LTC facility. Currently, they represent a smaller percentage of South Carolina’s population, but long run growth trends show that the state’s 85+ population as a percent of total state population will grow by 50% over the next 20 years, compared to 30% nationally.

Figure 4

Population 85+ Years Old in South Carolina vs. U.S. (2010-2030)
% of Total Population

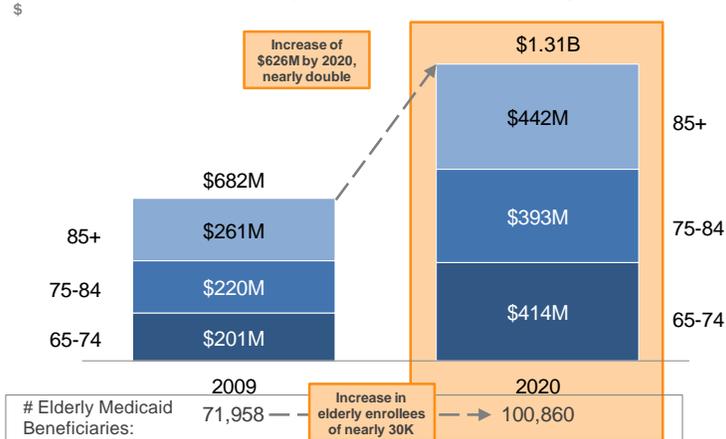


Source: U.S. Census Bureau

Given these demographic trends, even using a very conservative 2.5% annual medical inflation rate, South Carolina’s LTC expenditures will nearly double by 2020. However, given the infrastructure expansion necessary to maintain the existing LTC system, a 2.5% medical inflation rate is probably too low, and actual costs would likely be even greater.

Figure 5

South Carolina Estimated Elderly Population Medicaid Spending (2009-2020)



Source: U.S. Census Bureau; MSIS data (2009); Lucas Group analysis

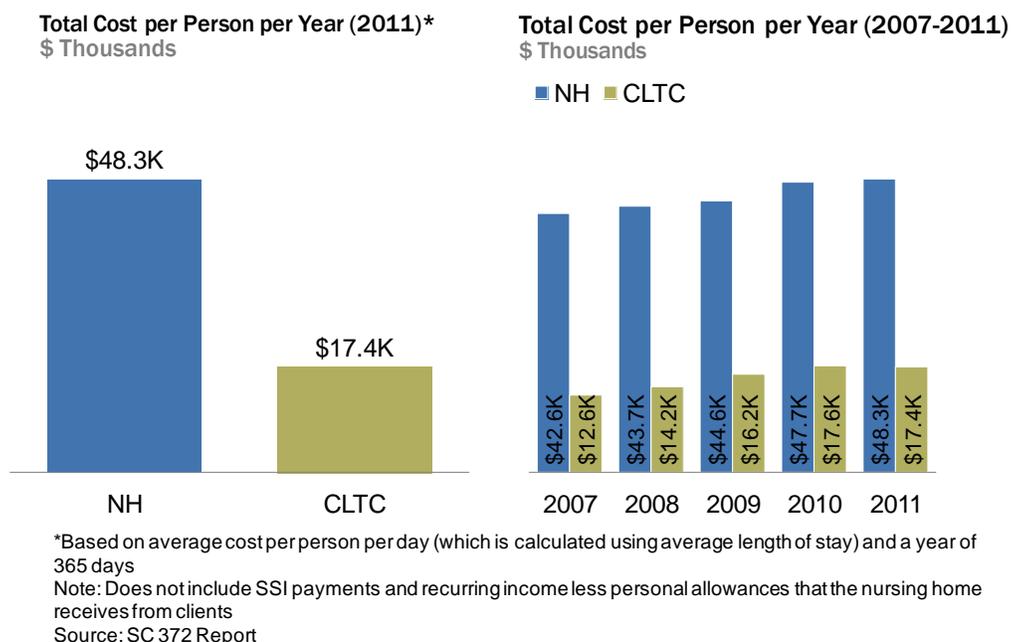
Medicaid has become the primary cost driver for South Carolina’s budget. Over the next two decades, LTC will likely be the primary cost driver within the Medicaid program. For this reason, it is critical that the state begin efforts now to reform the long term care system to ensure that seniors will continue to be able to receive assistance in a manner that is efficient, cost-effective and quality driven.

South Carolina’s History of Long Term Care

Nationally, the Medicaid LTC system began by offering nursing home coverage for poor, frail seniors and disabled adults. In 1983, the South Carolina received a federal waiver to cover Home and Community Based Services (HCBS), which allowed for these same individuals to receive care in their homes.

Statewide, home care services are significantly more cost effective than nursing home (NH) care. In 2011, nursing homes services cost, on average, \$48,300 annually, while CLTC cost \$17,400 per beneficiary (see Figure 6) (both amounts include costs for acute care).

Figure 6



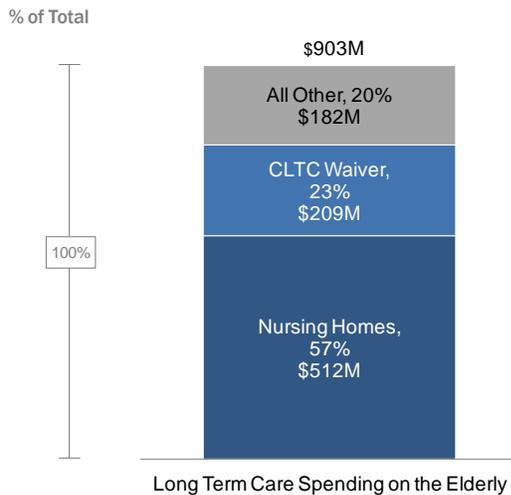
Despite the financial advantage to providing LTC services in community based settings, as well as the preference of 3/4 of seniors to receive care in their own homes and communities, South Carolina continues to direct more financial resources to nursing facilities in comparison to HCBS through Fiscal

Year 2011, though annual growth in home care has exceeded that of nursing home care over the past five years. When you consider all Medicaid populations in South Carolina, however, including those that are developmentally disabled, overall utilization of community services is much higher.

In 2010, South Carolina’s Medicaid program spent \$512 million for nursing homes, versus just \$209 million for community based care services. While the caseload for the programs was fairly similar, the significant disparity in expense demonstrates the financial effectiveness of community care (see Figure 7).

Figure 7

Medicaid Elderly Long Term Care Spending Estimates (2010)*

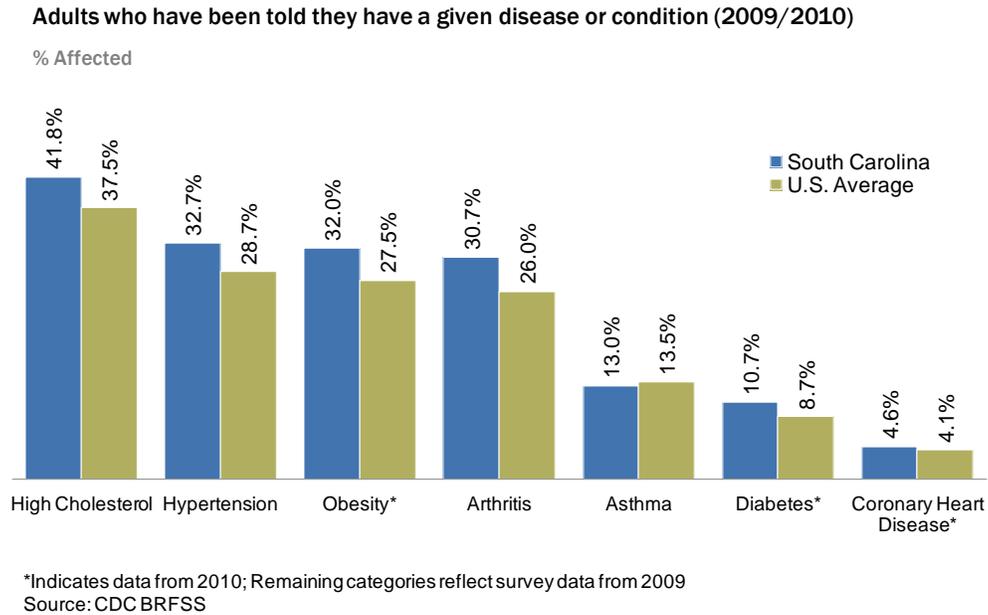


*Long term care includes spending on nursing facilities, home health, and personal care and excludes ICF/MR and mental health facilities; The amounts spent on Nursing Homes and the CLTC Waiver are taken from the SC 372 report, but the total of \$903M is estimated based on Kaiser Family Foundation data from 2008 and MSIS data from 2010
Source: Kaiser Family Foundation; MSIS data; SC 372 report; Lucas Group analysis

While South Carolina spent \$721 million on nursing homes and community based care in 2010, the state also spent \$182 million on care for seniors not in a long term care setting. Much of this was for premium assistance and other acute care costs for seniors. Many of the individuals receiving this care are likely to ultimately become participants in the Medicaid LTC program.

Statistically, South Carolina has a high prevalence of a number of chronic diseases that often either lead to long term care placement directly or are part of a co-morbidity that results in a need for higher level services. At present, there is little coordination among the state (Medicaid) and federal (Medicare) governments to identify those individuals who might become nursing home eligible and bring specific care to ensure that their health condition does not deteriorate, requiring a LTC placement.

Figure 8



One positive step that SCDHHS is currently implementing is the federal Money Follows the Person (MFP) grant. This program began as a result of the Deficit Reduction Act of 2005, as a way for states to identify new opportunities to expand home and community care and consumer choice in Medicaid. After several years of inactivity, SCDHHS is once again participating in the MFP grant and has re-assembled a MFP stakeholder group that is actively considering a number of plans to enhance community alternatives.

South Carolina has taken steps to move toward a system of Medicaid long term care that moves away from a costly nursing home based system toward a home care structure that provides care to seniors in the setting they prefer. However, with a focused effort, the state can become a national leader in developing a LTC system that places the primary focus on home care and shifts it away from expensive institutional settings.

Challenges Facing South Carolina’s Long term Care Evolution

Ultimately, South Carolina’s ability to reform its Medicaid program to meet the growing number of seniors and ongoing budget realities will depend on the state’s capacity to keep poor, frail elders in more efficient, community based care and out of more expensive nursing home placements. The effort to place more and more nursing home eligible seniors in community based services rather than nursing homes is often called “rebalancing” a LTC system. This typically does not involve moving a large numbers of seniors and adults with disabilities who are currently in nursing home settings back into the community, but instead diverting incoming Medicaid-eligible LTC individuals to HCBS settings before

they are placed in a nursing facility. There are a number of challenges that SCDHHS must overcome before this can occur.

Backlog

Currently, there are approximately 3,000 individuals who have applied for home and community based services and 223 who are seeking nursing home admission through Medicaid. Unlike a traditional ‘waitlist,’ most of these seniors and disabled adults have not yet been determined to be both financially and medically eligible for Medicaid services.

While SCDHHS profiles and prioritizes prospective beneficiaries, those most in need are reviewed first for determination. The average wait time for a waiver slots is approximately six months, during which time a senior’s health condition could deteriorate to the point where they might require more extensive nursing home care, instead of community services.

Infrastructure

South Carolina has a robust network of community based service providers, with the capacity to add additional beneficiaries. However, there is wide variance in quality as well as integration of services. The Aging and Disability Resource Centers (ADRCs) provide an entry point for frail seniors and disabled adults to obtain important information about Medicaid and LTC services, but many are unable to assess the capacity and performance of community care providers. Moreover, a lack of stable funding source has raised concerns about the ability of the ADRCs to enhance their capacity to be a focal point in the SC LTC delivery system.

The multitude of these providers, and lack of ongoing quality information, leads to a fragmentation of the marketplace, offering uneven results to program beneficiaries. Furthermore, as more seniors require care, both those covered by Medicaid as well as private pay patients, there will be a greater demand for qualified para-professionals, such as personal care aides, and nursing personnel across the state. This will require an ongoing focus between SCDHHS, para-professionals, nursing providers, and higher education facilities – including the South Carolina Board of Nursing.

Lack of Community Options

Unlike many states, South Carolina Medicaid lacks a mid-level care option for seniors. Typically, this involves assisted living facilities that can bridge the care gap between home care, with nursing and home care visits, and intensive nursing home care.

Mid-level care represents a less costly alternative to nursing facilities, while still providing seniors and disabled adults care in a community setting. Presently, when a beneficiary’s medical needs become greater than possible to maintain a home-based placement, the only remaining option is in a nursing facility.

Additionally, in order to create a more robust community based network, a number of building blocks must be put in place or expanded. These include community housing, adult day care and adult care homes. Beyond this, the state should consider seeking federal approval to cover room and board for Medicaid-eligible residents, reimbursement for which is currently only covered for nursing facilities. This would be in addition to the state's Optional Supplemental Benefit program that provides state housing assistance to a limited number of frail seniors who choose to remain in less expensive community settings.

Care Coordination

Critical to allowing seniors to “age in place” – staying in their own homes and communities as long as possible – is the ability to coordinate appropriate primary and acute health care services to those receiving HCBS. Currently, these services are often disconnected and lacking holistic case management.

The result of this lack of full integration is more frail seniors and disabled adults requiring costly hospital visits and premature, expensive nursing home placements.

Additionally, the lack of coordination of care among those elders who are not at a nursing home level of care, but who have chronic illnesses and who are receiving acute care or Medicare premium assistance, represents a significant future liability, as these individuals are likely to see their health deteriorate to the point of needing LTC services. These seniors will often see their symptoms worsen and require intensive, costly care later.

Furthermore, many service providers lack incentives to make HCBS the primary focus. Physicians have no incentive to recommend community based care and, also, many are not even aware of the option. Given that the reimbursement structure is based on the number of open cases and that the large number of cases on backlog means that when one senior moves to a nursing facility, another case emerges, case managers have little incentive to take every step to keep a senior in the community. Hospital and nursing home discharge planners also have little incentive to make community based care the primary priority and there is no systemized coordination within the hospital and nurse discharge community. Moreover, some of these discharge planners either are not fully aware of, or do not know how to utilize, the community options available.

Solutions for Bringing Reform to Medicaid Long term Care

South Carolina should begin an aggressive “Community First” approach to long term care that puts the primary emphasis on keeping frail seniors and disabled adults in home and community settings. This will provide both care seniors prefer and a significantly more cost-effective solution for the state's Medicaid program.

With the demographic shift taking place in South Carolina, the option of doing nothing and continuing on the current path will rapidly expand the state's Medicaid budget and force a number of challenging

policy options. Nationally, many states are reconsidering how to deliver LTC services given this reality. Given these circumstances South Carolina has a significant chance to be a leader in care for seniors.

The goal of this effort should be a strategy of spending 50% of the state’s long term care resources on home and community based settings and 50% on nursing home care by 2020. Given that Medicaid nursing home expenses are currently roughly two and half times the outlays for HCBS, this will require a significant transformation in the delivery of Medicaid LTC in South Carolina.

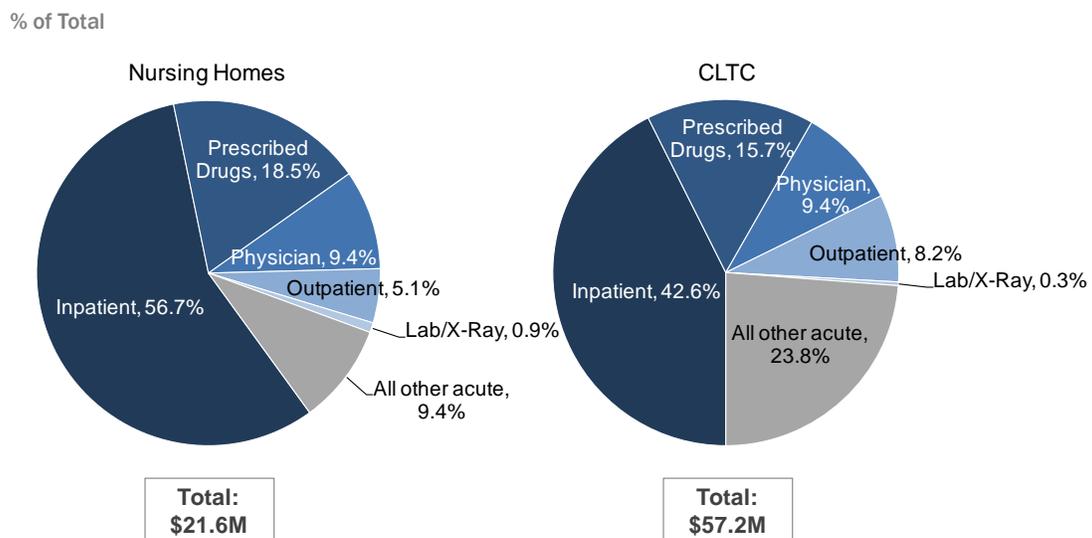
This will entail bringing in an entirely different concept of long term care to the SC Medicaid program. In order to do this, the Medicaid program must begin to shift to a client focus, not maintaining a silo-based approach of care systems, such as hospital, mental health, developmental disability or acute medical need. South Carolina can only maximize its efficiencies by taking a holistic, patient-by-patient view.

To do this, a reengineering process will require engaging in care coordination for all seniors and disabled adults enrolled in the LTC system to manage their care actively to reduce hospitalizations and ensure that participants stay in the most community-oriented, lowest cost setting possible. This means that any mental health, disability or other acute care need must be managed together, and not within separate structures.

South Carolina, in particular, would benefit from better coordination of services for Medicaid eligible LTC patients. While the number of individuals receiving long term care in nursing facilities is fairly similar to the number in community settings, those in home care required 265% greater acute care costs (see Figure 9). Coordinating all medical services for these individuals will result in fewer hospital visits, better care and quality of life and significant savings to the Medicaid program.

Figure 9

South Carolina Acute Care Spending, Nursing Homes vs. CLTC (2011)



Source: SC 372 report

Additionally, the system will need to establish more community based care options for Medicaid beneficiaries, including mid-level care. The key emphasis for an effective, efficient, quality LTC system must be to bring the right care at the right setting, at the right time. To do this, the state cannot have gaps in care, but seamless transitions between varying levels of care.

SCDHHS must also develop a transparent and clear definition of the backlog or “waiting list” for LTC services to determine if applicants are, in fact, Medicaid eligible. Beyond this, the state needs a definitive prioritization system that ensures that applicants’ health does not deteriorate while waiting for services to the point where those who might have been able to receive care in a community setting will now need nursing level care. The Lucas Group believes that with a robust nursing home diversion strategy and the ability to expand community placements, there is enough funding in the system to provide care for all those currently waiting for services if the resources were distributed in a Community First structure. With a more focused effort on delivering efficient quality-based care, there is no need to add more funds to the system with the current caseload.

For those receiving care, a move to rebalance South Carolina’s LTC system would be evolutionary, not revolutionary. Today, there is roughly the same number of individuals using Medicaid receiving care in the community as in nursing home settings. With a robust home care infrastructure, coupled with greater care coordination and additional levels of care, the move to equalizing resources would require a significant, but not radical shift in care delivery. For many seniors, the transition would represent a positive development with focused, organized care and more community options.

Lucas Group Recommendations

In order to reform South Carolina’s long term care system, it is critical to have alignment of the interests of the three primary participants: the state, representing the taxpayers and delivering on the goal of providing needed care; the providers, seeking an appropriate level of compensation for their services; and those receiving LTC services, who want quality care in the least restrictive setting possible.

Having reviewed the details of the state’s LTC system as well as the approach that other states have taken, several of which are detailed in this report, The Lucas Group recommends that South Carolina implement a Community First Choice model by initiating a capitated, full-risk managed care system for the delivery of long term care services. This would mean that managed care organizations (MCO) would competitively bid for the providing of services that include mid-level care, care coordination and pay-for-performance components that will align the interests of patients, providers and the state. The MCOs would also be responsible for coordinating care for eligible seniors in an integrated manner across all Medicaid services.

Eligible seniors would benefit because, as such, a contract would be based on a rate for all beneficiaries regardless of which LTC setting they receive care. The MCO would also have a tremendous financial incentive to provide high quality care in the least restrictive – and thus least costly – setting possible.

Poor quality would mean that the beneficiaries' health would likely deteriorate, necessitating a move to a higher level – and more expensive – setting. As the MCO would lose profit when the individual moved to a more restrictive setting, they would work diligently to provide high quality care.

Providers would benefit because they would have the choice to participate, or not participate, with qualified MCOs depending on whether or not they would accept their rate. If a provider felt a rate was too low, they could simply stop contracting with one or more of the MCOs. This would be very different than depending on the state to go through a rate setting process and working to adjust to a certain Medicaid rate determined statewide. The State can also set a minimum rate (like Tennessee and Hawaii did) to ensure that there is a network willing to provide access to care.

The state would benefit because the MCOs would be incentivized to provide high quality care in the least restrictive setting possible. The competitive bid process by MCOs would tend to drive down costs to taxpayers, and move inefficiencies out of the system.

Such contracts must include numerous quality indicators that would ensure positive client outcomes. The role of SCDHHS in LTC would be to focus clearly on ensuring that selected MCOs and Medicaid providers had unambiguous quality indicators and met these standards. This would also allow SCDHHS to refocus energy on overhauling the LTC eligibility function to clear the state's backlog and move resources into streamlining the screening process.

The federal waiver development, request for proposals, vendor selection and contracts for managed care organizations will be critical to the success of such an LTC system transformation. Other states have undertaken similar efforts, but each state has different criteria, local concerns and legacy structures that demand an individualized approach to reforming the Medicaid program. This area must be a top priority for any LTC transformation effort.

Financial Benefit

Implementing a Community First Choice approach, as well as other changes to improve the efficiency of the Medicaid long term care system in South Carolina would have substantial financial savings opportunities. A detailed model included in this report outlines how an aggressive approach of these steps can produce savings of over \$1 billion through Fiscal Year 2021. Assuming that South Carolina maintains a federal medical assistance percentage (FMAP) of 70% during this period, this would represent a savings of approximately \$300 million in state general funds over a 10-year period.

Alternately, SCDHHS could follow an incentive-driven strategy that rewards providers for following best practices and paying for performance. This approach, if implemented with a concerted effort to realize a Community First Choice model, could still produce savings of over \$800 million in total funds and \$240 million in state general funds over the same time period.

Conclusion

Given South Carolina's changing demographics, the state can hardly continue down its current path. Medicaid is on a trajectory to expand to nearly one-third of South Carolina's total budget by 2020, with no end in sight to this growth. Reforming the state long term care system will be a significant first step in developing a sustainable, viable state budget that continues to deliver services for years to come.

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Scope of Project

South Carolina Department of Health and Human Services (DHHS) is evolving the way it manages and pays for populations needing Long Term Care (LTC), particularly those that are chronically ill and high cost. Toward that end, SCDHHS is in the process of developing a strategic model for South Carolina that establishes a new national best practice for rebalancing long term care.

SCDHHS retained The Lucas Group to assist with the development of a strategic vision and high level plan to facilitate SCDHHS leadership's efforts to plan and achieve this multi-faceted vision for rebalancing long term care that acts to drive unnecessary costs out of the system and create a systemic environment where more beneficiaries are treated in home and community based settings. The purpose of this report was to review current South Carolina practices for managing LTC and integrating and coordinating care of these high cost populations.

In analyzing and assessing current practice, The Lucas Group was also asked to consider practices of other states that have been successful in rebalancing LTC, and use this information to develop elements and alternatives for a strategic vision and high-level plan for SCDHHS to consider. The objective of the project, therefore, was to assess critical elements of the LTC system, and develop a strategic vision with alternatives the state can consider in driving unnecessary costs out of the LTC system and promoting cost effective, and quality enriched care. In developing such recommendations, The Lucas Group was asked to, wherever possible, support community based alternatives to nursing facility, hospital and other high cost institutional care. When this is not possible, we were asked to review incentives that could be in place for nursing facilities to care for the residents with the most complex needs.

Thus, this Lucas Group report not only assesses and analyzes SCDHHS current LTC practices, but it also makes recommendations for CLTC process improvements for the near term and a comprehensive strategy that integrates primary and acute care with long term care within a reasonable period of time. This report supports the creation of an integrated person-centered health home for all enrolled seniors based on care coordination and managed care integration strategies and includes innovative incentives, risk-based contracting, and data-driven cost, quality, and outcomes measurement. The goal of The Lucas Group work on this project is to provide integrated quality long term care in the desired settings for South Carolina's seniors while improving value to South Carolina taxpayers.

Overview: The South Carolina Long Term Care Medicaid Program

The scope of the need for and costs of long term care services and supports across the country needs to be a fundamental concern for the states. Medicaid is the largest single payer source for long term services and supports. Across the United States (US), state Medicaid agencies spend 43% of every dollar on long term care. In 2007, a total of 6% (3.6 million people receiving long term care services) of all

Medicaid beneficiaries across the US accounted for nearly half of all total Medicaid expenditures (\$144.7 billion of \$ 300 billion). Only a third of elderly beneficiaries used long term care services and supports, yet they accounted for 87% of all expenditures on the elderly.

The disparity between the nationwide average annual cost for people receiving Medicaid long term care services and supports, and those who are not is startling: \$43,296 for those receiving long term care and \$3,694 for those who are not. Acute care (23%), institutional care (45%), community based Long term care (29%), and mixed LTC (4%) represent the totality of long term care services and supports across the country.

Despite a continued movement towards states decreasing reliance on institutional care many states, such as South Carolina, find their long term care systems overly reliant on the most expensive LTC service and, as a result, are facing unsustainable costs over the next decade while being unable to provide the choices to remain home or in a community setting that most people desire.

Community Long Term Care Medicaid Waiver

Under Medicaid law, Medicaid eligible seniors that are assessed to need nursing home level of care but desire to remain in the community can do so if the state has a waiver program that allows for an array of community based services that provide the needed care in the community. In the 1970s, South Carolina had one of the first successful community based care programs in the country for seniors on Medicaid who had become eligible for nursing home care. These first pilot programs demonstrated the capability of HCBS to serve as an alternative to nursing facility placement. They led to a statewide home and community based waiver program that began in 1984. The program is now known as Community Choices, and it services over 14,000 Medicaid recipients per year. It is the major means in place whereby Medicaid recipients determined to be at nursing home level of care are offered an alternative to nursing facility placement.

Community Choices Long Term Care (CLTC)

CLTC offers a variety of programs to serve individuals wanting to live in their homes. They must need assistance with their care and be eligible for nursing facility level of care. The waiver offers a service package that includes fifteen services designed to assist consumers in meeting their long term care needs at home. Consumers can choose from several service delivery options, ranging from all agency-based services to various levels of self-direction, and have opportunities to manage their own care.

CLTC area offices are staffed by nurses and case managers who work with eligible persons and families to plan, coordinate and authorize needed services.

Head and Spinal Cord Injury Waiver

This waiver is designed for persons 0-65 years of age with head or spinal cord injuries, or similar disabilities. A seventeen-service package is designed to meet the needs of this population in their home setting.

Mechanical Ventilator Waiver

This waiver provides an array of in-home services to persons age 21 years or older who meet skilled or intermediate level of care, and are dependent on mechanical ventilation.

Program of All-inclusive Care for the Elderly (PACE)

Palmetto Senior Care (PSC) and the Methodist Oaks PACE are two PACE programs that provide comprehensive care that allows frail, elderly consumers to live within their communities. This program serves persons 55 years and older. It provides all Medicare and Medicaid covered services, as well as any other items or medical, social or rehabilitation services that an interdisciplinary team determines the person needs.

As consumers make use of the above waiver programs on an ongoing basis, it has become evident that, by providing options, consumers are able to make the most use of their service dollars to meet their individual care needs. This will assist in rebalancing South Carolina's long term care system and provide a focus on prevention of nursing home placement. It will also increase the ability to maintain a wider variety of individuals with varied care needs in community settings of their choosing.

Because the vast majority of Medicaid seniors eligible for nursing level care that are living in the community get services through the CLTC Choices waiver program, The Lucas Group was asked to focus its attention and scope of review on this waiver program and that utilize services through CLTC.

Chronic Illness in SC

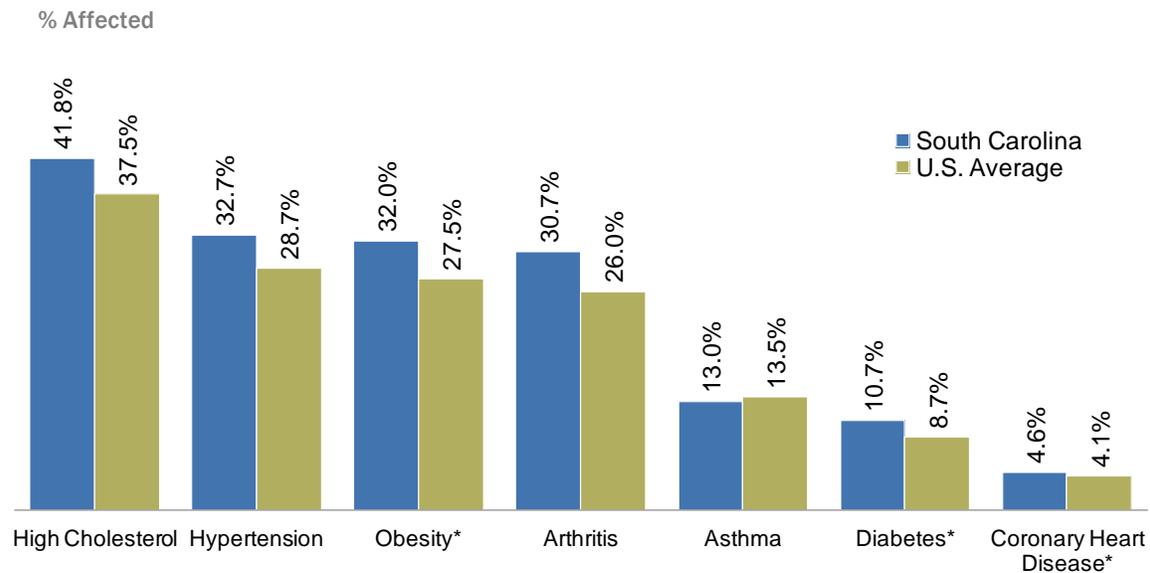
Those who have met LTC Medicaid eligibility through the CLTC program also typically need a wide range of health and non-medical supportive services, including specialty and behavioral health services, prescription drugs, durable medical equipment, rehabilitation therapies, home health and long term care services. They also must be linked to supportive services, such as housing and non-emergency transportation.

Many suffer from persistent and lasting medical conditions that require ongoing professional intervention that, if left untreated, could lead to the need for expensive emergency care, hospitalization and/or death. Examples of chronic illness include diabetes, chronic obstructive pulmonary disease (COPD), asthma, chronic renal failure and lupus erythematosus. These diseases are typically debilitating to those who suffer from them, and highly expensive to treat through their progression.

In South Carolina, the prevalence of illnesses that impact many of the Medicaid seniors desiring to remain in the community is greater than the national average. On average, adults in the state exceed national averages in high cholesterol, hypertension, obesity, arthritis, diabetes, and coronary heart disease all.

Figure 10

Adults who have been told they have a given disease or condition (2009-2010)



*Indicates data from 2010; Remaining categories reflect survey data from 2009
Source: CDC BRFSS

Moreover, a number of individuals who receive Medicaid have a chronic condition (and nearly half of them have more than one), including multiple physical and behavioral needs. Nationally, these beneficiaries account for less than 15% of the Medicaid population; however, the cost of their care represents approximately 50% of all program expenditures.

Nevertheless, many of these beneficiaries typically gain access to Medicaid through the CLTC program and also meet income eligibility standards. Once eligible for Medicaid through the CLTC pathway, elder beneficiaries who have chronic illnesses, are at risk for hospitalization and or nursing home care. These elders typically are high utilizers of prescription drugs and therapies designed to stabilize the chronic condition. Many have multiple in-patient and out-patient hospital visits throughout the year, and often use hospitals' emergency departments for services.

Meet the Faces of Elders Needing Long Term Care in South Carolina

Anita¹

In a trailer park in Lexington, South Carolina, Anita and her daughter Mary live together. They are 82 and 62-years-old respectively. After spending some time on the waiting list, Anita is being assessed for nursing home care eligibility.

Mary is in poor health; she is partly deaf and uses a walker. Mary explains that it's difficult to take care of her mother. Mary is having hip surgery soon and is worried that nobody will be able to watch her mother during that time.

Anita is 5 feet, 4 inches tall and weighs 152 pounds. She has had two heart attacks, back surgery to scrape off arthritis, failing kidneys, a failing liver, and is physically weak. She falls in her house often. Not long ago she fell - hitting her face on the kitchen counter and had to visit the emergency room. Anita receives no treatment or therapy. She is resistant to any help from her daughter, and is sometimes combative. Anita is hard of hearing and suffers from dementia. She knows what time *Wheel of Fortune* is on television, but doesn't know the current year or her home address. She scratches her arms so much that they bleed. She also has poor hygiene.

Mary keeps the house locked to prevent her mother from running away. In the past, she has received in-home help from Helping Hands, which is a personal care agency, but Mary doesn't like having strangers in the house.

Mary can no longer afford the co-pays and additional costs for her mother's medicine. Mary has already spent \$40,000 taking care of Anita. Last year both Mary's son and husband died – she is short of family support. She needs help for her mother.

In her current state, Anita's health is likely to deteriorate to the point where she will require being placed in a nursing home, and with her financial profile, she will likely qualify for Medicaid.

Elizabeth

Elizabeth is 89-years-old, and lives in a split-level home just outside of Columbia with her daughter Wonda, and her son-in-law. Elizabeth is being assessed to determine if she is eligible for community care.

Elizabeth is blind. She is 5 feet tall and 144 pounds. She has dementia, degenerative joint disease, arthritis, can barely walk and has just 4 teeth. Elizabeth can remember the past clearly but has difficulty remembering the present.

Wonda, Elizabeth's daughter, is energetic and optimistic. Much of her strength comes from her involvement in the church. The church community has helped provide support to her family. Wonda is retired after having worked 30 years for the Social Security Administration. With this background, her understanding of community support appears above average. Her husband is a preacher in the local church and her grown children have moved away.

Wonda would like three to four hours of community support for her mother per day to provide a break from her providing care. Wonda dedicates all her time to her mother, and has no free time to enjoy her own life. She needs help.

Nora

Nora is a 95-year-old female who has been living in a nursing home for the last six months and has been on Medicaid for the past four years. Nora has been a widow for nine years and has one daughter that lives out-of-state. Her husband was a worker in a textile mill for many years and Nora was a homemaker. Throughout their lives, Nora and her husband worked on a limited income. In 1990, they lost their pension because the textile mill closed and the company declared bankruptcy. After her husband died, Nora continued to live independently in their mobile home located in a rural South Carolina town. Neighbors and church members helped Nora with shopping, laundry, and bill paying. Recently, Nora had broken her hip after chopping wood to heat her home. She was transferred to the nursing home for rehabilitation after a hospital stay for surgery to repair the broken hip. Nora's other health conditions include leg ulcers, anemia, arthritis, hypertension, and cardiovascular disease. A social worker at the nursing home where Nora lives heard about the Money Follows the Person nursing home community transition program and discussed the program with Nora, and Nora seemed very interested in the prospect of returning home with assistance. Nora met with a state nurse transition coordinator and the following concerns were found regarding her transition back home: 1) Nora's home was in extreme disrepair (including no running water or septic tank), and 2) Nora would be living alone without 24-hour supervision.

Nevertheless, Nora was evaluated to determine if she qualified for the CLTC program waiver services. It was determined that she is qualified to return home under the CLTC waiver after spending over six months in the nursing home (*Note: Since the time of Nora's story, the time required has decreased from six months to 90 days*). Nora's daughter lives out of state, although she calls weekly and visits occasionally. Neighbors and church members help Nora with shopping, laundry, and bill paying. The custodian of the church, and other church members, did a great deal of work to the home to get it to a more habitable condition. Prior to her return home, other supports such as a septic tank and well for running water were installed and 24-hour emergency response system put in place. In addition, HCBS under the CLTC waiver, such as, Adult Day Healthcare (ADHC) three times per week, and personal care services two days per week (for four hours each day), were authorized.

Nora started her ADHC program where she enjoyed the socialization and activities three times per week, which she had not had before. She was also able to attend a chair exercise class at the ADHC program and this continued to assist her with gaining strength after her hip operation.

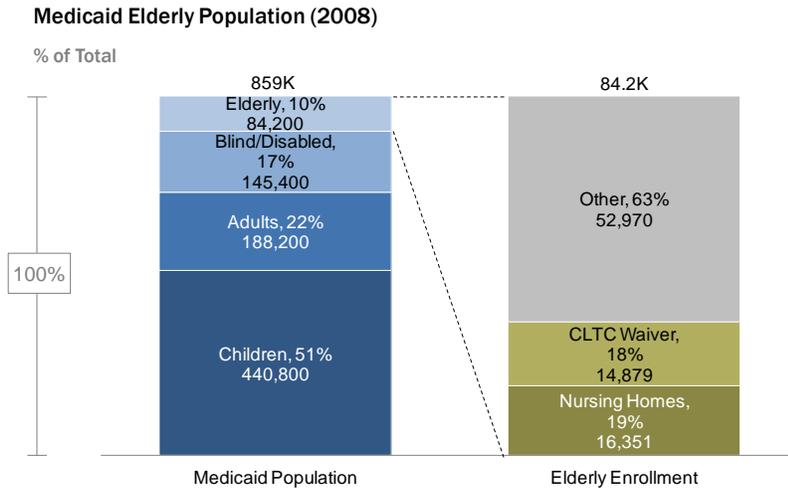
The CLTC program has a service called Care Call, which tracks the services provided to Nora via telephone. The ADHC program and the personal care worker enter data via telephone every time they provide a service to Nora. This information is then transferred electronically to Nora's client record in the computer database. The CLTC Case Manager tracks and monitors Nora's attendance at the ADHC program as well as the amount of time the personal care worker is with Nora. This ensures Nora is receiving the appropriate amount of service on the correct day and for the appropriate length of time. If there is a problem with these services, immediate action is taken by her case manager based on the real time data transaction capability of the Care Call system.

The CLTC case manager also checks on Nora monthly, even if Nora does not contact her. Nora presented as well-adjusted and her health condition appeared to be stable. Nora did not present with any cognitive or behavioral problems or changes. She sees her doctor as needed and one of her church members usually drives her to these appointments. Her home continues to be livable and safe for her to navigate. Nora states that she truly believes she could not have continued living at home without all these supports put in place. She enjoys the activities at the ADHC program and she is pleased with the services provided by the personal care worker. The ADHC nurse monitors Nora's blood pressure and checks her leg ulcer that has now healed since she has returned home. The ADHC nurse reports health concerns to Nora's doctor. To date, Nora's health has been stable. Nora knows how to operate the emergency response system and carries it with her at all times when she is home. Her neighbor continues to call her daily, but Nora also has church members as back up if her neighbor is not able to call. Nora states that she has also enjoyed the increased contact from her daughter.

The Medicaid Long Term Care population in South Carolina

In South Carolina, in Fiscal Year 2010 there were 998,179 individuals enrolled in the Medicaid program, accounting for 21.6% of the entire South Carolina population². In 2008, approximately 10% consisted of elders at least 65 years of age that were determined to be eligible for Medicaid services (see Figure 11). Out of this number, 16,351 were in nursing homes, approximately 14,879 were eligible for nursing homes but were receiving HCBS under the CLTC program, and approximately 52,970 were seniors that were not at the nursing home level of care but were eligible financially for Medicaid services because of their low income.

Figure 11

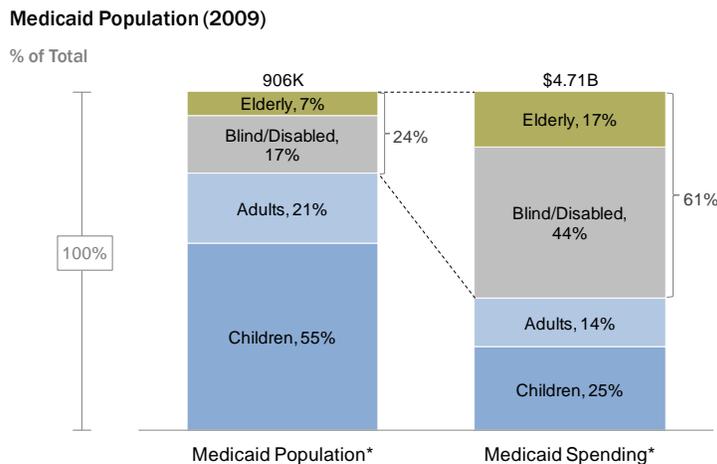


Source: Kaiser Family Foundation; SC 372 report; Lucas Group analysis

In 2009, these Medicaid elders consisted of only 7% of the entire Medicaid population as the recession saw many adults and children enroll in the program, yet seniors account for over 17% of the total Medicaid program costs. The adult blind and disabled population has many of the same chronic illnesses and needs as many of the seniors in nursing homes and on the community waiver. The aged, blind and disabled (ABD) population accounted for 24% of the total enrollees and 61% of the total Medicaid costs (see Figure 12).

When one begins to closely examine the overall costs of the program, therefore, and the costs of these Medicaid eligible beneficiaries, it becomes apparent that attention must be focused on strategies designed to lower costs and promote quality with this Medicaid population.

Figure 12



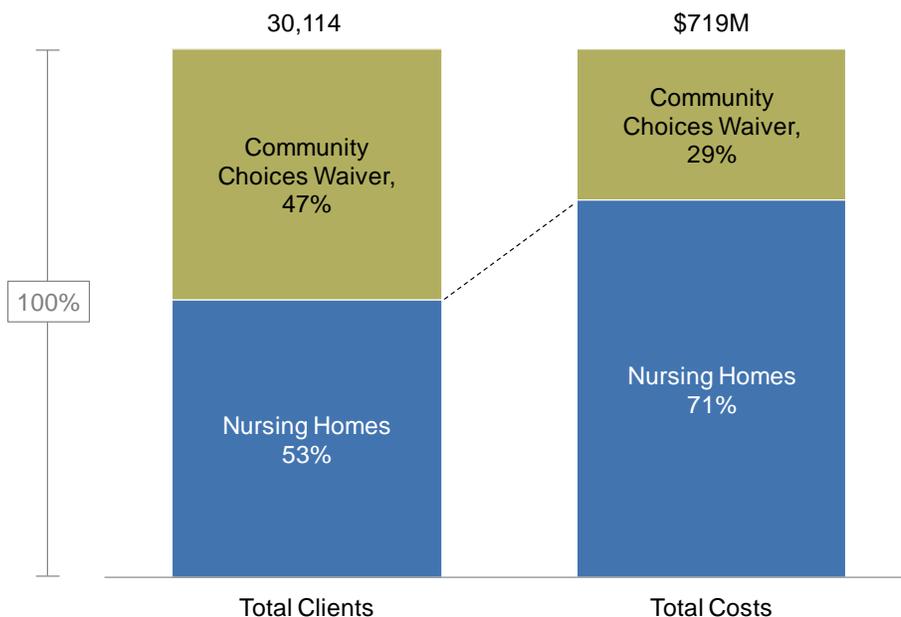
*Unknown and BCCA women (approx. 32,000 beneficiaries and \$884M) not included in percentages but represented in totals
 Source: MSIS data; U.S. Census population estimates; Lucas Group analysis

Of the 30,114 Medicaid eligible elders in 2011 that were determined to be eligible for nursing home level of services, 47% were residing in the community under the Community Choices waiver program but accounted for just 29% of the total costs (see Figure 13). At the same time, 53% of the Medicaid eligible elders in nursing homes accounted for 71% of the total spending.

Figure 13

Nursing Homes vs. Community Choices Waiver Clients and Costs (2011)*

% of Total



*Note: Small discrepancy exists between reported number of clients in nursing homes on the SC 372 report and in MSIS data
Source: SC 372 report

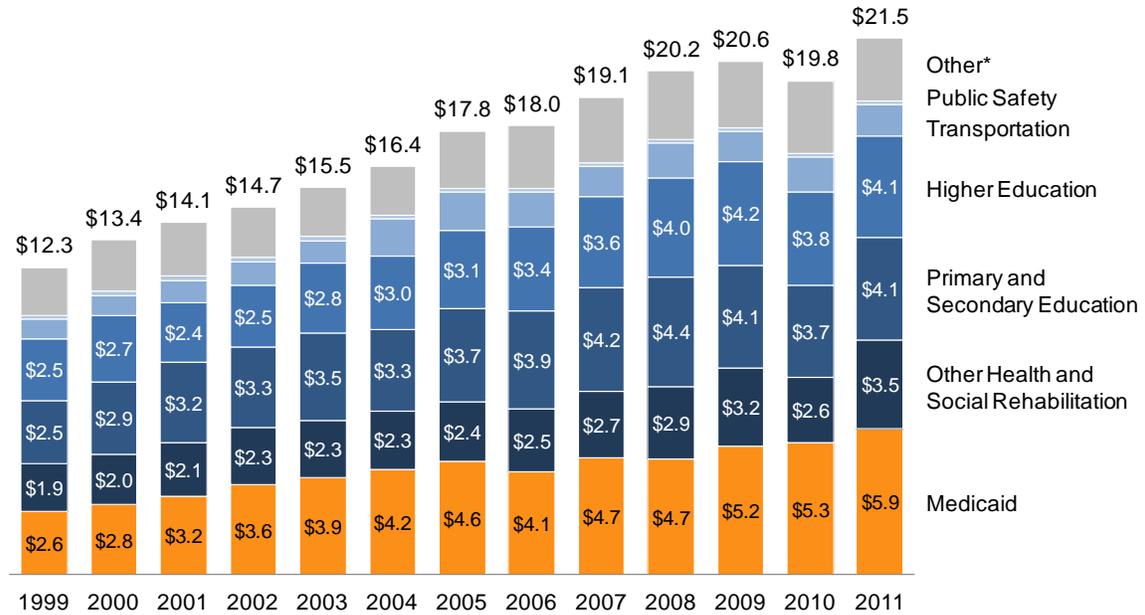
Medicaid Long Term Care Spending in South Carolina Today

In FY 2011, South Carolina spent approximately \$5.9 billion in total funds on its Medicaid program (see Figure 14). That represents approximately one quarter of total fund spending in the state .

Figure 14

SC Expenditures of Total Funds (1999-2011)

\$ Billions



*Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Correctional; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Aid to Subdivisions
 Source: SC Budget and Control Board; Lucas Group analysis

The top five spending categories for South Carolina are: Medicaid (\$5.9 billion), Higher Education (\$4.1 billion), Primary and Secondary Education (\$4.1 billion), Other Health and Social Rehabilitation expenditures (\$3.5 billion), and Transportation (\$1.4 billion). The total spending for FY 2011 was \$21.5 billion.

From FY 1999 to FY 2011, Medicaid spending in South Carolina has been growing at a rate of 7.2% per year, whereas total fund spending has been growing at a rate of 4.7%.

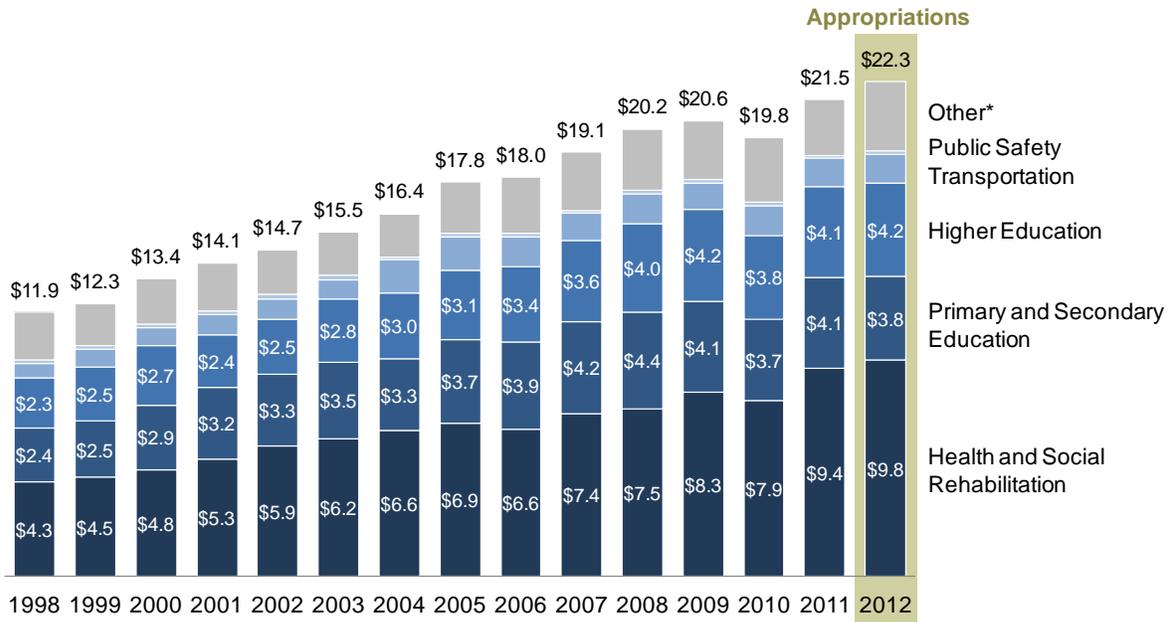
Medicaid spending makes up the majority of all spending in health and social rehabilitation programs in South Carolina, and which, at 7.2% per year, has shown the most significant growth in the entire state budget for Fiscal Years 2011 and 2012.

South Carolina expects growth in many of its major expenditure categories except primary and secondary education, which is slated for an 8% cut from FY 2011 to FY 2012 (see Figure 15). From FY 1998 to FY 2011 primary and secondary education had grown at a rate of 4.1% per year.

Figure 15

SC Expenditures and Appropriations of Total Funds (1998-2012)

\$ Billions

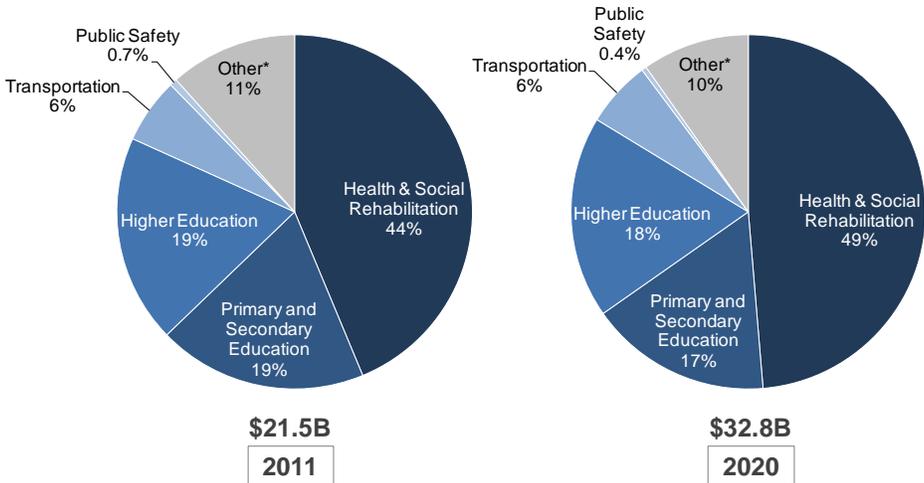


*Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Correctional; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Aid to Subdivisions
 Source: SC Budget and Control Board; Lucas Group analysis

At the current rate of spending from FY 1999 to FY 2011 for all state departments and programs, health and social rehabilitation expenditures will grow to nearly half of all total fund expenditures in South Carolina by 2020, squeezing funds from education and public safety (see Figure 16).

Figure 16

SC Expenditures of Total Funds Forecast (2011-2020)
% of Total

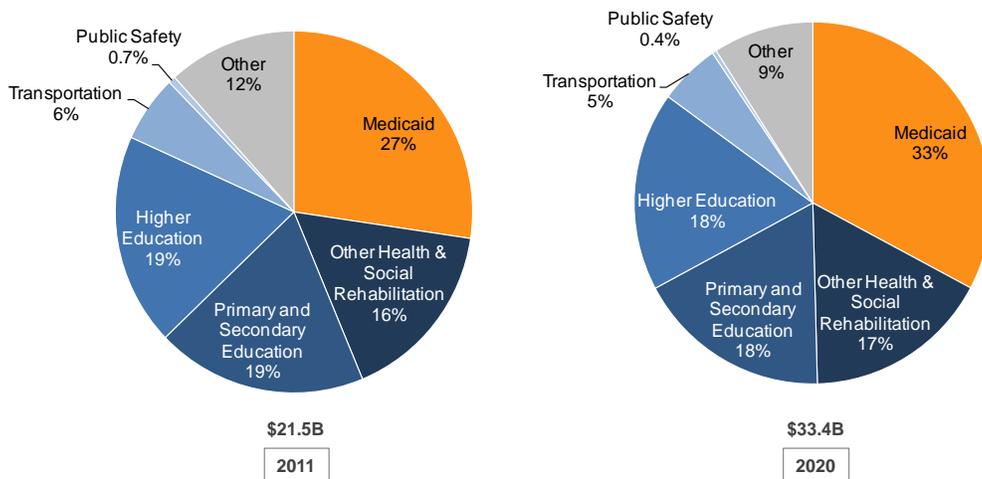


*Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Transportation
Source: SC Budget and Control Board; Lucas Group analysis

Moreover, at the current rate of spending, Medicaid alone will grow to 33% of the entire South Carolina total budget by 2020, also having a significant impact on funds available for education and public safety (see Figure 17).

Figure 17

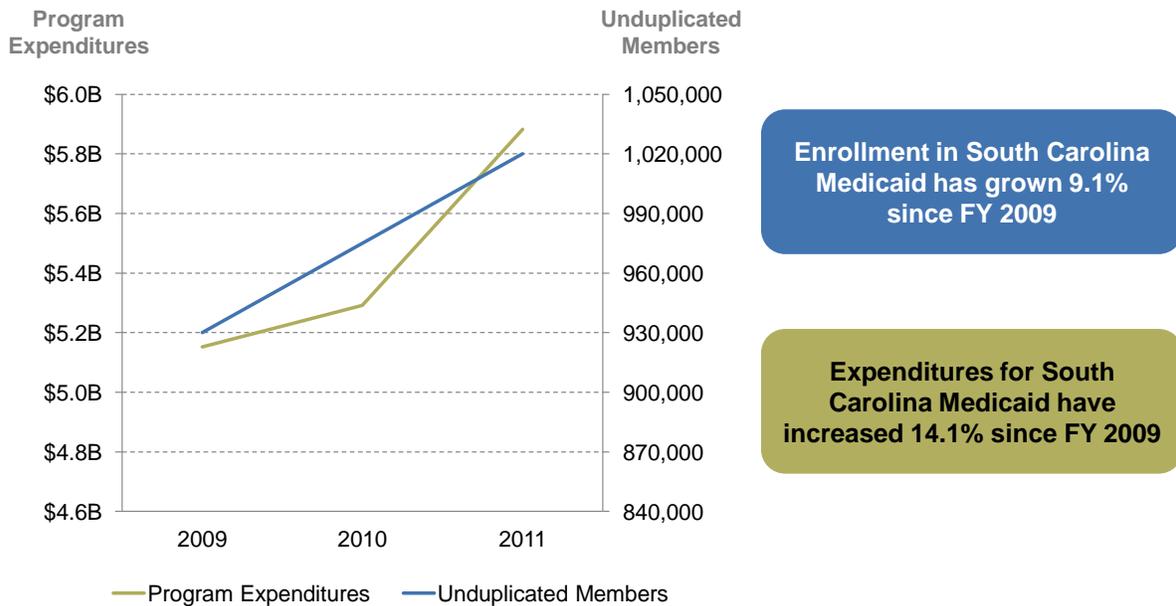
SC Expenditures of Total Funds Forecast (2011-2020)
% of Total



Note: 2020 estimates based on slightly different growth rates than used on previous slide, resulting in modified forecast numbers
*Includes: Legislative; Judicial/Adm. Law Judges; Executive and Administrative; Conservation, Natural Resources, and Economic Development; Regulatory; Debt Service; Transportation
Source: SC Budget and Control Board; Lucas Group analysis

Figure 18

3-Year Trend of South Carolina Medicaid Members and Expenditures (2009-2011) \$ Billions and # of People



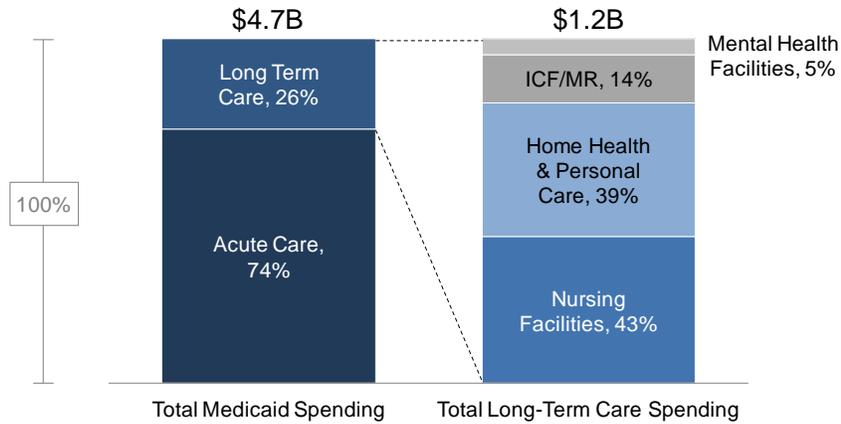
Source: SC DHHS

Long Term Care Spending

Of the approximate \$4.7 billion a year spent on Medicaid in 2009, South Carolina spent approximately \$1.2 billion dollars a year, or 26%, on long term care (see Figure 19). The vast majority of the long term care spending is on elders who are eligible for Medicaid services because of their income levels and elders, who are determined to be at a nursing home level of care, that receive their care in nursing homes or in the community. The remaining 74% is spent on acute care, which is also spent on many of the same chronically ill elders that are Medicaid eligible.

Figure 19

Medicaid and Long Term Care Spending (2009)
% of Total



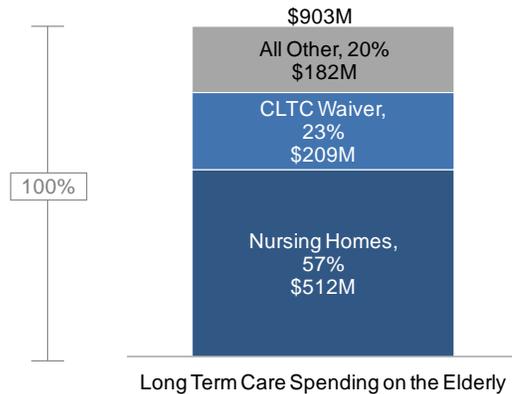
Note: Acute Care includes inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, family planning, dental, vision, other practitioners' care, payments to managed care organizations, and payments to Medicare; Long Term Care include nursing facilities, intermediate care facilities for the mentally retarded, mental health, home health services, and personal care support services
Source: Kaiser Family Foundation; MSIS data; Lucas Group analysis

Long Term Care Expenditure Trends Show Institutional Bias in South Carolina

In 2010, \$903 million was spent on Medicaid long term care services for the elderly, and about 80% of this spending was for Medicaid elders determined to need nursing home level of care (see Figure 20).

Figure 20

Medicaid Elderly Long Term Care Spending Estimates (2010)*
% of Total



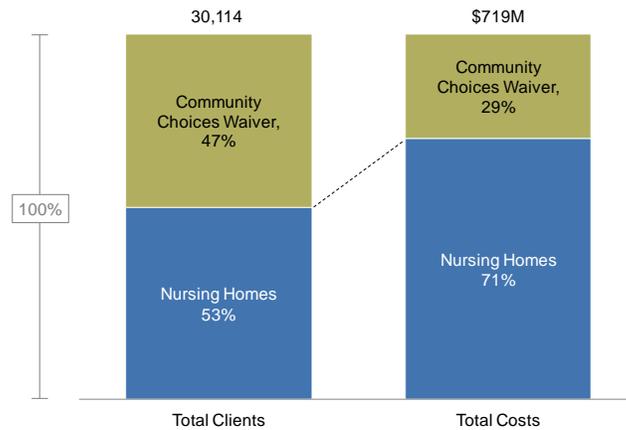
*Long term care includes spending on nursing facilities, home health, and personal care and excludes ICF/MR and mental health facilities; The amounts spent on Nursing Homes and the CLTC Waiver are taken from the SC 372 report, but the total of \$903M is estimated based on Kaiser Family Foundation data from 2008 and MSIS data from 2010
Source: Kaiser Family Foundation; MSIS data; SC 372 report; Lucas Group analysis

As for the expenditures on Medicaid for eligible elders that have been determined to meet nursing home level of care, most of the expenditures are in nursing homes rather than the community under the community waiver programs. Although the Medicaid population determined to be eligible for nursing homes and that of CLTC are similar (53% nursing home, 47% CLTC), nursing homes make up 71% of all spending (see Figure 21). This is true even where the average length of stay in nursing home per year is much less than the average length of stay for eligible seniors being served in the community under the CLTC Waiver (see Figure 22).

Figure 21

Nursing Homes vs. Community Choices Waiver Clients and Costs (2011)*

% of Total



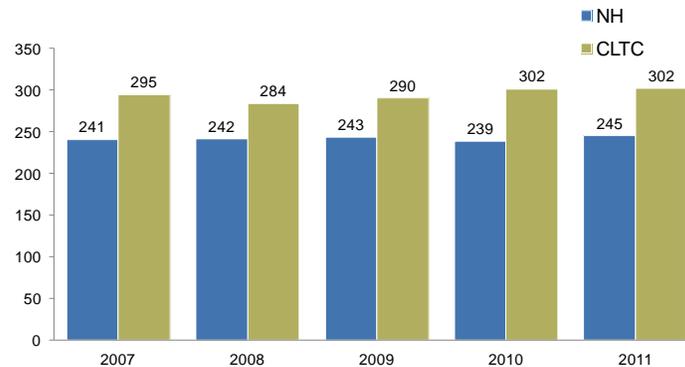
*Note: Small discrepancy exists between reported number of clients in nursing homes on the SC 372 report and in MSIS data
Source: SC 372 report

Figure 22

On Average, Length of Stay for Eligible Seniors in Community Under CLTC Waiver Greater Than Stay in Nursing Homes

Average Length of Stay (2007-2011)

Days



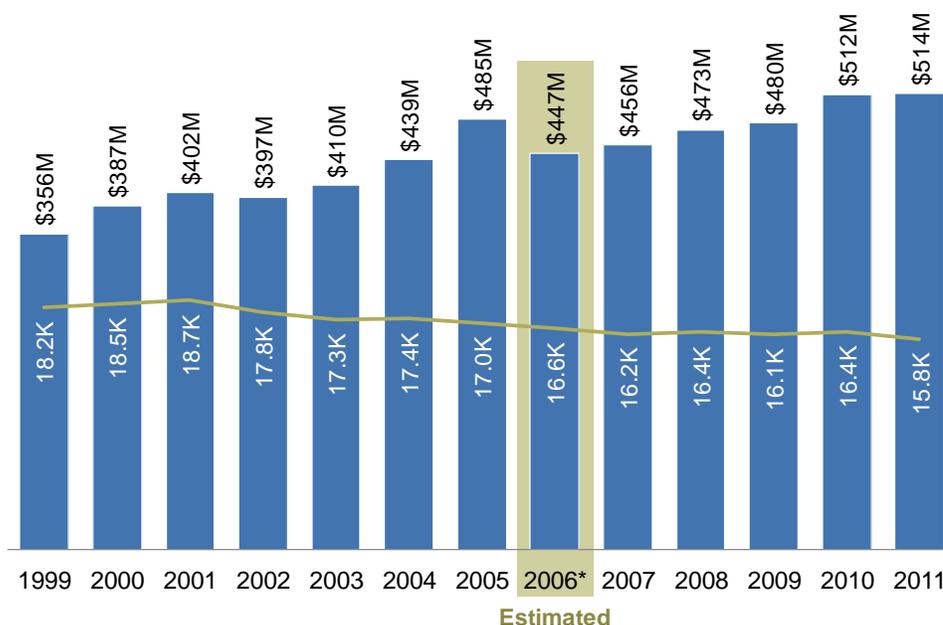
Source: SC 372 report

Moreover, nursing home expenditures continue to increase even while the number of nursing home beneficiaries in South Carolina has been declining since 1999 (see Figure 23). From 1999 to 2011, nursing home spending increased at a rate of 3.1% per year, while the number of beneficiaries decreased 1.1% annually.

Figure 23

SC Medicaid Nursing Facility Expenditures and Number of Beneficiaries (1999-2011)

\$ Millions and # Beneficiaries



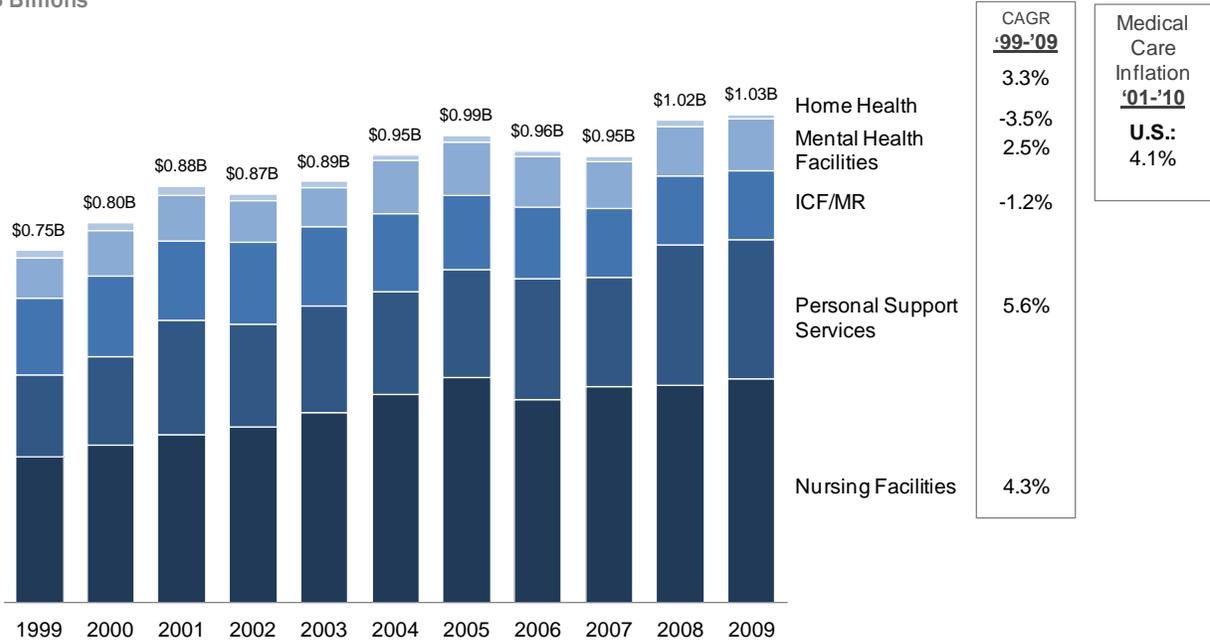
*Full-year data for 2006 estimated based on 9 months of available data
Source: SC 372 report

Overall, Medicaid LTC expenditures are increasing, and expenditures in nursing facilities are growing faster than the overall LTC Medicaid growth (see Figure 24) Medical Care Inflation from 2001 to 2010, which is 4.1% per year. During that same time, nursing facility spending increased at a rate of 4.3% per year.

Figure 24

SC Medicaid LTC Expenditures by Service Category (1999-2009)

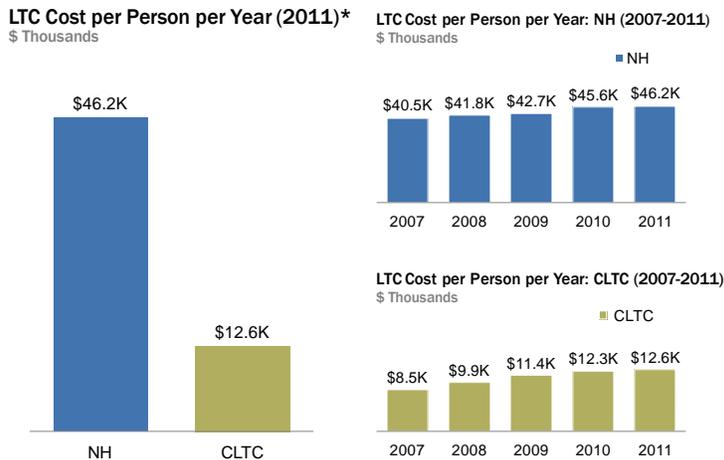
\$ Billions



Source: MSIS data; Bureau of Labor Statistics; Lucas Group analysis

Long term care annual rates per person for 2011 are almost four times greater in nursing facilities than under CLTC program, not counting acute care costs (see Figure 25). In 2011, nursing home LTC costs were \$46,200 per year versus CLTC costs of \$12,600 per year.

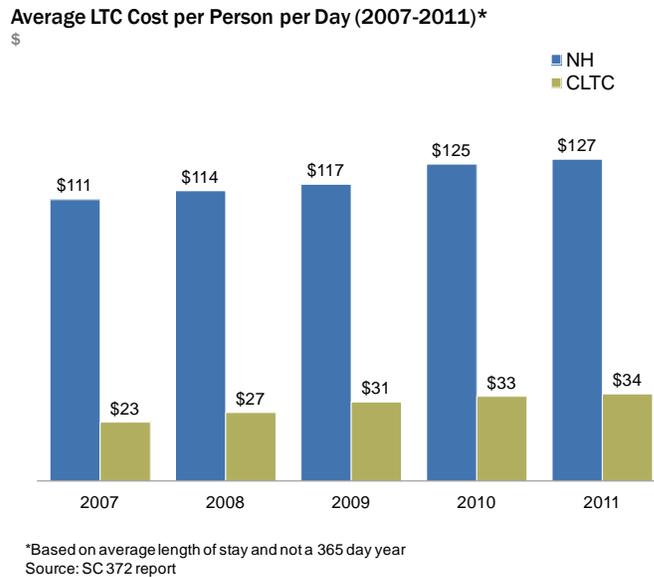
Figure 25



*Based on average cost per person per day (which is calculated using average length of stay) and a year of 365 days;
 Note: Does not include SSI payments that the nursing home receives from clients; Does not include acute costs
 Source: SC 372 report

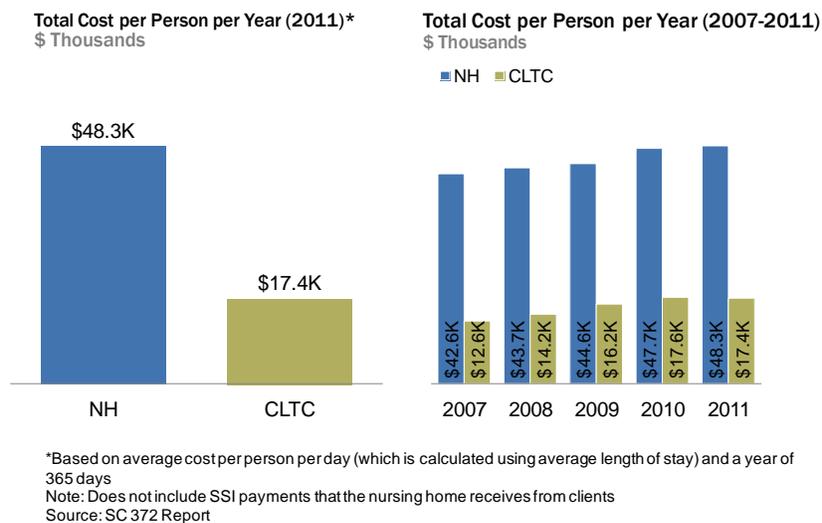
Moreover, the average LTC cost per day in a nursing home is four times greater than that on the community waiver (see Figure 26).

Figure 26



When adding the acute care costs, which are higher in the community than for those in nursing homes, the annual rate per person is nearly three times greater for nursing homes than community care under the CLTC waiver (see Figure 27). Acute care services include lab, X-ray, outpatient, inpatient, physician, and related prescriptions.

Figure 27



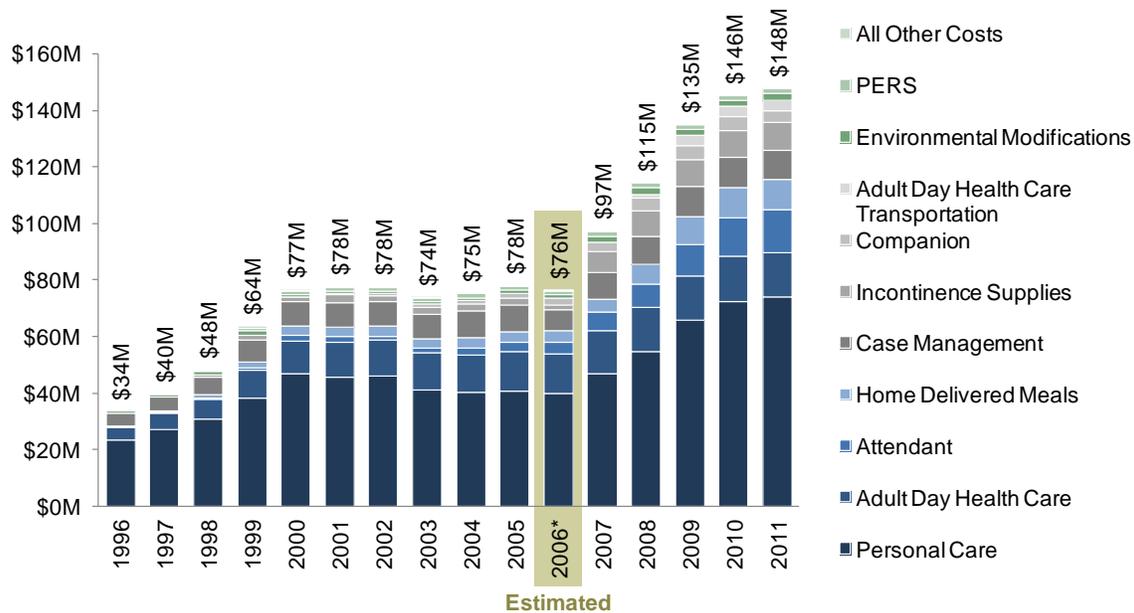
South Carolina has Seen a Recent Increase in Support for Community Based Services

Since 1996, CLTC costs have been growing at a significant rate particularly in the last few years in most categories of service (see Figure 28). This shows a measure of commitment to an array of community based services that are needed to help keep a nursing home eligible Medicaid elder in their home. Similar to nursing home spending, this growth rate surpasses the rate of growth for the entire Medicaid program over the same time period.

Figure 28

SC Long Term Care Waiver Costs (1996-2011)

\$ Millions



* Full-year data for 2006 estimated based on 9 months of available data

Note: All Other Costs includes: Telemonitoring; Respite; Chore Services; ADHC Nursing; Nursing Home Transition; and Counseling Services; Costs first incurred for PERS 1998; Adult Day Health Care Trans. 2008; Companion 2000; Incontinence Supplies 1998

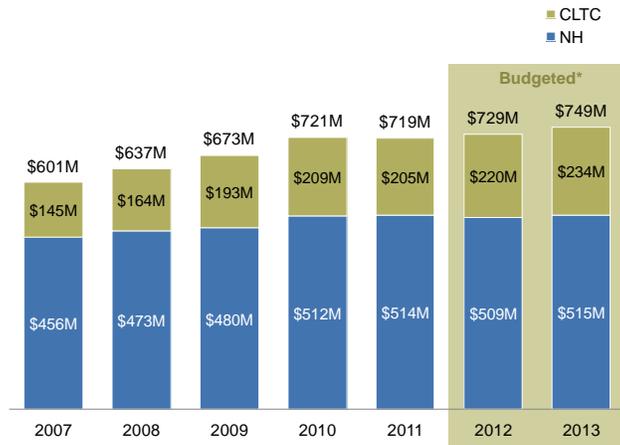
Source: SC 372 report; Lucas Group analysis

Since 2007, CLTC waiver costs have been growing at a rate of 9.0% per year (see Figure 29), due to a slight increase in census, rate increases for a number of services, the addition of some new services to the waiver during that time period (including transportation, telemonitoring and adult care home services).

South Carolina's FY 2012 and FY 2013 budgets accounted for continued increases in these costs, while at the same time showing a relatively stable rise in costs of nursing homes over the next couple of years.

Figure 29

Total LTC and Acute Costs and Budgeted Amounts (2007-2013)
\$ Millions



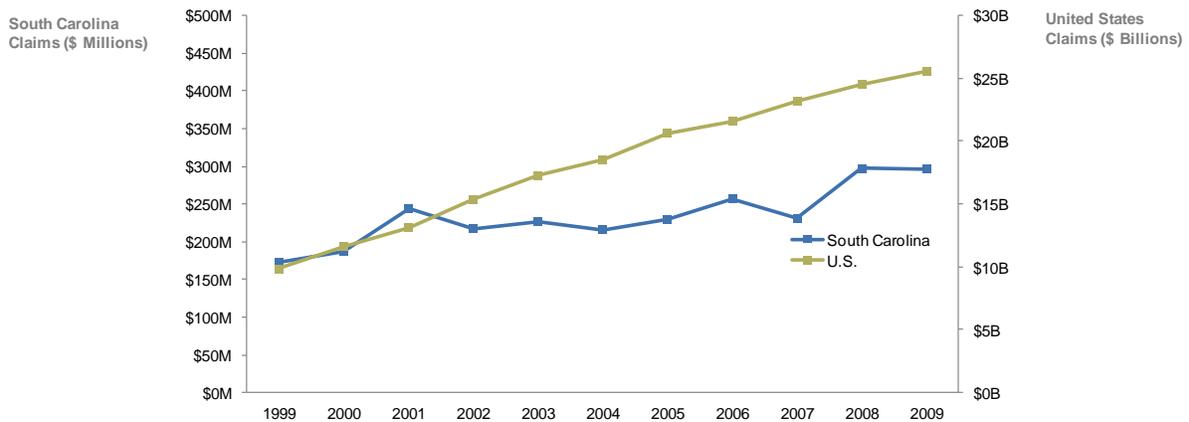
*CLTC 2012-2013 acute costs estimated using growth from 2007-2011: 2012 \$59.2M and 2013 \$61.4M
Source: SC 372 report; SCDHHS; Lucas Group analysis

When comparing South Carolina’s spending on community based services for Medicaid eligible seniors with physical disabilities, however, South Carolina lags behind other states in terms of rates and amount of financial support in the community. South Carolina has lagged in following the US trend on spending for personal care. From 1999 to 2009 growth was 10.0% per year for the United States and 5.6% per year for South Carolina (see Figure 30). In many of these other states, unlike South Carolina, personal care services are part of the state’s Medicaid State Plan services and are also available outside its waiver population.

Figure 30

South Carolina And U.S. Medicaid Personal Care Expenditures (1999-2009)

\$



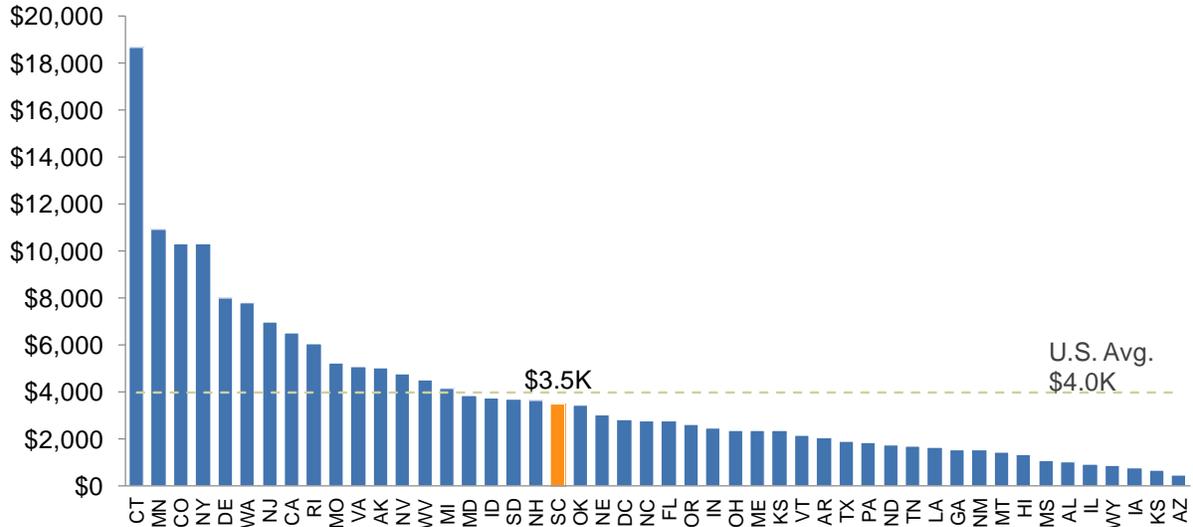
Source: MSIS data; Lucas Group analysis

South Carolina's long term care, personal care expenditures per beneficiary are less than the national average. In South Carolina, personal care expenditures are \$3,500 per year versus a United States average of \$4,000 (see Figure 31).

Figure 31

Medicaid Personal Care Expenditures per Beneficiary by State (2009)

\$ Thousands



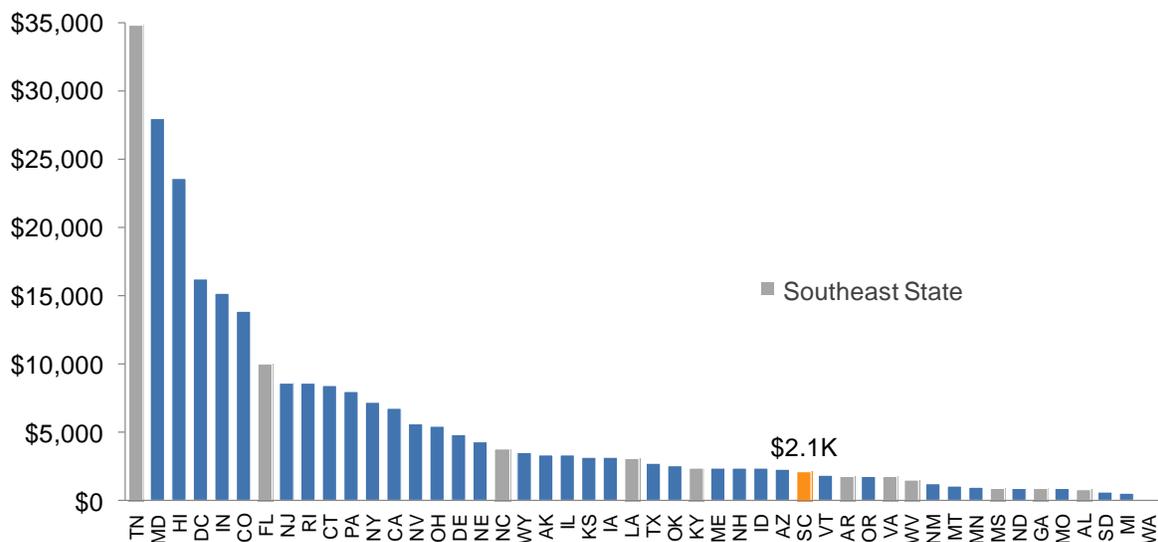
Note: Data not available for Massachusetts, Utah, or Wisconsin

Source: MSIS data

Moreover, South Carolina's spending on home health for these same beneficiaries is well below the national average (see Figure 32). In 2009, South Carolina spent \$2,100 while the United States average was \$5,900 and the Southeast average was \$2,900.

Figure 32

Medicaid Home Health Expenditures per Beneficiary by State (2009)*
\$ Thousands



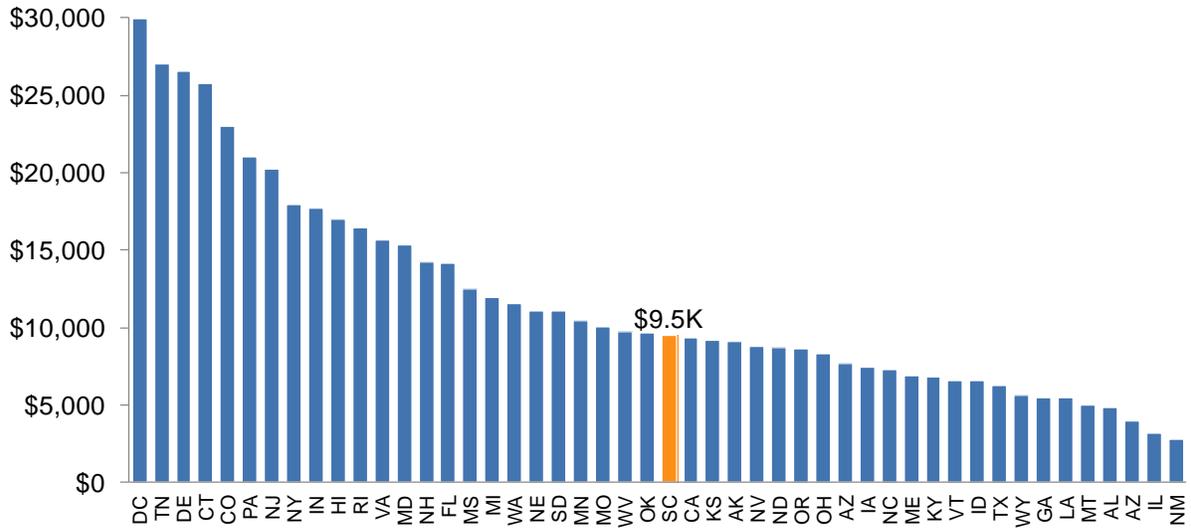
*Southeast Average does not include Tennessee
 Note: Data not available for Massachusetts, Utah, or Wisconsin
 Source: MSIS data

This is one of the main reasons why South Carolina’s long term care spending per beneficiary is lower than the national average (see Figure 33). In 2009, South Carolina spent \$9,500 while the United States average was \$11,700.

Figure 33

Medicaid LTC Expenditures per Beneficiary by State (2009)*

\$ Thousands



*Southeast Average does not include Tennessee
Note: Data not available for Massachusetts, Utah, or Wisconsin
Source: MSIS data

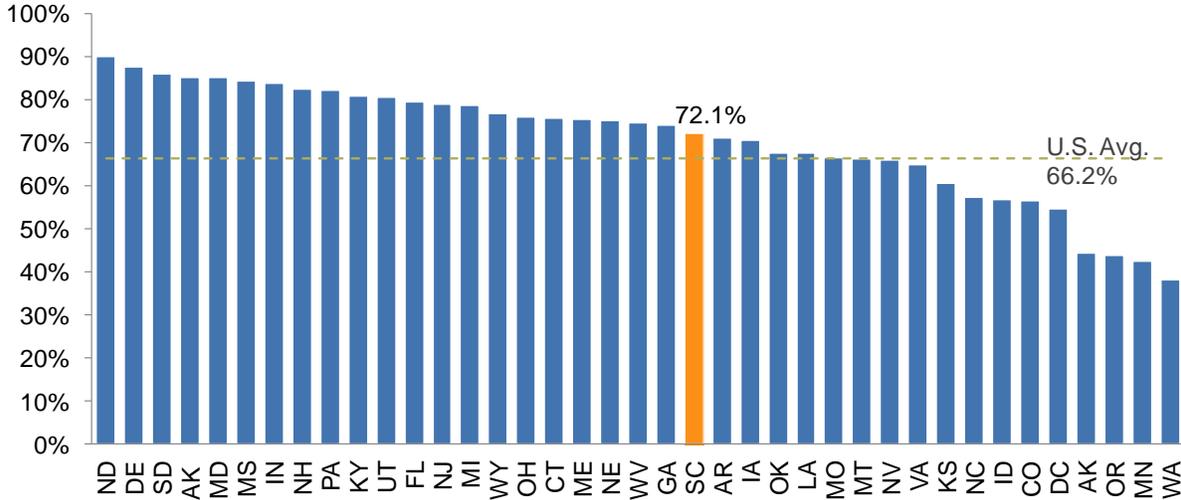
Comparing South Carolina LTC Spending to Other States also Shows an Institutional Bias

However, when one compares South Carolina’s spending on nursing homes compared to the national average an entirely different picture emerges; one that shows a high institutional bias. The Medicaid institutional expenditures on the aged and disabled Medicaid population in South Carolina at 72.1% are higher than the national average of 66.2% (see Figure 34).

Figure 34

Medicaid Institutional Expenditures on the Aged and Disabled by State (2009)*

% of Total Institutional and Community Expenditures on the Aged and Disabled

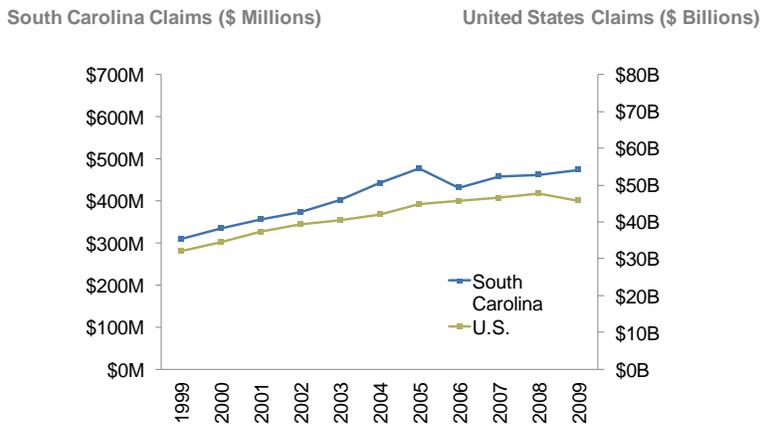


Note: Insufficient data to determine rankings for AZ, CA, HI, IL, MA, NM, NY, RI, TN, TX, VT, and WI
 *Institutional includes nursing home services; Community includes personal care, home, health, PACE, and HCBS
 Source: Thomson Reuters

In addition, South Carolina’s spending on nursing homes has also exceeded the United States trend in nursing home expenditures (see Figure 35). From 1999 to 2009, South Carolina’s expenditures grew at a rate of 4.3% per year while the United States average was 3.7%.

Figure 35

South Carolina And U.S. Medicaid Nursing Home Expenditures (1999-2009)

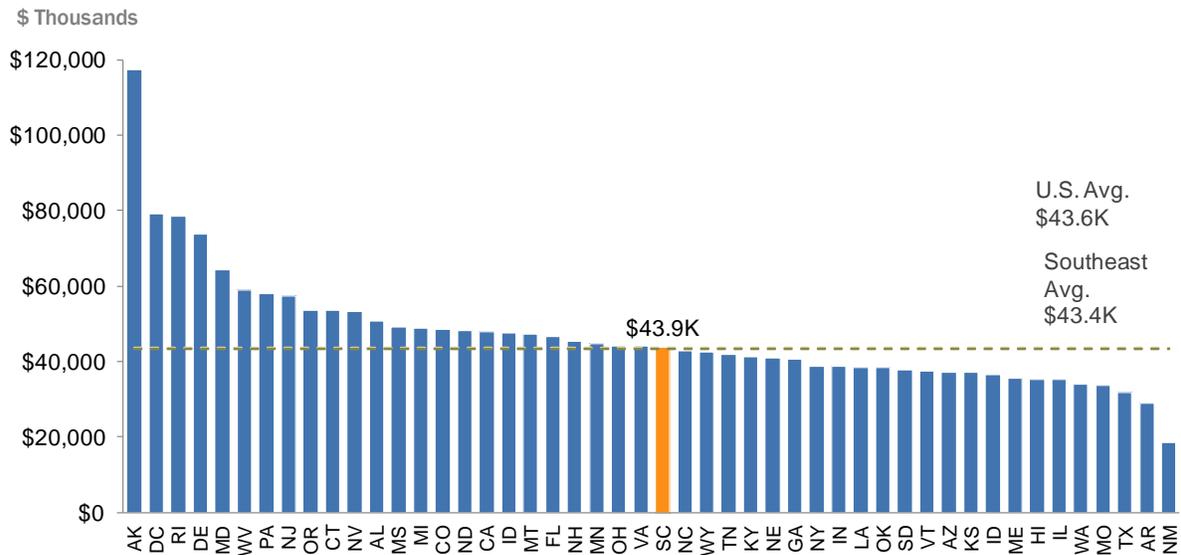


Source: MSIS data; Lucas Group analysis

Moreover, when looking at nursing home costs per person on a yearly basis, South Carolina’s long term nursing home costs are also greater than the United States and Southeast average (see Figure 36). In 2009, South Carolina’s expenditures were \$43,900, compared to \$43,600 and \$43,400 for the United States and the Southeast respectively.

Figure 36

Medicaid Nursing Home LTC Expenditures per Beneficiary by State (2009)*



*Adjusted to yearly rates by using an average stay of 243 days; Does not include acute costs or additional payments by SSI
 Note: Data not available for Massachusetts, Utah, or Wisconsin
 Source: MSIS data; SC 372 report; Lucas Group analysis

South Carolina is also slightly higher than the national and Southeast averages in the average daily amounts paid for nursing homes per person. In 2009, the average daily nursing home rate per person in the United States was \$121.11 per day, and the Southeast average was \$120.60 per day, whereas the South Carolina average was \$121.95 (see Figure 37). This does not take into account the amount the facility gets each month from the elder in their Social Security payments or other sources of recurring income, less any personal allowance.

Figure 37

Average Daily Nursing Home Paid Amounts in Selected Southeastern States (2009)
\$ per Beneficiary per Day



*Assumes an average nursing home stay of 243 days
Source: MSIS data; Lucas Group analysis

Cost Difference Between Nursing Home Care and CLTC in South Carolina

According to SCDHHS, the 2011 amount paid per day for Medicaid eligible seniors in nursing homes, less any personal Social Security payment is \$132 per day, and the amount for CLTC waiver services is \$48 per day (see Figure 38). This takes into account the acute care spending for both nursing home and CLTC. Thus, for each beneficiary transferred or diverted from nursing homes to CLTC, there is a potential savings of \$30,874 per person per year.

Figure 38

Potential Savings per Beneficiary (2011)
\$ per Client

	Nursing Home	CLTC	Savings
Per Diem Rates	\$132	\$48	\$84
Annual Costs per Client	\$48,272	\$17,398	\$30,874

For each beneficiary transferred or diverted from nursing homes to CLTC, there is a potential savings of \$30,874 per person each year

Source: SC 372 report; Lucas Group analysis

Fee-for-Service and Lack of Coordination of Care Contribute to High Costs

A primary issue contributing to high acute care costs and high nursing home costs in South Carolina is the fact that, for Medicaid aged beneficiaries and chronically ill seniors who remain in the community, their medical care through Medicaid is essentially unmanaged and not coordinated with their home and community based plans of care and needs.

Currently, all LTC Medicaid beneficiaries, other than those receiving non-acute care services in nursing homes, in South Carolina seek medical care for their illnesses and Medicaid pays the claim after receiving a bill for services. This is commonly referred to as fee-for-service (FFS). This FFS environment creates a fragmented delivery system and is ill-designed to meet the needs of many elder Medicaid beneficiaries, whether it is preventative services or services designed to address chronic illnesses.

Statewide, SCDHHS has instituted a Primary Care Case Management program (PCCM) through the Medical Health Networks program. The value of this program is that it does provide a medical home for those beneficiaries who choose to enroll. The model, however, is coordinated with neither the CLTC program nor the community case management system. The Lucas Group understands that only 2,000 or so of SCDHHS's waiver participants (of approximately 14,000 waiver enrollees) have chosen to enroll in the PCCM model. Further, there is a structural problem within the PCCM model as they are not at risk for hospital admissions and emergency room use, whether appropriate or not. Medicaid payments for hospital and emergency room use (as well as other services) remain FFS payments from SCDHHS under a PCCM model.

The FFS model creates incentives to provide as many services as possible, while doing little to encourage providers to manage the mix and volume of services effectively. It also has little ability and few leverage points for inducing improvements in care for elder Medicaid beneficiaries, and does not allow for the most competitive rate of reimbursement to providers.

Moreover, the lack of integration inherent between a medical FFS payment model and a home and community based waiver thwarts a care-coordinated approach to a person's needs across the acuity spectrum from high-end hospital care, possible need for short term nursing facility rehabilitative services, and adjustments for HCBS. This results in fragmentation of an integrated continuum of care that is timely, effective, and cost-efficient.

Recognizing this issue, SCDHHS has recently assembled a Coordinated Care Improvement Group (CCIG) that is examining the issue of coordinated care within its current managed care design and will be exploring the feasibility of integrating long term care and/or behavioral health into a more coordinated care network. We believe this is a positive step.

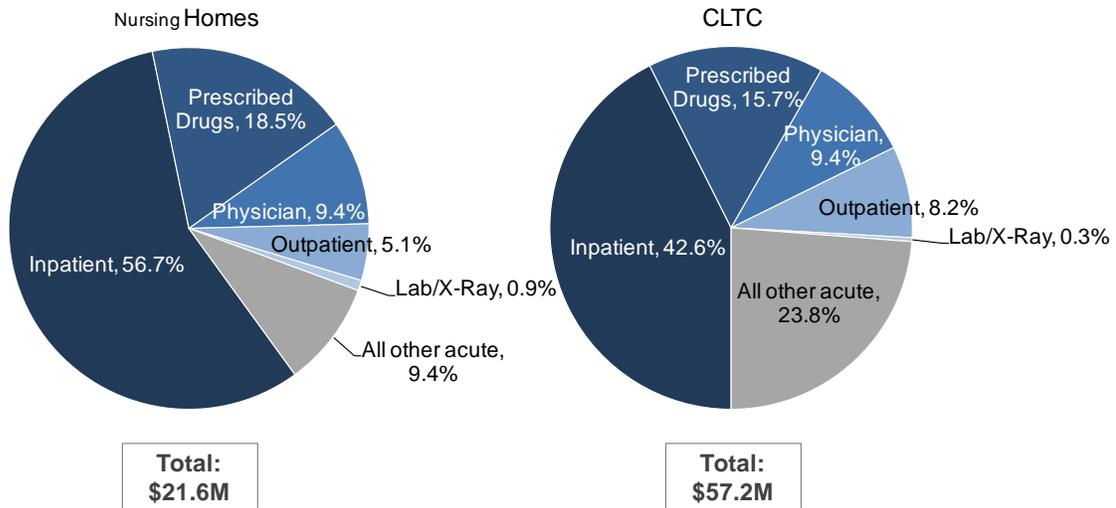
Acute Care Costs are Rising

Acute care costs among Medicaid elders in nursing homes and on the CLTC waiver are growing at high rates, due to lack of comprehensive care coordination. Since 2007 nursing home inpatient rates have grown at a rate of 12.5% per year, and CLTC inpatient rates have grown at a similar 11.7% rate. Outpatient costs have grown 33.8% per year during the same time period for nursing homes and 40.2% per year for CLTC waiver recipients. All other acute care costs have remained stable since 2007.

Figure 39

South Carolina Acute Care Spending, Nursing Homes vs. CLTC (2011)

% of Total

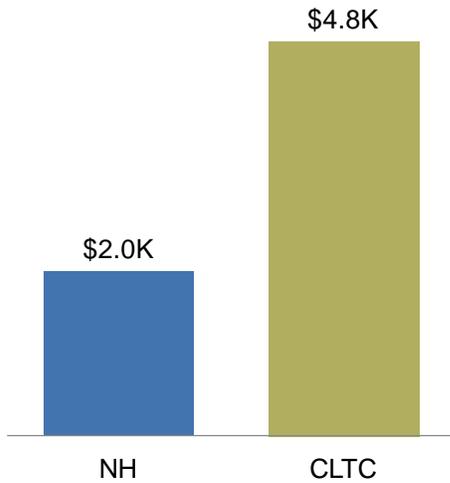


Source: SC 372 report

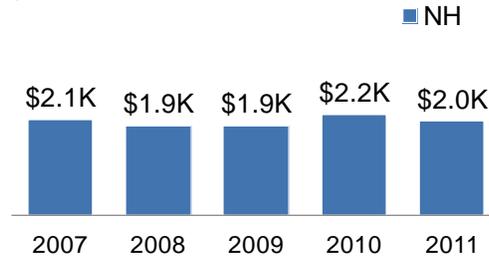
Moreover, SCDHHS spends approximately \$57 million a year on acute care costs for those beneficiaries living in the community under the CLTC waiver, more than two times the amount spent on Medicaid seniors in nursing homes (see Figure 39). The cost per person is over \$2,800 more for individuals living in the community. The unmanaged and uncoordinated fee-for-service system in the community contributes to many of these costs. Reduced hospitalizations and high cost episodic care will result in savings in a more coordinated and managed environment.

Figure 40

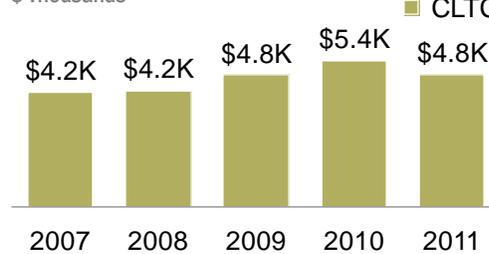
Acute Cost per Person per Year (2011)
\$ Thousands



Acute Cost per Person per Year: NH (2007-2011)
\$ Thousands



Acute Cost per Person per Year: CLTC (2007-2011)
\$ Thousands



*Based on average cost per person per day (which is calculated using average length of stay) and a year of 365 days
 Note: Does not include SSI payments that the nursing home receives from clients
 Source: SC 372 report

States Across this Nation Calling for Transformational Change in Medicaid LTC

Many states across the country are beginning of the process of developing FY 2013 Executive Branch budget recommendations and are facing the prospects of further reductions in state spending. The blistering recession the country has faced for the past three years has resulted in significant reductions to state government budgets – resulting in cuts primarily targeted on Medicaid and education. One of the results of this revenue reality that states continue to face has been a significantly increased focus by state Medicaid authorities for innovation, based on an integrated, client-centered medical home model that is connected to the prioritization of multiple chronic care conditions, high cost enrollees, innovative contracting, and payment reform. Several states have taken significant steps towards integrating or coordinating Medicaid LTC, behavioral health, and acute and primary medical care/pharmacy in a variety of strategies, using allowable CMS mechanisms in an effort to address comprehensive services delivery, improved access, quality improvement, and cost containment. For LTC, this means an effort to keep seniors in homes and communities for as long as possible with high quality, integrated care.

Over the next 12 to 18 months, Lucas Group expects to see several states implement difficult, yet necessary, transformative decisions that rebalance their long term care programs towards more integrated community based alternatives that dramatically change their state programs and budgets (Medical/Pharmacy, LTC, Developmental Disability/Special Needs (DDSN), and Behavioral Health), coupled with strategic organizational restructuring of state health and human services.

Kentucky, Florida and New Hampshire are the most recent states to enact transformative change in their Medicaid programs based on an integrated, community based, Medicaid managed care model. These changes are designed to support the implementation of integrated health care and services while responding to continued reductions in state budgets and current, and anticipated, reductions in federal funding. It is important to note that nationally, several states have implemented integrated risk-bearing coordinated care strategies, including Long Term Care and Behavioral Health, that manage access, quality, and costs of their Medicaid program and achieved improvements in access, quality, and cost efficiencies.

Lucas Group research anticipates that state interests regarding “gainsharing” between the Medicare/Medicaid dual eligible populations will be further clarified by CMS during the same period of time states will continue to be challenged by limited funding.

In May of 2011, the National Association of States United for Aging and Disabilities (NASUAD) reported that at least 23 states were actively engaged in major reform to their Medicaid programs with 15 states intending to implement program and payment reform based on variety of managed care capitated, at risk service delivery contractual methods including long term care.

In September of 2011, the AARP, The Commonwealth Fund, and SCAN partnered together and released “A State Scorecard on Long Term Services and Supports for Older Adults, People with Physical Disabilities and Family Caregivers.” This ground breaking report focused on: Affordability and Access; Choice of Setting and Providers; Quality of Life and Quality of Care; and Support for Family Caregivers. One of the major statements from this report was that states that performed well across the board did so by:

- “Improving access to needed services and choice in their delivery by transforming their Medicaid programs to cover more of the population in need and offer the alternatives to nursing homes that most people prefer.”
- “Facilitating access to information and services by developing effective ‘single point of entry’ systems so that people who need services can find help easily.”
- Addressing the need of family caregivers by offering legal protections as well as the support and services that can help prevent burnout.”

The Lucas Group Team believes a “rising tide” of support for a balanced LTC system exists today. The Lucas Group Team has met with over 100 people across the state since the beginning of the project, representing the multiple interests and concerned citizens in South Carolina including AARP, community providers, nursing facility providers, SC Protection and Advocacy, professional hospital staff engaged in

transition management, managed care organizations, medical health network organizations, citizens representing themselves and the disability community, academia, the PACE program, CLTC Central and Regional Office staff, and SCDHHS state officials representing budget, rate setting, and managed care.

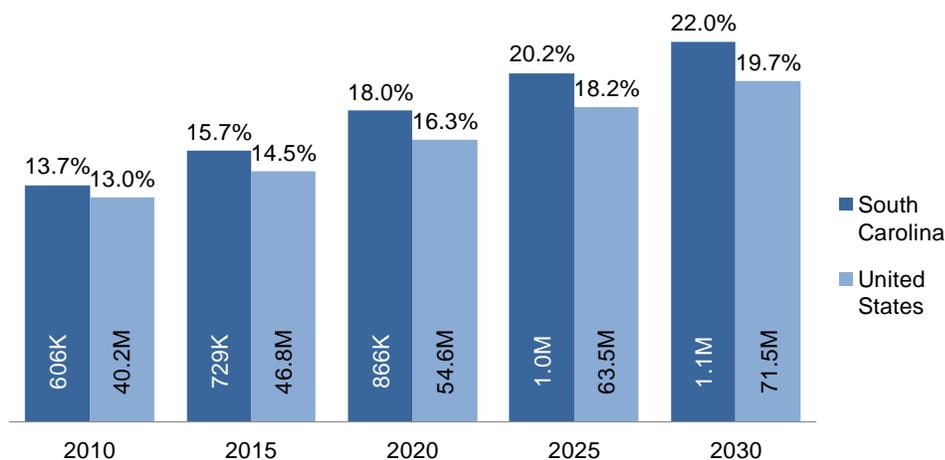
The concepts of a comprehensive continuum of care based on acuity, a Community First Choice culture that includes nursing facilities as a vital partner and resource based on acuity, an identified “single point of entry” for seniors and their families to acquire knowledge, information and assistance with the complexity of South Carolina’s long term care system, integrated acute/primary care/pharmacy, and payment reform appear to be commonalities that can be supported as the fundamental drivers of transforming South Carolina’s publicly paid long term care system.

South Carolina’s Aging Demographics: A Call to Action

South Carolina’s elderly population of those over 65 years of age is projected to grow from 13.7% people to 22.0% of the people from 2010 to 2030 (see Figure 41). Meanwhile, the United States population over 65 will increase from 13.0% to 19.7% from 2010 to 2030.

Figure 41

Population 65+ Years Old in South Carolina vs. U.S. (2010-2030)
% of Total Population

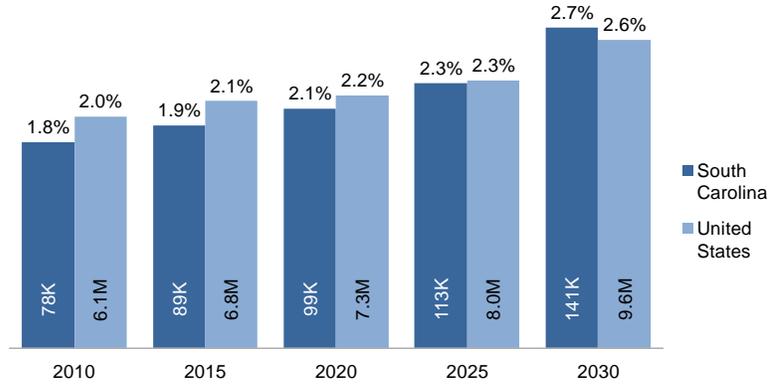


Source: U.S. Census Bureau

South Carolina’s population over 85 years of age will also increase over the next 20 years, from 1.8% in 2010 to 2.7% in 2030 (see Figure 42). Meanwhile, the over 85 population in the United States will increase from 2.0% of the total population in 2010, to 2.6% in 2030.

Figure 42

Population 85+ Years Old in South Carolina vs. U.S. (2010-2030)
% of Total Population

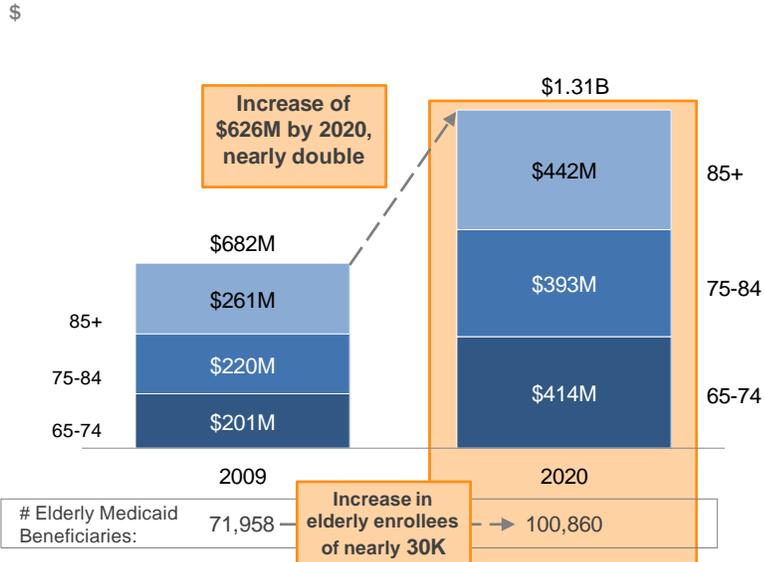


Source: U.S. Census Bureau

Assuming inflation of long term care costs at 2.5% per year and factoring in population growth, South Carolina’s elderly Medicaid spending will nearly double to \$1.3B by 2020 (see Figure 43).

Figure 43

South Carolina Elderly Population Medicaid Spending (2009-2020)



Source: U.S. Census Bureau; MSIS data (2009); Lucas Group analysis

Building the Case for Balancing South Carolina’s Long Term Care System: Focusing on Community First Choice Option for Chronically Ill Seniors

South Carolina has worked in several areas to promote increased access to home and community-based services. These include changes in services, additional waiver slots, partnerships with other agencies, service rate increases, nursing home transition efforts, increased consumer direction, and program expansions.

In the past, rates for personal care, attendant care, companion, adult day health care, home delivered meals, and nursing services have all increased to encourage provider retention and new provider enrollment for these home and community based waiver services. In addition, the following new services have been added to the Community Choices Waiver: nursing facility transition services, limited appliances, additional incontinence supplies, telemonitoring, hand held showers, transfer benches, shower chairs, raised toilet seats, nutritional supplements and adult care home service. The State also continues to expand limits on the waiver services that are currently in place.

SCDHHS has also recently entered into an agreement with the South Carolina State Housing Authority to expand its ability to perform home modifications such as door widening, roof repairs, grab bar installations, limited plumbing repairs, and floor repairs. This partnership has substantially increased the modifications available to waiver recipients.

South Carolina also has been expanding long term care service offerings through the state Medicaid plan, including an expansion of the PACE program to a second two-county site.

Despite all of these improvements, there are many other areas where South Carolina can position itself to make more significant short and long-term changes in its long term care system. South Carolina needs to focus on the Community First Choice option prior to nursing home placement for most all seniors eligible for nursing services. This focus will allow South Carolina to catch up to the vast majority of states that have already made major program improvements to achieve a balanced long term care system. The following sections of this report consists of what we heard, what we found and what recommendations we suggest that will assist South Carolina in achieving a more fiscally sound, prudent, and quality-enriched balanced long term care system for all its seniors.

Building Blocks for a Balanced System

States that are most successful in managing their long term care program have developed and implemented a balanced system that relies on home and community based services first to meet consumer long term care needs. “Rebalancing State Long term Care Systems” (Robert Mollica and Susan Reinhard) was published in *Ethics, Law and Aging Review* (2005) and included an analysis of the components of an ideal LTC system. The issues listed below remain relevant today and provide South

Carolina a framework for changing to a Community First Choice culture and an acuity based system that provides more choices for consumers to be supported in cost-effective home and community based services.

- **Philosophy** - The state's intention to prioritize services and supports to people with disabilities in the most independent living situation and expand cost-effective HCBS options should guide all other decisions. How a state views quality of life for older adults and people with disabilities, and the importance of participants having a choice in how their services are provided, may be the most important factor in having a balanced Long Term Service and Support (LTSS) system. Surveys of these populations have consistently and reliably identified that they strongly support options other than costly institutional care.
- **Array of Services** - States that do not offer a comprehensive array of services designed to meet the particular needs of each individual, and to address the needs of people of all income levels, will have more people admitted to institutions than will states that provide an array of options. Recipients should have an array of services from which to choose, enabling them to select those that are most important to meet their needs and preferences.
- **State Organization of Responsibilities** - Assigning responsibility for overseeing the state's LTC system to a single administrator has been a key decision in some of the most successful states that have made progress or balanced their LTC systems. States such as Tennessee, Oregon, Washington, New Hampshire, Vermont, and Massachusetts have organized their health and human services agencies/departments in a structural alignment supporting integrated state Medicaid policy and purchasing strategies with long term care, behavioral health, and developmental/intellectual disability services in support of integrated and comprehensive state health policy formulation, implementation, budgeting, and outcomes thereby removing the "silo" bureaucracies of the past.
- **Coordinating Funding Sources** - Coordination of multiple funding sources can maximize a state's ability to meet the needs of people with disabilities. We believe this is an essential priority for SCDHHS as it moves towards a more integrated Community First Choice option in the future.
- **Single Appropriation** - This concept, sometimes called "global budgeting," allows states to transfer funds among programs and, therefore, make more timely decisions to facilitate serving people in their preferred setting. This shows an even greater commitment to person-centered care, instead of provider-centered budgeting. It also gives flexibility to the single state Medicaid agency in utilizing federal and state Medicaid resources to maximize the Community First Choice option for its chronically ill Medicaid population desiring to remain in their homes or alternative community settings.
- **Timely Eligibility** - Hospitals account for nearly half of all nursing home admissions. When decisions must be made quickly at a time of crisis, state Medicaid programs must be able to arrange for HCBS in a timely manner. Successful states have implemented procedures that either presumes financial eligibility for Medicaid HCBS or "fast track" the eligibility determination process. CMS, in its Balancing Incentive Payment Program which offers an

enhanced match for some community based services, is suggesting at a minimum that financial eligibility and programmatic eligibility functions be co-located.

- **Standardized Assessment Tool** - Some states use a single tool to assess functional eligibility and service needs, and then develop a person-centered plan of services and supports. This standardized tool helps to minimize differences among care managers and prevent unnecessary institutionalization. Such a tool also can be used to collect consistent data, leading to better system management. States such as Maine, Virginia, Washington, and Wisconsin have implemented comprehensive standardized assessment tools, and New York is pursuing a universal electronic assessment instrument and system across disabilities based on interRAI (inter Resident Assessment Instrument).³
- **Single Entry Point** - A considerable body of literature points to the need for a single access point allowing people of all ages with disabilities to access a comprehensive array of LTC services. Effective systems that determine eligibility, coordinate services, and monitor quality can support people who have their own resources to pay for services, as well as those who qualify for public programs. A robust system of information and assistance is critical, as most people with disabilities and their families have a difficult time navigating a complex system.
- **Consumer Direction** - The growing movement to allow participants a greater role in determining who will provide services, as well as when and how they are delivered, responds to the desire of people with disabilities to maximize their ability to exercise choice and control over their daily lives.
- **Nursing Home Transition**- Some states have made systematic efforts to regularly assess the possibility of transitioning people out of nursing homes and into their own homes or more home-like community alternatives. Medicaid payment for transition services is a critical component of the success of these efforts. Some states assign staff to visit nursing homes regularly to identify, assess, and help people relocate from the nursing home to the community. State staff, and the staff of managed care companies assuming the risk for the care of nursing home residents, regularly visiting nursing homes should be considered a best practice for transition and the MFP demonstration program.
- **Quality Improvement** - States are beginning to incorporate participant-defined measures of success in their quality improvement plans. Wisconsin and Tennessee have implemented strategies within their managed care based LTC systems that assures participant input into the quality improvement plans of their service delivery systems.⁴
- **Integrating Health And LTC Services** - A few states have developed methods for ensuring that the array of health and LTC services people with disabilities need are coordinated and delivered in a cost-effective manner. For many people, the ability of states to do so is complicated by differences in how Medicare and Medicaid programs are administered – especially among people age 65 and over, the great majority of those receiving Medicaid are eligible for Medicare as well. Arizona, Hawaii, Tennessee, Texas, and Wisconsin have

implemented robust models that are based on managed care approaches for integrated services for individuals with long term care needs.⁵

Building Blocks for a Balanced System



What We Heard in the Field

The Lucas Group participated in several meetings with the CLTC Regional Office Directors and visited two of the offices on site. The Lucas Group also conducted a web-based survey of all 11 regional offices. The survey consisted of 15 questions covering a wide range of topics. The Lucas Group was impressed with the quality, insights, and recommendations made throughout the responses. Our analysis indicated a cluster of consistent responses to many of the questions that are compatible with Lucas Group Recommendations for Process and Program Improvements. The following selected statements from the complete results of the survey are indicative of the dedication and knowledge of the Regional Office Directors and represent consistent themes and ideas expressed by many.

1. Driving out unnecessary costs:

- Service level approval by state employees has helped some but still depends on standards set in each area office.

2. Why do so many folks end up in nursing homes instead of their own homes?

- Families don't know there is another service.
- Long waiting list.
- Not enough respite care providers.
- SC offers no in-home respite services for the families.
- Lack of family support.

- Participant requires more care than CLTC can offer.

3. How would you improve the CLTC system?

- We are wasting time on intake.
- Improve communication/work flow between CLTC and Medicaid eligibility.
- Change the qualification guidelines to make it more accessible. There are a lot of folks who have problems understanding the SC system. While improvements have been made to making it a one stop referral process, there are still too many barriers from making the Medicaid application to actually getting services in the home.
- More modern, referral application via internet versus phone.

4. What connection to local hospital discharge planners do you have?

- We do work closely with local discharge planners but not necessarily in a coordinated process.
- Nurse Coordinators see and talk with discharge planners on a regular basis but most of the conversations center around NHP. Even though discharge planners are encouraged to make CLTC referrals as appropriate, most of the time they feel frustrated with CLTC's long waiting lists and find it more helpful to make referrals for home health services which can evaluate immediately. Once home health evaluates then they are typically the ones to make the CLTC referral. We definitely need to coordinate better to improve the referrals for waived services.
- The office nurses visit the local hospitals for nursing home evaluations, so they have a working relationship, but not toward community based care.

5. Do you have care transition responsibility for persons leaving hospitals?

- We do not have care transition responsibility. If we could get them into Home Again, we would. But usually the waiting list is so long that they are in a nursing home or back home before we get them.
- Yes. I think we do. I think it is appropriate and helpful when CLTC can work with the hospital case manager (CM) and the family and have some services close to being in place when the person leaves the hospital.
- No, we do not have transition care responsibility.

6. Describe the capacity of home and community based providers in your region, and the ability for them to handle more waiver slots in the future?

- Residential care such as adult home service? or Residential home as in boarding home. I think the answer to either way is no.
- There is a lot of competition and excess capacity.
- Our area is very limited with residential care facilities that accept OSS payment. There are 2 services that we need providers to expand into our area that should SC

substantially expand CC slots. They are ADHC & Respite Care Providers. We need to locate central areas within the area offices and promote the need for these two services.

- Need more housing options
- There are not enough mentally ill Day Care programs; there is a need for more ADHC providers and Respite Care providers.
- There need to be more smaller homes where 6-8 people can receive care.

7. Do you feel SC is effectively coordinating efforts to rebalance long term care across all agencies that handle the waiver programs for chronically ill seniors, including those that are disabled and mentally ill?

- I do not think SC is effectively coordinating efforts to rebalance across all agencies. DHHS-CLTC is being used as a place to send people that could be better served by DDSN and Mental Health agencies. Even when DDSN or MH have an opening for one of our participants on the appropriate program, the DDSN worker or MH worker presents it to the participant in a way that deters the participant from changing. However, I think that CLTC is serving a lot of participants that should be on other programs rather than CLTC.
- No, SC is not effectively coordinating efforts to rebalance LTC across agencies. I suppose that there is little incentive for state agencies to do so. Handling the mental health piece across agencies is especially needed.
- There should be more interagency meetings in counties and state.

8. Why do you think people choose nursing homes?

- Need services as soon as possible.
- Have no family support.
- Need 24 hour care.
- Forced in placement without adequate knowledge.

9. Where are you interacting with potential applicants to inform them of their long term care options?

- In the past we have told people about their options at medical events, and they learn through contact with their doctors and hospitals. It is possible beneficiaries fall through the cracks and do not learn all their options. People also learn about their options on TV.
- It's like a network. People find out from home health agencies, hospital discharge planners, personal care providers, and nursing homes.

10. How well do you think the current assessment process for HCBS waiver services is working? Are there any organizational or process improvement strategies you would like to see implemented:

- It would be helpful to tighten up our intake criteria to make it more compatible to our level of care criteria.
- I think the current assessment process works very well. I do think there are some parts of the assessment that should not be completed at the initial assessment time by the nurse as it takes a lot of time and effort on gathering information and then so many of the applicants never apply for Medicaid and never enroll in the program.
- Has improved since we went to Phoenix.

11. How well do you think the financial eligibility offices for HCBS waiver services is working? Any organizational or process improvement strategies you would like to see implemented?

- Takes forever, the range is 6 months to never completed.
- Financial Eligibility worker located in all regional offices to concentrate on CLTC referrals.
- It works better in my two counties than in most other areas of the state. Yet we spend too much time sending forms back and forth by regular mail. We need to have the capability to e-mail ALL forms between CLTC and Medicaid Eligibility, as we're both part of SCDHHS.
- No way to track speed because it is manual.
- Would like to connect electronically.
- Should centralize intake.
- Understaffed and overworked.

12. Based on the current staffing of your regional office do you think the scope, amount, and productivity of the workload is just about right, too little, or too much?

- We are understaffed and overworked.
- We need more nurses.
- Currently my office has been 1 nurse short since last December 2010. Now here it is almost December 2011, and I have another nurse that is retiring. I have also been short the lead team nurse position all of 2011. It would greatly improve efficiency, productivity and sense of teamwork if these positions were filled. The nurses workload is high. The nurses do much more work than is reflected when tracking completed assessments. A nurse may go to visit a waiver applicant and spend twice as long at that one home explaining estate recovery issues, talking about the program- to several family members- and never make an assessment and yet this is not reflected in their "productivity". The nurses spend time talking with families and applicants, people who call the office looking for help, working with case managers, etc. that is not captured in this number. When you have decreased nurses, you also have to ask the nurses that you do have to travel farther distances which takes much of the work day. I think that the staffing of the office should also be based on the number of the participants on the program in your office and the number of applicants on the waiting lists, etc. I think the case manager II' s

(CMII) are also overworked. In my office which has a large # of Community Choices and HIV cases, I have 2 CMII's. But these 2 CMII's have more cases to team staff, more questions to answer and things to follow up on than they can handle. If we had another CMII then we could track things more carefully and find errors and improve services. I also am concerned about the administrative support staff of the area offices as it appears to be decreasing. I think we often think because things are automated, that we can do with less people, but I do not think this is the case. It is very difficult to manage a large office with only 3 support staff to assist. Salaries are at the very lowest of the state and do not compare from office to office. There should be some way to make salaries more equitable or we are going to lose qualified workers who are excellent employees.

- Regarding nurse coordinators, we have 1 position that was vacated one year ago and we have been unable to fill. The other nurse coordinators have tried to compensate for this vacant position but they are beginning to get burned out.

13. Given South Carolina's receipt of the recent CMS grant focusing on Dual Eligibles services Integration Innovative Models, what ideas or strategies would you suggest to develop a "seamless" system for people eligible for home and community based services.

- I do not understand Dual Eligible Services and how that is going to impact our program.
- Not sure of this policy yet.
- Since I have little understanding of how this will impact Community Long Term Care participants, I am not able to give any strategies or ideas.
- I am unclear as to how this is going to impact the participants we serve. Many we serve are dually eligible.
- I am not familiar enough with these concepts to know.
- These systems could be improved if easier understood by consumers allowing for voluntary enrollment and disenrollment at any time. Models could improve health care reform if it allowed for home making type services or companion services for the elderly and disabled. Models could improve health care reform if participation would focus on preventions; allowing persons to receive In-home care if they do not qualify for nursing home care because they are higher functioning for the SC criteria for nursing home level of care.

14. Are there any planning efforts, strategies, augmentation to current practice that address integrated health homes and comprehensive care management models that address improved access, outcomes, quality, and cost efficiency?

- I am not familiar with these concepts to know.
- Agency should be involved with health home.
- Need more info/not familiar with this program.
- These systems could be improved to more easily be understood by consumers allowing for voluntary enrollment and disenrollment at any time.

- Models could improve health reform if it allowed home making type services or companion services for the elderly and disabled. Models could improve health care reform if participation would focus on prevention; allowing persons to receive in-home care if they do not qualify for nursing home care because they are higher functioning for the SC criteria for nursing home level of care.

15. If someone cannot be served in home do you have a residential care alternative? If SC were to substantially expand the number of community slots would the provider capacity be there in the community to serve their needs with quality? If not, what steps should be taken to make sure the capacity meets the need?

- Services are very restricted under community choice under DSS.
- Need more housing options.
- There needs to be more smaller homes where 6-8 people can receive care.
- Yes, there is capacity with varying levels of quality.
- Licensure of personal care aides in SC would be a wonderful thing to promote the profession and ensure better quality of care. We need other housing options, for example group homes for four to six seniors with a live-in caregiver in each home.

The Process, Best Practice and Recommendations for Change

Comprehensive Assessment

States all have instruments (manual or automated) to assess a person who needs long term care supports and services. The assessments determine medical eligibility (level of care) for publicly funded long term care programs and often serve additional purposes, including service plan development and quality monitoring. Automated versions allow states to collect data for decision support and management of their programs.

States have also been developing universal assessment instruments that can be shared across multiple programs, for different populations and different agencies. These instruments can help promote community choices for consumers by only requiring one assessment to determine functional eligibility for multiple programs. The universal assessment can also reduce the need for staff to complete multiple assessments when a consumer might qualify for more than one program. Data collected in the assessment can be used by states to project service and budgetary needs and prioritize individuals for services when budgets are limited.

A well-designed comprehensive assessment can offer many benefits to a state, such as promoting choice for consumers, reducing administrative burdens, promoting equity, capturing standardized data, and automating data systems to indicate programs for which an individual is likely eligible.⁶

Comprehensive assessment information and data systems can also support state efforts to project future service, support and budget needs and prioritize individuals for services when waitlists are present or budgets are limited.

South Carolina Assessment Process

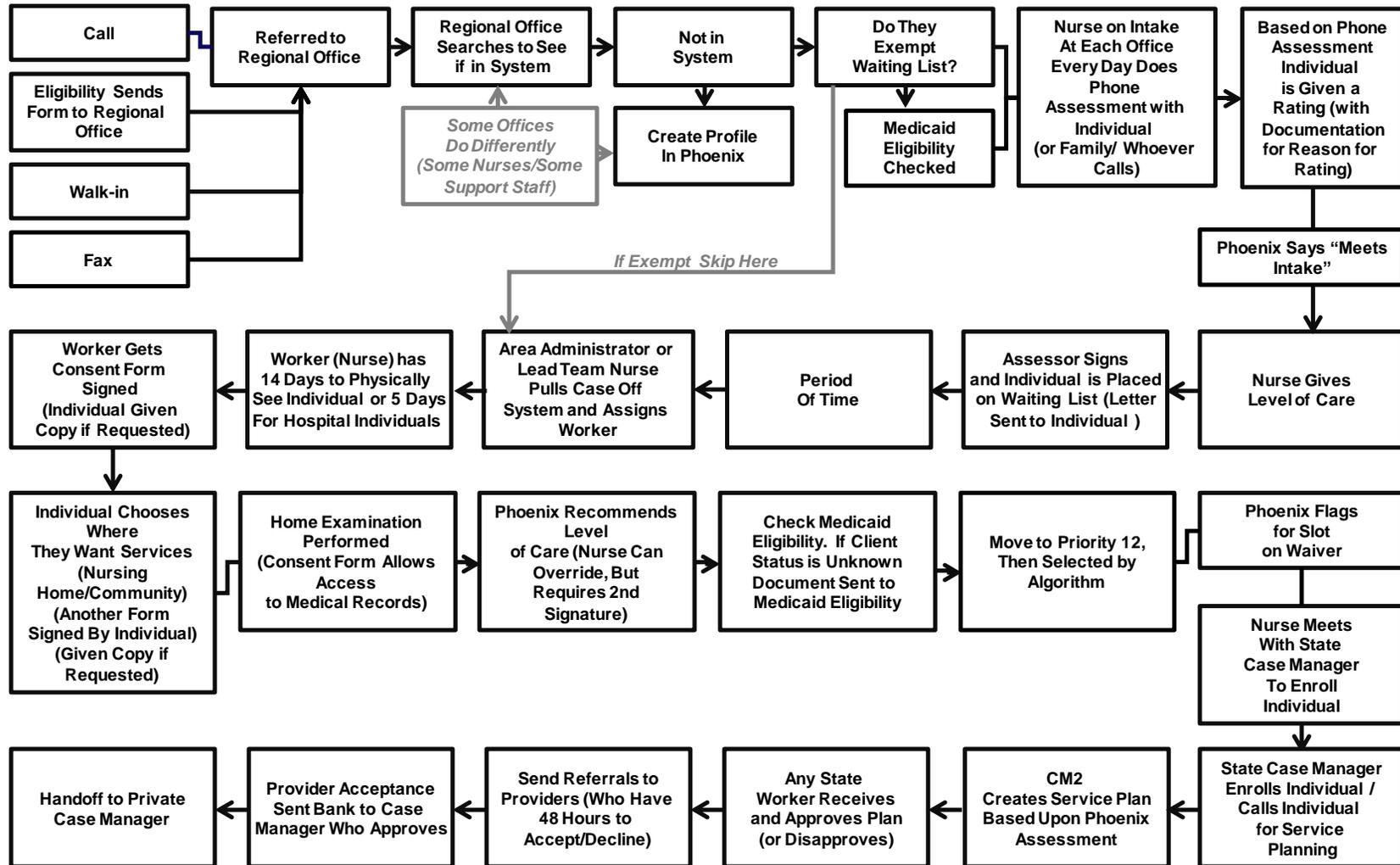
In 2003, the South Carolina Case Management System for Medicaid HCBS waivers and the state's Quality Management System were highlighted in the Center for Medicare/Medicaid Services Promising Practices in Home and Community Based Services. The PHOENIX system was the next iteration of the state's automated assessment process, programmed by state staff, and includes waiver assessments, nursing home assessments and nursing home resident conversions to Medicaid. PHOENIX is not used for the Integrated Personal Care Program. Needs identified in the assessment process are populated on the service plan and must be addressed during the service planning process. The new assessment process has been in use for about a year.

PHOENIX includes most of the categories included in the interRAI (MDS-HC) Home Care ("interRAI" is a collaborative of researchers from many countries that have created a comprehensive assessment tool used by several states and countries) that provides for categorizing responses in the Activities of Daily Living section from "Independent" to "Total Dependence." This allows for comparison of nursing home clients to waiver clients using the data in the minimum data set (MDS) for nursing homes.

In 2004, the South Carolina – Care Call (automated voice verification provider monitoring system) was added to the Center of Medicaid/Medicare Services Promising Practices in Home and Community Based Services. The system allows for the monitoring and verification of the providers delivering services under the state's home and community based waivers. Providers check in and check out as they deliver services in a participant's home. The system has been expanded to include all home and community based providers, including case management contractors. The system is connected to the Medicaid Management Information System (MMIS) for payment to the providers. This makes the completion of the CMS (Center for Medicare and Medicaid Services) Form 372 annual waiver reporting an efficient process.

The CLTC assessment process (DHHS Form 1718) is used for 13 programs. The current assessment process asks consumers up front if they want to go to a nursing home or a home and community based option, without a concentrated focus on explaining how home and community based options can meet a consumer's long term care needs. The attached chart (see diagram below: SCDHHS Long Term Care Entry Process) outlines the CLTC's intake and assessment process.

DHHS Long Term Care Entry Assessment Process



- Intake is performed by nurses in the regional offices
- Assessment administered by regional office nurses
- State case managers/level 2 develop initial plan of care and related costs
- Case/plan of care referred to individuals who choose community based case manager; any changes to plan of care referred back to the regional office for review
- Recent CLTC initiation of a final review/approval process for the plan of care by a designated CLTC senior staff member
- The Community Choices Priority Levels 12 step system does not address acuity and includes administrative process steps related to financial eligibility and status of the application of the nursing assessment.
- As of 8/1/11, there were 2,273 Priority Level 8 (assessed for intermediate/skilled care) cases lacking verification of Medicaid eligibility.

Concerns and Suggestions Raised in Field Regarding Assessment Process

Some of the concerns raised in the field by SCDHHS staff we met regarding the current Assessment process are as follows:

- The current process is an administrative burden and generated inconsistencies.
- Attention to reducing the amount of administrative paperwork (e.g. financial eligibility forms) the nurse assessors are required to manage should be assessed with a goal of increasing the amount of face-to-face assessment time.
- The implementation of the PHOENIX assessment in the field received positive reviews.
- The process to be assessed and authorized for services takes too long.
- The financial eligibility process significantly delays a person's ability to access home and community based services.

Several suggestions were made in interviews and the regional office surveys to improve the intake process:

- Staff have suggested that nurses not be used for intake .
- Staff support an automated intake system.
- Staff suggested a web-based intake process be developed and many suggested that the intake process be centralized.

Assessment Process Recommendations

The newly implemented PHOENIX assessment for South Carolina already includes features that the federal government (CMS) suggested need to be included in a comprehensive assessment to fulfill the Core Data Set requirement in the Balancing Incentive Implementation Manual. The five domains included in this manual are activities of daily living, instrumental activities of daily living, medical conditions/diagnoses, cognitive functioning/memory and behavior concerns –all of which are addressed

in PHOENIX. The Implementation Manual also lists 54 assessment topics that are recommended – many of which are in the South Carolina PHOENIX assessment.

In addition, the PHOENIX produces data and reports that allow the state to analyze their progress in complying with CMS quality assurance waiver protocols. While having this information available electronically saves the state considerable time in producing evidence for CMS, there are still states who produce their quality management information through time consuming manual processes.

The system allows assessors/case managers electronic access to a large number of forms and processes that the assessors need to make sure are completed. This is also a significant efficiency for the workers.

The recommendations below are meant to improve processes and to move the state forward in the use of data to drive consistent decisions for consumers.

Intake:

The current intake process assigned to nurses in the local offices could be performed by trained social workers or other professional state staff at the regional offices freeing up the time of nurses to do assessments that would more effectively use their training and expertise for medically complex cases.

The intake process could also be adapted as a web-based tool for individuals/family members, including the Aging and Disability Resource Centers as an entry point for access to long term care to complete and submit directly. CMS also recommends that states moving forward on the Balancing Incentives implementation plan include a web-based intake/screening tool so consumers/families, and other agencies (e.g. ADRCs) can complete and submit directly. Note: recently SCDHHS made a positive adjustment to their process of managing calls/letter/email requests for services and information at the regional office level in an attempt to decrease variance and address recent resource reductions. SCDHHS is adopting a process based on a centralized/virtual intake process that the SCDHHS central office will manage.

Level of Care Assessment/Handoff to State Case Manager:

The Lucas Group recommends that South Carolina use other professionals in addition to nurses to complete comprehensive assessments. The SC process where the nurse completes the level of care and then hands off the assessment to a state case manager is cumbersome. It can add time to the process and has the potential to lose any information the nurse may have about the client that is not documented in the assessment. The client would benefit from one person initially completing the assessment and the service plan. Other states use professional staff other than nurses to perform level of care assessments.

- Wisconsin staff that performs functional assessments have Bachelor's degrees (preferably in a human services related field), complete on-line training, and must pass a test to be certified. They also meet national AIRS certification requirements.
- Washington requires a Master's degree and two years of paid experience or a Bachelor's degree in Social Work, Human Services, Behavioral Sciences or an allied field and three years of experience.
- Virginia requires a minimum of an undergraduate degree in a Human Services field, or a licensed nurse, plus two years of experience in a Human Services field working with the elderly.

Nurse expertise could be made available to social worker assessors for medical consultation.

Consistency in the hours authorized:

The Lucas Group recommends later in this report that an acuity based case mix rate setting methodology for nursing home services be developed based on the MDS 3.0 data set. In addition, the Lucas Group recommends that a case-mix (acuity based) system that places home and community based clients into categories should be developed that includes an algorithm for a maximum hourly authorization by category to assure consistency. This could also be used for residential rate setting when residential services are added to the waiver.

A contractor or the state entity that programmed PHOENIX should review the system and the data they collected to determine the ability to add this to the current instrument. If the feasibility study determines it is not possible then the state could move to the MDS-HC interRAI (used by more than one state and allows comparisons with nursing home data collected through the MDS and includes a case - mix system that places clients into distinct service-use/intensity categories).

The State of Washington system (CARE) categorizes clients into 17 levels and includes an algorithm that sets a maximum number of home care hours or a residential rate for each of the levels. Wisconsin's Functional Screen establishes a maximum budget in its algorithm that can be expended for the client in the state's managed long term care program— Family Care. Two states that plan to rollout automated comprehensive assessments in 2012 (Arkansas and New York) are using the MDC-HC interRAI and will include algorithms to authorize home care hours by category.

Staff – both at headquarters and the field – were concerned about the unexplained variation by region in the amount of hours authorized, especially for attendant care (reimbursement to family caregivers for in-home care). Recently, the state required hours to be approved by state staff. This has resulted in an increase in fair hearings, but has not solved the regional variation issue. Moving to a case mix system will help assure that clients with similar needs receive similar authorizations.

Family Caregiver Support Documentation:

A consistent way to document caregiver (including family) support should be added to the activities of daily living and instrumental activities of daily living sections. In addition, the information should automatically be included in the service plan to assure consistency. Currently, this information is documented in “Caregiver Supports” but the caregiver information does not populate the service plan. Information about caregiver burden is collected and the need documented for help for the caregiver is automatically included in the service plan.

The Wisconsin functional screen includes the following categories in their assessment: UP -Unpaid caregiver will continue, PF-Current publicly funded paid caregiver will continue, PP-Current privately paid caregiver will continue, N-Need to find new or additional caregivers that SC should consider.

Integrated Personal Care/OSS:

The current assessment process for IPC and OSS is not part of PHOENIX. It should be incorporated into PHOENIX and not be stand-alone systems. This would allow the agency to have a more complete set of information about all of its clients.

Financial Eligibility:

The financial eligibility process is currently a serious barrier for persons being able to access home and community based services in a timely manner. The current process needs to become more efficient and would benefit from the establishment of a workgroup suggested by the Bureau Chief of Medical Eligibility with a goal of eliminating the need for paper to be submitted if information can be obtained electronically, expediting the disability determination process, and engaging staff and/or ADRCs to assist clients and families who are having difficulty obtaining necessary information.

There appears to be a perception that the process does not happen in a timely manner because potential beneficiaries simply do not submit the necessary documents. SCDHHS should consider a more consumer-friendly and systemically supportive approach involving the ADRCs that enhances the “no wrong door/single point of entry” requirements in the CMS State Balancing Incentives Program/PPACA/Section 10202.

CMS has reiterated that if states are to effectively rebalance their long-term care services and supports systems from institutional to community based care the timeliness of HCBS eligibility determinations must be improved. CMS encourages states to propose creative methods for streamlining and speeding up eligibility determinations to help overcome the barriers that can prevent individuals and families from remaining in the community.

Number of Case Management Contractors:

Based on limited state and local office administrative resources (who are required to train, approve hourly authorizations, and monitor contractors), SCDHHS should consider reducing the number of contractors. This could be accomplished by redefining a qualified case management contractor as an agency and not contracting with independent providers. In an integrated care model case management responsibilities may be transitioned to health plans.

During state and field interviews it was noted that case manager contractors currently have no incentive to keep home care costs down, assure the need for medical services is followed up on, or to determine someone ineligible. The number of agencies and independent case management contractors has increased significantly, creating excess capacity.

Other state agencies:

The South Carolina Department of Disabilities and Special Needs (SCDDSN) is an operating entity for Medicaid waivers for its clients. It does not use PHOENIX or CARE Call. For efficiency purposes, the state should use CARE Call for DDSN providers. Their current assessment process should be analyzed for future inclusion into the PHOENIX system to comply with federal core standardized assessment requirements.

Integrated Care:

For a future integrated care model SCDHHS needs to develop the data set that provides information about the client's home and community based, nursing home, and health care expenditures. This will be essential for the actuarial work that needs to determine capitation and any risk adjustments.

National Trends Toward Universal Assessment

Several states are using the interRAI HC-Home Care assessment instrument. It was designed to be a user-friendly, person-centered assessment system that informs and guides comprehensive care and service planning in community based settings around the world. It was designed to be compatible with the Long Term Care Facility system implemented in US nursing homes (MDS). The domains include:

- Identification Information
- Intake and Initial History
- Cognition
- Communication and Vision
- Mood and Behavior
- Psychosocial Well-Being
- Functional Status
- Continence

- Disease Diagnosis
- Health Condition
- Oral and Nutritional Status
- Skin Condition
- Medications
- Treatment and Procedures
- Responsibility
- Social Supports
- Environmental Assessment
- Discharge Potential and Overall Status
- Discharge
- Assessment Information

The interRAI HC-Home Care also includes a quality monitoring system, a case-mix system that places clients into distinct service-use/intensity categories (RUG III-HC), screening systems to identify appropriate care pathways for clients.

The 2010 Patient Protection and Affordable Care Act (ACA) also creates the Balancing Incentives Payment Program (BIPP) that requires the state to make structural changes to its home and community based program in order to be eligible for enhanced match. One of these requirements is the use of a Core Standardized Assessment instrument, “development of core standardized assessment instruments for determining eligibility for non-institutionally-based long term services and supports described in (f)1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary’s needs for training, support services, medical care, transportation, and other services, and develop an individual service plan to address such needs.”

Current information about what will be required to comply with the BIPP includes a Common Data Set of five domains:

1. Activities of daily living—eating, bathing, toileting, mobility (in/out of home), dressing, hygiene, positioning, transferring
2. Instrumental activities of daily living—preparing meals, housework, shopping, managing money, transportation, telephone use, managing medications
3. Medical conditions/diagnoses
4. Cognitive functioning/memory—diagnoses tied to cognitive function, memory, judgment/decision-making
5. Behavior concerns—injurious, destructive, socially offensive, uncooperative, other serious behavior concerns

Best State Assessment Practices

The information below includes profiles of selected state tools included in the Balancing Incentive Program Implementation Manual, October 2011. These assessments are considered best practices because they encompass multiple populations, - for example, developmental disabilities and multiple programs. Some include use by the Aging and Disability Resource Center.

Profiles of Selected State and National Tools

A national inventory of tools for CMS identified seven assessment tools developed at the state level, and six assessment instruments used more broadly across states worth profiling for their unique design qualities, processes, use across multiple populations or programs, functions, and/or capacity for automation. Each of the state tools is summarized below:

- Colorado – The Department of Human Services (DHS) and Department of Health Care Policy and Financing (HCPF) use the Uniform Long Term Care (ULTC) tool to assess individuals of all ages, and across populations. The tool is used alone or in combination with other tools to assess LTSS needs for DHS’ community-based programs. For example, in the developmental disability system, the ULTC tool is used to determine an individual’s level-of-care eligibility for Colorado’s HCBS waiver programs, and in combination with the Supports Intensity Scale (SIS) to identify support needs to inform an individual’s service planning process.
- Maine - Maine’s Medical Eligibility Determination (MED) Tool is used to determine medical eligibility for a variety of State and Medicaid funded LTC services. In use since 1998, the MED was built using the MDS-HC tool (described below) as a foundation, but modified and expanded to meet eligibility requirements for Maine-specific programs and services. The tool is automated, used statewide and also has a section assessing an individual’s capacity for consumer-directed services.
- Massachusetts – The Massachusetts Real Choice Functional Needs Assessment was developed by the University of Massachusetts Medical School and the Center for Health Policy and Research between 2003 and 2005 as part of a CMS-funded Real Choice Systems Change Grant. While not ultimately selected for widespread use across the state, this modular assessment tool contains a core set of questions (including a Level I Intake section and a Level II Long Term Supports section) that can be used regardless of population or program, and a set of additional Level 3 “modules” to meet specific population, program or service information needs.
- Minnesota – In 2012, Minnesota’s Department of Human Services (DHS) will begin using the web-based, MnCHOICES Comprehensive Assessment to assess the needs of children, adults, and the elderly for LTSS. DHS currently uses a variety of assessment and screening

documents to determine eligibility for LTSS. The MnCHOICES tool will replace all long term assessment processes to ensure greater consistency across all lead agencies in the State. Their goal is to implement a single framework for access to, and assessment of, coverage and services options. The assessment has three phases: initial screening/intake, a full health and functional assessment, and a support planning module. As an automated application, responses to specific questions trigger the addition or removal of subsequent questions, as required.

- Virginia – Since 1994, all publicly funded health and human resource agencies in Virginia have been using the Virginia Uniform Assessment Instrument (UAI) to collect information for determining the long term care needs and service eligibility for individuals, and for planning and monitoring their needs across agencies and services. The UAI contains both a short assessment (Part A) and a full assessment (Parts A and B). Part A is primarily an intake/screening document, which can be completed by phone and used to assess whether or not a full assessment is needed. The full assessment (Part B) is a comprehensive evaluation of individual functioning, and is designed to gather enough information to begin a service plan. This assessment is designed to be completed as a face-to-face interview with the individual.
- Washington – The Washington State Department of Social and Health Services uses the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine eligibility for individuals applying to or receiving aging or disability services. Washington has used the CARE tool since 2003 to gather information for determining program eligibility, benefit level, and assist with services planning (including consumer choices and preferences).
- Wisconsin – Developed by the State’s Department of Health Services, Wisconsin’s Functional Screen system consists of three functional assessment tools: the Wisconsin Adult Long Term Care Functional Screen, the Functional Eligibility Screen for Children’s Long Term Support Programs, and the Functional Eligibility Screen for Mental Health and AODA (Co-Occurring) Services. Each tool uses a web-based application to collect information about an individual’s functional status, health, and need for assistance from programs serving the elderly, and/or people with physical or developmental disabilities. The screen determines functional eligibility for certain mental health services, adult long term care programs and children's long term support programs. Screeners (typically social workers, nurses or other professionals) who have taken an online training course and passed a certification exam are able to access and administer the screen. The children and adult tools have been tested and considered valid and reliable.

Level of Care—HCBS/Nursing Home Care

States individually determine the programmatic eligibility for nursing home care and home and community based waivers. The functional eligibility for HCBS 1915(c) waivers must be the same as nursing homes. States that have a restrictive definition based on a medical model cannot capture Medicaid financing through waivers for persons who are assessed as having intensive needs for assistance with activities of daily living, but no nursing needs. The need for nursing care is one of the main reasons that older people and people with disabilities rely on support to continue living in the community.

Broadening eligibility standards can allow Medicaid financing for home and community based services to prevent institutionalization that some states currently fund with state only programs. New Medicaid home and community based authorities under the ACA require states to establish functional eligibility below their nursing home level of care to encourage development of a broader set of supports to meet the needs of consumers who require long term care, and prevent institutionalization.

South Carolina Process

The South Carolina level of care definition has not changed since 1994. The state considers a combination of clinical and activities of daily living in its level of care process. To meet skilled level of care, a person must need at least one of the 11 skilled services listed below (adapted from Medicare), and have at least one of the following functional deficits.

Skilled Services

1. Daily monitoring /observation and assessment due to an unstable medical condition which may include overall management and evaluation of a care plan which changes daily or several times a week.
2. Administration of medications, which require frequent dosage adjustment, regulation, and monitoring.
3. Administration of parenteral medications and fluids, which require frequent dosage adjustment, regulation, and monitoring.
4. Special catheter care.
5. Treatment of extensive decubitus ulcers or other widespread skin disorder.
6. A single goal-oriented rehabilitative service (speech, physical or occupational therapy) by a therapist 5 days per week.
7. Time-limited, goal-directed, educational services provided by professional or technical personnel to teach self-maintenance.
8. Nasogastric tube or gastrostomy feedings.
9. Nasopharyngeal or tracheostomy aspirations or sterile tracheostomy care.
10. Administration of medical gases.

11. Daily skilled monitoring or observation for conditions that do not ordinarily require skilled care that may result in special medical complications.
12. Individual is totally dependent in all activities of daily living.

Functional Deficits

1. Requires extensive assistance (hands-on) with dressing and toileting and eating and physical help in bathing. All four must be present and, together, they constitute one deficit.
2. Requires extensive assistance (hands-on) with locomotion.
3. Requires extensive assistance (hands-on) to transfer.
4. Requires frequent (hands on) bladder or bowel incontinence care; or with daily catheter or ostomy care.

Intermediate Level of Care

A person can meet the intermediate level of care criteria in either of two ways:

1. Requiring at least one of the four numbered intermediate services below and having one of the numbered functional deficits listed above, OR
2. Having at least two of the functional deficits above.

Intermediate Services

1. Daily monitoring of a significant medical condition requiring overall care planning in order to maintain optimum health status.
2. Supervision of moderate/severe memory, either long or short term, which requires significant intervention in overall care planning.
3. Supervision of moderately impaired cognitive skills manifested by decisions which may affect an individual's own safety.
4. Supervision of moderate problem behavior manifested by verbal abusiveness, physical abusiveness, or socially inappropriate /disruptive behavior.

South Carolina appears to be the only state that groups dressing, toileting, eating and bathing and considers all of them together to be one functional deficit. In most states these are viewed as separate activities of daily living. Most states who rely on activities of daily living in their level of care process would determine that a substantial need in two or three of these would make a person eligible for services.

In October 2005, Rutgers conducted a study entitled "Establishing Nursing Home Level of Care: How States Vary". This study recognized that states use one of four criteria:

1. Medical conditions or needs;
2. A combination of medical conditions/needs and functional impairments;

3. Functional impairment alone; or
4. Scores from an assessment instrument.

They also arrayed the states along a continuum in the following table:

South Carolina was identified as having a moderate threshold for nursing home admission/waiver

Array of Selected States Along Continuum of Nursing Home Admission Criteria				
1 (Low)	2	3 (Moderate)	4	5 (High)
CA	AR	AK	AZ	AL
DE	IL	CO	NC	HI
KS	IA	CT	UT	ME
NH	IN	FL		MD
OH	LA	GA		TN
OR	MI	ID		VA
RI	MN	MA		
WA	MS	MO		
WY	NE	MT		
	OK	NJ		
	TX	NM		
	VT	ND		
	WI	PA		
		SC		

eligibility that included nursing as well as activities of daily living needs in the level of care process.

States have been provided several CMS authorities to address differential levels of care, offered services, and eligibility. On August 6, 2010, CMS issued a “State Medicaid Director’s letter” that addressed significant changes to the Section 1915 (i) waiver authority made by the Affordable Care Act. States now have the flexibility to provide HCBS to an identified population that does not require an individual to meet an institutional level of care to qualify for HCBS listed in Section 1915 (c)(4)(B), and may include services provided to individuals to persons with chronic mental illness as well as other services identified by the state and approved by the Secretary, with the exception of room and board. Based on a state plan amendment process, Section 1915 (i) require states to specify needs based eligibility criteria and cannot limit the number of individuals who can receive services, cannot establish a waiting list, and cannot limit services to a geographical area or political subdivision. The state is permitted to target specific Section 1915 (i) services to a state-identified population.

Additional CMS authorities that states may access seeking long term care programmatic and financial flexibility, include the comprehensive aspects of Section 1115 Research and Demonstration projects,

state plan-based, self-directed personal assistance based on Section 1915 (j), the Innovation Community First Choice option based on Section 1915 (k), and the opportunities for integrating primary/acute medical and long term care services based on a combined Section 1915 (b) and Section 1915 (c) waived systems approach.

Notes from the Field

- The waiting list discourages people from choosing a home and community based option.
- The qualification requirements should be changed to make the program more accessible.
- Participants require more services than the current waiver can provide.
- There is no 24-hour care option available.
- There needs to be more housing options, including homes, where a small number of people can be served.

Recommendation: Consider New Levels of Care That Reflect Community First Choice Priority

South Carolina should consider a new and more appropriate level of care for both community based services and nursing facility services.

The Lucas Group believes that it is important that consideration of adapting a new level of care approach take place in a business environment that recognizes the critical role the nursing home industry can provide. Nursing homes can serve Medicaid recipients with a higher level of acuity over time and have competitive access to become providers for new, mid-level residential options and other community based services.

South Carolina can look to other states and consider using its waiver, or similar authority, to seek an approach that would entail a more restrictive nursing home definition, and a less restrictive functional definition for home and community based services. Both Vermont and Rhode Island have approved waivers that combine nursing home and home and community based funding and categorize people, depending upon assessment of needs, into 3 levels—Vermont has the following levels: highest need, high need, and moderate need and Rhode Island has highest need, high need and preventive need.

The intent is to serve only persons in the nursing home level who are determined to be at the highest need level. These people can also be served in community services. Clients in the levels below highest need qualify only for HCBS to meet their needs. These programs include a mid-level of care that supports people in community based residential programs that cannot live at home, but need protective supervision or tasks that cannot be scheduled on a routine basis. These level of care models have resulted in significant increases in nursing home diversions in both states. If South Carolina were to

adopt this approach, the assisted living and adult family care and home models would need to be added to the array of options offered through Medicaid.

Assessment

In this model with a broader program eligibility, the assessment would need to be revised to include the new programmatic eligibility and more clearly emphasize the ability of the community services capacity to meet a person's long term care needs and prevent institutionalization. Nursing home residents should be identified earlier for community options during the hospital and/or nursing home assessment process.

MDS Data

The state should analyze the MDS data for nursing homes and determine how many low need residents are served, e.g. PA and PB categories. Residents in these categories have no nursing needs and can be appropriately served in the community.

Level of Care Rhode Island Example

Institutional Level of Care Determination Policy: Nursing Facility

Rhode Island made use of the program flexibility and comprehensive aspects of the Section 1115 Research and Demonstration waiver authority to achieve rebalancing their long term care program by implementing a continuum of care based that includes a "highest, high, and preventive" level of need and related care and services.

Highest Need Group

Individuals who meet any of the following eligibility criteria shall be eligible and enrolled in the Highest Needs group:

1. Individuals who require extensive assistance or total dependence with at least one of the following:

- Activities of daily living (ADL):
- Toilet use
- Bed mobility

- Eating transferring
- AND require at least limited assistance with any other ADL.

2. Individuals who lack awareness of needs or have moderate impairment with decision-making skills AND one of the following symptoms /conditions, which occurs frequently and are not easily altered:

- Wandering
- Verbally aggressive behavior
- Resists care
- Physically aggressive behavior
- Behavioral symptoms requiring extensive supervision

3. Individuals who have at least one of the following conditions or treatments that require skilled nursing assessment, monitoring, and care on a daily basis:

- Stage 3 or 4 skin ulcers
- Ventilator/respirator
- IV Medications
- Naso-gastric tube feeding
- End stage disease
- Parenteral feedings
- 2nd or 3rd degree burns
- Suctioning
- Gait evaluation and training

4. Individuals who have an unstable medical, behavioral or psychiatric condition(s) or chronic or reoccurring conditions that require skilled nursing assessment, monitoring and care on a daily basis related to, but not limited to at least one of the following:

- Dehydration
- Internal bleeding
- Aphasia
- Transfusions
- Vomiting
- Wound care
- Quadriplegia
- Aspirations
- Chemotherapy
- Oxygen

- Septicemia
- Pneumonia
- Cerebral palsy
- Dialysis
- Respiratory therapy
- Multiple sclerosis
- Open lesions
- Tracheotomy
- Radiation therapy
- Gastric tube feeding
- Behavioral or psychiatric conditions that prevent recovery

5. Individuals who do not meet at least one of the above criteria may be enrolled in the Highest Needs Group when the Department determines that the individual has a critical need for long term care services due to special circumstances that may adversely impact the individual’s health and safety.

High Need Group

Individuals who meet any of the following eligibility criteria shall be eligible and enrolled in the High Needs group:

1. Individuals who require at least limited assistance on a daily basis, with at least two of the following ADLs:

- Bathing/Personal Hygiene Dressing
- Eating Toilet Use
- Walking/Transfers

2. Individuals who require skilled teaching on a daily basis to regain control of, or function with at least one of, the following:

- Gait training Speech
- Range of motion
- Bowel or bladder training

3. Individuals who have impaired decision-making skills that require constant or frequent direction to perform at least one of the following:

- Bathing Dressing

- Eating Toilet Use
- Transferring
- Personal hygiene

4. Individuals who exhibit a need for a structured therapeutic environment, supportive interventions and/or medical management to maintain health and safety.

Preventive Need Group

Individuals who meet the preventive service criteria shall be eligible for enrollment in the preventive needs group. Preventive care services are designed to promote and preserve health and safety or to alleviate symptoms to address functional limitations. Preventive services may avert or avoid institutionalization. Individuals in need of the following services, who can also demonstrate that these services will improve or maintain abilities and/or prevent the need for more intensive services, will be enrolled in the preventive need group:

1. **Homemaker Services:** General household tasks including basic home and household assistance for a health condition or to address functional limitations. The services include meal preparation, essential shopping, laundry and cleaning for individuals without social support systems able to perform services for them. These services may be performed and covered on a short-term basis after an individual is discharged from an institution and is not capable of performing these activities themselves.
2. **Minor Environmental Modifications:** Minor modifications to the home may include grab bars, versa frame (toilet safety frame), handheld shower and/or diverter valve, raised toilet seats and other simple devices or appliances such as eating utensils, transfer bath bench, shower chair, aids for personal care (e.g. reachers) and standing poles to improve home accessibility adaption, health or safety.
3. **Physical Therapy Evaluation and Services:** Physical therapy evaluation for home accessibility appliances or devices by an individual with a state-approved licensing or certification. Preventive physical therapy services are available prior to surgery if evidence-based practice has demonstrated that the therapy will enhance recovery or reduce rehabilitation time.
4. **Respite Services:** Temporary care giving services given to an individual unable to care for themselves because of the absence or need for relief of those persons normally providing the care. Respite services can be provided in the individual's home or in a facility approved by the State, such as a hospital, nursing facility, adult day services center, foster home or community residential facility. An individual qualifies for these respite services if he/she requires the services of a professional or qualified technical health professional or requires assistance with at

least two activities of daily living. The demonstration approval period is January 16, 2009, through December 31, 2013.

Nursing Home Rate Methodology

SCDHHS sets reimbursement rates for nursing facilities serving Medicaid reimbursed residents based on a prospective rate that is cost-based and adjusted by the state per Medicaid State Plan requirements. The South Carolina rate setting method does not consider resident acuity factors (individual resident need for care) in the determination of payment. As a result, it is difficult for the state to know what the level of need (acuity) for nursing facility care is across the system.

States and SNF Case Mix Reimbursement Methods

The federal government and 35 states currently use case mix reimbursement methods for payment of skilled nursing facility/nursing facility care. These case mix payment methods have several key components and one important variance in application:

- SNF/NF case mix payment is based on a prospective payment system (prior to care given; therefore the method is predictive by design).
- Implementation of a case mix classification system (MDS 3/RUGS IV) that essentially predicts the volume of care a resident needs and “grouped” into a care category (“group”) with residents with similar care needs.
- Aggregate resident (facility specific) group care category placement determines a “case mix index” (CMI), which distinguishes the care/resources needed by the “average resident” in each group.
- The CMI triggers the paying entity (federal government, states, MCO’s utilizing case mix payment methods) rate, or amount paid.
- Payment methods are permitted by CMS to vary state-to-state, but the general outcome is that the higher the CMI (acuity level), the higher the payment rate.
- A significant amount of research has been conducted on the outcomes for states that have implemented acuity-based case mix SNF/NF payment methods. Generally speaking, the research indicates strong evidence that case mix payment methods employed by states results in SNFs/nursing homes serving residents with a higher level acuity.
- A 2010 study by Grabowski for the U.S. DHHS found that 39 states used prospective SNF reimbursement: 4 states used prospective class/flat rates; 18 states used facility specific rates; 2 states used resident specific rates; 14 states used combined facility/resident specific rates; 2 states used “pure” retrospective payments; and 7 states used a combined prospective/retrospective rate setting method.

- States use case mix Medicaid nursing facility rate setting methods to improve quality, determine the level of acuity they intend to balance between facility-based care and home and community based services, control costs, and provide incentives. State incentive payments are generally constructed to address:
 - Access Incentives
 - Quality Incentives
 - Efficiency Incentives

Examples of state Medicaid nursing facility enhanced access payments based on a case mix payment method include:

- Georgia provides a facility rate adjustment for residents with moderate to severe cognitive impairment.
- Maryland provides an enhanced rate for tube feeding, decubitus ulcer care, IV related care, central intravenous lines, and ventilator care, essentially “complex care”.
- Massachusetts provides incentive payments for residents with developmental disabilities and facilities with 75%+ residents with multiple sclerosis.
- Mississippi provides incentive payments for NFs to build Alzheimer’s units.
- New Hampshire provides incentive payments for residents with traumatic brain injury or ventilator dependent care needs.
- New York provides incentive payments for residents with AIDS, traumatic brain injury, complex pediatric care, ventilator dependent care, and neuro-behavioral care needs.
- Oregon provides incentive payments for complex medical care needs.
- Washington provides incentives for exceptional care needs based on an approved facility plan and case-by-case basis.

States that have implemented access incentive rates have targeted medically complex cases that have been waiting in hospitals excessive periods of time, increased nursing facility admission of medically complex cases, and provided an incentivized building block for nursing facilities to serve persons with the highest levels of acuity and medical complexity that can effectively support a Community First Option balanced system for prevention and mid-level care needs.

MDS 3.0/RUGS IV/Acuity and Case Mix

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing facilities and hospitals with a swing bed agreement and consolidated billing. A fundamental feature of the Medicare SNF PPS was the inclusion of a case mix methodology to determine nursing home resident care services needs and health status. Since the late 1990s, the most

widely used approach for SNF/NF quality and reimbursement methods has been the Resource Utilization Groups (RUGS) system.

In 2005, CMS implemented a national nursing home study of staff time (STRIVE: Staff Time and Resource Verification Project) which resulted in the RUGS IV classification system that incorporates more refined data from the Resident Assessment Instrument (RAI) - Minimum Data Set version 3.0 (MDS 3). Before October 1, 2010, Medicare and well over half the states established SNF/NF payment rates based on MDS 2/RUGS 3. Effective October 1, 2010, CMS updated the MDS 2 with further refinement for clinical relevance and accuracy of MDS resident assessments, increased the voice of residents in their assessment, and increased the efficiency of the reports represented by MDS 3.

Simultaneous to the release of MDS 3 CMS revised the RUGS grouper methodology with the release of RUGS IV. The RUGS IV update was based on the STRIVE research project which focused on staff time measurement data and added 13 additional RUGS (53 to 66) and focused on nursing services and “hands on” staff time on an individual basis. RUGS IV is based on the premise that CMS reimbursement should pay for the “utilization” of labor hours billed on any given day. RUGS III permitted concurrent therapy, which permitted the actual time coded to exceed the actual time the therapist(s) worked.

The RUG IV grouper codes, embedded in the CMS Health Insurance Prospective Payment System (HIPPS), represent specific sets of resident characteristics (case mix groups) on which payment decisions/determinations are made under prospective payment systems. HIPPS codes have been created for nursing homes (1998), health home agencies (2000), and inpatient rehabilitation facilities (2002).

The RUG IV Group Codes Are:

- Rehabilitation Plus Extensive Services
- Rehabilitation
- Extensive Services
- Special Care High
- Special Care Low
- Clinically Complex
- Behavior Symptoms and Cognitive Performance
- Reduced Physical Function

Important changes in the MDS 3 that will impact RUGS grouping include:

- IV/meds/feeding moved from “extensive services” to “clinically complex”
- Parenteral/IV feeding qualifiers moved from “extensive services” to “special care high” category
- Special care category reconfigured to “high” and “low” categories to support more accurate case mix indexes

- Combined “impaired cognition” and “behavior category” into one

Generally speaking, the impact on case mix reimbursement methods is that the changes to “concurrent therapy” rules will result in lowering the rehabilitation categories (assumedly less expensive based on MDS 3/RUGS IV/STRIVE data) and increasing the nursing care portion of the RUGS categories. Additionally, the realignment of service categories (Clinically Complex Care is increased from 6 to 10 groups) based on ADL scores and IV meds being moved to “Clinically Complex Care” should support a higher acuity level being served by nursing homes, but could be offset by improved clinical care (hours of direct care) from lower levels of acuity.

The Lucas Group recommends that CLTC implement an acuity-based case mix rate setting methodology for nursing facility services based on the MDS 3 data set and, possibly, the use of the RUGS IV grouping technology. States that have utilized acuity-based case mix rate setting methods have been able to assure that nursing facilities’ valuable services are being used for the highest level of severity, have access to acuity-based data that should assist in tracking those nursing facility residents who are “getting better”, and can assist nursing facilities in determining the case mix based assignment of higher and lower cost services. The use of acuity measurement in the nursing facilities will provide CLTC information that can be compared and analyzed with acuity-based information produced by the assessment process and services planning of home and community based services in a comprehensive data based LTC systems management framework. CLTC should consider consulting with the SCDHHS Medicaid services contracted actuarial firm in determining the best method for South Carolina to establish a nursing facility case mix reimbursement system.

The Lucas Group notes that South Carolina’s “percent of nursing home residents with low care needs” is well below the national median of 11.9%. Based on the data included in the “AARP State Long Term Services and Supports Scorecard, 2011” South Carolina’s “percent of nursing home residents with low care needs” was at 6.5%.

Money Follows the Person

Money Follows the Person (MFP) was authorized by Congress in section 6071 of the Deficit Reduction Act of 2005 (DRA). MFP helps individuals maintain their Medicaid coverage - it “follows” them as they make their transition.⁷ Under MFP, states claim an enhanced match rate for the first 365-day post-transition period for participants who transition from an institutional setting into the community.⁸

The goals of MFP are to:⁹

- 1) *Increase the use of HCBS and reduce the use of institutionally-based services;*

- 2) *Eliminate barriers and mechanisms in State law, State Medicaid plans, or State budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long term care in the settings of their choice;*
- 3) *Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and,*
- 4) *Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.*

Section 2403 of the Patient Protection and Affordable Care Act extends MFP through September 2016, and appropriates an additional \$450 million for each FY 2012-2016, totaling an additional \$2.25 billion.

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States began transitioning MFP beneficiaries in 2008. Since December 2010, almost 12,000 individuals have returned to the community through MFP. One year after transition to the community, MFP participants reported improvement in the quality of their lives. Nearly 60% of MFP participants reported being satisfied with the way they lived their life while still in institutional care. This percentage increased to 81% one year after the transition to community based care. MFP participants report a high level of community integration and inclusion after transitioning to community living, and are generally more satisfied with the care they received, had fewer reports of unmet personal care needs, and more reported their caregivers treated them with respect and dignity.¹¹ Nearly all participants reported an ability to get to needed places such as work, shopping, or the doctor's office pre- and post-transition. MFP has been described as a "God-send" and "key program" to help states with their transitions.¹²

The DRA also defines eligible community residences, the enhanced federal medical assistance percentage (FMAP – that rate at which the federal government cost shares with states for Medicaid), and the targeted populations for MFP. As defined by Section 6071(b)(6) of the DRA, the term "qualified residence" means, with respect to an eligible individual:

- A home owned or leased by the individual or the individual's family member;
- An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or, a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.¹³

The DRA defined the Enhanced Federal Medical Assistance Percentage (FMAP) as being equal to taking the published FMAP for a State, subtracting it from 100%, and dividing the total by half, and adding that percentage to the published FMAP. As an example, a State that normally has a 50% FMAP will have a 75 percent FMAP under MFP. The enhanced MFP FMAP cannot exceed 90%. The enhanced rate is available for qualified services provided to an MFP participant for 365 days after transition from an institution.¹⁴ The federal match for administrative expenses is 100%.

Federal MFP rules specify five MFP population groups:

1. Elderly people over age 65
2. People with disabilities under age 65
3. People with intellectual disabilities

transitioned a total of 90 consumers. Additionally, the State has received three other Real Choice grants that have been used to build and modify its long term care infrastructure. These programs have been used in the past to rebalance the system towards more community based alternatives.

However, the South Carolina MFP grant remained in inactive status, as the State chose not to submit the operational protocol as required by the grant, until May 2011.

In May, the State chose to reactivate the MFP grant. Its plans for reinstatement have expanded the targeted populations for transition beyond nursing facility elders to institutionalized children with behavioral health problems, children and adults in mental health facilities and adults in ICF/MRs. South Carolina also has hired two staff to administer the grant and coordinate the program and have begun to follow a work plan for development and coordination with stakeholders.

With this renewed emphasis on balancing the long term care system the state is revising their Operation Protocol and expects to transition a total of 445 residents out of institutions over the life of the program. The goal for 2012 is 20 residents voluntarily transferred out of nursing homes to the community and thereafter it is expected that 50 residents each year will be relocated to the community from nursing facilities through 2016.

State Benchmarks and Timeline

Transition Benchmarks

The stated transition benchmarks provided to CMS under the grant are as follows:

Benchmark: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each fiscal year of the demonstration.

South Carolina will assist 445 individuals to relocate from the following types of qualified institutions:

- Nursing Facilities
- Intermediate Care Facilities for Persons with Intellectual Disability
- Psychiatric Residential Treatment Facilities

Figure 45

Category	Target Group	CY12	CY13	CY14	CY15	CY16	Total
# of transitions from NFs	Elderly	10 (0.04%)	20 (0.18%)	20 (0.18%)	20 (0.18%)	20 (0.18%)	90 (0.76%)
	Physical disabled	10 (0.04%)	30 (0.27%)	30 (0.27%)	30 (0.27%)	30 (0.27%)	130 (1.12%)
# of transitions from ICFs/MR	MR-DD	20 (1.42%)	31 (2.21%)	53 (3.79%)	53 (3.79%)	53 (3.79%)	210 (15%)
# of transitions from PRTFs	Children with mental illness	3 (6%)	3 (6%)	3 (6%)	3 (6%)	3 (6%)	15 (30%)
Total		43	84	106	106	106	445

Benchmark: Reduction in % of institutional care as proportion of total LTC caseload.

Timeline

The State's timeline, required under the grant, for implementation is as follows:

Figure 46

Task Name	Start	Finish	Deliverables
Overall Project	2011	2016	Reinstatement of the Home Again Program
Develop Operational Protocol	07/2011	10/2011	Operational Protocol
Review Protocol plan w/ DDSN and CLTC	10/2011	11/2011	Feedback and Modifications
Send to CMS Technical Assistance Consultants	11/2011	12/2011	CMS Protocol Modifications
Send to CMS Project Officer	12/2011	12/2011	Finalized Protocol and Service Funding
Implementation, Contracting, Provider Recruitment, and Training	1/2012	3/2016	Meeting Program Benchmarks and Objectives

Agreed Upon Program Requirements

- CMS will require SCDHHS to show increases in spending on community based LTC.
- CMS will require SCDHHS to meet an additional benchmark that it not increase the proportion of people receiving institutional LTC out of the number eligible to receive institutional LTC.
- South Carolina will have to remain part of the national evaluation of MFP and the evaluation will continue to look at rebalancing measures including the split in the budget between institutional and community based LTC.
- The home and community based waivers will be the means for transition.
- For persons transitioned under the grant the States' services dollars match from the federal government will increase from 70% to 85%.
- A person must reside in the nursing home or intermediate care facility, or psychiatric residential treatment facility for 90 days to be eligible for transitioning with the enhanced match.
- A qualified person will be on the enhanced match service package for one year.

The value of MFP to the state – besides allowing individuals to live in community settings of their choice – is enhanced federal match for services for a year, administrative funding to address system/infrastructure changes to further develop home and community based services, the ability to analyze barriers to effective transition and an opportunity for the state to address these concerns.

Moreover, plans also call for a requirement that the MDS 3.0 Section Q add a question that is asked: “Do you want to talk with someone about the possibility of returning to the community?” This will prompt staff to follow through in a systematic manner to assure a resident’s goals are addressed. There will also be more local coordination with discharge planning.

MFP is only one tool the state can use to assure people have choices to meet their long term care needs. In addition to relocating residents who are eligible for MFP (lived in an institution for 90 days), the state will need to develop processes to assure consumers know their options and that the institutional census can be managed and reduced through diversion, reduction in length of stay, and relocation as early as possible.

All state agencies that have a role in the South Carolina LTC system need to be engaged in how to improve processes to assure that people who have long term care needs are aware of home and community based services as the first option to meet their needs. There needs to be a sense of urgency that includes analyzing current processes that appear to be a barrier to timely authorization of services, e.g. HCBS financial eligibility.

Nevertheless, the MFP grant will allow the State to build on its past successes in transitioning individuals to home and community based care. This grant will also provide the opportunity for South Carolina to analyze its long term care funding streams. The goal is to actualize maximum flexibility for individuals’ choice in their future decision making regarding their care needs. It must be recognized that these transitions will be in addition to the overall statewide diversion and transition efforts that normally

occur under the Medicaid program and will take place along with other enhanced efforts in South Carolina to rebalance long term care.

Selected State MFP Profiles

Tennessee

October 1, 2011, Tennessee launched their 5-year long MFP program, under their CHOICES program. To facilitate this, TennCare MCO's care coordinators will work with nursing facilities and discharge planners. The care coordinators will screen and assess residents to determine their need for the MFP program. According to Michelle Morse Jernigan, MFP director, the state plans to transition 2,175 people out of nursing homes and back into their communities.¹⁶

Tennessee has been awarded \$119,624,597 for their MFP demonstration program.¹⁷

Texas

The Texas Money Follows the Person program preceded the federal MFP demonstration. Between September 2001 and June 2007 it helped over 13,000 people transition from nursing homes. As a result of these programs Texas has significantly more transition experience than most states.¹⁸ As of March 2011, Texas is responsible for nearly 1/3 of all the MFP transitions nationwide. The original Texas MFP program has transferred 33,000 people from nursing facilities to their communities and the current MFP Demonstration has transitioned 5,000.¹⁹

When the MFP Promoting Independence program began in 2001, the state sent a letter to every Medicaid-eligible nursing home resident, describing the program and the opportunity to leave the facility and live in the community.

Six relocation contractors across Texas, provide transition services. Referrals to the MFP program come from a variety of sources, including ombudsmen and relocation contractors visiting with nursing home residents in response to Minimum Data Set (MDS) information. Approximately 94% of the elderly and persons with disabilities who transition out of nursing facilities use community based alternative (CBA) waiver services. The program is consumer-directed and it allows the client to hire and fire the home care worker of his or her choice.²⁰

The local ombudsmen are well educated about the MFP program. In the program's infancy, some relocation specialists were not allowed access to nursing homes by nursing home staff. Local ombudsmen were able to educate nursing home staff, thereby enabling the relocation specialist to gain unobstructed access to nursing home residents.

According to Patty Ducayet, Texas State Ombudsman, part of the State's success is because it chose to make MFP a priority. The program saved Texas money and provided people with a choice in their lives.²¹

As of 2011, the Texas MFP program has been awarded \$142,700,353.²²

Challenges to Texas MFP²³

- The transition takes a long time.
- The ombudsmen and relocation specialists may disagree about the best options for nursing home residents.
- Lack of affordable housing.
- Challenge of finding homes for medically complex cases.

Best Practices in Texas MFP²⁴

- No waiting list for HCBS for those who are Medicaid eligible.
- Transitional Assistance Services provides up to \$2,500 to cover household goods, rent, utility deposits, etcetera.
- Relocation Service Contractors help with transition.
- Community Transition Teams, which are public-private networks, meet regularly to eliminate common barriers to MFP participants.

MFP Best Practices

After conducting research on MFP best practices and speaking to a number of state MFP leaders, the following is a list of practices that have been highlighted as successful in transitioning Medicaid elders, who have been in nursing homes for more than six months, back to the community:²⁵

- Develop standardized processes for transition coordination and planning to ensure collaboration between transition coordinators and Medicaid HCBS waiver programs.
- Make it easier for participants to enroll in MFP.
- Clarify the roles and responsibilities of transition coordinators and waiver case managers, to prevent MFP participants from getting lost in the system.
- Give transition coordinators the flexibility to devote more time to individuals with greater needs.
- Allow transition coordinators to make frequent home visits and calls to MFP participants following the transition.

- Provide one-on-one help to MFP participants and build relationships with local public housing authorities. This frees transition coordinators of the need to become experts in complex housing programs.
- If there is a housing shortage, have housing specialists organize seminars on how to start small adult family homes.
- Operate multiple transition programs to help anyone transition, regardless of whether they qualify for MFP.
- Bring in strong leaders especially during the start-up period, to gain support and commitment from key stakeholders.
- Hire skilled, knowledgeable, and dedicated transition coordinators.
- Take advantage of MFP's flexibility to tailor onetime moving expenses.
- Provide expert one-on-one help with housing.
- Have a nursing facility transition system in place prior to the start of the demonstration.
- Dedicate field staff to the demonstration with clearly identified tasks and communication protocols.²⁶

Summary of Money Follows the Person Grant Applications 2010	AR	CA	CT	DC	DE	IA	IN	KS	KY	LA	MD	MI	MO	NC	ND	NE	NH	NY	OK	OR	PA	TX	VA	WI	WA
	Description in Application of ADRC of ADRC/MFP Partnership at Time of Application																								
No formal collaboration to date			X		X	X									X					X	X		X	X	
Involved in mutual advisory capacity								X	X					X		X						X			
ALL ADRCs play active role in MFP activities				X			X			X	X						X		X						
Some ADRCs play role in MFP activities	X	X											X												
Not Specified												X						X							X
Descriptions in Application of Project Goals and Objectives																									
Increase number of NF screenings/ transitions			X		X	X				X					X						X			X	
Improve Coordination between ADRCs, MFP and other stakeholders			X	X							X			X	X		X		X						X
Expand ADRC infrastructure/geographic areas		X	X			X		X			X			X				X			X		X	X	
Expand NF transition infrastructure	X	X		X	X								X				X		X		X		X	X	
Educate/ market to support culture change	X	X			X				X	X		X	X	X		X	X				X		X	X	
Enhance IT database/tracking systems	X								X				X			X	X			X					X
Description in Application of Expected Outcomes																									
State wide coverage					X			X															X	X	
More educated NF staff RE: MDS 3.0 and transitions						X		X						X	X		X								
Specified number of transitions annually			X	X		X	X			X			X	X	X		X		X		X			X	
Increase # NF residents who receive options counseling	X	X				X	X	X	X			X	X			X	X						X		
Fully functional IT tracking/resource database		X						X									X			X	X				
Description in Application of Planned Role for ADRC in Transition Activities																									
Screening, identifying and assessing candidates			X	X			X							X			X						X		
Providing options counseling	X	X		X	X	X			X	X		X	X		X	X	X		X			X	X	X	
Establishing service plans & coordinating services			X	X	X	X			X	X			X				X		X						
Implementing service plans and facilitation access to HCBS										X	X														
Establishing/ strengthening quality assurance and CQI				X				X					X												
Strengthening infrastructure to facilitate transitions		X		X										X			X			X		X	X	X	X
Educate/Outreach to state agencies and NH about MDS 3.0 Section Q					X	X		X						X	X										

Source: Summary of Money Follows the Person Aging and Disability Resource Center Collaboration Grant Applications 2010, http://www.adrc-tae.org/tiki-download_file.php?fileId=3008

Notes from the matrix above:²⁷

- *Descriptions in Application of Project Goals and Objectives*
 - *IA: No duplication of current MFP services*
 - *NC: Fund community conversations to develop interest in MFP*
 - *ND: Enhanced capacity to provide options counseling*
 - *NY: Identify diagnoses associated with unwanted NF stays*
 - *WI: Accurate and timely Sec Q referrals*

- *Description in Application of Expected Outcomes*
 - *CT: Elimination of ADRC/MFP "programmatic silos"*
 - *DC: Decrease in overall NF census*
 - *MI: 100% of all Sec Q referrals to receive I & R/A*
 - *MO: Overall increase in the number of referrals due to successful marketing*
 - *NC: 2 new ADRCs*
 - *NE: Increase the quality of matches for each referral*
 - *NH: Training to be conducted by Granite State Independent Living (CIL) & Bureau of Health Facilities Administration*
 - *NY: Develop Hospital Discharge protocols to prevent unwanted NF admissions*
 - *VA: Strengthened partnerships between all stakeholders*
 - *WI: High consumer satisfaction*

Nursing Facility Diversion and Transition

Diversion services are targeted for individuals who are at high risk of nursing home placement, and currently reside in the community, hospital, or short-term nursing home. Diversion encourages LTC beneficiaries to return to their communities, rather than nursing homes or hospitals, when their community can provide an appropriate level of care.

Transition services are targeted for individuals who live in nursing homes (beyond “short term” status) who could return to the community with the appropriate level of services and support available and desire to do so. The goal of transition is to encourage beneficiaries in hospitals and nursing homes, to move back into their communities. Transition helps provide support for the move by assisting with the costs and planning necessary to provide proper infrastructure and medical support. CLTC is reinstating MFP demonstration grant through the development of the “Home Again” II program, which will assist in aiding nursing facility transitions.

A More Robust and Coordinated Diversion and Transition Strategy Needed

The Lucas Group observed advocates and providers support for a more robust diversion and transition strategy rebalance SCDHHS.

The Lucas Group met with advocacy and community provider stakeholders, who indicated that focused information and diversionary interventions are needed prior to the point of hospital discharge. This would assure that individuals and families not only have the correct information about their options within the Medicaid program, but also have immediate assistance in accessing CLTC designated professionals to assist with diversion planning on a real time basis. In order to achieve the maximum number of appropriate diversions there needs to be significant improvement in the assurance of continuity of care across all SCDHHS paid services so that the individual and their family are informed and prepared when discharge to a nursing home is imminent. Moreover, a need exists for hospital discharge planners to “pay attention” to home and community based options instead of nursing home admissions, or at least recognize the community based care as a first option. There appears to be unnecessary variance across the state.

Many of the current clients served on the Community Choices waiver have family support which helps allow them to live in the community. For some people this support is not available and there are services that need to be added to the waiver to meet their needs. Our cost savings analysis contained in The Lucas Group Perspective and Recommendation shows how adding needed community LTC services to the Community Choices waiver will result in savings over the short and long run. In order to capture these savings, however, SCDHHS will need to reinvest some of the net savings into enhanced community services under our recommended new and improved Community Choice First option Integrated Care model (see Lucas Group Perspective section).

Highlights of Success: The Lucas Group Observations from Other States

Lucas Group contacted a number of state Medicaid offices and interviewed state officials in charge of various nursing home transition and diversion services. We have highlighted their comments below:

- The state has made diversion a priority.²⁸
- Focus on the development of in-home programs first, and then focus on diversion. By starting with the expansion of in-home services, a state can build upon existing systems rather than invest considerable resources in developing new and/or additional infrastructure. Diversion programs are easier to build and implement than transition programs. As a strategy, states should focus on diversion first and build transition programs once community support systems are in place.²⁹
- Educate hospital social workers and discharge planners about the available programs.³⁰ Visit beneficiaries before they move into a nursing home. It is better than waiting until they move into a nursing home because they still have existing family resources. The state agency can offer respite.³¹
- Staff assists beneficiaries with completing enrollment paper work.³²
- Send staff to hospitals and nursing home to speak with those who are interested in leaving. Work closely with the ombudsman as well.³³
- Utilize transition coordinators that are state employees who work inside of nursing homes.³⁴
- Use the Coleman Care Transitions Intervention (CTI) model. CTI is a four-week process that encourages patients to take a more active role in their health care. Patients receive specific tools and skills that are reinforced by a "transition coach" (a nurse, social worker, or trained volunteer) who follows patients across settings for the first four weeks after leaving the hospital and focuses on the following components:³⁵
 - Medication self-management;
 - Use of a patient-centered health record that helps guide patients through the care process;
 - Primary care provider and specialist follow-up; and
 - Client understanding of "red flag" indicators of worsening condition and appropriate next steps.
- The MFP program is a critical approach towards the rebalancing of long term care. MFP helps provide the 100 to 200 hours of augmented services often needed to complete a transition. Unfortunately, this program is often overlooked and underutilized. Make use of the MFP program.³⁶
- Refine targeting criteria for transition to better identify which short stay residents are most vulnerable to an unnecessarily long stay.³⁷
- Make the legislature aware of the savings of diversion and transition techniques.³⁸

- Assist beneficiaries with finding housing through Housing and Urban Development (HUD).³⁹
- Create brochures to educate each segment of the waiver population. Make the brochure comprehensive, easy to read and available to the entire population.⁴⁰
- Utilize the Area Agencies on Aging (AAA) to handle care management services. They are the best advocates for the elderly.⁴¹
- Utilize global budgeting to encourage the more efficient use of funds.⁴²
- If people are eligible for Medicaid in a nursing home they should be eligible for community care. Make it easier to roll them over, so they do not have a break in eligibility.⁴³
- Utilize discharge planners that work for MCOs.⁴⁴
- Work closely with providers and parties of interest when developing programs.⁴⁵
- Have oversight into payments and timeliness. Monitor complaints to keep everyone happy. Keep the program fair for all parties involved.⁴⁶
- Make agency modifications to the organizational structure and culture to support diversion and transition activities.⁴⁷
- Create partnerships and utilize co-location of agency staff in hospitals.⁴⁸
- Extensive outreach and educational efforts with family members.⁴⁹
- Utilize a single point of contact for diversion and transition.⁵⁰
- Credentialing is important. Make sure care providers are qualified to provide services.⁵¹
- Frequently monitor success of program. Monthly Status of transitioning efforts. For example, a members report, quarterly care coordination report, semi-annual nursing facility diversion report, quarterly nursing facility to community transition report, monthly HCBS missed visits report, and quarterly consumer direction of HCBS report.⁵²
- Work with relocation contractors.⁵³
- Post-relocation support.⁵⁴
- Dedicated housing vouchers.⁵⁵
- Consumer-directed services.⁵⁶
- Transition assistance services.⁵⁷
- Increase outreach to institutional residents.⁵⁸
- Enhance peer outreach and program education. Program Education (PE) is an in-person contact with the resident to provide in-depth information about Medicaid and other home and community-based services. PE can consist of several meetings and phone calls to educate the individual and their representatives. They can be knowledgeable on details of medical, financial, and technical eligibility, time frames, and process.
- Create a financial penalty for plans if nursing home occupancy exceeds baseline based on the previous year.⁵⁹
- Offer incentive payments in contracts to reward increasing the use of HCBS and decreasing institutional care.⁶⁰
- In contracts, include a three to four percent decrease in institutional care over two years. Find a balance between incentivizing appropriate HCBS use while being realistic about what plans can do in relatively short periods.⁶¹

State Profile: Ohio

Ohio has one of the highest nursing home bed capacities and utilization rates in the country.⁶² Like South Carolina, Ohio faces a significant growth in their aging population. By 2020 the population over 60 years of age, is projected to increase by 25% and to more than double by 2040.⁶³

During the period of March 2010 to May 2011, The PASSPORT Administration Agencies (PAAs) identified 3,799 high-risk Ohioans for an intervention program. There were 2,244 diversions and 1,555 transitions.

After six months, 80% of diversions and 74% of transitions were still alive and were residing in the community. Much of the program's success was attributed to the collaborations with hospitals and partnerships with health networks and nursing facilities.

Ohio Aging Network Diversion and Transition Strategies⁶⁴

Figure 47

Category	Diversion Activity	Transition Activity
<p>Identification</p> <p>Innovations to better find community-dwelling consumers at risk of nursing home placement, and nursing home residents with the potential to return to the community.</p>	<ul style="list-style-type: none"> • Target hospitals with high discharge rates to nursing homes and/or that have heavy rehab caseloads (designed for non-waiver consumers). • Provide information to caregivers about home care options (for non-waiver consumers). • Identify current waiver participants who are at high risk of nursing home placement. • Give waiver recipients a Program ID card and a medical information card for use when working with hospitals and doctors. 	<ul style="list-style-type: none"> • Use state and nursing home information systems to identify individuals who could transition from nursing homes. • Partner with LTC Ombudsman to identify nursing home residents appropriate for transition. • Use MDS data to identify nursing homes that serve a high proportion of low case mix residents. • Identify hospitals that include licensed nursing home beds.
<p>Service</p>	<ul style="list-style-type: none"> • Provide more intensive 	<ul style="list-style-type: none"> • Care managers assigned to

<p>Interventions that more effectively assist high nursing-home-risk consumers to stay or return home.</p>	<p>services to current waiver recipients:</p> <ul style="list-style-type: none"> • Increase service plans. • Clinical rounds to improve care. • Caregiver training and support. • Special plan for participants in nursing home. • Target those in need of high-risk case management. <ul style="list-style-type: none"> • Implement models to work with hospitals to improve discharges and readmissions (both waiver and non-waiver consumers). This could involve co-locating case management in the hospital. • Implement models to work with caregivers to assist in supporting family member to remain in community (both waiver and non-waiver consumers). • Refer consumers to levy programs or non-Medicaid services, including: mental health, Centers for Independent Living (CIL), and housing (non-waiver consumers). • Link consumers to waiver programs including PASSPORT, Assisted Living waiver, Ohio Home Care (non-waiver consumers). 	<p>nursing homes for routine visits.</p> <ul style="list-style-type: none"> • Care managers follow up on individuals who might be potential transitions – either referred by ombudsman program or identified in PAR or MDS database review. • Refer potential transition consumers to appropriate program such as: PASSPORT, Assisted Living, Ohio Home Care, Centers for Independent Living (CIL) or Home Choice. • Reduce or eliminate the convalescent care exemption.
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By applying proven diversion and transition techniques, South Carolina can reduce the medically unnecessary use of nursing homes and hospitals. This strategy can also be developed and coordinated along with the MFP Home Again II program.

Evidence-Based Care Transition Models to Be Considered

Nationally, Agencies on Aging (AoA) and CMS have supported research and demonstration of several Evidence-Based Care Transition Models that should be considered for appropriate use in the CLTC system. These models would be equally effective if embedded in a comprehensive and integrated managed care system. They include:

- **BOOST (Better Outcomes for Older Adults through Safe Transitions):** this program is a hospital-to-home transition model; is team oriented, PCP focused in the community/no explicit care coordinator; 30 days duration; designed to decrease re-hospitalizations within 30 days of discharge.
- **The Bridge Program:** This program is a hospital-to-home social work-based transitional care model that starts in the hospital and continues after discharge to the community for 30 days. A unique aspect of this model is linking the hospital-discharged person/family with ADRCs that are an integrated partner with the transition process.
- **Care Transitions/Coleman Model:** This program is a hospital-to-home transition model designed to be a client centered interdisciplinary intervention that targets continuity of care across multiple settings and (participating) practitioners. The model is based on medication self-management/education, use of a Personal Health Record, follow up, and use of a “Red Flag” checklist. A Nurse Transition Coach works with the patient/family throughout the 30-day duration of the program.
- **Transition Care Model (TCM/Naylor model):** This program is a hospital-to-home transition model that identifies patients with two or more risk factors for re-hospitalization and is cognitively “intact”. The program utilizes a Transitional Care Nurse, on call seven days a week, and makes home visits as needed with telephone access available for up to three months post discharge.
- **GRACE (Geriatric Resources for Assessment and Care of Elders) (Practice Based/Chronic Care Conditions/Home Based):** This program is designed for people at high risk of re-hospitalization and is primary care physician office based. The model utilizes a nurse practitioner and social worker that partner with the PCP, geriatric specialists, and other involved health professionals in a team-based approach to community/home based care. Duration of the program is long term.
- **Guided Care (Practice Based/Chronic Care Conditions/EHR):** This program is a product of Johns Hopkins University and is based on the use of a specially trained Guided Care Nurse who works in partnership with 2-5 PCPs and other members of a person’s health team. The Guided Care Nurse utilizes eight inter-related clinical processes including assessing the client and primary

caregiver in the home setting, monthly monitoring of patient's conditions, and assists with transitions in and out of hospital stays. The program makes use of an EHR system.

Each of these six models has some similarities (target population) and several key differences. Not all settings, such as a university based health system, are replicable. SC would need to consider the range of care a person with multiple chronic care conditions requires, their cognitive abilities to self-manage, and the natural supports the person has or does not have available in the home. In any event, SCDHHS should consider plans for seamless transitions in across the delivery spectrum, including ensuring timely follow up with providers and adequate self-management skills

The two best practice models that have generated considerable interest and are replicable are the Care Transition/Coleman model and the Transitional Care/Naylor model. The Care Transition/Coleman model appears suited for straightforward diagnoses upon hospital discharge where “a little help” for “low touch needs” would be helpful for a short period of time based on the individual's ability to self-manage. For more medically complex cases the Transitional Care/Naylor model appears to be an appropriate choice based on the use of a Nurse Practitioner who acts more as a navigator/advocate and has prescribing authority; they can adjust medications if there is a need. This model is well suited for people with multiple chronic care conditions who need assistance with self-monitoring and need “high touch” care.

Nursing Home Diversion and Transition Recommendations and Nexus to State LTC Balancing Efforts

SCDHHS needs to develop and implement coordinated incentives to keep individuals in the community at critical points: pre-hospital admission with a focus on dementia, hospital discharge planning activities and within the nursing facilities targeting short-term stays, MDS 3 low acuity individuals, and people who respond to the “Q” question on the MDS 3. The state should also consider obtaining MDS data that shows which nursing homes have a higher level of lower acuity nursing home residents and concentrate on interviewing these residents for discharge potential/transition to home and community based settings. Community based care incentives for chronically ill or “complex cases” must also be aligned with case management in the field in order to promote diversionary strategies and process so that South Carolina is doing all it can to ensure a return to the community where appropriate, and where quality services are provided. Separate payment methodology that drives appropriate decision making, rather than payment per case where there is no real incentive built around community based care, needs to be explored – provided individuals' care plans are still less than costly institutional care.

It was reported that in South Carolina, after a person is assessed to be eligible for nursing home placement and is admitted, that no case manager is assigned to follow that person in the nursing home. States that have had significant reduction in the Medicaid nursing home census have staff assigned to nursing homes. Designated staff is in the nursing homes on a regular basis, have contact with the

nursing home admission/financial office, interview residents about their preferences and work with them to move as soon as possible. This process can also be combined with nursing home transition efforts outside of MFP as this does not require the resident to be in the home for 90 days. SCDHHS could benefit from assigning staff to perform this function as it would help with the reduction of Medicaid permit days. The state may want to consider reassigning staff that currently perform level of care assessments in hospitals and nursing homes to this function. The redesignation of trained case managers could also perform this function. It was reported that there are very few denials of eligibility as a result of these assessments and nursing home case management could be more effective in managing the nursing home population.

Additionally, some hospital and personal care community providers think that physicians may not be as well educated on the array of community services available for diversion to the community in complex care and chronically ill cases. CLTC and SCDHHS need to ensure appropriate member education and capacity to self-manage transitions across health care settings. This could include assessing for health literacy as well as developing an individual's skill sets for current and future care needs.

Additional Process Improvements

Additional process improvements to the current system that promote a robust diversion and transition strategy may include:

- SCDHHS should develop a strategy that places designated professional staff in nursing homes to support identifying people who wish/can transition back to the community and assist families, and nursing home staff in the process. Additionally, CLTC should consider working with nursing facilities to identify Medicare Part A admissions for persons with or eligible for Medicaid enrollment upon NF admission in order to assure these people are immediately identified for transition (based on medical status), thereby assisting nursing facilities for continued census capacity for Medicare Part A admissions. This approach can support South Carolina's nursing facilities role for high acuity Medicaid paid cases as the LTC system balances over time.
- Nursing services are currently provided by family members, but for the person who has no family this service should be added to the waiver, including nurse delegation that can be a more cost-effective way to meet a person's nursing needs.
- Provide incentives to nursing homes supporting transition back to the community for current residents who wish (and can) return to the community, or disincentives to those facilities that do not offer transition services.
- Provide metric-based incentives to case managers to assist people on the waiver to divert nursing home admissions when possible and transition back to the community after a hospital admission from the community. As stated above, this may include reforms to payment methodologies.
- Assure that all available housing resources, including the Housing Authority, are connected to the CLTC system and have specific plans and goals to provide approved housing units for individuals in need of transition based on a level of care framework.

- Integrate the use of MDS 3 data into the Home Again II program to identify individuals with low acuity and positive responses to the “Q” question.
- Consider the use of predictive modeling based on MDS 3 data and Medicare data as available to achieve a clear understanding of the individual’s total cost for Medicaid paid nursing home services. Predictive modeling has many uses including early identification of people who may require nursing home admission.
- Consider expanding the use of adult foster care models as part of transition services, possibly coupled with direct admission into adult day health services. The state’s adult foster care home model currently serves 1 resident. This model has proven to be an effective model in other states in keeping nursing home level of care seniors in the community. We believe the adult foster care model should be considered for expansion to up to four residents, which still meets the MFP qualified residence requirement.
- SCDHHS should consider the strategic placement of diversion and transition staff to assure maximum effectiveness, timely provision of services, maximum coordination with hospital and community providers, and seamless required activities and processes that support successful diversion and transition strategies.
- Build upon the Home Again II Stakeholders Group by considering compatible policy integration strategies among, DMH, and DDSN, within SCDHHS with an initial focus on cross-department housing needs.

Medicaid Eligibility Process Change Key to Enhanced Diversion Plan

Additionally, the current long term care financial eligibility process is too slow (see following section on waiting lists) and is negatively impacting the length of stay on the HCBS waiting list. This is providing a barrier to the timely authorization of services and has led to increased admissions into nursing facilities. SCDHHS should establish a workgroup to identify efficiencies, changes in process that would simplify and reduce length of time to process applications. The workgroup should also include the Lieutenant Governor's Office responsible for the Aging and Disability Resource Centers and the Disability Determination process managed by Vocational Rehabilitation. Currently ADRC staff are assisting families with the application and submitting applications electronically, but could coordinate better with CLTC.

Key Additional Service Options Need to be Added to Further Enhance Diversions and Transitions

Additionally, The Lucas Group recommendation includes the development and implementation of a mid-level care/assisted living component to the home and community based waiver. The lack of a real meaningful mid-level option is a significant barrier, since the current waiver does not include residential services that can provide 24/7 services to people whose behavior or cognitive abilities make it difficult for them to live alone in their own home. Adding nursing services through the community waiver, augmenting adult day care services from a social only model to a social/medical model, and addressing

the lack of family support for many seniors through supported living services are critical considerations for development of community based options. The state could also choose to offer limited prevention services to Medicaid elders who are chronically ill, but not yet at the nursing home level of care. These limited services could go a long way in lengthening the time for higher cost Medicaid LTC services.

Conclusion

Further consideration of The Lucas Group recommendations here, and our overall plan for a more Integrated and coordinated managed care model for the delivery of long term care services to Medicaid seniors in South Carolina, will assure nursing home diversion, transition, and MFP program success, while at the same time moving South Carolina's long term care system to a more appropriate and balanced manner.

Waiting Lists

SCDHHS currently defines the waiting list as all people who have applied, and are seeking, waiver services whether or not they have met final eligibility requirements. To be placed on the Community Choices Waiver Program (CCWP) or nursing home waiting lists, the way the lists are currently maintained, an individual must simply apply (or have another person or agency apply on their behalf) at an area CLTC office, or call an area CLTC office.

Currently, CLTC has 12,382 slots in its CCWP, after 550 additional slots were added in the FY 2011-12 Appropriations Act. Of the 12,382 slots, 12,380 are currently filled (as of 4/23/12). According to CLTC, there is currently a waiting list of 3,034 (as of 4/23/12). The waitlist for the CCWP was close to 4,000, however, recently South Carolina significantly increase the number of slots in this waiver program, resulting in a concurrent decrease in the waiting list.

Additionally, there are 15,845 nursing home slots and 223 individuals on the nursing home facility waiting list (as of 3/30/12), including 120 applicants that were in an acute care hospital (as of 11/14/11). The number of individuals on the nursing home facility waiting list was also higher until a recent change SCDHHS made. For those seeking nursing home admission, SCDHHS now pulls electronic lists monthly and contacts everyone on the list to ensure that he or she is still seeking admission. Those who are already in nursing home, or who are no longer seeking admission, are removed from the list. This ensures that the figures are not over reported.

For the 10-year period ending December 31, 2010, CLTC averaged 2,486 CCWP enrollments annually, with a low of 2,377 in 2001 and a high of 3,317 in 2008. In the month of October 2011, 926 individuals applied for nursing home placement and 868 individuals applied for CCWP placement. CLTC staff indicates that there is currently an average wait time for eligibility and services of six months.

Current SC Policies and Practices

The way the current process is set up by CLTC, an individual is placed on the CCWP waiting list once he or she calls (or a relative, health agency, etc. calls) and expresses an interest in participating in the program. During the initial call, CLTC staff asks about the consumer's ability to perform certain activities of daily living (transfer, locomotion, bathing, dressing, toileting, eating), whether or not the individual has a caregiver system in place, and other risk factors (been to emergency room frequently, numerous prescriptions, etc.).

At this point, since 2008, the individual is assigned a priority score (1-100) based on the answers given during the phone assessment and a determination is made regarding the level of care that the applicant needs. Someone in need of assistance in performing the basic functions will have a skilled level of care and a priority score closer to 100 – meaning they are at the top of the waiting list – than an individual who does not need assistance to perform basic functions. If the individual does not have an intermediate or skilled Level of Care, they are given the option of remaining on the waiting list and assigned a low priority score.

Prior to 2008, the wait list was prioritized on a first come, first served basis and each area CLTC office maintained its own wait list, with its own cap (calculated based on formula that took into account such criteria as population and poverty level in the region). In 2008, CLTC received a Real Choices Innovations Grant and initiated a stakeholder-engaged process that resulted in modifications to waiting list procedures. One change started in 2008, and continuing today, was the CCWP was managed by one statewide waiting list.

For each additional week that someone is on the waiting list, one point is added to his or her priority score. After six months on the waiting list, the individual's priority score is automatically moved up to 100. Once someone reaches a priority score of 100, and there is more than one individual with a priority score of 100, open slots are filled on a first come, first served basis.

After the phone assessment is performed, and the priority score is assigned, the individual must still have an in-home assessment performed to confirm the information CLTC received during the phone assessment. The in-home assessment typically does not occur until the CLTC staff estimates that the applicant will be able to obtain a CCWP slot within 30 days (based off of rank on the statewide waiting list).

Currently, CLTC places individuals on the waiting list in one of 12 priority levels, based upon what assessments have been performed and the status of their Medicaid Eligibility (a description of all 12 priority levels can be found in the Appendix). Prior to applicant's enrollment in the CCWP, he or she must matriculate to Priority Level 12 (in-home assessment has been performed, Level of Care is determined to be intermediate or skilled, and Medicaid Eligibility has been verified), even if they have a priority score of 100. The applicant with a score of 100, but not yet a Priority Level 12 will be passed over until he or she becomes a Priority Level 12 case. The CLTC staff indicated that their goal is to never

have more than 100 people in the Priority Level 12. Also, nurse assessors are supposed to work the waiting list every 30 days.

The Financial Eligibility Process and its Impact on the Waiting List

In theory, once a person initiates the process of applying for CLTC services, they are also applying for Medicaid Eligibility at the same time (two separate application processes) – unless they qualify for Supplemental Security Income (SSI), in which case they can skip the Medicaid Eligibility process.

In practice, however, this is not always the case. During our research we uncovered many cases where the Medicaid Eligibility assessment application was not submitted until after the in-home assessment was performed.

SCDHHS Medicaid Eligibility estimates that, once a completed application is received, on average it takes 20 days to complete a financial eligibility assessment for the CCWP, and 35 days to complete a financial eligibility assessment for institutional care. If an applicant seeks to qualify for disability, it could take 45-90 days longer for the Medicaid Eligibility process to be completed due to the time it takes for the Social Security Administration to return documentation to the state agency.

When processing applications for the CCWP, Medicaid Eligibility must verify the applicant's income, the wages that the applicant earns and other resources (bank statement, insurance, etc.). When processing applications for institutional care, Medicaid Eligibility must also perform a five-year "look back" to determine if the applicant has made any transfers of assets within the previous 60 months that, if the transfers had not been made, would have prevented the individual from financially qualifying for Medicaid. If the individual has made transfers, Medicaid Eligibility must determine if the transfers can be excused. If they cannot be excused, Medicaid Eligibility must calculate a penalty to be assessed before the individual may qualify for Medicaid.

Wait List Exception Policies and Recommendations

The CCWP waiver program has established the following exceptions to the waiting list (all individuals must still meet Medicaid financial requirements):

- If an individual has been in a nursing home facility for 90 days or more, they are waiting list exempt and may enroll in the CCWP.
- If an individual was previously enrolled in the CCWP prior to entering a nursing home facility, they are waiting list exempt and may re-enroll in the CCWP.
- If an individual becomes financially ineligible (and is removed from the program), but regains eligibility within one month, they return back to the CCWP without going on the waiting list.
- Individuals that are the recipients of organ transplants are waiting list exempt and may enroll in the CCWP.

- If an individual was removed from the program because they were in an institution, and stayed in the institution for a full calendar month, they may return back to the CCWP without going on the waiting list.
- An individual referred by Adult Protective Services will exempt the waiting list and enroll in the CCWP.

Recommendations on Improving the Wait List Process and Backlog

In evaluating the admission, assessment, and, ultimately, enrollment processes for the CCWP The Lucas Group believes that the following three goals should be set for any recommended change to the current wait list:

1. Better prioritize (triage) individuals on the CCWP waiting list based on their Level of Care needs, ensuring that those with more advanced Level of Care needs are enrolled in the program sooner.
2. Define the CCWP waiting list more strictly than it is currently defined to give an accounting of the number of applicants that are, or when all assessments are complete likely will be, eligible to enroll in the CCWP or go into a nursing home.
3. Ensure that individuals that have applied for admission to the CCWP do not get “lost in the process”.

The Lucas Group recommendations for meeting these goals are as follows:

1) Establish a more senior-friendly application process with the all agencies working in a more integrated manner with a clear “No Wrong Door” policy, with applications funneled to CLTC main office in Columbia.

The current application process, specifically the financial eligibility process, is complex and can be quite daunting to a senior – particularly a senior whose mobility makes it difficult to gather the documentation necessary to successfully submit a financial eligibility application.

Lucas Group recommends that the CLTC, Medicaid Financial Eligibility and the Aging and Disability Resource Centers (ADRCs) develop a more integrated, seamless process; which currently seems to be inadequate. CLTC should work with area offices and other agencies to ensure that there is a clear “No Wrong Door” policy that will assist individuals in beginning the application process. All applications should be funneled to the main CLTC office in Columbia to ensure that each applicant receives the appropriate attention (a change that CLTC is in the process of implementing).

The goal should be to someday establish the ADRCs as a “Single Point of Entry” that seniors can go to throughout the process that will assist the individual in submitting necessary paperwork and monitor the progress of the applicant’s case until the individual either receives a slot in CCWP or nursing home, or a determination is made that they do not qualify for the CLTC program. While the ADRCs now have all 10 centers up and running, they still do not likely have the capability of serving as a SPOE for the

CCWP. For the ADRCs to serve as the SPOE, they would need to build their capacity and work in better coordination with CLTC.

If the ADRCs were to serve as the SPOE, they would also assist in gathering preliminary information regarding the applicant's basic social, health and economic needs and provide the applicant with information about other available services and programs in their community. This SPOE should also be available for all seniors as a resource for information on all other senior services in the area - not only those that are eligible for Medicaid.

Other states, such as Wisconsin, have ADRCs established as the SPOE. In 2001, Wisconsin began implementation of Wisconsin Family Care and designed ADRCs as the single entry points where seniors, as well as those with disabilities, could find information and advice about programs in their local communities in the five initial counties where the program was rolled out. The ADRCs also provide benefit specialists to assist applicants with applying for Medicaid long term care services, as well as other public and private benefits and services. With the help of the ADRCs, the Wisconsin Family Care Program has successfully been able to bring together a number of programs, funded with state and federal resources, and provide its citizens a long term care benefit that fits each individual's needs and wishes.

One of the initial goals of Wisconsin Family Care was to eliminate the waiting lists in the five counties within two years. By establishing the ADRCs as a single point of entry, working with case management organizations, Wisconsin was able to achieve this goal.

2) ADRC staff should assist the applicant in properly filing the financial eligibility application and assist in monitoring the progress of the applicant's case through the assessment processes. The SCDHHS nurse should NOT be in charge of gathering applicant's financial eligibility paperwork.

In talking with staff, and reviewing cases on the Phoenix system, The Lucas Group found that one of the most significant delays in the assessment process involves the delay in individuals gathering the information necessary to complete the financial assessment application and properly filing the application. Oftentimes, the individuals that have the most trouble gathering the information are the individuals who need services the most. Further, the longer these applicants go without assistance, the greater the risk of injury to that person – creating a poor health outcome and additional expense to the system.

As of August 1, 2011, there were 396 individuals in Priority 10 (defined as a person determined to have a Level of Care of intermediate or skilled during the in-home assessment, but Medicaid Eligibility Not verified) and 2,273 individuals in Priority Level 8 (defined as a person determined to have a Level of Care of intermediate or skilled during the phone assessment, but Medicaid Eligibility NOT verified). Much of this is due to applicants not having submitted a complete financial eligibility application. If ADRCs, with assistance from advocacy groups and other charitable and community organizations, were to assist these individuals in submitting the financial applications then there would not be this backlog in the

Priority Level 8 segment and a determination would be made as to whether or not the applicant qualifies for CLTC services.

The current system places the burden on nurses to continuously follow up with applicants to make sure their financial eligibility application is complete and submitted. This is unrealistic, given that the nurses' primary role is to perform assessments of applicants. Naturally, after following up with the applicant a couple of times on whether their financial eligibility paperwork is complete, this task takes on a lower priority and becomes an afterthought.

By utilizing the ADRCs to assist the applicant throughout the assessment process, the applicant has one person that they can call with questions, one person that's sole involvement in the case is to ensure that the applicant's case is progressing adequately, and the nurses can focus their efforts on performing assessments.

Other states, such as Wisconsin have assigned management of applications for enrollment into long term care to the ADRCs, with success.

3) Financial eligibility assessment should be performed after the applicant's phone assessment is completed and Level of Care is determined to be intermediate or skilled. The in-home assessment should not be performed until financial eligibility is approved.

In talking with CLTC staff and reviewing cases in PHOENIX, Lucas Group found that a large number of individuals on the current CCWP waiting list are individuals that have not financially qualified for Medicaid, either because they have not submitted a complete application or Medicaid Eligibility is not processing the application quickly.

Requiring Medicaid Eligibility approval prior to performing the in-home assessment will conserve CLTC resources by only performing in-home assessments for individuals that qualify for the program and, once the individual's Level of Care is confirmed, allow the applicant to receive services quicker.

4) A person should not be considered to be on the waiting list until he or she has been determined to have an intermediate or skilled level of care during the phone assessment and has been determined to be financially eligible for Medicaid.

The way the waiting list is currently maintained allows for the inclusion of individuals that do not, and likely will not, ever qualify for the program. The Lucas Group recommends that individuals not be placed on the waiting list until the phone assessment has been performed, the individual has been given a Level of Care that qualifies them for services, and a determination is made that the individual financially qualifies for Medicaid.

This will give SCDHHS and policy makers a better idea of the true size of the waiting list and also ensure that once an applicant's in-home assessment is completed, he or she can immediately begin to receive services.

Another method should be developed to provide an account of the unmet demand and individuals waiting to have assessments performed. However, at no point should individuals that do not qualify for CCWP, either by a determination that they do not meeting Level of Care or Medicaid Eligibility, be allowed to remain on any waiting list. If they wish they may apply again in the future, but they should not remain on the waiting list.

5) Area offices should have access to information relating to Medicaid Eligibility assessments and vice versa. Alternatively, Eligibility should document in PHOENIX where each case stands, as well as changes in the case.

There needs to be a link between CLTC and Medicaid Eligibility. In discussions with both CLTC staff and Medicaid Eligibility staff, Lucas Group was told of the need for each division to have a better understanding of where each case is in the application process.

If Recommendation #1 is accepted, and at some point the ADRCs are established as the single point of entry at some point in the future with the responsibility of monitoring and assisting with each individual's application process, then the ADRCs should be linked in to this system as well.

6) If an individual, currently in a nursing home facility, wishes to leave the nursing home facility and enroll in the CCWP, allow them to do so immediately.

Currently, an individual must remain in a nursing home for 90 days before bypassing the CCWP waiting list and receiving a slot in the program. The policy should be changed to allow individuals in nursing home facilities that want to go back into the community the opportunity to do so as quickly as possible. These cases should be given high priority by staff and receive the first slots that are available.

It will be necessary for CLTC to monitor the entrants into nursing home facilities to ensure that individuals are not going into nursing homes simply to bypass the waiting list. If this is found to be occurring, CLTC will need to institute a set period of time.

7) If an individual, currently in a hospital, wishes to enroll in the CCWP, allow them to do so after five days.

Currently individuals must remain in the hospital for 90 days before bypassing the CCWP waiting list and receiving a slot in the program. The Lucas Group recommends that these individuals be able to do so after five days in the hospital. For an individual to be in the hospital for five days they must have an acute care condition. Once they no longer have an acute care condition they should be allowed to exempt the CCWP waiting list, begin receiving services, and recover at home. We understand that CLTC has recently instituted this policy on a trial basis, with 23 individuals exempting the waiting list thus far. We recommend that this policy be retained on a permanent basis.

The five-day requirement, as opposed to immediately being able to bypass the CCWP waiting list, will prevent individuals from checking into the hospital just to bypass the waiting list.

These cases should be given the highest priority and moved out of the hospital as soon as it is medically possible.

8) Each area office should review the highest 100 ranked cases in their area every week to ensure that each non-Priority Level 12 case is progressing adequately and, if it is not, determine why it is not and fix the problem. Throughout this monitoring, there should be a focus on applicants with a priority score of 75 or higher.

In our review of cases in the PHOENIX system we have found instances of individuals “falling through the cracks” of the process. In one applicant’s case, no progress had been made on the case in well over a year. By reviewing the top 100 cases each week, the likelihood of this happening in the future is greatly diminished. Additionally, individuals with the highest level of needs will move through the application process faster and begin to receive services, and reducing the risk of injuring themselves.

9) Each week the state CLTC office should review all cases with priority scores of 75 and greater (based on Level of Care, not time on wait list) to ensure that each non-Priority Level 12 case is progressing adequately and, if not, determine why it is not and fix the problem.

Similar to the logic of Recommendation #8, having the state CLTC office review each case of individuals with a priority score of 75 or higher on a weekly basis, CLTC can ensure that those with the highest level of needs are moving through the system efficiently and will receive services before injuring themselves, and requiring hospitalization or nursing home care.

Also, if the area offices know that the state CLTC office is monitoring these cases on a weekly basis, their level of attention to detail will increase.

10) Once an individual with a priority score of 75 or higher reaches Priority Level 12, but no open slots exist in the CCWP, offer some basic level of services to the individual until a slot opens up and they are enrolled in the CCWP.

Individuals with priority scores of 75 or higher (due to in-home Level of Care assessment) should begin to receive some very basic services once they reach Priority Level 12 status. This will prevent deterioration of the individual’s condition, costs to the system due to hospitalization and allow the individual to remain in the community longer.

11) Ensure that in both hospitals and nursing home facilities, individuals (and their families) are aware of the CCWP as an alternative to nursing home facilities, as well as the services that are provided through the CCWP.

When CLTC nurses perform Level of Care assessments, they must explain to the individual that there is an option for them to remain in the community and receive services individually prescribed to them, based on their condition. The nurse should also explain what services the individual would receive, how the process works and cases of individuals with similar conditions that have successfully remained in the

community. Finally, a written document should be left with the individual and/or family stating the same information and a phone number to call if they have questions.

The area supervisor should also monitor cases of individuals going into nursing homes and contact the individual, or their families, and offer the same explanation if they believe it is reasonable for the applicant to remain in the community.

12) There needs to be a single, identifiable person that is in charge of monitoring/managing the CCWP waiting list.

Currently no single person is responsible for monitoring the CCWP waiting list - it is all done on PHOENIX. Going forward, there should be a single, identifiable person charged with maintaining the waiting list and ensuring that it is flowing properly. This individual will also be responsible for ensuring that individuals in nursing homes and hospitals that want to return to the community are accommodated as quickly as possible.

The individual charged with monitoring the CCWP waiting list should have medical training in order better prioritize (triage) the waiting list based upon the applicants' medical needs; ensuring that those who are most susceptible to rapid health deterioration receive services first.

13) Institute the use of reminder notices in the process that are automatically generated and sent to appropriate staff, supervisors and directors when preset deadlines are not met with each case.

Today technology exists to automatically generate messages at certain points in time (for example, our smart phones alert us when we have meeting). This technology should be put to use when cases have been dormant for a certain period of time, or a task (such as the financial eligibility assessment) has not been completed in a certain number of days. Messages should be automatically sent to appropriate staff to signal that there may be a problem. The individual charged with overseeing the waiting list should also receive these notices and design a plan to cure the problem.

Waiting List Case Examples

The following examples were recently pulled off the PHOENIX system and illustrate cases that would have had different outcomes had the Lucas Group's recommendations been in place.

Person #1:

First called a local office on February 28, 2010, to seek assistance. At this time a phone assessment was performed and the individual was determined to have a skilled Level of Care (be in need of assistance with transfer, locomotion, bathing, dressing, toileting and eating) and placed in Priority Level 8 (needs in-home assessment and Medicaid Eligibility verified).

Nothing occurred with the case until four months later, on June 28, 2010, when the individual called the local office to request assistance. Nearly three months passed after this call, when another agency called the area office on September 17, 2010, to check on the status of Person #1's case. As of

November 11, 2011, Person #1 holds the first slot on the CLTC waiting list, but no action has been taken on the case since the call in September of 2010. No progress has been made on this case since the first day Person #1 called here local CLTC office nearly 20 months ago.

This case demonstrates how a couple of the recommendations, if implemented at the time, could have prevented the situation that Person #1 has endured. First, if the ADRCs had been established as the single point of entry, and an ADRC staff member was following Person #1's case, the individual would not have gone unnoticed for well over a year. Second, if Medicaid eligibility processing had commenced immediately after Person #1 called in and the phone assessment was performed, it is significantly less likely that 20 months would have passed with this individual "lost" in system. Third, if the local office had been reviewing the 100 oldest cases on the wait list on a bi-weekly basis, the inattentiveness to this case would have been recognized a lot sooner. Fourth, if the state CLTC staff had been monitoring the cases with priority scores of 75 or higher on a weekly basis, this individual's would have progressed quicker. Finally, if a system was in place to automatically generate messages after certain periods of time with no action on the case, and a single person designated with responsibility of managing the waiting list, the scenario would have been prevented.

Person #2

This individual was in a nursing home and covered by some source other than Medicaid. Person #2 desired to remain in the nursing home, but needed to undergo assessment to determine if they were Medicaid eligible. In August 2010, a nurse performed an assessment and determined that the individual met Level of Care and Medicaid financial eligibility requirements. The individual remained in the nursing home and payment was transferred to Medicaid, however, this case continues to remain on the waiting list 15 months after it should have been closed.

This case demonstrates how a couple of the recommendations, if implemented at the time, could have prevented the situation that Person #2 has endured. First, if the local office had been reviewing the 100 oldest cases on the wait list on a bi-weekly basis, the inattentiveness to this case would have been recognized a lot sooner, and Person #2 would no longer be on the waiting list. Second, if the state CLTC staff had been monitoring the cases with priority scores of 75 or higher on a weekly basis, this individual would no longer be on the wait list. Finally, if a system was in place to automatically generate messages after certain periods of time with no action on the case, and a single person designated with responsibility of managing the waiting list, the individual would not be unnecessarily adding to the population on the waiting list.

Person #3

On June 15, 2010, another agency called CLTC to refer Person #3, who was diagnosed with Alzheimer's. During the phone assessment it was determined that the individual was totally dependent, with exception of "transfer" (in which extensive assistance was needed). Person #3 was assigned a priority score of 100.

On January 31, 2011 – seven months later – there was a phone conversation between the individual's daughter and CLTC (record does not reflect who initiated the call), during which the daughter said that Person #3 was on hospice, but wished to remain on the waiting list. On March 1, 2011, a nurse was assigned to perform an in-home assessment, which was done two days later and confirmed the Level of Care assigned during the phone assessment. The nurse also sent Person #3's paperwork to Medicaid Financial Eligibility for approval March 3, 2011. The following are the next case entries in Phoenix:

- 4/12/11 – Nurse emails Eligibility to check status of application processing.
- 5/3/11 – Eligibility responds that no application was ever received.
- 5/11/11 – Person #3's daughter calls to inform nurse that a second application had been sent to Eligibility.
- 5/12/11 – Nurse calls Eligibility to confirm second application was received.
- 5/31/11 – Nurse emails Eligibility to check status of application processing.
- 7/8/11 – Nurse emails Eligibility to check status of application processing.
- 7/18/11 – Eligibility responds that application is pending.
- 7/29/11 – Nurse emails Eligibility to check status of application.
- 8/12/11 – Nurse emails Eligibility supervisor to inform that this application is pending and has not heard anything.
- 8/26/11 – Eligibility supervisor responds that application is pending.
- 9/2/11 – Nurse emails Eligibility supervisor to check status of application.
- 9/23/11 – Nurse emails Eligibility supervisor to check status of application.
- 9/30/11 – Eligibility supervisor responds that application is pending.
- 10/31/11 – Nurse emails Eligibility to check status of application.
- 11/9/11 – Person #3 receives approval from Medicaid Eligibility.

This example demonstrates a number of relevant points. First, it demonstrates the dedication that the nurses have to the patients that they serve. Second, if the ADRCs had been established as the single point of entry, or charged with assisting in filing the financial eligibility application, and an ADRC staff member was following Person #3's case, the ADRC staff member would have been able to follow up with Medicaid Eligibility instead of the nurse, and been better equipped to assist in gathering necessary information and correcting any problems with the application. Second, if Medicaid eligibility processing had commenced immediately after Person #3 called in and the phone assessment was performed, the individual would have immediately begun receiving services when the in-home assessment was completed on March 3, 2011. Third, if there was a technological link between CLTC and Medicaid

Eligibility, each side would know what needs to be done to process Person #3's case quicker, without being forced to wait on email responses. Fourth, if the state CLTC staff had been monitoring the cases with priority scores of 75 or higher on a weekly basis, the state office could have spoken to their counterparts in Financial Eligibility and gotten this case moving, rather than relying local staff to do this. Finally, if a system was in place to automatically generate messages after certain periods of time with no action on the case, and a single person designated with responsibility of managing the waiting list, a person clearly in need of services would not be forced to continue without assistance.

Person #4

This individual applied for CCWP at a local Medicaid Eligibility office on July 7, 15, 2010, and the case was referred to an area CLTC office. On July 30, 2010, CLTC contacted Person #4 and did a phone assessment. During this assessment that Person #4 was suffering from colon cancer and congestive heart disease, in need of help with all activities (except toileting), and assigned a priority score of 100. Five months later, on December 22, 2010, CLTC attempted contact Person #4 by phone, but got no answer and left a message. On five more occasions over the next three months SC CLTC attempted to contact the individual via phone, but got no answer and left messages. On March 31, 2011, CLTC spoke with Person #4 on the phone and confirmed that they were still interested in remaining on HCBC waiver waiting list.

Three months later, on June 27, 2011, CLTC assigned the case to a nurse for in-home assessment, which was performed on July 12, 2011, and Level of Care was confirmed. On July 21, 2011, the family notified the nurse that an application had been submitted for Medicaid Eligibility, but Eligibility said they did not receive one. On August 2, 2011, Patient 4's family says they are sending another application and confirm the Medicaid Eligibility received the application a week later. On October 4, 2011, Eligibility informed the nurse that the application is not complete. The notations in PHOENIX did not indicate that either Eligibility or the nurse have spoken to Patient #4 (or their family) to inform them that the application is not complete. The entries in PHOENIX indicate that the last time anyone from CLTC spoke to the applicant was on August 2, 2011.

This case demonstrates how a couple of the recommendations, if implemented at the time, could have prevented the situation that Person #4 has endured. First, if the ADRCs were assisting in filing Medicaid Financial Eligibility applications, and an ADRC staff member was following Person #4's case, the individual would have received the assistance necessary to file a complete application. Second, if Medicaid Eligibility processing had commenced immediately after Person #4 called in and the phone assessment was performed, there would never have been an in-home visit before the Medicaid Eligibility was confirmed. Third, if the local office had been reviewing the 100 oldest cases on the wait list on a bi-weekly basis, the inattentiveness to this case would have been recognized a lot sooner. Fourth, if the state CLTC staff had been monitoring the cases with priority scores of 75 or higher on a weekly basis, state staff could move along this individual's case. Finally, if a system was in place to

automatically generate messages after certain periods of time with no action on the case, and a single person designated with responsibility of managing the waiting list, the individual would either have Person #4's Medicaid Eligibility confirmed, or have the individual removed from the waiting list.

Care Coordination and Case Management

The Lucas Group considers care coordination to be a fundamental aspect of the client centered medical home and a primary factor in the reduction of fragmented care between a Medicaid FFS primary/acute medical care benefits structure and LTC benefits provided through a waived services model.

“Care coordination” is defined by AHRQ (2010) as “a conscious effort to ensure that all key information needed to make clinical decisions is available to all patients and providers. It is defined as the deliberate organization of patient activities between two or more participants involved in a patient's care to facilitate appropriate delivery of health care services.”

The CLTC requirements for Choices case management states that “the objective of case management is to provide services counseling and support and to assist participants in coping with changing needs and making decisions regarding long term care. It also ensures continued access to appropriate and available services.”

Current Case Management Practice in SCDHHS

Currently SCDHHS has no formal requirements among SCDHHS, MHN's, and FFS providers for coordination of care for LTC waiver participants. Many waiver participants have multiple chronic care conditions and require care in several settings, oftentimes under the authority of different departments or agencies charged with their care. This is particularly true for elders who may have mental illness or other physical or developmental disabilities. CLTC considers the community based case management system as “care coordinators.” While this is fundamental for CLTC Choices waiver services there is a significant absence of an operational and comprehensive, integrated approach to “care coordination” with the FFS primary care providers and MHNs serving waiver participants.

Waiver participants are also excluded from MCO enrollment, but waiver participants may enroll in MHN's. Based on interviews with CLTC staff, MCOs, and a MHN. The Lucas Group has found there are no formal CLTC contracted linkages with the MHNs that should be the basis of developing a care coordination team on behalf of the waiver participant (patient-centered), nor the CLTC case management agency contracts or individual CM provider agreements.

The Lucas Group research and interviews with South Carolina leaders involved with the CLTC system at the community and MCO/MHN level indicates that integrated care coordination/case management best practice has yet to be planned and implemented in the CLTC program. A gap in contracted care

coordination expectations has yet to be bridged between specific disability-based case management and primary care/health home care coordination that supports integrated person-centered care.

Several CLTC staff mentioned an overabundance (and redundancy) of case management agencies/individual providers, significant variance in quality, and the time consuming effort in the managing of provider relations, including providing continuous training. CLTC has the opportunity to consider options such as agency requirements, including specific care coordination requirements, and RFQ process to address stated concerns resulting in a more efficient, less expensive, and higher quality case management system.

There are administrative linkage requirements for MCO enrollees transitioning from a hospital to a nursing home. The linkage requirement appears more process-oriented and a hand off under current MHN requirements to CLTC rather than a system designed for a Community First Choice option diversion. Although South Carolina has achieved a robust 78% managed care penetration rate, the recipients CLTC serves are limited to the FFS system (dual eligibles or people who choose not to enroll in the MHNs) or the MHNs (1,835 waiver enrollees according to SCDHHS as of September 2011).

Future Options for Care Coordination/Case Management

Should CLTC choose to retain the current community case management system consideration should be made to restructure the system by assessing the value of multiple agencies and independent case management providers in light of inconsistencies across the system.

In any future case management and care coordination model, CLTC and SCDHHS should ensure an adequate infrastructure capable of assessing and managing individuals with high behavioral health needs at critical points along their health trajectories. SCDHHS could implement incentive payment strategies that drive integration of medical and behavioral health. This could occur at the state and/or the individual provider level.

The Lucas Group sees a possible opportunity for SCDHHS, DMH, and DDSN to develop a comprehensive strategy that implements (e.g. PPACA: 2703) a care coordination model that addresses the fragmentation that exists between the medical FFS system, the HCBS waivers, and state institutions. The target population should be individuals with multiple chronic care conditions that use multiple systems within the state's Medicaid program.

The Lucas Group Perspectives final recommendation is for SCDHHS to implement an Integrated Medicaid managed long term care system approach. This model is based on integrated care coordination and case management across all services a person receives within a patient-centered health home, including long term care services. This model requires comprehensive care coordination among any Medicaid provider who serves an eligible CLTC Choices participant within an integrated managed care framework.

The CLTC Match Question

SCDHHS currently receives a 75%/25% CMS match rate for the skilled medical professional tasks of the state nurses and a 70%/30% CMS match rate for state and MMIS paid case managers. The Lucas Group recommendation of expanding the role of state nurses for specific targeted tasks should not compromise the current state match requirements and The Lucas Group Perspective final recommendation includes state nurses continuing to perform clinical assessments for program eligibility. The Lucas Group recommendation to evolve the case management system into a comprehensive care coordination role in an integrated model should reinforce the current state match requirement.

Assuming SCDHHS were to retain current case management functions and for whatever reason CMS reverted the match requirements to 50%/50% the following data indicates the potential increase in case management costs according to SCDHHS:

2010 CLTC Case Management Totals: 30%/50% State Match Analysis

Figure 48

Services	Community Choices	HIV	30% State Match	50% State Match	Potential Increased State Costs
Contract Mgt./State CMs	\$3,320,209.00	\$277,121.00	\$1,079,199.00	\$1,798,665.00	\$719,466.00
MMIS/Community CMs	\$7,330,368.00	\$588,618.00	\$2,375,695.80	\$3,959,493.00	\$1,583,797.20
Totals	\$10,650,577.00	\$865,739.00	\$3,454,894.80	\$5,758,158.00	\$2,303,263.20

Source: SCDHHS: 10/25/11

The Lucas Group recognizes the rightful concern of CLTC of possibly losing federal match for case management services. In an Integrated Medicaid Managed LTC model, current case management services would be upgraded to comprehensive care coordination services managed by a contracted MCO. These costs would be paid by a capitated rate which could avoid the loss of federal match if the care coordination component is effectively designed, or mitigate the loss given the size of the CLTC program as a whole and the effect of capitated rates.

Community Service Capacity

There are natural stress points between Medicaid programs and provider systems, usually focused on rates and regulations. This said, CLTC appears to have a provider community that strongly supports rebalancing the state's LTC system along with supportive advocacy, such as AARP and the SC Public Health Policy Institute. There is, however, a lack of some critical options that are fundamentally necessary to support a Community First Choice rebalancing initiative.

Housing

Medicaid requirements inherently limit options to meet individual needs and coordinate services effectively. For example, Medicaid funding for room and board is only available in institutional settings. Housing options for seniors with dementia, behavioral health and other low level nursing care needs, however, are a critical component of a Community First Choice balancing effort. The MFP stakeholders group includes the Housing Authority and this is a good place to start for "bricks and mortar." It is recommended that this stakeholder group conduct a thorough evaluation of housing options available to low income Medicaid seniors, including coordination of effort with federal low income housing officials. A detailed plan and roadmap should be designed by this group that will provide options and recommendations for future housing support for many frail and low-income Medicaid seniors wanting to remain in the community.

It is worth noting that some states are asking CMS for limited housing support within its Medicaid program in order to further its efforts to rebalance long term care and keep chronically ill seniors in the community.

The State of Ohio, for example, submitted its demonstration model to CMS on February 1, 2011, seeking housing support in its plan to integrate care for dual eligible seniors. Building on a similar stakeholder process, Ohio identified accessible housing as a primary barrier to transition from institutional settings to community settings through MFP and other transition efforts. In order to maximize community placements, Ohio, in its request "is asking that a limited housing support service be approved as a Medicaid covered service and the allowance to use Medicaid funds to provide room and board for individuals receiving services in community based congregate settings." South Carolina would be well advised to follow Ohio's request as an example.

Integrated Personal Care

The issue of lack of housing support for frail elders may become even more problematic in the future if South Carolina is unable to successfully address the concerns raised by CMS in the use of Medicaid funding in its Optional State Supplementation (OSS) Program. OSS provides a cash supplement to some low-income aged, blind, or disabled persons living in approved community residential care facilities (CRCFs). The supplement is given to enable the recipient to pay the cost of living and it is paid directly to

the facility, by the state, on behalf of the recipient. The State does not receive Medicaid match for OSS payments, however, the state does provide personal care services to some of these residents determined to be at the Medicaid level of care.

This Integrated Personal Care (IPC) support is covered by Medicaid and averages about \$300 per month for each resident participating. This is an important state supplemental program and approximately \$5.6 million a year is spent to offer IPC support. Without this type of care, many of these seniors in South Carolina would otherwise be in nursing homes or other high cost form of institutional care.

However, CMS has informed the State of South Carolina that its IPC program funding is in jeopardy. In a letter dated July 30, 2010, from CMS Assistant Regional Director Jackie Glaze to then-Director Emma Forkner, CMS explained that the IPC program arrangement was in violation of federal law in that these types of personal care services are only available in South Carolina to individuals living in “residential care facilities” (CFCRs) and that in order to comply with the law, these services had to also be available to Medicaid eligible seniors that are in their homes and need them. Because this type of personal care option is not available to the entire senior Medicaid population, South Carolina was informed that they had 90 days to correct the problem and/or file an amendment to the state plan meeting the requirements or face losing this source of funding.

We understand that South Carolina is in on-going discussions with CMS regarding a resolution of this issue. We urge SCDHHS officials to draw upon CMS as a partner here in addressing the current IPC issue and open a dialogue that could lead to continued support and funding as the basis of its plan to rebalance long term care. We are aware of states that have successfully integrated similar support programs within a broader waiver authority, and we believe there are options for successful resolution under our recommended plan for an Integrated Medicaid Managed LTC system. The U.S. Secretary of DHHS has the authority to waive this requirement so as to continue this vital service without such a budget impact to the State of SC.

Adult Care Homes

One promising program that South Carolina is launching is adult care home program. The State’s adult care home model currently serves a very limited number of residents. This model has proven to be an effective model in other states in keeping nursing home level of care seniors in the community. The objective is to provide assistance with activities of daily living in an alternative, less restrictive, home-like setting for elderly and physically disabled adults who wish to live in the community but who do not have other viable housing options due to physical, emotional, developmental or mental impairments. The service can be provided for a limited or indefinite time period based upon the needs of the participant.

We believe the adult care home model should be considered for expansion to up to four residents, similar to other state programs. In this program, much like child foster care, eligible Medicaid seniors are able to move in and live in homes with caregivers that provide less expensive care and support for frail Medicaid eligible elders who would otherwise be in nursing homes. These elders have no other

means of support and this type of care and shelter can provide an important vehicle in the state's overall rebalancing efforts. It is just one of a number of options that should be available and we urge South Carolina to follow the lead of a number of states that have instituted these types of programs for many frail elders.

Nursing Services

Additionally, there is a critical lack of an integrated SCDHHS policy regarding the availability of nursing services for people at risk of nursing home admission. CLTC should consider analyzing MDS 3 data for current nursing home residents with low-level acuity and low-level nursing care needs as potential MFP participants. Access to short term home care nursing needs should be looked at as an alternative to nursing home admissions embedded in an integrated diversion plan that includes a more robust home care nursing component. Targeted availability of nursing services in home and programs, such as adult day health, should be looked at as elements in developing diversion strategies and added to the services offered under CLTC.

Case Management

There appears to be general agreement that a robust provider market is available to meet current demand for case management services. Several CLTC staff members have mentioned an overabundance of case management agencies/individual providers and significant variance in quality. Staff have also indicated it is time consuming to manage them and provide continuous training. As we have mentioned previously, CLTC has the opportunity to consider options such as agency requirements, including specific care coordination requirements, and RFQ process to address stated concerns resulting in a more efficient, less expensive, and higher quality case management system.

Adult Day Services

Adult day services can be a key service for Medicaid seniors in the community suffering from Dementia, or similar chronic illness. Adult day programs allow people with Alzheimer's disease or other dementia to continue living at home yet receive the care they need, allowing family caregivers much-needed respite, as well as the opportunity to continue working outside the home.

There are two basic types of adult day services programs. One is based on a medical model and the other on a social model. The medical model or "adult day health care" programs provide nursing and rehabilitative services as the primary focus. Participants who attend such programs usually have multiple chronic conditions that require medical monitoring and/or a nursing intervention, and medication administration at least once during the day. The medical model provides comprehensive medical, therapeutic and rehabilitation services and is eligible for Medicaid reimbursement. The social model offers supervised activities, peer support, companionship and recreation. The primary emphasis of social model programs is socialization and recreation. The social model of adult day care emphasizes

supervised group activities such as crafts, gardening, music and reminiscence. These services address the functional limitations and social isolation common among older people with dementia. Participants in this model may require some assistance with the activities of daily living (e.g., eating, bathing, dressing, and mobility), but they generally do not require skilled nursing care.

Both models provide a secure, protected environment, and assist frail or cognitively impaired older adults to remain in the community for as long as possible. SCDHHS should, at the minimum, consider offering adult day medical services as part of the CLTC waiver.

Aging and Disability Resource Centers in South Carolina

The Lucas Group has recently been advised that South Carolina has achieved statewide coverage of Aging and Disability Resource Centers (ADRCs). The Lucas Group believes that ADRCs provide an effective entry point for seniors trying to determine the extent of and availability of long term care Medicaid services in the community. The ADRCs are a recognized best practice.

The Lucas Group recommends that a formal relationship between CLTC and the ADRC system be established that clearly empowers the ADRC system to work collaboratively with the CLTC single point of entry/no wrong door model that also supports the requirements of the MFP and other PPACA options. Furthermore, Lucas Group recommends that the State consider making the ADRC system, which currently is under the Lieutenant Governor's Office, an administrative entity under SCDHHS.

SCDHHS should consider the untapped capacity ADRCs could provide as more seniors remain in the community and the general population ages. Standard practice, training, and continuous collaboration represented through standing meetings (including the central and regional offices of Medicaid Financial Eligibility) will strengthen the role of South Carolina's LTC system and should provide the "single point of entry" system that is a hallmark of well-developed state LTC systems. The expansion of ADRCs across the state provides excellent timing for consideration and inclusion of the valuable roles they have played in other states as CLTC plans and implements a balancing initiative. Roles that ADRCs have successfully contributed to in other states include:

- Collaborating with the state Medicaid agency in re-designing the long term care system.
- Coordinating outreach across the state in a comprehensive manner.
- Performing/coordinating eligibility determination.
- Delivering enrollment/disenrollment counseling.
- Advocating for seniors and their families.
- Contracting to perform case management for LTC managed care organizations.
- Contracting to train MCO case managers on the availability of community services and local environment.
- ADRCs play a designated role in 15 states with MFP grants with a focus on transitions assistance. CLTC should have a dialogue with the existing ADRCs to explore a partnership as the MFP program develops.

- Coordinate prevention, wellness, and health promotion activities as they target seniors across the range of state prevention, wellness, and health initiatives.

Mid-Level of Care/Assisted Living Medicaid Option

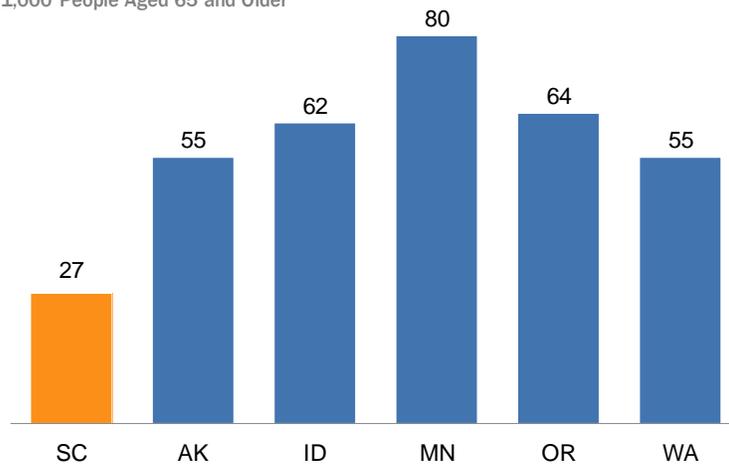
As mentioned, South Carolina currently provides a limited personal care support service for a number of eligible low income seniors that meet a required level of care that are living in CRCFs throughout the state. These residential care facilities are licensed by the Department of Health and Environmental Control (DHEC), and could provide some additional capacity under the state’s home and community based waiver program to provide an array of community based services for frail elders on Medicaid that are determined to need a higher level of care than those that are in their homes. This mid-level service option is available in a number of states under the HCBS waivers and we believe South Carolina needs to extend its waiver services to allow for this option along the continuum of care, in order to successfully rebalance its long term care program.

When compared to other states, South Carolina has an unusually lower number of assisted living and residential care units per aged person than other states in country and would, in all likelihood, have to add capacity to this market.

Figure 49

Assisted Living and Residential Care Units per 1,000 Population Aged 65 and Older (2011)

per 1,000 People Aged 65 and Older



Source: AARP, the Commonwealth Fund, and the Scan Foundation State Long-Term Services and Support Scorecard (2011)

If a mid-level of care/assisted living option were available under the CLTC waiver for many seniors, who have already been determined to need nursing home level of care, and have a higher degree of care needs than most eligible seniors, many of these seniors could remain in the community – and at a lower cost than institutional care. States with such a mid-level/assisted living option under their home and

community based waivers pay an average of \$2,100 per month to offer an array of nursing and personal care services for these Medicaid eligible seniors that would otherwise be in nursing homes, at an average rate of approximately \$4,000 per month.

To ensure quality of care, The Lucas Group believes the state can look to the current DHEC residential care regulations, or offer other more stringent regulations. The Lucas Group is aware of issues raised by advocates related to quality of care in some CRCFs, and SCDHHS should work with LTC stakeholders, and perhaps the MFP stakeholder group, to ensure that the care for these Medicaid frail seniors is not compromised.⁶⁵ The Assisted Living Federation of America (ALFA) recently completed work in the State of Georgia, where they were able to help pass legislation creating a new licensing class for state assisted living facilities. This allows for additional federal Medicaid funding and will pave the way for continued growth in mid-level care residential facilities, which will further relieve the burden of high cost institutional care in the State of Georgia. SCDHHS may want to look to this recent effort and develop ideas on a future strategy consistent with the goals of providing quality mid-level of care.

The Lucas Group met with a number of nursing facility owners and representatives that have expressed a great deal of interest in this option. States that have been successful in rebalancing efforts have worked collaboratively with their nursing home community to provide these types of options. In some states, nursing homes have recognized the need to transform its business culture to allow for more independent community settings. Some have been allowed to convert wings or beds to this more independent option and some have also opened up assisted living facilities nearby the nursing home as one continuum of care community. Based on the prior experience of other states The Lucas Group spoke with, if this community living option were available to more nursing home level seniors, and reasonable rates were offered for quality of care, the market for assisted living in South Carolina would increase and meet the demand.

While the CLTC system believes there is an adequate provider capacity at this time, The Lucas Group recommends new and enhanced services such as waiver-based preventive services, targeted nursing services (agency and private duty), mid-level care residential services, adult foster care services, enhanced adult day care services, and integrated occupational and physical therapy services that supports a Community First Option home and community based system that will provide an opportunity for new provider business plans and capacities.

Managed Care and Other Models and Opportunities to Rebalance LTC

Both nationally and in South Carolina, most Medicaid beneficiaries today needing long term care services receive their care through a fragmented fee-for-service (FFS) system. Long term care costs continue to account for greater proportions of Medicaid spending all over the country, not just in South

Carolina, and the nation's aging population is generating increasing need for services. This is motivating many states to look for ways to offer consumers broader access to home and community based options, while at the same time better managing overall long term care spending. Thus, more states are interested in expanding long term care options.

With the exception of LTC waiver beneficiaries having the option to enroll in a MHN, there do not appear to be any contractual linkages between CLTC and current, existing SCDHHS managed care systems.

Nationwide, states are looking for qualitative and cost-efficient methods of expanding the use of managed care methods, providing a person-centered health home, risk sharing, focusing on high cost multiple chronic care condition enrollees, the dual eligible population, and people currently served in FFS medical and waiver-based services and supports.

These coordinated and managed care programs vary from one state to the next in terms of target populations, covered benefits, enrollment options, and contracting. The decisions states make in the design of long term care managed care programs are dependent on their different resources, histories and political environments.

What Managed Care for Elders in South Carolina Can Offer

For Medicaid eligible seniors in South Carolina who are determined to be at the nursing home level of care, including some that are also eligible for Medicare, more effective coordination and management of care can offer the opportunity for:

- Access to a true medical home, meaning less bouncing through the system;
- Prevention-focused primary care;
- Enhanced use of technology, such as telemedicine and “ask a nurse” hotlines;
- Ensured use that providers are employing best clinical practices and benchmarks;
- Specialized care for co-occurring disorders and enhanced behavioral health treatment;
- Better monitoring of prescription drugs, limiting adverse reactions; and
- Coordination of services, reducing unnecessary duplication of procedures and making certain that beneficiaries have access, such as transportation, to care.

Moreover, for the state, with the inclusion of effective care coordination and care management in the managed care model, it creates a vehicle for:

- Healthier citizens – particularly among the most medically fragile citizens;
- Purchasing systems of care based on value;
- Better adherence to best practices focusing on patient-centered treatment;
- Greater accountability; and

- Budget predictability over time and cost containment.

Finally, for providers who will make up the network of any LTC managed care model, the business case for wanting this type of care coordination and effective care management strategies may include:

- Assistance with care coordination for complex populations;
- Better disease management and treatment for illness, including behavioral health;
- Steadier or higher reimbursement; and
- Avoidance of bureaucratic administrative procedures in fee-for-service Medicaid.

It is important for South Carolina to carefully consider how they plan to establish either a physician/practice-specific or team-based health home in the LTC balancing initiative (given the majority of participants are in the fragmented FFS system), the implementation model of the dual eligible Innovation project, and future MCO contracts that integrate LTC with primary and acute care as well as pharmacy benefits. South Carolina has an opportunity to link the PPACA 2703 care coordination enhanced FFP support for eight quarters with its dual eligible innovation concepts. The possibility of creating a transitional care service based on the Care Transitions/Coleman and Transitional Care/Naylor models makes sense from an ROI perspective to utilize this enhanced FFP thereby decreasing the states cost significantly to pilot, and having the time (two years) to determine if the approach is cost effective.

South Carolina's Health Home Network

South Carolina currently has a medical health network, which some have referred to as a form of managed care. This MHN system is based upon the primary care case management model in which patients are assigned to a primary care physician who is responsible for managing the quality, appropriateness, and efficiency of the care they receive.

Some states use PCCM in their Medicaid programs, either as the sole delivery system or in conjunction with managed care systems. It retains all the FFS components we have mentioned previously and in South Carolina, the MHN vendor is paid a small per member, per month fee to provide the medical home for the Medicaid eligible beneficiary.

Currently, there are less than 2,000 seniors on the CLTC waiver that are enrolled in this network. This network is not responsible for the payment or utilization of services outside of the primary care system, and they are not at risk for any unnecessary emergency room usage or any increase in nursing home usage, and there is lack of coordination for persons with long term care needs.

Moreover, there is no integration between primary care and behavioral health needs. Although it provides for the important primary care needs, for many chronically ill seniors, many of which have co-

occurring disorders requiring constant attention, this PCCM system is not the most effective or desirable option for those who wish to remain in their homes.

As mentioned previously in the report, recently SCDHHS established the “Medicaid Coordinated Care Improvement Group” for the purpose of examining current Medicaid coordinated care systems in South Carolina, what is working, what is not working, and develop policies that address health outcomes improvements, efficiency, and patient and provider satisfaction. The work plan also includes a review of Medicaid managed care best practices in other states. The Lucas Group believes this is a crucial planning endeavor and is pleased to provide specific recommendations and related information that will assist this effort.

Risk-Based Managed LTC Programs

In this model, the State would pay a per-person fee to provide a MCO, who has experience working with these populations, to deliver quality comprehensive care for these groups. In most managed care models the MCO assumes full risk and is responsible for any costs that are in excess of an actuarially sound negotiated per-person fee. Usually the fee is on a per member per month basis. The role of the MCOs would be to work with a variety of providers and healthcare organizations to establish supportive and meaningful relationships between providers and patients. MCOs also develop comprehensive treatment plans, and coordinate specialist care for patients. These services are provided in an environment that seeks to optimize health-related outcomes, promote the appropriate use of cost-effective medical care, and reduce unnecessary hospital stays and emergency room visits. When managing the care for the LTC population, the MCOs would provide additional services that are particularly important to this population. Some of these value-added services include:

- Access to a 24/7 medical advice line;
- Care management services;
- Access to relevant health information to manage their medical condition(s);
- Transportation services; and
- Reduced or non-existent consumer co-payments/cost sharing.

Under a managed care model, the State would develop strict quality, prevention and access standards to ensure that these benchmarks are being met and to rigorously review outcome data to see that the populations are seeing health improvement. It would also take into consideration the special needs and requirements of the Medicaid aging and disabled population and offer a more personalized, individual-focused care strategy, which would be included in the managed care contract or contracts. Additionally, the state would still manage eligibility, which would allow them an additional opportunity to focus on ensuring patients meet level of care standards.

At this point in time there are three basic full risk Medicaid Managed Long Term Care (MMLTC) models (Contractor at Risk) that states have implemented or are considering implementing.

Medicaid Low Integration Model:

- Medicaid LTC Only
- HCBS
- Nursing home care
- Medicare services not included

Medicaid Integration Model:

- HCBS
- Nursing Home Care
- Medicaid-covered primary care services
- Medicaid-covered acute care services
- Medicaid-covered pharmacy
- Medicare services not included

Medicaid-Medicare Integration Model:

- HCBS
- Nursing home care
- Medicaid-covered primary care services
- Medicaid covered acute care services
- Medicaid covered pharmacy
- Medicare acute care benefits
- Medicare prescription drug benefit

It should be noted that dual eligibles can be enrolled in Medicare managed care (MA) and still receive Medicaid LTC services in a FFS Medicaid program or a Medicaid only MMLTC model.

States need to consider the “maturity” of their business model with managed care. Although several states have moved their LTC systems into managed care, many have yet to do so. States need to consider one or two-step strategies towards LTC managed care based on their current capacities, provider readiness, IT systems capacity, stakeholder involvement, and political and public receptivity.

States with Risk-Based Medicaid Managed LTC Programs

States that currently have Medicaid Managed LTC programs in place include:

- **Arizona:** Arizona Long Term Care System: aged/disabled; NH/LTC level of care; mandatory enrollment; primary, acute, LTC services; single blended rate.
- **Hawaii:** Quest Expanded Access Program (QExA); Section 1115 waiver; mandatory for aged, blind, disabled, including dual eligible. Acute care services, behavioral health; NFs; HCBC services and full range of all other Medicaid covered services Beneficiary class
- **Massachusetts:** Massachusetts Health Senior Care: all aged; voluntary enrollment; primary, acute, LTC services; capitated primary, acute, LTC services; rate cells based on risk.
- **Minnesota:** Minnesota Senior Health Options: all aged; voluntary enrollment; capitated primary, acute, LTC services; rate cells based on risk.
- **New York:** New York MLTC: aged/disabled; NH/LTC level of care; voluntary enrollment; capitated LTC services with rate cells based on risk; primary and acute services are FFS.
- **Wisconsin:** Wisconsin Family Care: aged, disabled with NH/LTC level of care; mandatory enrollment; capitated two cell for LTC; primary acute services are FFS.
- **New Mexico:** New Mexico implemented the COLTS (Coordination of Long Term Care Services) program in 2008. This approach coordinates Medicaid State Plan General Health/Personal Care Options services within a mandatory enrollment 1915 (b) waiver combined with a 1915 (c) Home and Community Based Services LTC waiver.
- **Tennessee:** Tennessee has implemented an approach to managed long term care that The Lucas Group has analyzed in depth. Tennessee examined a variety of long term delivery system options to achieve its overall goal of improving access and providing choices for consumers needing long term community based care. The state concluded that the best vehicle was to integrate the long term care system into its primary/acute care managed care system: TennCare. The state felt that this was the only way to truly align all parts of the Medicaid system. Once this decision was made, the state began working with its managed care contractors that had experience in managing long term care benefits in other states. Together, they designed ways to provide a single set of Medicaid services to covered beneficiaries and expanded access to home and community based services to divert nursing home placement and transition beneficiaries out of nursing homes where appropriate. In addition, the state began working with stakeholders to address concerns that providers and advocates might have with managed care and worked together to build strong consumer protections into the program.

Today, the three TennCare managed care organizations are responsible and at risk for providing the full continuum of long term care services, including nursing facility and HCBS services, in addition to all primary, acute, and behavioral health services for eligible members. Care coordination is provided by the health plans, and focuses on support for member preferences regarding services and settings as well as intensive transition services between care settings. This integration positions the state for undertaking a unique demonstration of how to integrate all care for adults who are dually eligible. Our team is very interested in looking closer at the Tennessee model as a significant model for South Carolina to use to balance long term care.

States that are legislatively required or are considering transforming their current LTC waiver systems into risk-based managed long term care include Florida, Maryland, New Jersey, Rhode Island, and New Hampshire.

Those who have embraced Medicaid managed care for the aging population believe it can deliver better access and better quality at a more predictable cost. Managed care can also provide an infrastructure that is more accountable for support more sophisticated quality monitoring and improvement, which is often not a feature in traditional FFS systems. One national Medicaid expert asserts that states have developed standards of performance and monitoring capacity under managed care that far exceed what is possible under traditional Medicaid FFS.

While a Medicaid LTC managed care strategy can bring significant savings to Medicaid – as will be seen below – it has many differences from a standard managed care environment. Because of the specific needs of this population, the care is more highly intensive, and would likely include a considerable use of care managers to guide those with chronic illness through the health care system. This would likely be coupled with the use of technology, such as telemedicine, to enhance the quality of care, improve health and ultimately deliver even greater savings by reducing hospital and nursing home utilization. Ultimately, the form and details of a full-risk managed care program would be tailored to fit the specific needs of the South Carolina Medicaid program, the seniors it serves and the stakeholders of the senior Medicaid population.

Accountable Care Organizations

The concept of an “Accountable Care Organization”(ACO) continues to hold promise as a managed care derivative model for the high-risk population with multiple chronic care conditions and long term needs. Although the fate of the 429-page, 65 clinical measure U.S. DHHS proposed rule is not certain at this time, it is clear there is great interest in the ACO model. The five key areas of the proposed rule are compatible with any state’s consideration of adopting a Medicaid managed long term care model: patient/caregiver experience of care, care coordination, client safety, preventive health, and at risk population/frail elderly.

The private sector approach to developing ACOs has moved into the operational phase with real results that can be analyzed and integrated into an ACO proposal. Blue Cross/Blue Shield of Massachusetts (BCBSMA) has implemented an “Alternative Quality Contract” that is based on a global payment platform. The financial goal of the contract is to reduce the medical cost trend by 50% over 5 years. The contract includes:

- Financial Structure
- Performance Measures
- Sustained partnership (5 years)
- Integration across the continuum of care

- Savings opportunities.

There are several risk mitigation strategies:

- Risk adjustment based on diagnostic cost groups
- Partial risk sharing (50% to 100%)
- Mandated re-insurance for individual client medical expenses over \$100,000
- Unit cost corridor which increases/decreases the Global Budget based on negotiations on provider fees
- Bonus incentives for performance based on quality measures

On July 15, 2011, a report was released by researchers at Harvard Medical School indicating BCBSMA was “meeting its twin goals of slowing the growth in health care costs while simultaneously improving the quality of patient care.” The BCBSMA alternative quality contract was started in 2009.

Health Homes

LTC Medicaid beneficiaries in SC with chronic conditions are costly. The current fragmented, uncoordinated, provider-centered health system has low value to the state as a health care purchaser. As already mentioned, there is growing evidence that primary care is vital to a high performance health system and that care management, care coordination, and transition services that support a client centered medical home model at the point of care can reduce other avoidable and costly services.

As a result, on November 16, 2010, CMS issued a “State Medicaid Directors” policy letter providing “preliminary guidance on the implementation” of Section 2703 of the Patient Protection and Affordable Care Act, entitled “State Option to Provide Health Homes for Enrollees with Chronic Conditions.” The purpose of Section 2703 is to provide states the option to provide this specific service delivery model as an “optional service” within a State’s Medicaid State Plan.

States may submit a State Plan Amendment (SPA) based on a CMS provided template. A waiver is neither required nor prohibited. The goal of Section 2703, augmented by Section 1945 of the Social Security Act (SSA), is for “States to address and receive additional federal support for enhanced integration and coordination of primary, acute, behavioral health (mental health and substance abuse), and long term services and supports for persons across the life span with chronic illness.”

Inclusive of the operational aspects of Section 2703, CMS defines three goals: improving the experience of care, improving the health of populations, and reducing per capital costs without harm. CMS expresses an interest in delivery systems beyond “traditional care case management programs.” It also addresses physician-based models and “a growing movement toward interdisciplinary team-based approaches.” Emphasis is also placed on per member per month (PMPM) payment structure for “care coordination and follow-up, linkages to social services, and medication compliance” as an expansion to medical home models.

CMS illustrates that some states have implemented “full-risk managed care plans and demonstrations approved under section 1115 of the Act to implement their medical homes.” CMS further expects States to coordinate and avoid duplication with existing medical home models and offers States technical assistance in this concern. They will also provide states that implement approved “health home services” for any eligible Medicaid enrollee a 90% FMAP rate “for the first eight quarters that a health home State plan amendment is in effect.”

CLTC waiver populations eligible for the program and enhanced match are as follows:

- Individuals with chronic conditions
- Mental Health Conditions
- Substance Abuse Conditions
- Asthma
- Diabetes
- Heart disease
- Overweight: BMI>25

Eligible individuals under the SPA/waiver must have at least two chronic conditions, one chronic condition and at risk for another, or one severe and persistent mental health condition. States may target eligible individuals with higher numbers or severity of chronic or mental health conditions and they must cover all categorically needy, eligible individuals who meet the State’s approved criteria, including 1915(c) eligible individuals. There is no statutory authority to exclude dual eligible and comparability is waived.

This new health home initiative allows for payment to health care providers operating as a designated provider or a health team. States may structure a tiered payment methodology tied to severity and they may propose payment methods that are “alternative methods of payment not limited to PMPM cap rates.”

The infrastructure that is needed to establish a health home under this provision could include:

- Team(s) of health professionals linked to a designated provider
- Physicians, clinical practices or clinical groups, rural health centers
- Community health centers, community mental health centers

- Home health providers or any other entity/provider determined by the State and approved by CMS (in SPA/waiver

CMS is also providing upfront support to states looking to establish health homes and will provide states \$500,000 for planning activities related to the development of a health home SPA or waiver based on a CMS approved Letter of Request.

If SCDHHS is interested in pursuing this important initiative, SCDHHS will have to:

- “consult and coordinate” with SAMHSA concerning the “prevention and treatment of mental illness and substance abuse disorders”
- Describe the methodology of calculating avoidable hospital readmissions, including data sources and measure specifications
- Provide the methodology of calculating cost savings from improved chronic care coordination/management achieved through the program including data sources
- Measure specifications and describe how health information technology (HIT) will be used
- Provide 10 quality measures related to the expectations of health home providers including “clinical outcomes”, “experience of care”, and “quality of care” plus articulate the data source(s), measure(s) specifications
- Describe how HIT will be utilized in each of the three domains
- Estimate cost savings
- Articulate data sources and frequency of collection for targeted population hospital admissions/rates, emergency room visits, SNF admissions, chronic disease management, coordination of care, and an assessment of program implementation

South Carolina should ensure that any future long term care strategy includes the concept of a patient-centered medical home. The Lucas Group recommends that SCDHHS should immediately begin discussions with CMS regarding inclusion of this important Health Home initiative in its overall rebalancing strategy. Whether there is continued reliance on the PCCM/MHN model, or the design of a full-risk, integrated managed long term care model, this new initiative and enhanced funding opportunity can provide an effective means for providing quality of care for many chronically ill seniors who would like to remain in their homes.

States that rely more on primary care have lower resource inputs, lower utilization rates, and better quality of care. Numerous studies demonstrate seeing a regular doctor is associated with fewer preventable emergency room visits and fewer hospital admissions. This will assist the state in reaching the goal of enhancing opportunities for more and more Medicaid eligible seniors to remain in their homes and communities.

Integrated Care for Dual Eligibles

Coupling the efforts of coordinating and rebalancing the long term care for Medicaid eligible seniors that have been determined to be at the nursing home level of care, with plans to integrate care between Medicaid and Medicare dual eligible, would move South Carolina the forefront nationally. With the shifting demographics occurring both nationally and in South Carolina, the number of dual eligible individuals across the state will soon grow rapidly. Finding a solution quickly will help resolve budgetary issues and make significant programmatic advances that will assist in rebalancing long term care and improving quality.

South Carolina should begin transforming how the state coordinates care to this elder Medicaid population and those who are dually eligible for both Medicare and Medicaid now. This new direction should focus on timely, efficient, quality care that is organized far beyond the fee-for-service model. There are many different possibilities that this transformation can take, and there are several models that have shown outstanding effectiveness that have been implemented in other states.

Special Needs Plans

Enactment of the Medicare Modernization Act (MMA) in 2003 introduced a new type of coordinated care health plan, the Special Needs Plan (SNP), into the Medicare Advantage program. SNPs are unique in that they can target enrollment to ‘special needs’ beneficiaries identified as:

- Institutionalized beneficiaries
- Beneficiaries with severe or disabling chronic conditions
- Beneficiaries who are dually eligible for Medicare and Medicaid (dual eligibles).

An additional approach to the dual eligible and long term care populations that nine states have implemented (AZ, CA, MA, MN, NM, NY, TX, WA, and WI), and several more are looking at, is the Dual Eligible Special Needs Plan/Medicare Advantage Model. Five of the implementing states require mandatory Medicaid enrollment and four are voluntary. Medicare enrollment is always voluntary. States have found it difficult to negotiate with Medicare in the past but the recent creation of the Center

for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office have provided attention and a sense of urgency in support of the 15 state Dual Eligible Demonstration grants.

Additionally, there is now a requirement for SNPs to have a written agreement with the Medicaid program in the state in which they operate. On July 8, 2011, CMS issued a state Medicaid Director's letter that explained what appears to be significant flexibility in establishing an integrated Medicare/Medicaid rate and the ability for states to share savings from Medicare/Medicaid integrated models. At this time, it appears only the 15 states who received dual eligible innovative grants are eligible to participate so this makes it strategically and tactically important for South Carolina to align its LTC balancing efforts with the duals grant and potential use of SNPs.

The Massachusetts Senior Care Option (SCO) integrated Special Needs Plan program started in 2004 as a CMS demonstration. In 2006, the participating health plans became MA SNPs. SCO, as the program is called, provides integrated Medicare and Medicaid services, including LTC. Participation remains voluntary at this time but this could change, as Massachusetts is a dual eligible demonstration grant recipient state. The MA SCO model should be considered by South Carolina as a significant model for the State's balancing efforts within its Medicaid managed care long term strategy.

Dual Eligibles State Demonstrations and Gainsharing

Many states are vitally interested in creating new and innovative approaches to providing quality services with proven outcomes while addressing cost containment and bending of the Medicaid cost curve during historic and lingering decreases in state general funds, as result of past and current economic conditions. States are keenly aware of the disproportionate Medicaid (15% total dual eligible population/39% of total national Medicaid expenditures) spending on dual eligible individuals with complex multiple chronic care conditions.

In 2010, CMS created the Federal Coordinated Health Care Office to address innovative state practices designed to improve quality and contain costs for the dual eligible population. In 2011, CMS awarded 15 states, including South Carolina, \$1 million planning grants to develop and submit innovative integrated plans that will implement innovative strategies inclusive of Medicaid and Medicare services for dual eligible individuals.

Moreover, Section 3021 of the Affordable Care Act, establishes the Center of Medicare and Medicaid Innovation office (CMMI) to test innovative payment and service delivery models. This provision includes specific models that CMMI can fund. Options include delivery models that promote care coordination and fully integrated care for dual eligible. The intent is to align financial incentives between Medicare and Medicaid systems and also share data that allows for effective quality analysis that can demonstrate savings with the most effective treatments, and in the most effective settings.

One of the most significant questions, among many, is how is CMS going to address the issue of potential cost savings – or “gainsharing” – for the states that include integrated Medicaid/Medicare plans inclusive of primary, acute, behavioral health, and long term care services and supports. This decision will have a significant impact on how states like South Carolina plan effective integrated care strategies for Medicaid dual eligible.

On July 8, 2011, CMS issued a “State Medicaid Director’s letter” that provides for two methods of financing available to the 15 demonstration states:

- A Medicare/Medicaid capitated model that would involve a three party contract among the state, participating health plans, and CMS. This model would allow for gainsharing savings in some method to be articulated, assumedly in the comprehensive contract.
- A managed fee-for-service model that would involve a contract between the state and CMS wherein the state would be responsible for care coordination and the delivery of fully integrated Medicare/Medicaid benefits.

The 15 demonstration states have taken an interesting and state-specific approach to implementing dual eligible integrated systems of care, thereby making the question of gainsharing, and how it will be implemented, a promising but complex issue for CMS and the states to work out:

- CA intends to use a county-based system to address dual eligible integration.
- TN and WI intend to use risk-based MCOs.
- VT intends that the state Medicaid agency would become the MCO for the dual eligible populations.
- CT, NC, OK, CO, and OR intend to use strategies that include ACO, integrated care networks, and PPCCM models.
- MA, MI, MN, SC, and WA intend to use different models including managed care, direct provider networks, community health centers, medical homes, acute hospital networks, MCOs, managed care, and FFS.
- NY intends to use the CMS planning grant to determine how to proceed.

Given the variety and complexity of the 15 demonstration states initial approaches to dual eligible integration strategies it is important to know that six states (MA, MI, OK, TN, WI, and VT) want to combine Medicare/Medicaid funds at the state level in some way important to the individual state. With this in mind, coupled with the July 8, 2011, CMS letter on dual eligible state demonstration financing proposed models, it seems reasonably assured that CMS will need to further refine how gainsharing will take place, as it is fundamental for states to assume any measure of risk, whether the state bears risk or contracted to an MCO or derivative model.

Demonstration states such as Washington have already opened a dialogue with the Office of the Secretary of U.S. DHHS to directly explore what options may be available for “flexibility plus technical and financial assistance” to support improvement strategies. South Carolina should consider starting a

dialogue with DHHS/CMS sooner rather than later based on the assumption this would reasonably improve the state's chances on achieving their objectives, given the ground breaking and complex nature of the CMS Medicare/Medicaid demonstration project.

SCDHHS is currently engaged with a stakeholder planning group specifically targeted to address options for the CMS Dual Eligibles Innovation Grant. The Lucas Group provides as an appendix to this Report the following information to assist this effort so that the broad range of options available to the states is available. This information includes:

- Affordable Care Act Provisions/Applicable Core Elements
- Current Medicare/Medicaid Authority Options for Integrating Dual Eligible Beneficiaries
- A Special Needs Plans Legal Timeline including engaged states
- Detailed analysis of Special Needs Plans by Type and Description
- CMS terminology Descriptions of the Five Types of Dual Eligible Special Needs Plans

We note that here that SCDHHS has stated its intention to align its efforts in moving forward on this planning grant with its efforts to rebalance long term care. We believe that is the right choice for the state, since many of the long term care beneficiaries eligible for nursing home services are also in need of the same type of integration and coordination of services

Financial Performance Incentives, Quality Standards, and Benchmarking

Throughout South Carolina's planning and development of strategies to balance LTC and move towards integration strategies across SCDHHS programs, the value of financial performance standards, quality standards, and the effective use of metric-based benchmarking will become the primary tool of measuring systemic effectiveness along with access, volume analysis, safety, and budget and program integrity. South Carolina should explore ways to use contractual incentives to achieve the goal of balancing long term care.

In Tennessee, for example, the capitation rates are being set with the expectation the long term care managed care program will result in a fundamental shift in how and where long term care services are provided. In order to promote movement away from institutional care and toward more home and community options, Tennessee factors in assumptions about the impact the Choices program will have on the mix of institutional and HCBS services provided to long term care beneficiaries.

In determining these assumptions, which include a three to four percent decrease in institutional care over two years, the SCDHHS has to find a balance between incentivizing appropriate HCBS use while being realistic about what plans can do in relatively short periods of time. The state plans to reassess these assumptions on an annual basis. In Hawaii, incentive payments are incorporated into contracts to reward increasing the use of HCBS and decreasing institutional care. This has led to reductions in nursing home placements and more community based slots being filled.

Quality standards should also be identified through contractual requirements and standard licensing, verification, and provider credential requirements. Additionally, state Medicaid agencies must require managed care plans to adhere to the standards of NCQA/HEDIS (Healthcare Employee Effectiveness Data and Information Set).

Unified/Global Long Term Care Budget

The Lucas Group recognizes that the SCDHHS budget treats long term care services in the community and nursing home in a silo format, where line item funding is determined during the budget process and SCDHHS has little ability to transfer funds from the nursing home line item to the community based care line item, even where there is a demonstrated savings to the taxpayer. The Lucas Group also recognizes that this may be a difficult issue to address because of the institutional care interests. Thus, SCDHHS should engage its long term care stakeholders before moving forward on this proposal.

However, states that have had similar strong provider interests have been able to pass laws that have given more administrative control over the handling of funds budgeted for both class line items. This has resulted in savings to the taxpayers and more chronically ill seniors living and remaining in their homes and communities.

Recently, Illinois passed a global budget law that we believe may be a model for SCDHHS to consider. For years, the State of Illinois has relied heavily on institutional care. They have experienced a similar funding disparity between community and nursing facility care as South Carolina.

This past year, the Governor signed House Bill 5420 (PA 96-1501), which requires the Governor to create a unified budget report in an effort to balance long term care and allow funding to follow the person. The Governor's budget for FY 2012 introduced the unified budget for long term care.⁶⁶

Other states have laws or rules that grant authority for Medicaid agencies to transfer long term care funds between nursing home and home and community care budget line items during a fiscal year has assisted states in building an effective community based care strategy and reversing the bias towards institutional care.

Between the nursing home and the waiver program budgets there is sufficient funding in the SC system to serve additional persons by providing low need nursing home residents with services in the community at less cost, transferring funding to community based services, and serving additional persons with the money saved. The state legislature should be encouraged to adopt a global long term care budget allowing transfer between the institutional and home and community based services.

The current system in South Carolina where nursing facilities are issued Medicaid permit days and nursing home budgets are based on the number of permit days, rather than the number of Medicaid beneficiaries that need that level of care, should be re-examined. States concerned about rising nursing

home costs have used the Certificate of Need process to limit the overall number of nursing home beds in a given state, but placing a limit on the number of Medicaid days a certain facility can charge and using this limit as a way to reduce the overall budget, especially during tight budget times, may not be the most effective way to reach the goal of rebalancing long term care. Granting SCDHHS flexibility to move Medicaid dollars around in the LTC system where they can be best used to meet the needs of the individual, in the most appropriate setting, has been demonstrated to be the most effective way to rebalance. Should South Carolina consider the idea here of granting SCDHHS such flexibility, perhaps, in exchange, the state should consider eliminating the system that grants limits on the number of billable Medicaid days per nursing facility.

IT Systems

The Lucas Group appreciates the detailed briefing by SCDHHS staff on the PHOENIX system. The PHOENIX system has been cited by CMS as a best practice. It has a considerable amount of relevant data available for management, staff, and providers. The Lucas Group was unable to clearly identify, however, how the available data is operationally used for the management of the CLTC system on a standards based platform: costs, performance, productivity, monitoring, trends, and variances. Thus, SCDHHS should find ways to utilize the PHOENIX system in the future for more performance-driving management and business reporting.

The Lucas Group's understanding is that MDS 3 data is not currently used. We do believe that MDS 3 data is an important tool for assisting the development of an efficient and effective Community First Option system of care and encourage SCDHHS to develop efficient means for utilizing this data to assist its chronically ill senior population with the services it needs at the right time and in the right settings.

There appears to be insufficient IT tools, such as groupers and predictive modeling to meaningfully support a more robust Community First Choice targeted option and strategy for Medicaid elders. It is important in the future that SCDHHS work closely with its providers and other departments, including DMH and DDSN, to use these and other similar tools to support a truly integrated community based Medicaid system that effectively identifies individuals with high cost, multi-system usage and multiple chronic care conditions. Identifying illness early on, targeting an integrated and coordinated approach to illness that is based on prevention and improves health status and wellness (e.g. smoking cessation, weight loss) will go a long way at improving quality of care and providing cost-effective, and necessary, medical services in the right settings at the right time.

Organization and Collaboration

The Lucas Group has appreciated the positive receptivity by the CLTC team and the information, support, time, and ideas that management and staff have shared. The Lucas Group has visited several regional offices, conducted a survey of regional office managers, and had numerous meetings around the state with state staff, providers, advocates and other stakeholders.

Although there have been recent staff reductions, the current CLTC system appears capable of managing the waiver and related nursing home responsibilities. The Lucas Group also believes SCDHHS is making strong progress in its outreach efforts to other agencies, providers, stakeholders and policy makers to begin the discussion of real transformative change in the way it manages long term care. The Lucas Group believes the MFP program and the dual eligible demonstration are great avenues for SCDHHS to continue building this support.

The Lucas Group was impressed with the direction SCDHHS is heading in regards to acknowledging the need to review its current practice involving the assessment process, care planning, case management, waiting list, financial eligibility, and establishing benchmarks in order to determine how best to approach the resource needs of a more robust diversion and transition effort and program development of housing options.

There is an excellent opportunity now for SCDHHS to increase coordination and communication actions among the three major disabilities, long term care, behavioral health and developmental disabilities, for the purposes of identifying effective and efficient approaches to developing integrated managed care, health homes and care coordination strategies, including identification of high risk and high /cost multiple chronic care condition populations; the use of IT tools such as grouping methods and predictive modeling, pharmacy management; housing development strategies; and cross-systems cutting rules and regulations.

The organizational structure of state health and human services departments/agencies has been a subject for change since the growth and size of state Medicaid programs surpassed the amount of unmatched designated state general funds that had historically been designated for state supported services.

In 2006, the University of Minnesota released a CMS funded report on “State Long Term Care Systems: Organizing for Rebalancing.” This report outlined three primary strategies for state health and human services approaches to state HHS structure integration:

- Integration of programs with Medicaid including institutional and home and community based programs, and integration of Medicaid long term care support programs with other state operated, or state funded, programs that are not part of Medicaid.
- Integration of functions and programs for all long term care consumers (LTC, DD, SPMI) regardless of age or disability. (Texas, New Hampshire, Washington, Vermont)

- Integration through interagency collaboration. (New Mexico, Arkansas)

In April of 2011, the “Little Hoover Commission” of the state of California issued the report: “A Long Term Strategy for Long Term Care.” Priority recommendations included:

- “The Governor and Legislature should consolidate all long term care programs and funding into a single long term care entity within the Health and Human Services Agency, led by a long term care leader reporting directly to the Agency Secretary.”
- “The long term care department should retain a state-level global budget authority for all long term care programs and services.”

States will continue to face an ever changing federal health care reality directly connected to the continuing budget challenges almost all states are dealing with. The organization of state funded health and human services should support the priority goal of integrated, high quality, cost-efficient care and services and be flexible enough to respond to current and new strategic plans for improvements.

Under the current departmental structure, The Lucas Group recommends that SCDHHS work collaboratively with the Departments of Mental Health (DMH) and Developmental Disabilities and Special Needs (DDSN) to ensure the most effective implementation of a coordinated and integrated Medicaid LTC service delivery system that serves to promote its Community First Option. For many of the Medicaid seniors who are frail and suffer from one or more chronic or debilitating conditions, and are also in need of receiving services outside SCDHHS, the delivery of those services in the least restrictive setting, and at the right time, should have no bearing on which agency is responsible for care – especially when that responsibility rests with the state that has a duty to the individual and the taxpayer.

Thus, before deciding to adopt any Integrated Medicaid Managed Long Term Care option for seniors suffering from co-occurring disorders and disabilities, including providing care coordination, person-centered health homes, and mandatory enrollment, the state should also consider the most appropriate structure of the state agency charged in overseeing the care of these seniors.

The Lucas Group is aware that in the past the South Carolina General Assembly has considered bills to consolidate functions of state agencies responsible for the care of Medicaid beneficiaries who are served across departmental lines. As a part of its strategy, The Lucas Group believes SCDHHS should work collaboratively with other agencies, stakeholders and develop recommendations for the General Assembly to consider that are aligned with its efforts to rebalance long term care.

Furthermore, any state agency transformation strategy engaging in Integrated Medicaid Managed Care contracting also needs to assure that purchasing/contracting, quality monitoring, fiscal oversight, and program integrity resources are available to ensure quality of care, in the right setting, at the right time. These issues should also be considered by SCDHHS in its efforts to develop a future roadmap. Alignment here would not only provide cost savings to taxpayers, but would also assure and improve quality of care for recipients.

Integrated Medicaid Managed Long Term Care

The Center for Health Care Strategies recommends that states considering developing and implementing an integrated managed care strategy for medical and long term care benefits designed to rebalance their LTC systems utilize a best practices approach (CHCS: Profiles of State Innovation: 11/2010) based on “Ten Mileposts”:

1. Communicate a clear vision and identify a champion to promote program goals.
2. Bridge the gaps between state officials responsible for medical assistance and long term care.
3. Engage stakeholders to achieve buy-in and foster smooth program implementation.
4. Embrace a “No Wrong Door” philosophy for all HCBS to help consumers (and families) fully understand their options.
5. Deploy case management/care coordination resources strategically.
6. Use a uniform assessment tool, independent of provider (and state employee) influence, to ensure standardization and consistent access to necessary LTSS services.
7. Support innovative alternatives to nursing homes.
8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.
9. Take advantage of initiatives (and incentives) that help people move out of nursing homes and into the community.
10. Analyze relevant data to track quality of care metrics that reflect the vision of the long term care program (and integrated health services).

States that are considering developing integrated Medicaid managed care contracts need to consider basic elements of law, design, consumer and provider involvement, benefits design, financial model(s), quality and data requirements, etc. Key considerations include:

1. Contractual compliance with the Federal Medicaid Act and attending regulations; State Medicaid Manual; CMS authority requirements (generally 1915 (b), 1915 (c), and 1115; Medicaid State Plan; state Medicaid law and regulations; and relevant Federal/state case law precedents.
2. Public/Consumer/Family/Provider Education, Marketing, and Enrollment.
3. Access standards/point of entry.
4. Initial/eligibility assessments and ongoing care: transfer from FFS system to managed care capitated contract system.
5. Medical necessity or level of care standards for long term care services.
6. Role of Adult Protective Services.
7. Scope of services and provider network requirements.
8. Special Needs/ADA and title VI compliance.
9. Due process/appeals.
10. Financial and organizational requirements.

11. Public disclosure.
12. Reporting requirements.
13. Quality and incentivized performance improvement metric based standards.
14. Consumer involvement.
15. Enforcement provisions.

The Importance of State Statutes

The question of whether a state health and human services or Medicaid administrative agency can implement the rebalancing of long term care, and the integration of an existing fragmented fee-for-service system (possibly including behavioral health and developmental services), into a risk bearing, capitated integrated managed care model, with or without, an empowering state statute depends on existing state law and regulation. An important consideration for South Carolina to consider is the value of embedding significant rebalancing goals in state statute based on public awareness, transparency, the sharing of innovation between the executive and legislative branches and resulting support for sustainability of the vision.

Tennessee

For years the state of Tennessee's Medicaid paid long term care system was essentially institutional services or nothing. The state's rate of nursing facilities placements to community placements had been well over 90% nursing facility placements for years. In 2008, former Governor Phil Bredesen partnered with legislative leadership, consumers, families, advocates and providers to develop and unanimously pass the Tennessee Long Term Care Community Choices Act of 2008. This groundbreaking legislation focused on integrated long term care and medical services within the state Medicaid "TennCare" program that already included integrated behavioral health and medical services for the developmentally disabled.

Simply put, the goal of the Community Choices Act was to provide Tennessee's seniors and physically disabled people the first choice option of remaining in the community while reaching out to the community provider system and nursing facilities to help transform the system.

The Tennessee statute was written almost as a blueprint for reform and contains 31 individual sections of the Act. The following sections are worth noting as building blocks for South Carolina and other states considering providing integrated Community First Choice options for long term care.

The Tennessee Long Term Care Community Choices Act of 2008:

Section 2: Guiding Principles for a Transformed Long Term Care System

Section 4: Key Definitions

Section 5: Expanding HCBS Through and Integrated Long Term Care System

Section 6: Establishes a Single Point of Entry

Section 7: Streamlines the Eligibility Process for Home and Community Based Services
Section 8: Level of Care Eligibility
Section 10: Transitioning from a Nursing Home to Home and Community Based Services
Section 11: Assistance for Nursing Homes Seeking to provide HCBS services
Section 12: Residential Community Based Alternatives to Nursing Homes
Section 13: An Acuity Based Reimbursement Model for Nursing Facilities
Section 14: Consumer Directed Plans
Section 16: Expansion of non-Medicaid Options Program
Section 18: Promulgation of Rules
Section 20: Exemptions from Nurse Practitioners Act
Sections 21-30: Expanded Use of Assisted Living Facilities

New Hampshire

The New Hampshire state legislature passed the New Hampshire Medicaid Managed Care Law (SB 147-FN) during the 2011 session after many years of debate within the state. New Hampshire has taken a comprehensive approach to moving the state's Medicaid program into a full-risk capitated model within a specified and tight timeline. The New Hampshire Department of Health and Human Services was mandated to have the Request for Proposals "on the street" by October 15, 2011, and make recommendations on the final contract(s) to the Governor and Fiscal Committee by March 15, 2012.

The legislation is notable for clearly stating, "The managed care model or models providing the Medicaid services shall establish medical homes and all Medicaid recipients shall receive their care through a medical home." The bill specifies that "the Department (HHS) shall ensure no reduction in the quality of services provided to enrollees in the managed care model and shall exercise all due diligence to maintain or increase the quality of care provided." The New Hampshire legislature has mandated "capitated rate cells" for services including nursing facilities.

The bill spells out in detail that Mandatory MCO services shall include:

- Care Coordination
- Utilization Management
- Disease Management
- Pharmacy Benefit Management
- Quality Management
- Customer Services

The RFP approach envisions a multiple step process of mandatory enrollment based on the legislation's comprehensive approach of having all Medicaid recipients served through managed medical homes. No later than 2014 all medical, behavioral health, developmentally/intellectually disabled, and long term care populations (community and nursing facilities) will be provided through a managed care system.

Recently there has been a growing “wave” of state governors and legislatures moving to establish comprehensive integrated Medicaid managed care models that provide medical homes and include all populations.

Kentucky recently awarded three new MCO contracts to move towards achieving the recently re-elected Governor’s goal of covering all of their 815,000 Medicaid beneficiaries under managed care. In Florida, HB 7107 and HB 7109 were enacted into law during the 2011 session, both of which address the development and implementation of mandatory Medicaid managed care enrollment and coverage across 11 designated regions of the state. The legislation also includes incentivized savings and tort reform. Florida’s Agency for Health Care Administration has already submitted proposals to the Center for Medicaid Services that have a goal of comprehensive implementation by 2013. The total cost of the Florida Medicaid program is \$22 billion.

Getting Started

A fundamental requirement for a state health and human services agency’s to achieve the successful implementation of an Integrated Medicaid Managed LTC System is the creation of a comprehensive and adaptable high knowledge sanctioned Transformation Project Team that works from a project blueprint, includes internal and external participation, has identified behavioral/product milestones, is transparent, and is guided by timelines.

In order for states to successfully transform an existing fragmented fee-for-services system, inclusive of primary/acute care medical and waiver based services, a state needs to have market-based managed care purchasing strategy knowledge for the specific purposes of developing a precise RFP process, a values and business-based managed care contract, and a quality component that is clearly identified.

The following considerations should be included in the development of a strategy to implement an Integrated Medicaid Managed Care Long Term Care System:

1. Executive/Agency leadership needs to sanction and communicate the goals of, and the creation of, a Transformation Project Team.
2. A Project Manager needs to be named and necessary resources provided for the project.
3. Project Team members need to be named that represent the multiple areas of expertise that will be needed and thought should be given for a consumer and provider representative to be included.
4. A Consumer/Family/Provider advisory council should be identified for the purpose of working with and advising the Project Team in a reasonable manner and at critical junctures in the project.
5. A written, adaptable Project Work Plan, including tasks, task assignment, products, timelines and identified feedback adaptation strategies need to be developed working back from the successful implementation of an Integrated Medicaid Managed LTC System at the initiation of the Project Team.

6. The Project Team needs to have external identified knowledge expertise available for consultation and guidance when the needs the state's capacity cannot meet are identified.
7. The state Medicaid agency's actuarial firm should either be a member of the Project Team or a consultant to the team from the beginning of the project.
8. State MMIS and IT expertise needs to be a member of the team from the beginning of the project.
9. State subject matter experts in medical services, long term care, rules and regulations, quality, licensing, and appeals and hearings need to be represented on the Project Team.
10. Managed care contracting, RFP development and management, and risk management state expertise need to be represented on the Project Team, or identified and available from the beginning of the Project.
11. State-based Legal Council should be available to the Project Team on an as-needed basis and directly advised regarding the development of the RFP, draft contract, and the RFP appeals process should there be any.
12. A Communications Plan needs to be developed from the beginning of the project that identifies Project Team Leader communication responsibilities to the originator authority of the project, communication protocols among and between project team members, legislative leadership, consumers/families/advocates/providers, and the general public.
13. The Project Team should take advantage of learning from other states identified as best practice states or states that the team develops an interest in as the project unfolds.
14. The SCDHHS originator authority or their designee should establish a communications linkage with CMS from the beginning of the project to engender CMS buy-in and advisement as needed.

Incentives/Value Based Contracting/Pay for Performance

Value-based contracting is simply making sure you get what you pay for. In the health care industry, including Medicaid/Medicare and private markets, this simple business principle has been elusive primarily because there has and continues to be an on-going debate on what is a positive or negative health outcome for a specific procedure/encounter and what constitutes quality during that specific procedure/encounter and thereafter.

Given the difficulty of identifying "value" in the delivery of health services, states have made continuous improvement in their ability to effectively identify value within a Medicaid managed care contract. One of the primary methods of a state's ability to identify and measure a managed care contractor's performance, outcomes and quality is the contractual articulation of specific outcomes the state wishes to achieve and connect those outcomes with payment models and incentivized payments: "pay for performance". States need to consider whether they develop incentivized payments from adding additional dollars to the contract's financial requirements or construct a "hold back" from the capitation rates. States have found this to be dependent on how "high" or "low" their rates are relative to actuarial soundness.

The Lucas Group believes it is vital that state Integrated Medicaid Managed Long Term Care contracts include incentivized payments for the following outcomes within their managed care contracts to support rebalancing, a community first option culture, and choice:

1. Hospital-based successful “diversion” of an eligible person’s hospital discharge from a nursing facility admission to their home, or a community based alternative of the person’s choosing.
2. Nursing facility-based supported transition of a current nursing home resident back to their homes, or a community based alternative of their choosing.
3. Any enrolled dully licensed and credentialed practitioner’s successful intervention avoiding an emergency room encounter.
4. Access incentivized payment (preferably through an acuity based rate setting methodology) to nursing facilities for admission of a complex chronic care condition person (based on the state’s clear diagnostic based definition of complex chronic care).
5. An identified care coordinator/case manager’s actions that avoid immediate nursing home admissions.

In addition to targeted outcome-based incentives, states need to collect data on cost, quality, and user satisfaction and work directly with providers to consistently identify, support and implement best practices. CMS requires capitated health plans to participate in the NCQA/HEIDIS data and information set (HEIDIS is the acronym for Health Plan Employee Data and Information Set). The HEIDIS quality system includes eight domains:

1. Effectiveness
2. Access/Availability of Care
3. Satisfaction with Experience of Care
4. Use of Services
5. Cost of Care
6. Health Plan/MCO Descriptive Information
7. Health Plan Stability
8. Informed Health Care Choices

Quality Assurance and Medicaid Managed Care Contracting

The assurance of quality provided by Medicaid managed care plans has been a work in progress for many years and indeed had been a bone of contention for those members of the public and provider interests that do not support the use of managed care contracting methods. The good news is that through a combination of continuous research, advancing knowledge, and technology improvements state Medicaid authorities have powerful tools available to them that can reasonably assure elected officials, beneficiaries and the taxpayers whether a contracted managed care plan is providing an acceptable or unacceptable level of quality.

As previously mentioned, CMS requires Medicaid contracted pre-paid (capitated) health plans to participate in the NCOA/HEDIS data and information set. HEDIS data is computer-based, transferable, and should be web-based. HEDIS includes quality and performance data elements. The HEDIS system provides a foundation for states to add “Agency Defined Measures” that become contract deliverables by the contracted managed care organizations.

State Medicaid agencies are required to conduct External Quality Reviews of pre-paid managed care health plans by contracting with independent organizations that meet the criteria of participation. The purpose of EQRO is to assure CMS that states are adequately monitoring the voluminous data produced by the HEDIS measures, that managed care plans are meeting their contractual obligations, and that the system is engaged in quality improvement activities that are documented and data-based. State contracts for EQRO requirements must include:

1. Validation of MCO Performance Improvement Projects (PIPS) required by the state during the prior 12-month period.
2. Validation of plan performance measures required by the state and reported by the MCO during the prior 12-month period.
3. A comprehensive review conducted during the prior three-year period of time that determines the MCO’s compliance with state standards for access to care, structure and operations, and quality measurement and improvement.

States may also require the EQRO entity to conduct 5 optional activities:

1. Validation of encounter data reported by the plan.
2. Validity of consumer and provider surveys on the quality of care provided by an MCO.
3. Calculation of additional stated designated performance measures.
4. Additional Performance Improvement Projects
5. Specified studies on the quality of a specific clinical or non-clinical service at a point in time.

The final EQRO Technical Report, which is available to the public, must address:

1. Detailed description of the process of data aggregation and analysis was conducted and the method of how conclusions were drawn.
2. Assess the MCO’s strengths and weaknesses, quality, timelines, and quality of care. Recently many states have been focusing EQRO attention to chronic care conditions.
3. Assessment of the MCO’s prior year performance on addressing prior EQRO improvement recommendations.

State Medicaid authorities have considerable responsibility and opportunity to assure quality standards are identified, contractually required, evaluated and reported to the state for contract compliance and continuous quality improvement purposes. In order to effectively carry out this responsibility the state Medicaid agency needs to assure there is adequate, dedicated staff to direct and oversee the quality

assurance and improvement resources and tools that are not only required by CMS, but also identified by the state.

The Affordable Care Act outlines a strategy and specific provisions that are designed to improve quality and increase efficiency for the purpose of improving system performance. Section 3011 (a) of the Act directs the creation of a National Strategy to Improve Health Care Quality along, with a requirement that state and federal agencies work with the private sector to develop an implementation strategy (Section 3011 (b)). Section 3501 establishes The Center for Quality Improvement and Patient safety within the existing Agency for Healthcare Research and Quality.

The mission for this AHRQ entity is to identify best practices, distribute information and developed tools, and build capacity at the state and local level. How this is to be implemented is not identified. The Interagency Working Group on Health Care Quality (Section 3012) is designed to coordinate ACA-related reforms, improve efficiency and avoid duplication, and assess the alignment of activities in the public and private sector. How all of this will impact state Medicaid agencies and their programs has yet to be determined so it will be important for states to be both vigilant and opportunistic of what will help, and what will add additional burden, with a focus on information technology and the evolution and adaptation electronic health records technology and standardization. Key ACA state requirements to focus on include the Health Insurance Exchange and the expansion of Medicaid eligibility to nonelderly individuals below 133% of the Federal Poverty Level.

The National Academy for State Health Policy⁶⁷ issued a report, with support from the Commonwealth Fund, exploring quality and efficiency opportunities for states in the context of national health reform. The report points out “Five Key Components of Improving Quality and Efficiency”:

1. Data Collection, Aggregation, and Standardization
2. Public Reporting
3. Payment Reform
4. Consumer Engagement
5. Provider Engagement

The Lucas Group recommends adding a sixth and seventh component to the pursuit of quality and efficiency:

6. State MCO contracting needs to establish the quality framework upfront, be clearly identified, articulated in the contract, and prioritized through either incentives for performance or disincentives for non-delivery of quality defined deliverables.
7. The State must have the resources and capacity to receive, analyze, and respond to the significant amount of data required of MCOs based on HEDIS and state defined quality measures as well as utilize External Quality Review requirements to leverage access, quality services, efficiency, and compliance.

State “Best Practices” of Integrated Medicaid Managed Care Systems

The Kaiser Family Foundation reports that as of June 30, 2009, a total of 71.7% of all Medicaid enrollees were served in Medicaid managed care plans across all states.⁶⁸ The Center for Health Care Strategies reported in April 2010, that 5% of all Medicaid beneficiaries account for 57% of all Medicaid expenditures nationwide.⁶⁹ The key Medicaid populations that states have faced in creating quality-based integrated delivery systems that are cost-effective and can beat the annual Medical inflation factor are, in fact, primarily the 5% of all Medicaid enrollees: people with long term care needs, people with developmental and intellectual disabilities, people with multiple chronic care medical conditions, and, to a lesser extent, people with serious and persistent mental illness (approximately 35 states have behavioral health in some form of Managed Care: at risk or Administrative Services only contracts).

The expanding capacity of the private health market’s ability to effectively serve the Medicaid population (including the Aged Blind, and Disabled, Long term Care, Behavioral Health, medically complex cases, and dual eligibles) has provided state elected officials across the country the opportunity to address continuing budget pressures resulting from the economic recession the nation continues to experience. States that have yet to initiate integrated Medicaid managed care systems for these populations now have the benefit of studying and learning from the states that have already implemented integrated Medicaid managed care.

States that have been providing services to their high need populations based on a fee-for-service model have to develop the knowledge and capacities to administer managed care plans for this group of Medicaid beneficiaries. Best practice states have recognized the need to be administratively able to:

- Effectively develop an RFP process and clearly written state contractual requirements.
- Be able to explain the intricacies and performance of MCOs to elected officials, CMS, plan enrollees, and the general public.
- Provide incentives for targeted outcomes.
- Have the administrative capacity to manage fiscal solvency, reserves, medical loss payments, and administrative costs of the MCO.
- Provide disincentives for noncompliance based on a clear contractually defined method.
- Provide a forum for consumer/family/provider feedback to the state.

The Center for Health Care Strategies⁷⁰ has identified attributes of a Medicaid “best buy” managed care system/contract as follows:

- Stratification/triage by risk/need
- Integration of services
- Designated “care/medical home” and person centered care plan
- Consumer engagement strategies
- Provider engagement strategies
- Information Exchange among all stakeholders
- Performance Measurement and accountability
- Financial incentives based on quality care

The Lucas Group has taken into account the knowledge and available research as represented above on a comparative basis to the Medicaid managed care and FFS systems in place in South Carolina, visited TennCare officials and contracted managed care organizations in Nashville, and integrated the government experience of team members in Washington, New Hampshire, Tennessee and Virginia. The Lucas Group recommends SCDHHS look to the state models in Arizona, New Mexico, Hawaii and Tennessee in developing its own Integrated Medicaid Managed Long Term Care system. The following chart highlights the key ingredients of these three state integrated managed long term care models:

Figure 50 The Lucas Group Recommendations of State Models of Integrated Medicaid Managed Long Term Care to Watch

	Arizona	New Mexico	Tennessee	Hawaii
	ALTCS	CoLTS	Choices	Quest Expanded Access (QExA) Program
Implementation Date	1989	2008	2010	2009
Medicaid Authority	1115	1915 (b) 1915 (c)	1115	1115
Statewide	YES	YES	YES	YES
Eligibility	MANDATORY	MANDATORY	MANDATORY	MANDATORY - Aged, blind and disabled, including dual eligible
Beneficiaries Served	49,501	38,401	30,000+	38,000
Covered Services	Medicaid acute; behavioral health; NFs; HCBS services: alternative residential (adult foster care/assisted living); home delivered meals; home health agency; home modifications; Hospice (HCBS); personal care; respite care; transportation.	Medicaid acute; NFs; HCBS services: adult day health; respite; assisted living; private duty nursing; emergency response; maintenance therapies (OT, PT, ST); respite; environmental modifications; services coordination; community transition services; Good/services/relocation; and relocation specialist.	Medicaid acute; behavioral health; NFs; HCBS services: personal care visits; attendant care; homemaker services; home delivered meals; personal emergency response; assistive technology; micro home improvement modifications; pest control; community based residential alternatives; in home and inpatient respite care.	Medicaid acute, behavioral health; NFs; HCBS services and full range of all other Medicaid covered services Beneficiary class
Single Point of Entry	Local Arizona Long Term Care Services (ALTCS) offices: state	New Mexico Aging and Disability Resource Center	Community based Adult Disability Resource Centers (ADRCs)	State
Who Does the Clinical Assessment	ALTCS/state medical professionals	ADRC	MCOs with state oversight	State
Who Does Care Coordination/Case Management	MCOs	MCOs	MCOs	MCOs
How is Risk Contracted	MCO contractors at risk for all covered benefits.	MCO contractors at risk for all covered services.	MCO contractors at risk for all covered benefits.	MCO Contractors at risk for all covered benefits

The important fundamental similarities among the Arizona ALTCS, New Mexico Colts, Hawaii QExA and the Tennessee Choices integrated Medicaid managed care systems are:

- Mandatory enrollment for medical primary/acute services for those who are clinically eligible for long term care services across all three models and behavioral health in Arizona and Tennessee. New Mexico uses a statewide consortium to purchase all Medicaid and state only paid behavioral health services across all state agencies.
- All four models provide a single point of entry into the system.
- All four models provide a person-centered health home within an identified network of medical, specialty, and home and community based services.
- All four models are risk-based to the Managed Care Organization/Plan (Arizona contracts with some county based/local MCOs) and utilize capitated reimbursement.
- All four models have been assessed to meet the essential quality and performance standards as outlined above.
- Consumer response has been positive to date.
- The trend of nursing home use has been rebalanced towards more people being able to stay in the community since inception of the model/contract.
- Mid-level care, primarily assisted living, is offered as a meaningful community choice.
- All four states provide in home respite to support family caregivers.

The Story in Tennessee

In 2009, over 90% of Tennessee's citizens in need of long term care services, and found eligible, were admitted to nursing homes according to the state Medicaid office and national comparative data. As a result, many seniors and families who wanted community based services either had no choice but enter a nursing home, or were placed on long waiting lists for home and community based services. As mentioned above, the former Governor and legislative leadership rallied advocacy support from all stakeholders to rebalance their long term care system by changing the culture of the system to a Community First Option model, while assuring seniors and physically disabled people of a person-centered integrated medical home.

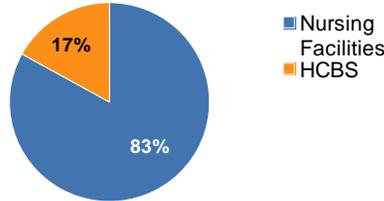
After Tennessee did the state agency work necessary to effectively design, RFP, and contract for integrated Medicaid services; contracts were awarded to three private sector Medicaid managed care health plans. The state divided up the plans into the following five catchment areas: East, West, Middle, EastWest and Statewide. After the first eight months of implementation, the state saw significant positive results in its new and innovative rebalancing strategy. In the Middle Tennessee area nursing facility enrollment decreased by 8.6% and home and community based placements increased by 50%.

Figure 51

Over the first 8 months after implementation of Tennessee CHOICES, enrollment in the HCBS program increased by over 50%

CHOICES Enrollment at Implementation in Middle TN (3/1/2010)

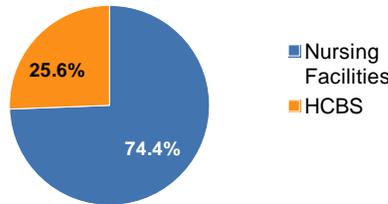
% of Total



4,394 new Middle TN members since go-live:
30.4% HCBS
69.6% NF

CHOICES Enrollment in Middle TN (11/11/2010)

% of Total



8.6 percentage points or >50% increase in HCBS percentage in 8 months

Source: TennCare CHOICES in Long Term Care: Improving Access to HCBS through Implementation of an Integrated Medicaid Managed Long-Term Care Program Presentation

Moreover, in all other catchment areas, the state saw similar results.

Figure 52

In the first few months of the Go-Live date, statewide enrollment shifted 6%

	3/1/10 or 8/1/10 Go-Live	New Enrollment	Balance as of 11/11/10	Percentage Point Shift in Balance
Middle	83% NF 17% HCBS	4,395 69.6% NF 30.4% HCBS	74.4% NF 25.6% HCBS	8.6% in 8 months
East	81% NF 19% HCBS	1,493 52.5% NF 47.5% HCBS	76% NF 24% HCBS	5% in 3 months
West	84% NF 16% HCBS	939 57.5% NF 42.5% HCBS	79.6% NF 20.4% HCBS	4.4% in 3 months
E/W Combined	82.5% NF 17.5% HCBS	2,432 54.4% NF 45.6% HCBS	77.4% NF 22.6% HCBS	5% in 3 months
Statewide	82.5% NF 17.5% HCBS	6,827 64% NF 36% HCBS	76.4% NF 23.6% HCBS	6%

Source: TennCare CHOICES in Long Term Care: Improving Access to HCBS through Implementation of an Integrated Medicaid Managed Long-Term Care Program Presentation

To date, the results have continued to be significantly positive. According to a TennCare presentation made earlier this year during the Governor's FY 2012 Recommended Budget process,⁷¹ the Choices program has resulted in an overall 8.2% reduction in nursing facility enrollment primarily accomplished by those seeking long term care services and an incentivized approach for nursing home transitions by the three managed care health plans. Expectations run high that an 8% to 10% annual reduction in Medicaid nursing facility admissions, and correlated increase in home and community based services admissions, will continue for the next several years. In Tennessee, the annual cost of a home and community based services placement is \$19,000 per year while nursing home placement costs \$55,000 per year. Thus, the state has already saved a substantial amount.

Hawaii, Texas and Wisconsin

Similarly, Hawaii and Texas have also chosen to implement large, private national and local managed care organizations among their contractors in a focused effort to provide integrated services through a medical home, and simultaneously "bend the cost curve" while effectively increasing access, quality, and care coordination. The Hawaii Medicaid managed care approach is called QUEST and is based on the values of: Quality Care, Universal Access, Efficient Utilization, Stabilizing Costs, and Transforming Health Care Delivery. The Texas Star Plus Program integrates acute medical and long term care services based on integrated services coordination including LTC services.

Wisconsin has implemented a program that contracts with regional managed care organizations to deliver long term care and behavioral health services. ForwardHealth Wisconsin provides integrated managed care services for the aged, blind, and disabled populations who are 65 years of age or older, may have physical disabilities, long term care, and behavioral health needs through a county based or privately held managed care organization. The MCOs are at full-risk with a ramp up of shared risk for three years of identified services.

Integrated Medicaid Managed Long Term Care Has Proven to Save Money and Improve Quality

The Integrated Medicaid Managed Long Term Care model provides states with savings without compromising quality and access. In fact, there is enough money in the current system to provide quality of care for Medicaid eligible seniors that desire to live in the community. The key for any state is finding ways to ensure that spending is targeted to people needs not provider needs and it is directed to appropriate services rather than on waste, inefficiency and higher cost settings.

The Institute of Medicine has provided a national platform for the discussion of "waste" in the U.S. health care system that could be eliminated without a loss in access or the quality of care if effectively

addressed. In October 2009, Thomson Reuters released a focused paper addressing the issue head on.⁷² In the report, the paper discussed the following critical issues facing the American healthcare system inclusive of Medicaid and Medicare and projected a range of inefficient and ineffective costs:

- Administrative System Inefficiencies: \$100 to \$150 billion
- Provider Inefficiency and Errors: \$75 to \$100 billion
- Lack of Care Coordination: \$25 to \$50 billion
- Unwarranted Use: \$250 to \$325 billion
- Preventable Conditions and Avoidable Care: \$25 to \$50 billion
- Fraud and Abuse: \$125 to \$175 billion

These numbers do not include estimates of costs from unhealthy and modifiable behavior: smoking, alcohol/drugs, and inactivity resulting in a number of chronic care conditions that are expensive to treat.

Clearly these numbers are staggering and need to be kept in mind when states and their citizens are engaged in major policy discussions to change their state Medicaid programs.

“Managed care”-based health care delivery, payment, and risk-bearing is not a new concept with state Medicaid programs. Prepaid group practices designed to coordinate health care started in the U.S. at least as early as the 1920s.⁷³ The Kaiser family created the Kaiser Permanente health insurance model for their employees during World War II. As of 2010, two-thirds of all Medicaid beneficiaries nationwide were enrolled in managed care plans of some type (Capitated/PCCM) and two thirds of this group are enrolled in health plans that primarily or exclusively serve Medicaid recipients.⁷⁴ The use of managed care methods to deliver and pay for health care services is not solely based on “savings.” The primary purposes of using managed care methods are to increase access, reduce fragmentation, coordinate care, provide a person-centered health home, and improve health status in a more efficient model than traditional fee-for-service.

There are a number of reports that outline managed care best practices and the various state models and programs, but there is very little national data illustrating each state’s Medicaid managed care capitated rates, total contracted dollars, and anticipated savings. Generally speaking, states “take the savings” up front prior to executing a managed care contract and the “savings” are calculated within the state budgeting process as a reduction against the future trend of traditional FFS increases.

The Lewin Group has been providing research on the question of state contracted managed care cost savings since at least 2004. In 2009, the Group released a report synthesizing 24 individual studies⁷⁵ covering the period of 1983 through 2007. Although there was variation among the state models, benefit design and populations covered all of the studies focused on capitated managed care models.

The report made several important conclusions that are worth repeating:

“First, the studies strongly suggest that the Medicaid managed care model typically yields cost savings. While the percentage of savings varied widely (from half of one percent to 20%), nearly all studies demonstrated a savings from the managed care setting.”

“Second, the studies provide some evidence that Medicaid managed care savings are significant for the Supplemental Security Income (SSI) and SSI-related populations.”

Specific state findings include:

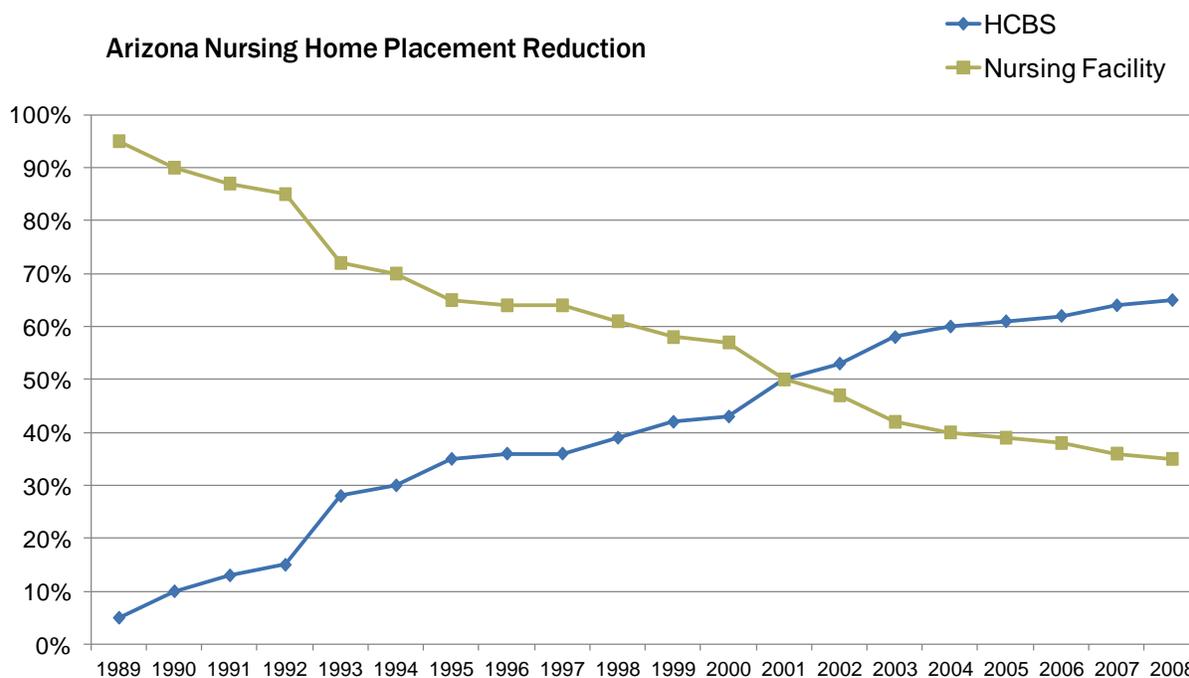
Arizona:

60% of total savings was from the SSI population.

19% savings: 1991

7% savings: 1983 -1993

Figure 53



Kentucky:

SSI Population: 25-34% of total between 1999 and 2003

2.8% savings: 1999

5.4% savings: 2000

9.5% savings: 2001

9.5% savings: 2002

4.1% savings: 2003

Michigan (includes SSI population):

9% savings: 2001

14% savings: 2002

16% savings: 2003

19% savings: 2004

Pennsylvania (includes SSI population):

10% to 20% savings: 2000-2004

(Savings are defined as managed care costs compared to fee-for-service costs projected forward annually. It is important to note that each state has implemented their own unique model so there are variations on what was being measured. All models studied, however, were capitated at-risk Medicaid Managed Care models).

New Mexico Coordination of Long Term Care Services (CoLTS) Integrated Medicaid Managed Long Term Care Program

The State of New Mexico implemented the CoLTS program in August of 2008. The program went statewide in April of 2009. The CoLTS program provides primary and acute medical services and long term care Medicaid benefits in an integrated capitated, at-risk managed care model. The CoLTS program is based on a 1915 (b) waiver and a 1915 (c) waiver. The “b” waiver permits New Mexico to require mandatory enrollment for eligible people, including the SSI population, in a managed care plan and the “c” waiver permits New Mexico to provide HCBS for long term care services for those who are found clinically and programmatically eligible. In addition to New Mexico’s use of both CMS waivers, the

CoLTS program weaves in a Medicare Special Needs Plan requirement for the contracted MCOs based on optional enrollment for Medicare paid services.

New Mexico developed the CoLTS program model with several targeted goals that include the rebalancing of long term care; improve care coordination based on a person-centered health home and services plan addressing primary, acute care, and long term care; provide people in need a seamless access to choice; decrease dependence on institutional care; and to begin to address coordination between Medicaid and Medicare benefits.

As of 2011, the CoLTS program had served 38,400 individuals and has achieved 207 nursing facility residents transitioning back to the community, 16,282 people in disease management programs, and the avoidance of 2,345 admissions to nursing facilities based on diversion intervention services prior to admission. The State expects a total of \$108.6 million in savings between 2009 and 2012 as a result of the mandatory enrollment “b” waiver. The CoLTS program determines Medicaid Eligibility Groups by levels of care, thereby incentivizing the managed care organizations to maximize the use of home and community based services, similar to the TennCare Choices model. The home and community based “c” waiver currently has a cap of 3,500 slots. People on the waiting list for home and community based services are eligible for the personal care option and home health services.

TennCare Choices

The TennCare Choices program was implemented in August of 2010. Choices adds Nursing Facility and Home and Community Based Long Term Care services/funding to the TennCare managed care model that already includes all medical, all behavioral health, medical services for the developmentally disabled and pharmacy (through a Pharmacy Benefits Manager model). The entire TennCare program is based on an integrated 1115 waiver.

The Thomson Reuters report of Medicaid Long Term Care Expenditures: FY 2009⁷⁶ indicates that, in FY 2009, Tennessee expended \$975,022,948 on nursing facility services (91.1%) and \$94,717,706 on community care (8.9%, including LTC HCBS, personal care, home health, and Pace). According to a TennCare budget report⁷⁷ to the Tennessee Governor in 2011, the Choices Program has increased the number of people being served in the community by 8.2% (a total of \$79,951,188 in one year) and an outstanding outcome of placing 33.9% of new enrollees requiring home and community based services and mid-level care and a reduction of 66.1% to the nursing facility rate of admission. The Tennessee capitated rates are tiered based on level of care need and acuity. Similar to New Mexico, medical necessity is not the standard for HCBS services eligibility. At a nursing home cost of \$55,000 per year for nursing facility care, \$37,000 for community based mid-level care, and \$19,000 per year for home and community based services, it appears that Tennessee is well on its way to being able to rebalance the long term care system, provide care coordinated medical homes for seniors and people with physical disabilities, provide for budget stability through the use of capitated rates, and potentially save a substantial amount of Medicaid resources for either reinvestment in TennCare or reduction in the burden on the state budget over a period of years.

The Lucas Group Perspective: Our Long Term Recommendation for a More Appropriate Balance of Long Term Care Medicaid Services in SC

Over the past four months, The Lucas Group has spent a considerable amount of time in South Carolina meeting and listening to seniors, AARP, advocates, nursing facility executives, community providers, SCDHHS contracted managed care health plans, South Carolina Protection and Advocacy, Area Agencies on Aging, Adult Disability Resource Centers, Institute for Families in Society at the University of South Carolina, South Carolina PACE program and SCDHHS and CLTC staff. The Lucas Group met several times with many of these people and organizations in an effort to assure accuracy of determining what kind of system South Carolina's seniors and physically disabled citizens have available to them, what they want, what the strengths, weaknesses and options for improvement are for the current CLTC system, and what the general willingness for change was across the spectrum of interests focused on the South Carolina Long Term Care system.

Most all the constituents of South Carolina's Medicaid Long Term Care system that we met with are enthusiastic to make the changes necessary to improve access, reduce fragmentation, integrate care through a person-centered health home, take the steps necessary to provide a Community First Choice LTC culture, add the services necessary to provide a comprehensive continuum of long term services and supports, and provide for a business environment that supports innovation and change. Any effective strategy to rebalance long term care in South Carolina will require working with all non-institutional and institutional providers in a collaborative way in order to best meet the needs of Medicaid eligible seniors along the continuum of care.

IMMLTC Community First Choice Plan: "50/50" by 2020

The Prescription model that The Lucas Group envisions is for South Carolina to implement the Integrated Managed Medicaid Long Term Care (IMMLTC) Community First Choice Plan, as mentioned and outlined above. The goal of this Plan is to integrate and coordinate medical and long term care services and resources, expand the continuum of care available in the community by adding mid-level care, enhanced adult medical day care, and the availability of nursing services in the community, and move towards balancing South Carolina's long term care system to expending 50% of the resources on nursing facilities and 50% of the resources on home and community based services by 2020-2021: "50/50 By 2020".

The Lucas Group is recommending that the South Carolina Department of Health and Human Services/South Carolina Long Term Care Program embark on a planning and implementation enterprise that integrates acute/primary medical, pharmacy with long term care services and supports based on a capitated, at-risk innovative contract that includes the development of mid-level community based care and incentivized payments/pay for performance for identified outcomes that support people to either remain in the community in a safe manner or ensure that they are cared for in the appropriate level of

care setting, with consistent attention to the person’s capacity for rehabilitation and return to the community. As pointed out in several sections of this report, The Lucas Group supports Integrated Medicaid Managed Long Term Care models because, when effectively contracted and monitored, they have proven to:

- Reduce fragmentation and unnecessary expense of stand-alone fee-for-service systems.
- Invest in enrollee outreach and education programs designed to promote the utilization of preventive services and health behaviors.
- Provide a health home to individuals based on a physician’s expertise to make appropriate specialty care when needed.
- Provide person-centered care coordination/case management.
- Channel care to providers and develop provider networks that practice in a cost-effective manner and do so metric analysis.
- Use lower cost services and products when available and clinically appropriate.
- Conduct provider profiling and strategies to assist providers with quality, cost-effectiveness, and accountability.
- Save a substantial amount of taxpayer dollars based on cumulative annualized savings compared to the maintaining the status quo into the future.

The Lucas Group recommends that SCDHHS begin a dialogue with CMS and ask for their assistance in utilizing a combined 1915 (b) and 1915 (c) waiver to implement the IMMLTC model. The Lucas Group has reached this conclusion primarily based on the fact that, with the exception of approximately 2,000 home and community based waiver participants who have voluntarily enrolled in the SC Medical Health Network/PCCM model, over 10,000 waiver participants remain in fragmented fee-for-service primary and acute care, along with the current Medicaid beneficiaries in nursing homes and those who are eligible for Medicaid- many who are chronically ill- but not yet needing nursing home level of care.

The “b” waiver will permit South Carolina to require mandatory enrollment in managed care medical services. By combining the “b’ and “c” waivers into one bid package with an integrated state-MCO contract, SCDHHS will be able to assure integrated care for those individuals found eligible for home and community based services through a “c” waiver level of care assessment. This model is similar to the successful New Mexico CoLTS integrated Medicaid Managed Long Term Care system. The model will also allow for a mid-level of care/assisted living option and the additional community services needed to keep seniors in the community for as long as possible. The Lucas Group believes this approach has the most potential to support rebalancing, provide quality of care and generate the most savings for the taxpayer.

The Lucas Group did consider several other options available based on CMS waiver and state plan authorities. The “universal” aspects of the 1115 waiver have been used by a growing number of states, such as Arizona, Tennessee and Rhode Island. This is also the approach Florida is currently taking to implement its managed long term care program that recently passed this past legislative session. This approach could give the state much more flexibility from federal regulations, as was the case in the

Rhode Island waiver. South Carolina may wish to use this demonstration authority and The Lucas Group believes that the state could clearly show that the demonstrated savings and budget neutrality over a five-year period.

However, given South Carolina's current structure of health and human services and continued program-specific focus on funding, and the need to move forward on rebalancing without unnecessary delay due to negotiations and administrative requirements, we believe it may be premature for the state to take advantage of the powerful ways in which an integrated multiple services platform and global budget represented in an 1115 waiver approach can increase access, decrease fragmentation, and control costs. The Lucas Group recommends, however, that SCDHHS seriously consider this approach in integrating behavioral health into the Integrated Medicaid Managed Long Term Care model should the first two-three years of implementation prove successful. Notwithstanding, both "b" and "c" and 1115 waiver approaches remain viable options.

Guide to Medicaid Authorities for Integrated Programs

Authority	Description	Key Flexibilities and/or Limitations
Section 1915(a): Exception to State Plan Requirements for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract	<ul style="list-style-type: none"> No waiver of State plan required <i>No mandatory enrollment or selective contracting</i> <i>States may use MCOs, PIHPs, or PAHPs</i>
Section 1932(a): State Plan Amendment Authority	<p>States plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas</p> <p>States may choose to include dual eligibles as part of a broader managed care program authorized under Section 1932(a)</p>	<ul style="list-style-type: none"> Permanent State plan authority and no “cost effectiveness test” Allows for selective contracting <i>No mandatory enrollment of dual eligibles; but dual eligibles may voluntarily enroll</i> <i>States may use MCOs or PCCMs</i>
Section 1915(b): Waivers	<p>Up to two-year, renewable waiver authority for mandatory enrollment in managed care and/or selective contracting with providers on a statewide basis or in limited geographic areas</p> <p>1915(b) waivers must demonstrate their access, quality and cost-effectiveness</p>	<ul style="list-style-type: none"> Allows mandatory enrollment of dual eligibles May provide additional, health-related services through 1915(b) (3) <i>States may use MCOs, PIHPs, PAHPs, PCCM</i>
Section 1915(c) Home and Community Based Services (HCBS) Waivers	<p>Waiver authority that permits States to provide long-term care services delivered in community settings as an alternative to institutional settings</p> <p>1915(c) waivers must be “cost neutral” and are renewable for 5 years after the initial, 3-year approval period</p>	<ul style="list-style-type: none"> <i>Cannot waive “freedom of choice”</i>
Concurrent 1915(a)/(c) Authority	Used to implement a voluntary managed care program that includes HCBS services in the managed care contract, when it is necessary for the State to ensure that individuals receiving services through the (a) are simultaneously enrolled in the (c) waiver	<ul style="list-style-type: none"> <i>Cannot waive “freedom of choice” or selectively contract with managed care providers</i>

Guide to Medicaid Authorities for Integrated Programs

Authority	Description	Key Flexibilities and/or Limitations
<p>Concurrent 1915(b)/(c) Authorities</p>	<p>Used to implement a mandatory managed care program that includes HCBS waiver services in the managed care contract; The 1915(c) waiver allows a State to target eligibility and provide the HCBS services; The 1915(b) then allows a State to mandate enrollment in managed care plans that provide these HCBS services</p> <p>States must apply for each waiver authority separately and comply with the statutory and regulatory requirements of each</p>	<ul style="list-style-type: none"> • Allows for selective contracting with managed care plans • <i>Requires administration of two separate, concurrent waivers with separate reporting requirements</i>
<p>Section 1915(i): Home and Community Based Services State Plan Option</p>	<p>States can amend their States plans to offer HCBS as a State plan optional benefit effective January 1, 2007</p> <p>Section 1915(i) services may be included in capitation rates when a State elects to provide home and community based services through managed care delivery systems</p>	<ul style="list-style-type: none"> • No level of care requirement • Cannot expand eligibility • Income cannot exceed 150% of the Federal Poverty Level (FPL) • States must establish needs-based criteria • Can waive statewideness • Can limit the number of participants • Cannot waive comparability • No renewal needed • No cost neutrality requirement
<p>Section 1115 Demonstrations</p>	<p>Broad authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program</p>	<ul style="list-style-type: none"> • Provide most flexibility to waive provisions in Section 1902 • <i>Must be budget neutral</i> • <i>Approval at the discretion of HHS and subject to Federal/State negotiations</i>

Attributes of IMMLTC South Carolina Must Consider

The following are attributes of IMMLTC that South Carolina will need to consider for any successful implementation of this Community First Choice option:

- Stakeholders need to be involved from initiation of the transformative planning process.
- The IMMLTC model requires a global budget, where SCDHHS has the flexibility to use budgeted long term care funds in the most appropriate settings.
- Quality Assurance and critical incidents reporting need to be clearly identified in the MCO contract.
- SCDHHS should maintain the responsibility for setting nursing facility payment rates.
- SCDHHS will need to decide on whether they want to implement one blended per member per month rate for all integrated services or consider a tiered blended rate per member per month model including high, mid-level, and low acuity. The state's actuarial firm can assist on determining which approach makes the best sense for South Carolina's current rates for medical, nursing facilities, and home and community based services.
- Nursing facilities that wish to participate should be accepted into any MCO provider network as long as they meet their certification and licensing requirements.
- SCDHHS nurses should continue to perform program eligibility assessments based on a universal, non-biased assessment tool as discussed earlier in this report.
- All home and community based services care planning, care coordination, and case management becomes the responsibility of the MCOs.
- SCDHHS needs to build the staff capacity and knowledge base to effectively manage MCO contracts and work with the MCOs on a day-to-day basis.
- The requirements for notifying Adult Protective Services needs to be clearly identified in MCO contracts and monitored by SCDHHS.

IMMLTC and South Carolina Dual Eligible Demonstration Grant

The Lucas Group also considered opportunities available to South Carolina as a recipient of a CMS Dual Eligible Demonstration Project grant funding.

South Carolina has over 150,000 dual eligibles enrolled in Medicaid today. This group represents 16% of Medicaid enrollees and accounts for 50% of all Medicaid expenditures, including long term care. In planning for IMMLTC implementation, The Lucas Group recommends that SCDHHS consider the Senior Care Options (SCO) model that Massachusetts proposes to modify as a dual eligible integrated model.

Massachusetts proposes that CMS make Medicare payments that are actuarially established to the state Medicaid agency (MASSHEALTH). The state Medicaid agency would then integrate Medicare/Medicaid actuarially established payments to contracted integrated care entities that are required to provide primary care-based providers, who meet state established core competencies as client-centered health homes. Contracted at risk MCO entities chosen to for the IMMLTC program would be required to administer Medicare/Medicaid as a single integrated care program for enrollees, including long term care and behavioral health.

Gainsharing between the state and CMS would be established based on the initial actuarial construction, compared to what it would have cost Medicare in the traditional fee-for-service model. Massachusetts is considering a global payment model per enrollee. South Carolina should continue its grant planning efforts and coordinate them with the rebalancing efforts.

A Financial Model that Supports IMMLTC

The Lucas Group conducted extensive and detailed financial/program modeling and analyses of three scenarios of South Carolina’s Medicaid Long Term Care System. The first scenario we modeled was a “Do Nothing Scenario” (see Figure 54). This model used past trend data (numbers served in NFs, community and costs) to the present and projected outward to 2021. The “Do Nothing” model projects that 20,072 people will be served in nursing homes at a cost of \$743,841,012 (62.4%) and 19,738 people will be served in home and community based services at a cost of \$447,483,012 (37.6%) for a total annual cost of \$1,191,324,025 in 2021.

Figure 54

Fiscal Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
NH # of lives	15,845	15,845	15,845	16,320	16,810	17,314	17,834	18,369	18,920	19,487	20,072
CLTC# of lives	14,269	14,982	15,582	16,049	16,531	17,027	17,537	18,064	18,605	19,164	19,738
Total # of lives	30,114	30,827	31,427	32,370	33,341	34,341	35,371	36,432	37,525	38,651	39,810
NH YOY % Change	-1.9%	0.0%	0.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
CLTC YOY % Change	-0.9%	5.0%	4.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Total lives YOY % Change	-1.4%	2.4%	1.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
NH Cost PP	\$32,418	31,445	31,382	32,041	32,714	33,401	34,103	34,819	35,550	36,296	37,059
CLTC Cost PP	\$14,385	14,138	14,440	15,278	16,164	17,102	18,093	19,143	20,253	21,428	22,671
NH YOY % Change	3.0%	-3.0%	-0.2%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%	2.1%
CLTC YOY % Change	1.9%	-1.7%	2.1%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%	5.8%
Total NH Costs	\$ 513,658,063	\$ 498,248,321	\$ 497,251,825	\$ 522,924,937	\$ 549,923,551	\$ 578,316,104	\$ 608,174,564	\$ 639,574,617	\$ 672,595,855	\$ 707,321,979	\$ 743,841,012
YOY Growth	1.0%	-3.0%	-0.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%	5.2%
Total CLTC Costs	\$ 205,256,502	\$ 211,824,710	\$ 225,005,645	\$ 245,197,651	\$ 267,201,689	\$ 291,180,368	\$ 317,310,894	\$ 345,786,374	\$ 376,817,243	\$ 410,632,823	\$ 447,483,012
YOY Growth	1.0%	3.2%	6.2%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
TOTAL	\$ 718,914,565	\$ 710,073,031	\$ 722,257,470	\$ 768,122,588	\$ 817,125,240	\$ 869,496,472	\$ 925,485,459	\$ 985,360,991	\$ 1,049,413,098	\$ 1,117,954,801	\$ 1,191,324,025
YOY Growth	1.0%	-1.2%	1.7%	6.4%	6.4%	6.4%	6.4%	6.5%	6.5%	6.5%	6.6%

This projection takes into consideration the most recent Milliman spending forecast for the remainder of FY 2012 and for FY 2013, which show reductions in costs per person in nursing homes and CLTC. These reductions were primarily as a result of reducing rates and permit days. In our “Do Nothing Scenario” we project that nursing home and CLTC costs will revert back to the average annual cost increase per year for the years 2014 to 2021. In reaching the average cost increase per year, we looked at fiscal years 2007 to 2011, since these were the most reliable data years post Medicare Part D clawback. That average cost increase per year for that time period was 2.1% for nursing homes and 5.8% per year for CLTC. In all our future projections we used the U.S. Census data population growth projections of 3% per year. That is how The Lucas Group arrived at our total nursing home and CLTC Medicaid cost projection for this scenario.

This annualized costs of the “Do Nothing” Scenario become the base figure for calculating the annualized estimated savings in our next model.

The second scenario The Lucas Group modeled is our principle recommendation: Integrated Managed Medicaid Long Term Care Community First Choice Plan. This scenario includes immediate enhancement of CLTC operations based on improvements to the assessment process, level of care determinations, enhanced coordination, diversion and transition efforts, financial eligibility process, and more vigilant attention to the community waiting list. Simultaneous to engaging in these process improvements, The Lucas Group is assuming that SCDHHS will take the necessary steps for implementation outlined above and appoint a Project Team to develop a full-risk, capitated, mandatory enrollment managed care RFP, contract, and product definition with a target date of July 1, 2013, to go live. The IMMLTC/Community First Choice plan projects that 13,438 persons will be served in nursing homes at a cost of \$475,051,524 (50.2%) and 25,823 persons will be served in home and community based services at a cost of \$454,327,380 (48.0%) in 2021 (see Figure 55).

Figure 55

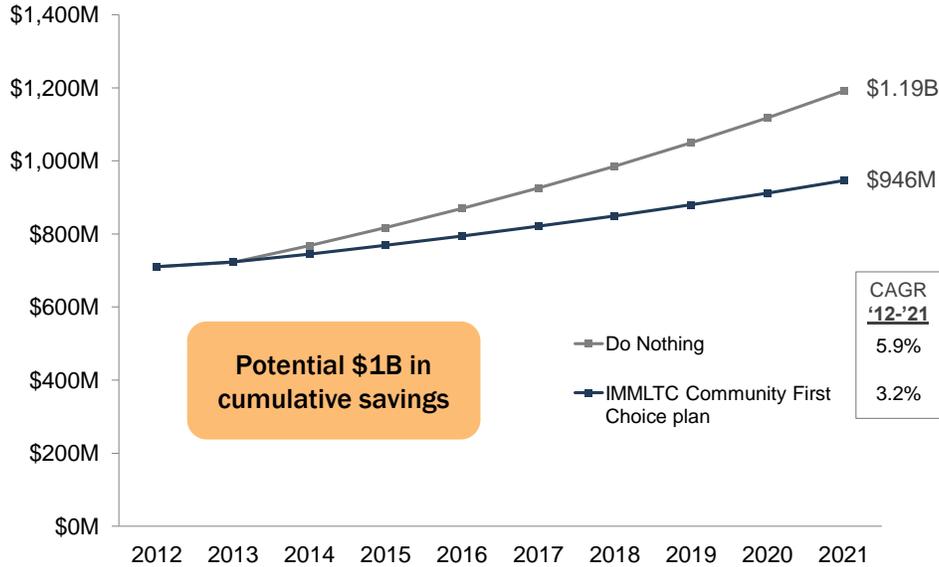
Fiscal Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total # of lives	30,114	30,827	31,427	32,370	33,341	34,341	35,371	36,432	37,525	38,651	39,810
NH YOY % Change	-1.9%	0.0%	0.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
CLTC YOY % Change	-0.9%	5.0%	4.0%								
Total lives YOY % Change	-1.4%	2.37%	1.94%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
NH # of lives	15,845	15,845	15,795	15,479	15,170	14,866	14,569	14,277	13,992	13,712	13,438
CLTC# of lives	14,269	14,982	15,482	16,690	17,921	19,175	20,452	21,755	23,083	24,439	25,823
Midlevel # of lives			150	200	250	300	350	400	450	500	550
NH Cost PP	\$32,418	\$ 31,445	\$ 31,382	\$ 31,853	\$ 32,331	\$ 32,816	\$ 33,308	\$ 33,808	\$ 34,315	\$ 34,829	\$ 35,352
CLTC Cost PP	\$14,385	\$ 14,138	\$ 14,440	\$ 14,801	\$ 15,171	\$ 15,551	\$ 15,939	\$ 16,338	\$ 16,746	\$ 17,165	\$ 17,594
Midlevel Cost PP			\$ 25,000	\$ 25,625	\$ 26,266	\$ 26,922	\$ 27,595	\$ 28,285	\$ 28,992	\$ 29,717	\$ 30,460
NH YOY % Change	3.0%	-3.0%	-0.2%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
CLTC YOY % Change	1.9%	-1.7%	2.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Midlevel YOY % Change			2.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total NH Costs	\$ 513,658,063	\$ 498,248,321	\$ 495,682,712	\$ 493,055,594	\$ 490,442,399	\$ 487,843,054	\$ 485,257,486	\$ 482,685,621	\$ 480,127,388	\$ 477,582,713	\$ 475,051,524
Total CLTC Costs	\$ 205,256,502	\$ 211,824,710	\$ 223,561,611	\$ 247,040,882	\$ 271,887,833	\$ 298,179,477	\$ 325,997,344	\$ 355,427,542	\$ 386,561,014	\$ 419,493,812	\$ 454,327,380
Total Midlevel Costs		\$ -	\$ 3,750,000	\$ 5,125,000	\$ 6,566,406	\$ 8,076,680	\$ 9,658,363	\$ 11,314,082	\$ 13,046,551	\$ 14,858,572	\$ 16,753,040
NH Total YOY % Change	1.0%	-3.0%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%
CLTC Total YOY % Change	1.0%	3.2%	5.5%	10.5%	10.1%	9.7%	9.3%	9.0%	8.8%	8.5%	8.3%
Midlevel Total YOY % Change				36.7%	28.1%	23.0%	19.6%	17.1%	15.3%	13.9%	12.8%
Total Costs	\$ 718,914,565	\$ 710,073,031	\$ 722,994,324	\$ 745,221,475	\$ 768,896,638	\$ 794,099,211	\$ 820,913,193	\$ 849,427,245	\$ 879,734,953	\$ 911,935,096	\$ 946,131,944
YOY Growth	1.0%	-1.2%	1.8%	3.1%	3.2%	3.3%	3.4%	3.5%	3.6%	3.7%	3.7%
Do Nothing											
Total Costs		710,073,031	722,257,470	768,122,588	817,125,240	869,496,472	925,485,459	985,360,991	1,049,413,098	1,117,954,801	1,191,324,025
Savings		-	(736,854)	22,901,113	48,228,602	75,397,261	104,572,266	135,933,746	169,678,145	206,019,705	245,192,080
Cum. Savings		\$1,007,186,064									

This model also includes 550 persons being served in mid-level care at a cost of \$16,753,040 (1.8%) a year by 2021. IMMLTC is projected to effectively rebalance South Carolina’s Medicaid Long Term Care system to a virtual 50/50 balance between nursing facility and home and community based expenditures. The total cumulative savings between 2013 and 2021 for this model is estimated to be \$1,007,186,064 (see Figure 56).

Figure 56

Total NH, CLTC, and ML Medicaid Costs by Plan (2012-2021)

\$ Billions



Note: NH = Nursing Home; CLTC = Community Long Term Care; ML = Mid-level
 Source: SC 372 report; Lucas Group analysis

These savings projections are reasonable when one considers the experiences of other states that have implemented similar integrated managed long term care, capitated and full-risk plans. The Lucas Group has also factored in cost increases per year in the community (2.5%) and nursing homes (1.5%) per year, which are lower than the historical spending patterns used above, but consistent with what we have seen in overall spending in other states that have gone through similar rebalancing efforts.

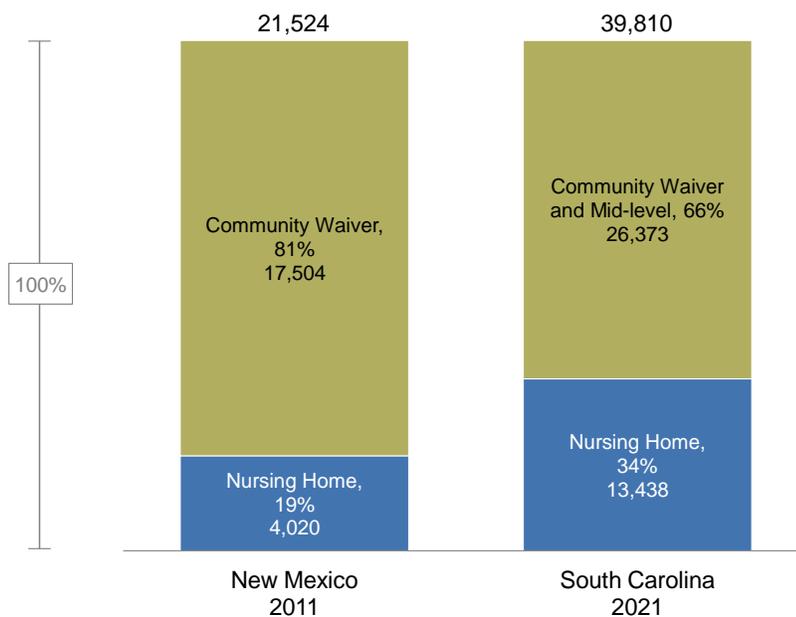
States have been able to achieve savings from the traditional FFS systems because of a more heightened and focused approach to quality community based services and the ability to coordinate and integrate care to keep seniors from high cost settings such as emergency rooms, hospitals and nursing homes, and shorten the lengths of stay in these high cost settings. In each of the states we reviewed that have implemented this type of model, The Lucas Group has seen LTC savings per year in the range consistent with the Lewin Report findings and, at the same time, increased spending on high-quality community services and significant reductions in nursing home admissions. The Lucas Group’s model projects savings off the “Do Nothing” base model beginning at 3% per year in 2014 and rising to 21% per year in 2021. The Lucas Group also projects a reduction in the number of nursing home Medicaid residents per year of 2.5%, which is entirely consistent with the incentives for enhanced diversion and transition that we have seen in systems in place in Tennessee, New Mexico and Arizona. Tennessee saw a reduction of

nursing home enrollment of 8.2% in its first year of implementation and Arizona has seen an average decrease in nursing home placements of approximately 3% per year since its enhanced managed long term care focus in 1989.

Moreover, recent results of New Mexico’s enhanced long term managed care effort indicate that our projections for balance in South Carolina are entirely reasonable. Today in New Mexico, out of their Medicaid population approved for nursing home level of care, 81% are on the community waiver and 19% are in nursing homes. In The Lucas Group projections, at the end of 2020, South Carolina would see 66% of its eligible seniors on the CLTC waiver and 34% in nursing homes (see Figure 57). There is no reason to believe that South Carolina cannot reach this goal by 2021.

Figure 57

Nursing Home vs. Community Populations in New Mexico (2011) and South Carolina (2021)
% of Total



Source: New Mexico Human Services Department; SC 372 report; Lucas Group analysis

It must be highlighted that this scenario assumes an implementation strategy that has SCDHHS beginning to move forward January 1, 2012, on many of the process improvement strategies The Lucas Group outlined in this report and being in a position to enhance its diversion and transition programs and community based care options by July 1, 2012, with the implementation of IMMLTC beginning July 1, 2013, as noted below (see Figure 58).

Figure 58

Community First Choice Process Improvements and Integrated Managed Medicaid Long Term Care (IMMLTC) Cost Savings Timeline

FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
January to July 2012: Kick-off <ul style="list-style-type: none"> Stakeholder/Community engagement Meet with General Assembly Community First Choice Option process improvement planning 									
<ul style="list-style-type: none"> Begin dialogue with CMS – proposed state plan changes, waiver amendments and/or adjustments Legislation Development of RFP 									
<ul style="list-style-type: none"> MFP implementation/diversion/transition plans continue Nursing Home caseload constant Nursing Home and CLTC costs follow current SC DHHS projections 									
July 2012: Enhanced CLTC with new Mid-Level Care Option <ul style="list-style-type: none"> Continue meetings with stakeholders, General Assembly, and CMS State plan changes and home and community-based waiver enhancements in place MFP in place Dual eligible grant planning continues 									
<ul style="list-style-type: none"> Community First Choice Option process improvements: assessment, single point of entry, level of care, waiting list, enhanced diversion and transition, enhanced coordination, payment reform, new enhanced community services and options, and assisted living/mid-level option begins MCO process continues/vendors chosen/networks to ensure access 									
July 2013: Integrated Managed Medicaid Long Term Care Community First Choice Plan “50/50 by 2020” <ul style="list-style-type: none"> Aggressive diversion and transition resulting in decrease of NH population and corresponding increase in CLTC and mid-level populations Process improvements in place Full risk mandatory managed long term care 									
<ul style="list-style-type: none"> Simultaneous Dual eligible grant implementation Annual growth rate of CLTC and ML per person costs limited to 2.5% Results in 50/50 cost balance between NH and CLTC/Mid-level by 2021 									
Savings per Year and Cumulative Total									
\$0	(\$0.7M)*	\$22.9M	\$48M	\$75M	\$105M	\$136M	\$170M	\$206M	\$245M
\$0	(\$0.7M)*	\$22.2M	\$70M	\$146M	\$250M	\$386M	\$556M	\$762M	\$1B

*The cost per year for mid-level care is higher than traditional CLTC, accounting for the slight increase in costs in 2013, before the cost savings of the Integrated Managed Medicaid Long Term Care Community First Option are realized
 Note: NH = Nursing Home; CLTC = Community Long Term Care; ML = Mid-level
 Source: SC 372 report; Lucas Group analysis

In addition to modeling the Integrated Managed Medicaid Long Term Care Community First Plan, The Lucas Group also looked at the possibility of the state using some of the savings attributed to IMMLTC to further develop and enhance its balancing efforts. In this third scenario, The Lucas Group added the idea of a Value-Based Purchasing Incentive Pool that could reward performance that was consistent with the state’s community based first choice priority. This scenario includes the full IMMLTC model but is enhanced by including a pay-for-performance incentive system, contracted by the state to the MCOs, that rewards activities in nursing homes, hospitals, physicians, and the community that diverts or transitions long term care recipients back to the community, or safely maintains them in the community through innovation or extraordinary effort.

The IMMLTC/Value Based Purchasing/Incentive Pool projects that a total of \$15 million will be available in 2014 and \$20 million in 2015 to reward such performance, growing at a rate of 10% per year up to 2021 where the amount would be a little over \$35 million dollars a year (see Figure 59).

Figure 59

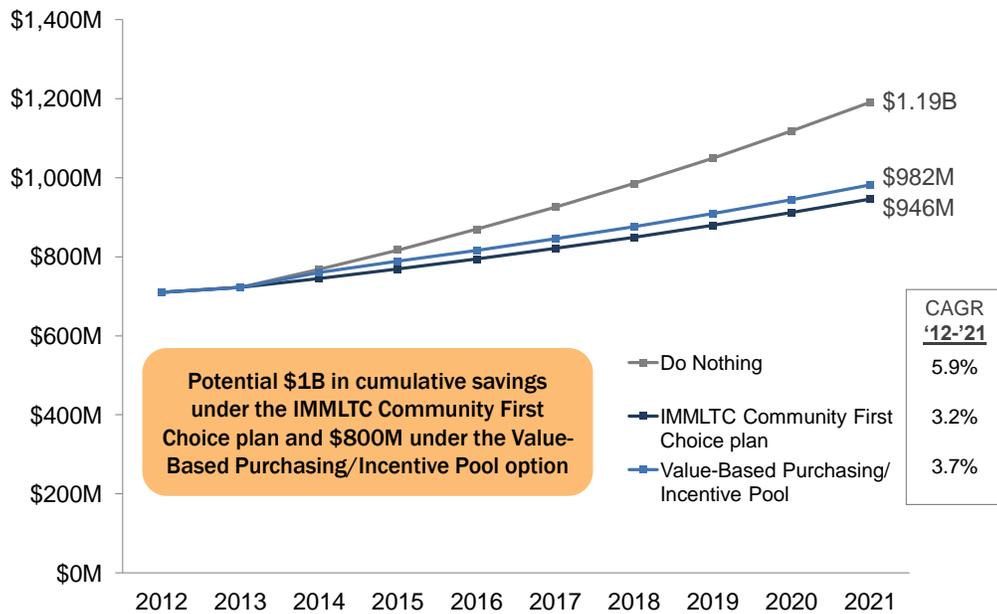
Fiscal Year	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Total # of lives	30,114	30,827	31,427	32,370	33,341	34,341	35,371	36,432	37,525	38,651	39,810
NH YOY % Change	-1.9%	0.0%	0.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
CLTC YOY % Change	-0.9%	5.0%	4.0%								
Total lives YOY % Change	-1.4%	2.37%	1.94%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
NH # of lives	15,845	15,845	15,795	15,479	15,170	14,866	14,569	14,277	13,992	13,712	13,438
CLTC# of lives	14,269	14,982	15,482	16,690	17,921	19,175	20,452	21,755	23,083	24,439	25,823
Midlevel # of lives			150	200	250	300	350	400	450	500	550
NH Cost PP	\$32,418	\$ 31,445	\$ 31,382	\$ 31,853	\$ 32,331	\$ 32,816	\$ 33,308	\$ 33,808	\$ 34,315	\$ 34,829	\$ 35,352
CLTC Cost PP	\$14,385	\$ 14,138	\$ 14,440	\$ 14,801	\$ 15,171	\$ 15,551	\$ 15,939	\$ 16,338	\$ 16,746	\$ 17,165	\$ 17,594
Midlevel Cost PP			\$ 25,000	\$ 25,625	\$ 26,266	\$ 26,922	\$ 27,595	\$ 28,285	\$ 28,992	\$ 29,717	\$ 30,460
NH YOY % Change	3.0%	-3.0%	-0.2%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
CLTC YOY % Change	1.9%	-1.7%	2.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Midlevel YOY % Change			2.1%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Total NH Costs	\$ 513,658,063	\$ 498,248,321	\$ 495,682,712	\$ 493,055,594	\$ 490,442,399	\$ 487,843,054	\$ 485,257,486	\$ 482,685,621	\$ 480,127,388	\$ 477,582,713	\$ 475,051,524
Total CLTC Costs	\$ 205,256,502	\$ 211,824,710	\$ 223,561,611	\$ 247,040,882	\$ 271,887,833	\$ 298,179,477	\$ 325,997,344	\$ 355,427,542	\$ 386,561,014	\$ 419,493,812	\$ 454,327,380
Total Midlevel Costs		\$ -	\$ 3,750,000	\$ 5,125,000	\$ 6,566,406	\$ 8,076,680	\$ 9,658,363	\$ 11,314,082	\$ 13,046,551	\$ 14,858,572	\$ 16,753,040
NH Total YOY % Change	1.0%	-3.0%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%	-0.5%
CLTC Total YOY % Change	1.0%	3.2%	5.5%	10.5%	10.1%	9.7%	9.3%	9.0%	8.8%	8.5%	8.3%
Midlevel Total YOY % Change				36.7%	28.1%	23.0%	19.6%	17.1%	15.3%	13.9%	12.8%
Total Costs	\$ 718,914,565	\$ 710,073,031	\$ 722,994,324	\$ 745,221,475	\$ 768,896,638	\$ 794,099,211	\$ 820,913,193	\$ 849,427,245	\$ 879,734,953	\$ 911,935,096	\$ 946,131,944
YOY Growth	1.0%	-1.2%	1.8%	3.1%	3.2%	3.3%	3.4%	3.5%	3.6%	3.7%	3.7%
Value-Based Purchasing Incentive Pool			\$ 15,000,000	\$ 20,000,000	\$ 22,000,000	\$ 24,200,000	\$ 26,620,000	\$ 29,282,000	\$ 32,210,200	\$ 35,431,220	
Pool YOY Growth						10%	10%	10%	10%	10%	10%
Total Cost after Pool		\$ 710,073,031	\$ 722,994,324	\$ 760,221,475	\$ 788,896,638	\$ 816,099,211	\$ 845,113,193	\$ 876,047,245	\$ 909,016,953	\$ 944,145,296	\$ 981,563,164
Do Nothing											
Total Costs		710,073,031	722,257,470	768,122,588	817,125,240	869,496,472	925,485,459	985,360,991	1,049,413,098	1,117,954,801	1,191,324,025
Savings		(0)	(736,854)	7,901,113	28,228,602	53,397,261	80,372,266	109,313,746	140,396,145	173,809,505	209,760,860
Cum. Savings		\$ 802,442,644									
Cum. Pool \$		\$ 204,743,420									

If this approach were taken, The Lucas Group’s model projects that the state would continue to see savings realized over each year from 2014 to 2021, with a cumulative savings amount estimated at \$802,442,644 (see Figure 60).

Figure 60

Total NH, CLTC, and ML Medicaid Costs by Plan (2012-2021)

\$ Billions



Note: NH = Nursing Home; CLTC = Community Long Term Care; ML = Mid-level
 Source: SC 372 report; Lucas Group analysis

The Lucas Group believes it would be wise for SCDHHS to work with its MCOs, nursing homes, hospitals, physicians and other community providers in designing the incentive program, which would incentivize behavior that provides quality, brings value to both eligible seniors and taxpayers, and continues to promote cost-efficient savings each year as South Carolina reaches the most appropriate long term care balance for its state.

Timeline and Steps for Implementation

2012												2013											
Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul					
▲ Stakeholder Engagement																							
Initiate Discussions with CMS General Assembly			Negotiations with CMS on Rate Build																				
												CMS Approval											
▲ Public Hearings																							
▲ Legislation																							
												RFP		RFP Responses Due		▲ Oral Presentations							
												▲ Awards Made											
												Contract Negotiations Begin		Contracts Finalized									
												Network Assessment		Complete Network Due and Evidence of Certification of Authority Required									
												▲ Begin Readiness Review											
												▲ Member Notification and Assignment to Health Plans											
												▲ Go Live											

It must be recognized that a number of steps in the proposed timeline and the eventual implementation of an integrated long term Medicaid managed care program require federal approval. SCDHHS should ensure that the federal authorities recognize the importance of its rebalancing efforts so as to prevent any unnecessary delay, should the state decide to move in this direction.

What SC Can Do Now

The Lucas Group recognizes that transformative system change is difficult for any state agency and that our recommended prescription will take some time before it is implemented and will not result in measureable savings or diversions and transitions for almost two years. However, throughout this paper The Lucas Group outlined a number of process improvements SCDHHS can make prior to full-scale implementation of IMMLTC. Many of our recommendations can be done in the short-term and create the kind of Community First Choice priority system needed to begin to balance the long term care system. This enhanced focus on diversion and transition strategies does not have to wait.

For example, today South Carolina can begin putting in place structures and plans to streamline the assessment process, create a truly integrated and effective single point of entry for seniors, work towards partnering with ADRCs in providing an efficient and senior-friendly single point of entry for long term care services, introduce a new assessment instrument and revised levels of care that focus on family and community support. Case management services can also be transformed into a true community care coordination system that is focused on maintaining support for seniors in the community. Additional community based services can be added to the CLTC waiver, such as private day nursing, adult foster care, a mid-level/assisted living option, and a more concentrated medical adult day care service component.

Changes can also be made to the waiting list that allow for consistent methods of prioritization and triage for persons in need of support before their condition deteriorates, and a transparent definition of just what it means to be on the “waiting list”. Moreover, changes to nursing home reimbursement methodology that are acuity driven and appropriately reimburses nursing homes for the care of illness, with incentives built in for shorter-term stays and re-entry to community. Hospitals and physicians can be more adequately educated on the community options available to frail seniors and more focused collaboration and coordination with discharge planners from hospitals and nursing homes, along with incentives to transition and rewards performance can be introduced.

All these efforts and more can begin now and bring change that is needed to many of South Carolina’s frail Medicaid elders who have been determined to be eligible for nursing home services. These changes will begin to transform the system and ensure that SCDHHS is moving in the right direction in preparation for the implementation of a new integrated and coordinated culture that will bring cost-effective, quality driven and lasting change to its long term care program. This is the right change and the right balance that these Medicaid eligible seniors deserve.

Appendix

Lucas Group Biographies

John Stephen, J.D.

John is founder and managing partner of The Stephen Group. In addition to experience consulting with state agencies, John provides the benefit of heading a state agency through a period of major change.

Among his many accomplishments, John has assisted Rhode Island Governor Donald Carcieri in drafting and negotiating the Rhode Island Global Medicaid Waiver. This landmark Waiver was granted by Secretary of Health and Human Services Michael Leavitt in December of 2008 and then subsequently adopted by the Rhode Island general assembly in January of 2009. The Waiver was the first Medicaid Waiver ever to place a cap on total Medicaid spending and provide a state with unprecedented flexibility from federal regulations. In its first three years, the Waiver has saved the State of Rhode Island over \$65 million and effectively rebalanced long term care so that more seniors can remain in their homes rather than nursing homes (*An Independent Evaluation of Rhode Island Global Waiver*, Lewin Group, December 6, 2011). Governor Carcieri called John's work an unqualified success and one that his state is tremendously grateful for. John also drafted a report for Illinois Governor Pat Quinn's taxpayer action board, which recommended over \$2 billion dollars in health care-related savings over a 5-year period, and a number of the recommendations have already been implemented. John was also asked by the State of Illinois Senate Special Committee on Medicaid Reform to provide key testimony in December of 2010 that has led to that State passing legislation that will result in over \$800 million in savings by rebalancing long term care away from high cost nursing home care. John also led The Lucas Group efforts in early 2010 to assist the State of South Carolina in re-organizing the state agency responsible for putting people back to work, and identifying over \$1.2 billion dollars in savings for the state unemployment insurance system, while offering a plan to cut taxes for small businesses. The Chairman of South Carolinas Senate Labor, Commerce and Industry Committee, W. Greg Ryberg, applauded John's efforts and stated that John's clear-headed and forthright analysis and advice illuminated the path for SC to fix its UI system and relieve the burden on small business.

In addition to his experience consulting with state agencies, John also assists corporate clients by conducting due diligence in health care-related transactions, and offering strategies for value-based growth. John has been involved in the recent national health care debate, where he has written extensively on the impact of unfunded mandates on state governments as a result of the language contained in House and Senate bills, was an advisor to the staff of United States Senator John Cornyn, and appeared at a number of town hall forums and public meetings to discuss the overall impact of the proposed legislation.

Previously, John served from 2003 to 2007 as Commissioner of New Hampshire's largest Department, the Department of Health and Human Services, where he was in charge of a \$1.8 billion dollar annual budget, and was able to contain Medicaid cost to less than a 1% growth during his four year term. As

Commissioner, John led the Department through a period of major innovation, including improving Medicaid operations and engaging families on assistance in work activities. He developed and implemented a nationally recognized Health Care Reform program that focused Medicaid on prevention, wellness and rebalancing long term care. John initiated disease management and care coordination programs that transitioned New Hampshire Medicaid away from treating the sick to keeping people healthy. Through John's efforts, Medicaid long term care home and community placements increased 23%, replacing more expensive nursing home placements, which dropped 11%. Moreover, during each of the four years John was Commissioner, New Hampshire ranked first nationally in the Kids Count survey. During that same period, the enrollment of low income, uninsured children into the States Medicaid and SCHIP program increased by 7500. John led efforts to transform welfare in New Hampshire, reducing the rolls by 20% and dramatically increasing work participation rates by bringing accountability to TANF.

John earned his undergraduate degree in Business Administration from the Whittemore School of Business and Economics at the University of New Hampshire and a law degree at the Detroit College of Law, Michigan State University. John is a respected author; he has written or co-authored eight books on various legal matters. He also serves as a guest lecturer at Babson College in Massachusetts where he has taught students entrepreneurial management skills and how to make government more efficient through innovative market-based solutions.

Richard E. Kellogg

Richard has served in the health and human services positions of Commissioner, Deputy, or Director in the states of Virginia, Tennessee, New Hampshire and Washington beginning in 1994 through 2011. Richard's scope of responsibility has included medical and pharmacy services, mental health and substance abuse service systems, psychiatric hospitals and developmental residential programs, developmental/intellectual disabilities community based services and support systems, and long-term care services systems. Prior to beginning his career in state government Richard was a successful CEO of local government and private sector organizations charged with managing and delivering comprehensive mental health, substance abuse, developmental/intellectual disabilities and long term care services inclusive of community based and inpatient modalities.

While working in state government Richard provided leadership to the successful resolution of several Department of Justice lawsuits involving civil rights/Olmstead within state psychiatric hospitals and developmental residential centers in real time as well as EPSDT related litigation involving children's mental health services. He is an expert witness in matters directly related to the right sizing and appropriate placement of state psychiatric hospital patients and residents of state developmental centers. Primary methods used to address DOJ and consumer choice systemic problems included increased community capacity building correlated with decreased reliance on state psychiatric hospitals based on a financial design, including Medicaid resources, that effectively leverages existing resources to the maximum extent possible on a platform of evidence based practice, community residential options, staff partnerships, training and outcomes measurement.

Richard established the foundation for a comprehensive plan addressing CMS waiver concerns and on-going Department of Justice litigation for Tennessee's system of care for people with developmental/intellectual disabilities.

While working in New Hampshire Richard helped guide the state through a transformative Medicaid Waiver process that rebalanced long term care, transformed the state's long term care system to a community based first option, and improved the state's Medicaid medical services program and mental health systems.

Most recently Richard served the \$8 billion dollar Washington State Department of Social and Health Services as Director of Integrated Health Services, reporting directly to the Secretary. In this capacity Richard was responsible for advising on all aspects of national health reform including financial ramifications and structural options for state government between the present, 2014, and beyond.

Richard earned his undergraduate and graduate degrees from the University of Vermont and engaged in advanced study at Dartmouth and Harvard. He has taught at the university level and been integrally involved with related subject matters at the University of Virginia and University of Washington.

Matthew L. Byron

Matthew has done consulting in government asset privatization, healthcare policy reform, cost containment and pension reform. Prior to joining The Lucas Group he was a Partner for a boutique investment firm in Greenwich, Connecticut. There he managed capital for sophisticated investors. Matthew has also worked on the trading floor of the Chicago Mercantile Exchange. There he assisted in the execution of over \$5 billion in trades. He specialized in the Russell, Nikkei and S&P 500 indices. He holds a Bachelors Degree of Science in Finance from Bentley College.

Clint J. Koenig, MD, MA MSPH

Dr. Koenig is currently the Medical Director of the Monroe Plan for Medical Care - a non-for profit Medicaid Managed Care Organization in Rochester NY. Monroe Plan has been nationally ranked on US News and World Report's best Medicaid Managed Care Plans. Dr. Koenig is the director of the Utilization Management Department where he oversees both nurses and physicians. At Monroe Plan Dr. Koenig has also developed quality initiatives on care transitions and academic detailing. Dr. Koenig has also co-chaired committees on care coordination and primary care based case management. Dr. Koenig is also a physician Surveyor for the National Committee for Quality Assurance (NCQA) and has surveyed national health plans as well as primary care medical homes. Prior to Monroe Plan, Dr. Koenig served as the New Hampshire State Medical Director from 2006 to 2007. As State Medical Director, Dr. Koenig was involved with the Granite Care, the state's care coordination project, and the State's process to re-authorize the sole SCHIP vendor. Dr. Koenig also served as the chair of the state pharmacy and therapeutics committee as well as a chair of a commissioner-appointed taskforce to address behavioral health issues in the rural region of the state.

Kathy J. Leitch

Kathy worked for the Washington State Department of Social and Health Services for over 30 years. In 2000 she was appointed as Assistant Secretary for Aging and Adult Services Administration. In 2002 she was appointed as Assistant Secretary for Aging and Disability Services Administration and served in that capacity until 2011. Prior to her appointment as Assistant Secretary she was the Division Director for Home and Community Services. She helped increase significantly the home and community based options available to consumers and reduced the Medicaid nursing home census from 17,500 to 10,500. In 2002 and 2007 she was the recipient of the Governor's Management/Leadership Award in the state of Washington. She served as the President of the National Association of States United for Aging and Disabilities from 2005-2007.

Greg Moore

Greg is the Policy Director to the New Hampshire House of Representatives. There he directs policy and message functions for a transformative change agenda in the New Hampshire Legislature. He develops research, coordinates leadership priorities. He works as a liaison with interested parties and state legislators to identify solutions to state's problems. He has direct message functions for House of Representatives.

Greg has been Director of Policy and Communication, Campaign Manager, and Communications Director to congressional and gubernatorial races. In these roles he has directed all aspects of the campaigns, including advertisement, field operations and earned media. Greg has also served as the Director of Public Affairs and Government Relations to the New Hampshire Department of Health and Human Services from 2003 until 2007. As a consultant he has developed grassroots issues advocacy campaigns for numerous corporate clients in to influence legislation in Massachusetts. Clients included Microsoft and Massachusetts High Technology Council. Greg was awarded the New Hampshire Associated Press Broadcasters, Spokesman of the Year, in 2005 and in 2007. He received the New Hampshire Public Health Association, Friend of Public Health Award (Public Awareness) award in 2006.

Greg graduated magna cum laude from Vanderbilt University with a B.S. in Computer Science and Political Science.

Brent Muller

Brent is an Associate Consultant at The Lucas Group, experienced in Medicaid long term care reform. He has also worked on various private equity due diligence cases in the safety and entertainment industries. Prior to joining The Lucas Group, Brent worked at Reynolds Systems, Inc., a private defense contractor, where he worked in process improvement and development and quality control. He received a B.S. in Chemistry from Yale University with a specialization in organic chemistry and additional study in economics.

Rory L. Rickert, R. Ph.

Rory is a Subject Matter Expert for The Lucas Group. He is currently CEO of Integrated Healthcare Services Incorporated. There he has assisted healthcare clients in winning over \$40 billion in awards since the inception of the firm's government business development practice. The company's pharmacy practice assists commercial healthcare clients in a number of key areas that include: enhanced sales of existing products and services, expansion to new markets, strategic positioning and specialized contract negotiation. The firm brings experience, contacts, and knowledge to clients to help speed existing growth, foster new growth, and reposition strategies for continued long-term success. The pharmacy practice dovetails with IHS' government business when the issues are dealing with government healthcare matters related to pharmacy.

Rory is also currently Principal and National Practice Leader for IHS' Pharmacy Practice. He has more than 25 years of progressive experience in the pharmaceutical industry.

He started as a clinical pharmacist at the Minneapolis Children's Medical Center and advanced to Corporate Vice President for AdvancePCS. There he was responsible for the oversight of corporate

accounts and government marketplace for the nation's largest independent health and wellness company. Rory led strategic planning and market positioning of AdvancePCS while it was owned by Rite Aid, a major retail pharmacy company. He was also Corporate Director for Home Nutritional Services, a national provider of home infusion therapy.

Rory is a nationally recognized speaker and industry expert in managed care, drug utilization and cost control, distribution channels and rebates, marketing, sales and delivery models in the pharmaceutical industry. He has been deposed as an expert witness in many cases including: Hall v. Medical Security Card, Co., Superior Court of Arizona, Association Benefit Services, Inc., v. AdvancePCS, a Delaware corporation, Caremark Rx Inc. a Delaware corporation and CaremarkPCS, a Delaware corporation, United States District Court for the Northern District of Illinois and State of Hawaii v. Abbott Laboratories, Inc. et al., (Merck) in the Circuit Court of the First Circuit State of Hawaii.

He has published papers for the Department of Defense Pharmacy and Senior Leadership, including: Proposed Pilot to Centralize the Administration of Specialty Drugs to DoD Beneficiaries (May 2007), Commercial Centralized Refill Capability Supporting Military Treatment Facilities (February 2007) and Enhancing TRICARE Referral Authorization and Notification Processes Through Interactive Automated Voice Services.

He has made presentations to PCMA, Department of Defense TRICARE Region 1, Axia Strategies Carrier Forum, Federal Healthcare Acquisition Conference, Illinois Society of Certified Employee Benefits Specialists and Advances in Building and Managing Home Care Provider Networks. Rory has also been interviewed by Managed Home Care Report, Home Care Magazine, Home HealthCare, Eli Yale Research Home Health Care and Medical Utilization Management.

Jeff Schilz, J.D.

Jeff is a Senior Consultant at The Lucas Group. Prior to joining the Lucas Group, Jeff served on the Senior Staff of South Carolina Governor Mark Sanford from 2008-2011 in a variety of capacities including Policy Director and Cabinet Director.

In his role as Policy Director, Jeff led policy analysis/development for all state and federal policy areas and oversaw the drafting of three Executive Budgets that annually prioritized spending for each agency in state government. These Executive Budgets identified specific line item cost savings and efficiencies of at least \$200 million (out of a state budget of roughly \$5.3 billion), with the final budget including over \$265 million in savings. Many of the cost saving proposals were recommended after reviewing the functions of different agencies and developing new operating structures that would consolidate agencies and eliminate redundant activities, producing a more efficient and responsive government.

Prior to working in the governor's office, Jeff was in private practice with a civil defense litigation law firm in Greenville, South Carolina.

Jeff holds a Bachelors Degree of Science from the College of Charleston and a Juris Doctor from the University of South Carolina School of Law.

Jeff currently serves on the Board of Trustees at the College of Charleston.

Erik Witkowski

Erik is a Senior Consultant at The Lucas Group and has over a decade of finance, strategy, and operating experience.

At The Lucas Group, Erik has played leadership and project management roles on assignments that included a strategic assessment of a specialty gift retailer, a cost-reduction effort at a large health insurance company, and over a dozen market assessment and due diligence projects.

After graduating from Harvard College, Erik earned an M.B.A. from Harvard Business School. He is also a Chartered Financial Analyst.

Acronyms

AAA: Area Agencies on Aging

AAFP: American Academy of Family Physicians

AAP: American Academy of Pediatrics

AAP: American Academy of Physicians

AARP: American Association of Retired Persons

ACA: Affordable Care Act of 2010

ACP: American College of Physicians

ADHC: Adult Day Health Care

ADL: Activity of Daily Living

AHRQ: Agency for Healthcare Research and Quality

AIDS: Acquired Immune Deficiency Syndrome

ALFA: Assisted Living Federation of America

AoA: Agencies on Aging

AOA: American Osteopathic Association

BCBSMA: Blue Cross/ Blue Shield of Massachusetts

BH: Behavioral Health

BMI: Body Mass Index

CARE: Comprehensive Assessment Reporting Evaluation

CCC: Clinically Complex Care

CCM: Chronic Care Model

CCWP: Community Choices Waiver Program

CFCR: Residential Care Facility

CHCS: Center for Health Care Strategies, Inc.

CLTC: Community Long Term Care

CM: Case Manager

CMI: Case Mix Index

CMII: Case Manager II

CMMI: Center of Medicare Medicaid Innovation Office

CMS: Centers for Medicare & Medicaid Services

CO: Central Office

CoLTS: Coordination of Long Term Care Services

COPD: Chronic Obstructive Pulmonary Disease

CRCF: Community Residential Care Facility

CTI: Coleman Care Transition Intervention

DD: Developmentally Disabled

DDSN: Developmental Disability Special Needs

DHEC: Department of Health and Environmental Control

DHHS: Department of Health and Human Services

DMH: Department of Mental Health

DRA: Deficit Reduction Act of 2005

EHR: Electronic Health Record

EQRO: External Quality Review Organization

FFP: Federal Financial Participation

FFS: Fee for Service

HCBS: Home and Community-Based Services

HCPF: Health Care Policy and Financing

HHS: Health and Human Services

HIPPS: Health Insurance Prospective Payment System

ICF: Intermediate Care Facility

ID: Intellectual Disability

IMMLTC: Integrated Managed Long Term Care

IPC: Integrated Personal Care

IT: Information Technology

LOC: Level of Care

LTC: Long Term Care

LTSS: Long term Services and Supports

MA: Medicare Managed Care

MCO: Managed Care Organization

MD: Medical Doctor

MDS: Minimum Data Standards

MDS-HC: Minimum Data Set - Home Care

MDS-HC: Minimum Data Standards Home Care

MED: Medical Eligibility Determination

MFP: Money Follows the Person

MHN: Medical Homes Network Program

MMLTC: Medicaid Managed Long Term Care

MPH: Master's in Public Health

MSIS: Medicaid Statistical Information Statistics

N: Need

NASUAD: National Association of States United for Aging and Disabilities

NC: Nurse Consultant

NCQA: National Committee for Quality Assurance

NF: Nursing Facility

NH: Nursing Home

OSS: Optional State Supplementation

OT: Occupational Therapy

PAA: PASSPORT Administrative Agencies

PACE: Program of All-inclusive Care for the Elderly

PASSPORT: Pre-Admission Screening Providing Options and Resources Today

PCCM: Primary Care Case Management

PCP: Primary Care Physician

PCS : Personal Care Services

PE: Program Education

PF: Publically Funded

PIPS: Performance Improvement Projects

PMPM: Per Member Per Month

PP: Private Paid

PPACA: Patient Protection and Affordable Care Act of 2010

PPS: Prospective Payment System

PSC: Palmetto Senior Care

PT: Physical Therapy

RAI: Resident Assessment Instrument

RCF: residential care facility

RFP: Request for Proposal

RUGS: Resource Utilization Groups

SAMHSA: Substance Abuse and Mental Health Services Administration

SC: South Carolina

SCAN: SCAN Foundation/LTC

SCO: Senior Care Options

SIS: Support Intensity Scale

SNF: skilled nursing facility

SNP: Special Needs Plan

SPA: State Plan Amendment

SPMI: Serious and Persistent Mental Illness

SPOE: Single Point of Entry

ST: Speech Therapy

STRIVE: Staff Time and Resources Verification Project

UAI: Uniform Assessment Instrument

ULTC: Uniform Long Term Care

UP: Unpaid

VR: Vocational Rehabilitation

Directory of Interviews

The Lucas Group met with or consulted with the following people to create this report.

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2011 The Lucas Group Survey of SCDHHS Regional CLTC Offices

1. Explain steps the Regional office does to drive unnecessary costs out of the LTC system and promote cost effective, and quality enriched community based care.

- All services authorized for participants are justified, reviewed and approved by trained staff.
2. Case managers are instructed to remember maintenance of effort clause when authorizing services- in other words, if another agency/group/individual is already providing the care is willing to continue, allow that and do not duplicate or replace with a CLTC service. 3. Area Administrators now are aware of how much is being spent weekly by service by program with new enhancement of PHX of Office Expenditures.
- Service level approval by state employees has helped some but still depends on standards set in each area office. (Our office begins with least amount of service hours and build upon that as needs can be justified.) ADHC service is promoted as much as possible, as this service offers the most for the dollars spent. Phoenix gives us some quality assurance info but probably not enough
- The overall cost of LTC does not involve me directly. We have recently been given the task to monitor and approve the need for service. Assignment of cases to NC to drive cost down.
- On new cases, Nurse Consultants do a comprehensive assessment, then, Case Manager II sets case up for services , considers all information and then develops a service plan to meet the participant's needs. Number of hours authorized is of paramount concern & must be justifiable. For on-going Community Choice participants, all services /hours must be approved by an authorized state employee. (Usually, Social Worker III and /or Area Administrator.) Cannot conclude however, that these measures "promote quality enriched community based care". May need to consider quality of service package versus quantity of slots filled. ????
- This was discussed at a meeting in the area office and have no additional comments.
- We store donated incontinence supplies in our office and encourage the case managers to deliver these supplies to participants before authorizing more. We utilize our State vehicle whenever possible to keep individual mileage reimbursement requests down. We are tough on Prior Approval requests for personal care services and usually recommend a split of PC I and PC II services rather than approving PC II only.

- Currently implementing the prior approval process to assess service needs. Nurses are being assigned to geographical areas to reduce travel expense.
- It is not so much things the local office does but we do take necessary steps to ensure Case Managers are following the Policy and Procedure already in place. The Lead Team Case Manager and CMII are primarily responsible for Prior Approval Authorization of services. As the AA, I monitor the higher level of services request. Case Managers are required to submit Rationale for Increase Hours form and they must document needs of the Participant. The area routinely gets some incontinence supplies and nutritional supplements donated by church groups and some local agencies. This serves as a resource to pass to our Participants. There are various reporting in Phoenix and this helps with monitoring service levels and ensuring quality case management on the Administrative side.
- Prior Approval Process. Travel planning. (Scheduling of home visits in same area). Referrals to other agencies. (Senior Companion Program and Lower Savannah COG, etc.). Determined participants in same home and allocated hours based on this factor. Strive to determine that all participants meet the level of care standards for program. LOC approvals by state staff.

2. Why do you think so many elderly and physically disabled people end up in nursing homes instead of remaining in their homes or accessing community based living options?

- Families don't know there is another service. Seniors learn their options from drug stores, home health groups. Nursing homes do NOT always tell people there is another option. They tell beneficiaries about options at health fairs and hospitals. Most people hang in there as long as can; they want to avoid nursing homes. When families hear about estate recovery it scares them
- Many of the elderly and disabled need/require 24 hour care and this not available from CLTC. Many families are now stressed with doing more with less, and they just cannot afford the care of an elderly person so NH has to be the option. Often times, families can deal with the elderly/disabled person until that person becomes totally incontinent and that will determine that a person has to go to the NH. Usually the last straw.
- Long waiting list, not enough respite care providers, we offer no in-home respite services for the families, lack of family support, participant requires more care than CLTC can offer,
- Limited family, community support and the need for care 24hrs. Some families may not have enough knowledge of the CLTC program.

- There seem to be several factors; they are: inability to serve clients at home before they reach nursing home level of care; the South Carolina (SC) level of care criteria is very restrictive (due to low state revenue/ funding); SC Medicaid budget crisis, affecting CLTC's ability to meet service needs; lack of funding for adequate amounts of incontinent supplies; and finally, family dynamics/situation.
- Often the family is in crisis and with the agency eligibility process and statewide waiting list is not an option for families.
- Lack of knowledge of CLTC waivers 2. Lack of reasonable housing options for the disabled and elderly. 3. Lack of in-home respite care as a CLTC waiver service
- There is a need for 24 hours of care. There is a lack of family support in the community for the elderly and disabled and many families lack knowledge of the CLTC program. In our region, there is a need for more Day Care facilities, Adult Care Homes and Respite Care Facilities.
- Because we are only able to provide limited services to this population and sometimes this is not enough. We see our Participant population getting younger and sometimes there is no one at home or in the community to provide round the clock care. While we have been able to serve more people in the CBWS program, there is still a very long waiting list in our region. Staff reduction/vacancies have been a big problem for us getting folks off the waiting list and into waivers. Another side is the financial criteria and getting them qualified
- Limited Family support. Lack of family commitment to provide care unless service is being paid for by DHHS. (Attendant caregiver program and companion services). Medical advice of attending physician. Forced for placement without having real knowledge of what is going on. Work schedule of family members. Needs exceed what can be met in community based program. Some participants require twenty-four hour care.
- Best place to be. They can't manage the other times. Incontinence is the main issue. Many people have mental health issues.
- Lack of family support. They are sick. Incontinent. Stroke or diabetes.

3. How would you improve the SC system to enable more beneficiaries to be served in home and community based settings in the near future?

- We need more slots and more nurses

- We are wasting time on intake
- Improve communication/work flow between CLTC and Medicaid Eligibility. Many apply for one but not the other- both agencies spend a lot of time working on cases that never get approved. Simply the process somehow - make the ME workers who work on CLTC cases more of a part of CLTC? CLTC/ SCDHHS must find a better way to project staffing needs and not wait for years to fill positions that are needed to assess beneficiaries to determine eligibility for the programs.
- We need more state workers to initiate these beneficiaries entering into HCBS and to follow-up with quality assurance.
- Educate medical staff and hospitals on community based programs. Participate in more Health Fairs.
- Provide a continuum of care for elderly/disabled clients.
- Social Security allows presumptive disability for HIV/AIDS for a six month period to apply for disability, which allows benefits during this period. The ability to enter applicants into the program without waiting could improve the success rate.
- The State Legislature must be educated regarding what CLTC would need (both funding for services and for more personnel) to significantly increase the number of participants served in the Community Choices Waiver.
- MD's should be educated about the CLTC program. Conduct more training and educational programs for medical staff throughout the counties. CLTC staff will plan to attend and promote Health Fairs to educate the community. Promote speaking engagements at various senior housing communities.
- Change the qualification guidelines to make it more accessible. There are a lot of folks who have problems understanding the SC system. While improvements have been made to making it a one stop referral process, there are still too many barriers from making the Medicaid application to actually getting services in the home.
- Solicit providers such as Wal-Mart to provide services such as wipes, space heaters, fans, etc. We pay \$7.00 for wipes and this product is available at Wal-Mart for \$2.00 or less. Fans and space heaters can be purchased at a lower rate.

- Limit service hours and encouraged family members to maintain their involvement in providing care. Family members are more dependent on CLTC for services since they can be paid to care for their family member. This has opened job opportunities for families and they call and state I want to be the attendant for my family member. This tends to lead to no commitment, but money geared
- Discontinue allowing family members to change their role status from primary caregiver so they can be the attendant for their child. We see so many times that the primary caregiver is the mother/parent caring for their child and they have selected in writing only that someone else be the primary contact when in fact the primary caregiver lives in the home with the participant and serves as the attendant and contact is made with the attendant which is not permissible since you are monitoring the work of the attendant.
- Family members are not always the best caregiver. Participants are afraid to address concerns when the family member is the caregiver. Sometime services are paid for and not delivered.
- We need to limit service hours.
- We need to review the appeal process when services are reduced to ensure that appeal examiners understand the program and that the intent of this program was never to meet all needs, but to supplement what families can do along with other coordinated services. We have created a history of dependence with budget restrictions.
- Everyone should get less help, but the same number of hours
- Wish we could hire for vacant staff spots, before staff actually leaves the office
- More modern, referral application via internet versus phone
- No referral available online currently
- Telemedicine
- Relax criteria – time wise drop the exception that people have to be in a nursing home for 90 days

- Level of care criteria is good
- Could serve more people with more staff
- Would need more CM2's

4. What connection to local hospital discharge planners do you have? Does your office have contact with hospital discharge planners to determine effectiveness for diversion into community based settings, and, if so, can you explain the process that is used? Is it a process that is coordinated, and how do you see the process improving in the future so that more seniors can live independently in the community?

- There is great communication, they know our number all too well
- Community groups are helpful
- Greenville Area on Aging
- United Way – hosts a meeting where they discuss difficult cases
- Hospital referrals are inconsistent, it often depends on who the discharge planner is
- We should get rid of Optional State Supplement (OSS)
- Roy would be the person to speak with about this, it sounds like he may be aware
- A CLTC Nurse Consultant is assigned to each hospital in this area. The hospital discharge planners and the assigned CLTC NC do seem to have a good connection and rapport. I see the CLTC nurses helping the hospital d/p planners with challenging cases. However, with the workload of the nurses, there is very little time to spend conferencing and collaborating with other professionals. In the "older days" of CLTC I think more emphasis was placed on working closely with discharge planners than is placed on that activity currently.
- We do work closely with local d/c planners but not necessarily in a coordinated process. NC's see and talk with d/c planners on a regular basis but most of conversations center around NHP. Even though d/c planners are encouraged to make CLTC referrals as appropriate, most of the time they feel frustrated with CLTC's long WL and find it more helpful to make referrals for HH services which can evaluate immediately. Once HH evaluates then they are typically the ones to make the CLTC referral. We definitely need to

coordinate better to improve the referrals for waived services.

- Receive frequent calls from local hospitals requesting levels of care. Great communication with hospitals and provided several trainings in hospitals with RN's and Social Workers.
- Our connection /responsibility to local hospital discharge planners is that we provide the level of care determination / certification on all Medicaid applicants choosing to enter facility under Medicaid payment, as well as the final determination on PASARR requests. It is well coordinated; however, there is room for improvement in terms of keeping discharge planners knowledgeable of services available (Medicare, Medicaid, VA benefits, Managed Care Programs, etc.)

Community Choice participants are not followed by their CM while in the hospital (with exception of a monthly contact call, if required). That said, an improvement may be that the CM follow their client more closely if hospitalized or in nursing home for rehab. By serving on Inter-agency committees, there is an opportunity to share knowledge of existing resources as well as ideas/ needs for community based clients. Also, our office offers and provides training for local hospitals. (I am currently working on an agenda for a November 18, 2011 training session for staff at Palmetto Richland Hospital)

- The office nurses visit the local hospitals for nursing home evaluations, so have a working relationship, but not toward community based care.
- We have almost daily communication with the d/c planners at our larger hospitals, and they are always glad to use CLTC as the major part of a patient's d/c plan. Their bottom line is to get the client out of the hospital ASAP. But they do little more than refer to CLTC or pursue residential care or nursing home placement.
- We have good communication with all discharge planners in various hospitals. We have provided training to various hospitals about the CLTC program and recently attended a Health Fair at a local hospital.
- In the Charleston region, there are eight hospitals we closely work with. MUSC, being the largest of the group and very active, I've met with the Director of Clinical Effectiveness and their billing coordinator to discuss our referral process. We e-mail with problems. I, along with a nurse consultant, have done In-services at MUSC and Trident Regional hospitals. Yes, very much. We have a working, positive relationship with discharge planners. Each hospital is assigned a nurse consultant responsible for working with the discharge planners. The hospital is familiar with the nurses and they contact the area office when guidance is needed. Also, referrals are faxed to the area office and nurse consultant on Intake that day

processes the referrals and makes the assignments. The hospitals can contact the Intake nurse consultant with questions or contact the LTNC and AA as needed for guidance on processing hospital discharges.

The process is coordinated. The process could improve with more nurses to quickly process the paper work. It would be good for the hospital to have access to the Phoenix system to make referrals and key the assessment. This could expedite the process.

- All participants hospitalized and seeking Medicaid sponsored nursing home placement should be assessed by CLTC prior to placement. I can't say diversion is an option. Generally, once the referral is received the decision has already been made for placement. However, discharge planners refer other participants that need community based services. We work together to ensure continuity of care on participants that are admitted to the hospital and enrolled in our program to ensure services are re-established upon discharge. A CLTC Case Manager housed at large local hospitals could perhaps deter nursing home decisions by giving participants and family members options to nursing home placement or allow them to make an informed choice.
- Good connection. One nurse per facility.
- We try to let them know about the changes
- Work with the hospital to coordinate
- Nurse sees people in hospital
- Discharge planners communicate with hospital
- Intake should be centralized
- More consistent intake would save money
- No effort made for nursing home diversion
- Discharge planners do not make an effort to find other options
- Beneficiaries feel overwhelmed

5. Do you have care transition responsibility for persons leaving hospitals?

- We do not have care transition responsibility. If we could get them into Home Again, we would. But usually the waiting list is so long that they are in a nursing home or back home before we get them.
- Yes. I think we do. I think it is appropriate and helpful when CLTC can work with the hospital CM and the family and have some services close to being in place with the person leaves the hospital.
- No
- None
- Yes, please refer to question #4.
- Not until the recent change to policy to exempt the waiting list for hospitals.
- We are responsible for assessing a client (referred to us by the hospital for home-based services) prior to d/c home, if at all possible. The d/c planner is responsible for ensuring home health (RN or PT, OT, ST) services are in place if the doctor orders skilled medical services. CLTC cannot actually enter the client into the waiver or provide services until that client is at home.
- No. Social workers in hospital settings have that responsibility. Nurse coordinators are assigned to various hospitals.
- Services are expedited based on need.
- Yes, discharge planners generally alert CLTC staff when participants are admitted and are ready for discharge to resume services. Perhaps it would be beneficial for hospital discharge planners to have access to MMIS which reflect enrollment of participants in different programs. Participants are not always in touch with the specific name of agencies, they know they are receiving services.
- Yes, along with the nursing homes
- When we are notified of discharge, we notify providers
- Other hospitals take on care coordination, work with families

- No we do not have transition care responsibility

6. Describe the capacity of home and community based providers currently in your region, and the ability for them to handle more waiver slots in the future? Is there a concern that there may not be enough capacity to handle a significant number of new community based waiver slots and is there a concern about the quality of community-based providers?

- There is a lot of competition and lots of excess capacity
- Tony might have data on capacity
- Some contractors do a better job finding quality employees
- Quality can be better or worse
- Beneficiaries often talk to their friends to find out about quality
- SCDHHS is in the process of creating a quality metrics
- I think that in this particular area of the state, we have an ample number of community based providers who are anxious to receive more waiver participants. I think these providers have the capacity to handle a significant number of new slots.
- We have adequate PC/meals/Incontinent Providers in our region for the most part. We may have a few sporadic issues because of participant living in isolated area. Case Management does concern me because the cm's are contract employees. If they don't like a participant or participant is difficult or participant lives in an isolated area, they can decline the case after they have covered the case for the full month. We have had "problem cases" go thru all provider choices with every provider declining. We do not have state staff that can manage these cases. Also, there are 2 other services that we need providers to expand into our area should SC substantially expand CC slots. They are ADHC & Respite Care Providers. We need to locate central areas within the area offices and promote the need for providers for these two services. The only real concern I have about the quality of care would be related to family members wanting to be paid Attendant/Companion and looking at this primarily as a resource for money first rather than participant's care first and money secondary. Quality of care can be difficult to assess if primary contact is also the paid Attendant. Participant/EOR may or may not be truthful.

- In this region we have a good representation of providers. In need of more ADHC providers and a desperate need for Respite Providers.
- In Region 5, we have over 100 personal care providers on our provider list; a high percentage of those do not and have never provided services to our participants. Thus, assessing the quality of their care and /or ability to provide service at any level is not possible. For providers that do have CLTC participants, it would be helpful for them to be ranked so that participants can choose from an extremely long list, much more intelligently. (Believe Central Office is working on this arduous task.)
- Anderson County has enough reliable providers of all services except Companion – Agency. Oconee County is very rural and lacks reliable providers of personal care as well as Companion – Agency. BOTH counties, indeed the entire state, needs available providers of Respite Care, both Residential and Institutional.
- At present, there is not a concern regarding adequate supply of providers
- We have adequate providers in the area. We do have some remote, rural areas where provider coverage is an issue. This has improved over the years but still these areas have fewer choices.
- -Yes, I feel we have adequate providers to meet the needs of participants that we serve. Some providers have few referrals. We need to enhance the standards and requirement of providers for enrollment. More monitoring of provider service delivery would be beneficial. We need to restrict as much as possible providers serving family members.
- Not many hospitals and nursing homes in the area
- Many areas are rural
- There are a lot of providers, it's never a problem to find them
- Able to handle expansion
- Area is a rich health care environment
- Nursing school locally

- Some quality, some are not
- Personal care aid has the most providers
- Adult day care does not have as many providers, would like to see it expand
- There is capacity for quality care
- 6 of the 25 providers get the most referrals and have the best reputation

7. Do you feel that SC is effectively coordinating efforts to rebalance long term care across all agencies in that handle waiver programs for chronically ill seniors, including those that are disabled and mentally ill? If not, explain why not? Do you think there could be better examples of effective options for improved coordination and collaboration in state LTC policy and operation that has a global view of the needs of the Medicaid beneficiary?

- DDSN will send us a lot of people, we don't know why they don't use their own waiver?
- Mental Health has very limited staff, they no longer visit homes. Beneficiaries must come to their office.
- I do not think SC is effectively coordinating efforts to rebalance across all agencies. I think that DHHS-CLTC is being used as a place to send people that could be better served by DDSN and Mental Health agencies. Even when DDSN or MH have an opening for one of our participants on the appropriate program, the DDSN worker or MH worker presents it to the participant in a way that deters the participant from changing. However I think that CLTC is serving a lot of participants that should be on other programs rather than CLTC.
- I think SC has made huge efforts to rebalance long term care between NHP and community services. There does need to be improved coordination between the different waivers. We have a number of participants on CC waiver that would be more appropriate for the HASCI waiver. I understand they have a long WL also but if they put our participants as a priority then we would have more open slots for folks that did not qualify with any other waiver. Also, we tend to have a difficult time coordinating info needed on mentally ill participants with state agency. These are participants who usually don't fit nicely into our LOC criteria and typically we need guidance/more info from Mental Health. Because of HIPPA and them not accepting our consent form, this causes delay in obtaining needed valuable info.

- Services are limited for the mentally ill homebound participant. In need of Day Programs for the mentally ill and the utilization of ADHC.
- I cannot give an informed opinion.
- No, the DDSN waivers are allowed to limit the number of individuals served to very small population and then give family members the CLTC office phone number. DDSN is allowed to bill for other services that often are expensive but have limited impact on quality of life for the applicants.
- No, SC is not effectively coordinating efforts to rebalance LTC across agencies. I suppose that there is little incentive for state agencies to do so. Handling the mental health piece across agencies is especially needed.
- There are not enough mentally ill Day Care programs; there is a need for more ADHC providers and Respite Care providers. We need develop a better avenue for mentally ill home bound clients to assess their particular needs.
- No. Folks are still waiting on services either because of the financial eligibility process or because waiting list are lengthy for community based waiver services.
- No, Coordination of meals is coordinated effectively. DDSN and Mental Health Agencies tend to refer their clientele to CLTC. This is not always the best means of treatment/care for these participants. DDSN contact with their participants is limited and sometimes once or twice a year. Needs of the mentally ill seems to be so unmet as well as disabled individuals. These individuals present with behavioral problems/challenges that require more than what can be met through DHHS. Vocational Rehab involvement with the disabled need to be reviewed for more involvement and structured services to meet the needs of their clientele. I strongly believe that all services agencies need to have a realistic view of their clientele, challenges they face and a commitment to serve regardless of the problems encountered.
- Many people should be on the DDSN waiver
- There should be more interagency meetings in counties and state
- Regional directors used to meet, but now they don't

8. Why do you think people choose nursing homes?

6 Need services as soon as possible

10 Have no family support

4 Have no housing

7 Other (specify) _____

- Vermont has a good system for placing people in homes. It's like total care. The local community in Vermont is very supportive too – helping elderly/ABD people keep jobs.
- Need 24 hour care
- Addressed above
- Family Members unwilling to commit to care of family members unless services are being paid for by other entities.
- Forced in placement without adequate knowledge.
- Work schedules of family
- Rehab - cardiovascular (stroke/amputation) family overwhelmed

9. Where are you interacting with potential applicants to inform them about their long term care options?

- In nursing homes? No. Not unless they ask.
- At agency
- Community/Health Fair

- At the annual Senior Expo
- Other Agencies (Trident Area Agency on Aging, Disability Resource Center, Agency Providers, disability boards, etc.
- It's like a network. People find out from home health agencies, hospital discharge planners, personal care providers, and nursing homes.
- In the past we have told people about their options at medical events, and they learn through contact with their doctors and hospitals. It is possible beneficiaries fall through the cracks and do not learn all their options. People also learn about their options on TV.

10. How well do you think the current assessment process for HCBS waiver services is working? Are there any organizational or process improvement strategies you would like to see implemented?

- I think the current assessment process works very well. I do think there are some parts of the assessment that should not be completed at the initial assessment time by the nurse as it takes a lot of time and effort on gathering information and then so many of the applicants never apply for Medicaid and never enroll in the program.
- I think our assessment process does work well. It would be helpful to tighten up our intake criteria to make it more compatible to our LOC criteria.
- Yes, Centralize intake to include several counties with economic and cultural similarities.
- The current assessment process for HCBS works well. A centralized intake system will certainly stream-line process, and this should begin January 2012.
- Centralized intake, which is coming soon, will streamline and give more consistency to the referral process. It will also speed up the assessment process by freeing up the Nurse Consultants to get out of the office and into the field to make home visits.
- There are no problems with the current assessment process. It has been previously suggested to centralize the intake process.

- I think it works well. Phoenix is a wonderful system. Care Call is a wonderful tool to monitor services. Centralizing the Intake process. Phoenix being a web base system allowing hospitals access to make referrals and input the initial assessment. Nurses could then verify information and establish level of care.
- Stronger implementation of the level of care process ensuring that participants meet the established level of care criteria initially and on-going. State workers review cases for loc determination, but we only see what is written, on site home visits would be beneficial to ensure continued eligibility of participants. This would mean more state staff needed to ensure this monitoring concern. Contract workers are paid by case; there is no incentive for them to disenroll a participant. Disenrollment would mean a reduction in their pay. To reduce service levels, could mean that participants request a new service provider or case manager.
- Financial Eligibility worker located in all regional offices to concentrate on CLTC referrals.
- Utilization of Lower Savannah COG in assisting participant with completion of Medicaid applications in areas available.
- Works well and the assessment is good
- Phoenix is helping
- Works well
- Consent form is disjointed with Phoenix
- Assessment of home environment is thorough and useful
- Working well
- Has improved since we went to Phoenix

11. How well do you think the current financial eligibility process for HCBS waiver services is working? Are there any organizational or process improvement strategies you would like to see implemented?

- Takes forever, the range is 6 months => never completed
- Companies take a long time to produce documents for beneficiaries
- They should weed out excessive documents
- Staff is overwhelmed
- The financial eligibility process needs to be reviewed and streamlined. If the CLTC nurses did not constantly call the ME office, we would very rarely receive a Client Status Document. The applicants get confused, do not receive needed applications. Often ME will say an applicant's paperwork was not received, when the applicant says it was. There has to be some way that this process could be improved upon. All of the Medicaid eligibility offices are not the same- some require more paperwork than others.
- Our smaller counties seem to manage better with the financial eligibility process and do a great job. From a CLTC perspective, participants are usually familiar with the local eligibility worker's name and feel comfortable with calling them for eligibility questions in these smaller counties. Unfortunately, our larger counties appear not to have enough trained Eligibility staff so we tend to see applications & updates to CLTC offices back-logged.
- The eligibility process is adequate given their perceived staffing issues. It would be helpful to have an assigned CLTC staff person (county). Also, continuity between hospital eligibility worker and county eligibility worker would be a much needed process improvement.
- Process is complicated for families who often are often overwhelmed and have limited education. Is it possible other states have a more streamlined process or has this been evaluated? Is it possible to explore with CMS the possible ability to allow a brief application with the longer require application to be completed with 6 months?
- It works better in my two counties than in most other areas of the state. Yet we spend too much time sending forms back and forth by regular mail. We need to have the capability to e-mail ALL forms between CLTC and Medicaid Eligibility, as we're both part of SCDHHS.
- There is a need for better access to MMIS. Within this region we have found that Medicaid eligibility is slow in returning the Client Status Document and we would like to

see this process to be more efficient. We would like to see 2 ME workers placed in the regional CLTC offices.

- ? I have seen much improvement with communication between the two divisions, CLTC and Eligibility. We are fortunate in that we are co-located and this makes it easier. We have a working relationship with the workers and they are responsive to e-mails. More eligibility workers directly responsible for determining financial eligibility for CLTC participants..
- Process is too long in some counties in determining eligibility. A financial eligibility worker located in all Regional Offices would be beneficial and should reduce the process or wait time if they are focusing on CLTC participants only.
- Not well
- Solution: "I wish they worked with us"
- Could they have an office located inside of SCDHHS?
- Not being processed fast enough
- Varies in county – process speed ranges
- Would like to connect electronically
- No way to track speed because it is manual
- It is inefficient
- Bugged down
- County often works well with us but they don't have much staff
- Usually turn over in 1 month
- Providers have been willing to provide services for 30 days, then bill retroactively

12. Based on the current staffing of your regional office do you think the scope, amount, and productivity of the workload is just about right, too little, or too much? Please add any thoughts you

may have about changes you might suggest that would improve the efficiency, productivity, and sense of teamwork in the regional offices.

- Understaffed and overworked
- Should centralize intake
- Get rid of OSS
- Scanners need software
- More nurses
- Outside of scope of work – Children PCA program – not waiver
- Takes up a lot of nurses time
- Currently my office has been 1 nurse short since last December 2010. Now here it is almost December 2011, and I have another nurse that is retiring. I have also been short the lead team nurse position all of 2011. It would greatly improve efficiency, productivity and sense of teamwork if these positions were filled. The nurse's workload is high. The nurses do much more work than is reflected when tracking completed assessments. A nurse may go to visit a waiver applicant and spend twice as long as that one home explaining estate recovery issues, talking about the program- to several family members- and never make an assessment- yet this is not reflected in their "productivity". The nurses spend time talking with families and applicants, people who call the office looking for help, working with case managers, etc. that is not captured in this number. When you have decreased nurses, you also have to ask the nurses that you do have to travel farther distances which takes much of the work day. I think that the staffing of the office should also be based on the number of the participants on the program in your office and the number of applicants on the waiting lists, etc. I think the CMII's are also overworked. In my office which has a large # of Comm Choices and HIV cases, I have 2 CMII's. But these 2 CMII's have more cases to team staff, more questions to answer and things to follow up on than they can handle. If we had another CMII then we could track things more carefully and find errors and improve services. I also am concerned about the administrative support staff of the area offices as it appears to be decreasing. I think we often think because things are automated, that we can do with less people, but I do not think this is the case. It is very difficult to manage a large office with only 3 support staff to assist. Salaries are at the very lowest of the state and do not

compare from office to office. There should be some way to make salaries more equitable or we are going to lose qualified workers who are excellent employees.

- Regarding NC's, we have 1 position that was vacated one year ago and we have been unable to fill. The other NC's have tried to compensate for this vacant position but they are beginning to get burned out. The assessment that NC's complete for CC/HIV waivers is the same assessment CM's complete for re-evaluations. NC's have so many other jobs that must be completed in a timely manner. Maybe it would be better if we had more state cm's so as to let state cm be the ones to complete the initial assessments, talk about potential services at this visit, etc. Families get so confused with so many people involved with our process. (NC sees the participant, CMII calls and enters into waiver, and then assigned cm sees again at IV.) Biggest problem with this would be because Feds give higher rate for nurses to make initial assessment. Also, with the recent change in Lead Team CM's being demoted in their supervisory title, this has cause negative and hurtful feelings. Nurses have always been brought in at a higher pay than the state case managers. This is common knowledge. Both roles play such an important part to make the area office successful but seems like higher up put more wedges between the 2 groups, like taking the LTCM's supervisory away.
- At present, all staff are feeling the stress of adding additional participants, i.e. larger caseload, more assignments, keeping up with policy changes. I do take teamwork seriously; thus, we have a Hospitality Committee who plan monthly events. We also plan fund raising events for our Client Fund. (**On Fridays I usually bring a baked good or doughnuts as a token of appreciation for the week's work & time for us to socialize.
- The office does not have nursing staff or the nurse support staff due to unfilled positions to keep filling slots. Suggestions for statewide intake have not been implemented yet, but should be beneficial.
- The work load for our (Area 11) State employees is too great. We really need a second Case Manager II as well as an additional Nurse Consultant. Having both would enable us to assess more applicants at any given time and enter more participants into the waivers more quickly, thus serving more people.
- Within our CLTC office we have many staff vacancies. This has become taxing on other staff members regarding work load (overload). There is a need for temporary or part-time RN's to complete nursing home conversions. Most of our case managers have reached their maximum case load capacity and it is foreseeable that there will be a need for more case managers to be hired. These problems have been addressed in

other surveys.

- Too much for areas with staff shortages. We could use a support staff dedicated to working the CC/HIV waiting list as a primary job function. All non-waiver children cases could be processed and managed by the Medically Complex division.
- No, additional staff is needed to assess and enroll participants in some Regional Offices. Area Administrators are too involved with enrollment, service level approvals. We need more time for community involvement and daily operation of the office. Contract staff requires accessibility for training and we need more concentration on quality assurance to ensure compliance with federal mandates. We need not only to ensure that timeliness standards are being met, but quality documentation, assessment, follow-up on problems identified, etc. There is no time for in depth quality assurance.
- Staff has too much work
- 1 Vacancy currently for a nurse
- 1 Vacancy for a lead nurse
- Large geographic area
- Why not let CM2's telecommute?
- Went from 8 nurses to 4, new nurse starts Sept. 2nd
- Down a data coordinator, down a team case manager and quality assurance
- Waiting list has almost doubled, people scoring 100 on the list need to get moved
- CM2's overwhelmed
- Intake should be centralized

13. Given South Carolina's receipt of the recent CMS grant focusing on Dual Eligibles Services Integration Innovative Models, what ideas or strategies would you suggest to develop a "seamless" system for people eligible for home and community based services?

- Medicare should pay for the first 30 days
- I do not understand Dual Eligible Services and how that is going to impact our program.
- Not sure
- We did have a presentation by Mr. Nathan Patterson in July 2011, but implementation has not started . I do think that any program to de-institutionalize clients, needs to start before the option/ decision for nursing home placement is made. Clients/families need an expedient, inclusive package of services to go home with, from the hospital or emergency room. If Medicare was mandated to pay for this, then dual eligibles could be managed by a community nurse manager, and followed through the continuum.
- Not sure of this policy yet.
- I'm not familiar enough with this model to comment.
- Provide Medicare recipients with information about Medicaid programs.
- Since I have little understanding of how this will impact Community Long Term Care participants, I am not able to give any strategies or ideas. Hopefully, the system will be for the purpose of making the application process less complicated and can provide more services to those dually eligible.
- I am unclear as to how this is going to impact the participants we serve. Many we serve are dually eligible. If they are involved in managed care they must disenroll to be enrolled in our program.
- Don't understand dual eligible grants
- Not familiar with program
- Not familiar with Dual Eligible's program

14. Integrated health homes and comprehensive care management models have become major goals of health care reform and many states seeking improved access, outcomes, quality, and cost efficiency. Are there any planning efforts, strategies, augmentation to current practice or new care delivery ideas/systems that you would recommend to achieve these goals in South Carolina?

- Spartanburg has the highest rate of geriatricians in the state, but most of them now work in nursing homes
- I am not familiar enough with these concepts to know.
- Not sure but one big need we see on a regular basis regarding comprehensive care management is the need for financial counseling for our participants. We try to find resources to handle the immediate problem (pay \$100 on light bill to keep utility company from cutting services off this month) but we do not have resources to offer financial counseling to help solve the big picture..
- None
- I have read about Oregon's proposal/experience with this, but really do not have enough knowledge to answer intelligently.
- N/A
- The IHH model is very interesting to me and should be explored as a viable option in our state. We've always been big on pilot programs...Maybe CLTC could partner with one other state agency (possibly DDSN), several residential care facilities, and several nursing facilities in one area of the state (Upstate?) to try this model.
- Applicants in the nursing home can bypass the waiting list; this allows a more efficient discharge to CLTC program.
- These systems could be improved if easier understood by consumers allowing for voluntary enrollment and disenrollment at any time. Models could improve health care reform if it allowed for home making type services or companion services for the elderly and disabled. Models could improve health care reform if participation would focus on preventions; allowing persons to receive In-home care if they do not qualify for nursing home care because they are higher functioning for the SC criteria for nursing home level of care.
- Homes for individuals with psychiatric problems with quality service delivery, case monitoring, and supervision with strong treatment efforts. More intense treatments and accountability. Staff trained to meet the specific needs of these clients.
- Should not just be medical people

- Agency should be involved in health home
- Need more info
- Not familiar with this program

15. If someone cannot be served in home do you have a residential care alternative? If SC were to substantially expand the number of community slots would the provider capacity be there in the community to serve their needs with quality. If not, what steps should be taken to make sure the capacity meets the need?

- Need staff
- There is residential care –not nursing home level
- Sliding scale diabetes cannot go to residential care
- Residential care such as adult home service? or Residential home as in boarding home. I think the answer to either way is no.
- Our area is very limited with RCF's that accept OSS payment. There are 2 services that we need providers to expand into our area should SC substantially expand CC slots. They are ADHC & Respite Care Providers. We need to locate central areas within the area offices and promote the need for these two services.
- Continued training of all staff and monitoring on the state level for compliance.
- Not sure about what you are asking here.....if a client enters our Community Choice program, we cannot serve them in a Certified Residential Care Facility (CRCF) and most likely they do not meet level of care. Increasing our slots would not have an impact on these facilities.
- N/A See #6
- Licensure of personal care aides in SC would be a wonderful thing to promote the profession and ensure better quality of care. We do have residential care facilities that have OSS (Optional State Supplement) -- meaning Medicaid -- beds, and years ago CLTC could provide certain services to RCF residents. That is no longer allowable. We need other housing options, for example group homes for four to six seniors with a live-in

caregiver in each home.

- Within our region, there is limited capacity at Residential Care Facilities. In this region, we have numerous providers available for CLTC services. The Integrated Personal Care Program should be expanded in Residential Care to allow the resident to remain in Residential Care rather than going into the nursing homes, this applies to those needing 24 hour care.
- Yes, there are many residential care homes in the area. There should be residential care facilities or homes designed specifically for taking care of the mentally challenge or those with mental disabilities. Currently, those individual have little choices and nursing homes may not be an appropriate placement. Residential Care facilities have in the past taken on that role but they are not staffed to handle this population. Hospitals tend to seek nursing home placement for this group due to few options. Residential care could be a substitute if specialized services were available to them.
- Enhance the requirement guidelines of current and potential providers. We have residential care facilities, but I feel we need better monitoring of facilities to ensure quality service delivery and appropriateness of placement. Yes, I feel we have the provider capacity.
- Services are very restricted under community choice under DSS
- Residential care is provided by private parties, very limited
- Yes, there is excess capacity
- We do not place people the state does
- Need more housing options
- Florida has done a lot for seniors
- There need to be more smaller homes where 6-8 people can receive care
- Most people like social interaction
- Yes there is capacity with varying levels of quality

Nursing Home Facility Providers Thoughts on Regulatory Reform

In talking with some of the nursing home facility providers, Lucas Group also learned that the state could relax some regulations, which allow the providers to reduce the cost of compliance. In most cases the state would realize cost savings as well. Although this particular issue may not be directly related to the scope of our analysis regarding the rebalancing of long term care, we believe it is important enough to highlight for policy makers to consider, since these stakeholder concerns related to cost of compliance could impact the state's overall plan.

A few notable regulations that should be reviewed to determine their effectiveness, given the cost to the providers to comply are:

- SNF dietary departments are currently being inspected on an annual basis by State Licensure, Food Sanitation and Certification at the Department of Health and Environmental Control (DHEC). The state should review this policy and consider extending the State Licensure and Food Sanitation inspections to a three-year cycle (and complaint-initiated inspections), for certified State Nursing Home Facilities that are in compliance for participation in the Medicaid and Medicare Program, and also had an "A" score on their last Food Sanitation inspection. Non-certified facilities should still be subjected to annual inspections. This would decrease the duplication of inspections and save the State money.
- Physicians are currently required to perform the initial history and physical for Medicaid residents in a nursing home facility. The state should consider allowing a nurse practitioner to perform this service with the M.D. signing off on the assessment.
- The state should consider a more structured Licensure Inspection and an Informal Dispute Resolution process to appeal citations. A structured inspection process, that included an opportunity for identified concerns to be discussed prior to the actual issuance of a citation, would allow the facility to provide additional information related to the identified concern. This would decrease the likelihood of a citation being issued when a deficient practice does not exist.

An IDR process would allow an avenue of appeal for issued citations in which the facility felt that there was not a deficient practice.

Health Reform Provisions Supporting Enhanced Care for Dual Eligibles

Affordable Care Act Provisions	Applicable Core Elements
<p>§2401 - The Community First Choice Option enables states to cover self-directed attendant care and transition services (e.g., first month’s rent and utility deposits) through a state plan amendment.</p>	<ul style="list-style-type: none"> • Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
<p>§2402 - The Removal of Barriers to Providing Home- and Community- Based Services provision amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to populations. The PPACA expands the §1915(i) State Plan Option in some areas, but eliminates states’ flexibility in others.</p>	<ul style="list-style-type: none"> • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
<p>§2403 - The Money Follows the Person (MFP) Rebalancing Demonstration provision extends MFP through 2016 and alters the required length of stay rules for individuals in facilities.</p>	<ul style="list-style-type: none"> • Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care
<p>§2602 - The Federal Coordinated Health Care Office provision establishes an office within the Centers for Medicare & Medicaid Services (CMS) to connect the Medicare and Medicaid programs to more effectively integrate benefits and improve coordination for dual eligibles.</p>	<ul style="list-style-type: none"> • Guidance from this office is expected to indicate its support for many of the core elements of integration.

Affordable Care Act Provisions	Applicable Core Elements
<p>§2701 - The Adult Health Quality Measures provision directs the Secretary to release an initial set of quality measures for Medicaid enrolled adults by January 1, 2011, and to work with states to develop a standardized format for reporting information based on the selected quality measures by January 1, 2013. This provision does not include long term services and supports (LTSS) - focused measures; however, this may provide a good opportunity for states to help develop national benchmarks for LTSS.</p>	<ul style="list-style-type: none"> • Adequate consumer protections, including an ombudsperson • Robust data-sharing and communications system
<p>§2703 - The State Option to Provide Health Homes for Enrollees with Chronic Conditions provision provides states with the ability to establish provider-based health homes for individuals with chronic conditions through a state plan amendment. Many dual eligibles would benefit from improved chronic condition management.</p>	<ul style="list-style-type: none"> • Comprehensive primary and specialty provider networks • Multidisciplinary care teams
<p>§3021 - This provision establishes the CMMI (CMMI) to test innovative payment and service delivery models. This provision includes specific models that CMMI can fund. Options include delivery models that promote care coordination and fully integrated care for dual eligibles.</p>	<ul style="list-style-type: none"> • Aligned financial incentives • Robust data-sharing and communications system
<p>§6703 - The Elder Justice Act of 2009 establishes numerous safeguards to protect frail elders from abuse and neglect. This provision includes grants and training to support the Long term Care Ombudsman program.</p>	<ul style="list-style-type: none"> • Adequate consumer protections, including an ombudsperson
<p>§10202 - The Incentives for States to Offer HCBS as an Alternative to Nursing Homes provision offers certain states an increase in federal match (FMAP) for HCBS services if the state meets specified requirements. To qualify for this provision, states must adopt a “no wrong door” enrollment process, conflict-free case management, and a standardized assessment instrument.</p>	<ul style="list-style-type: none"> • Comprehensive needs assessment • Personalized (person-centered) plan of care • Strong HCBS options, e.g., personal care

Current Authority Options for Integrating Care for Dual Eligibles Beneficiaries

Demonstration Authority

Medicare

Section 646: Section 646 of the MMA authorized Medicare Health Care Quality Demonstration Programs thereby establishing five-year demonstration programs to expand the physician group practice demonstration model and evaluate models to foster greater care coordination and disease management. This section expanded the definition of health care groups to include regional coalitions and integrated delivery systems in addition to physician groups. Most importantly, Section 646 allowed “health care groups” to incorporate approved alternative payment systems and modifications to the traditional FFS and MA benefit package. Authorized demonstrations must be budget neutral and can cover either FFS or MA beneficiaries.

State Example: North Carolina

Current Authority Options for Integrating Care for Dual Eligible Beneficiaries

Waiver Authority

Medicare

402/222: This waiver authority allows the Secretary to waive Medicare and Medicaid requirements to demonstrate new approaches to provider reimbursement, including tests of alternative payment methodologies, demonstrations of new delivery systems, and coverage of additional services to improve overall efficiency of Medicare.

State Examples: Massachusetts, Minnesota, and Wisconsin began their integrated programs using 402/222 waiver authority before moving to SNP authority.

Demonstration Authority

Medicare	<p>Section 646: Section 646 of the MMA authorized Medicare Health Care Quality Demonstration Programs thereby establishing five-year demonstration programs to expand the physician group practice demonstration model and evaluate models to foster greater care coordination and disease management. This section expanded the definition of health care groups to include regional coalitions and integrated delivery systems in addition to physician groups. Most importantly, Section 646 allowed “health care groups” to incorporate approved alternative payment systems and modifications to the traditional FFS and MA benefit package. Authorized demonstrations must be budget neutral and can cover either FFS or MA beneficiaries.</p> <p>State Example: North Carolina</p>
Medicare	<p>402/222: This waiver authority allows the Secretary to waive Medicare and Medicaid requirements to demonstrate new approaches to provider reimbursement, including tests of alternative payment methodologies, demonstrations of new delivery systems, and coverage of additional services to improve overall efficiency of Medicare.</p> <p>State Examples: Massachusetts, Minnesota, and Wisconsin began their integrated programs using 402/222 waiver authority before moving to SNP authority.</p>

Waiver Authority (cont.)

Medicaid

1115: Section 1115 of the Social Security Act authorizes the Secretary to waive certain federal requirements for the purpose of conducting pilot, experimental, or demonstration projects that are likely to promote the objectives of the Medicaid program. States have used this federal waiver authority to change their program in ways that would not otherwise be allowable under federal requirements (e.g., expanding coverage to new groups of people, modifying the delivery system, or changing the benefit package design). Projects are generally approved to operate for a five-year period, and states may submit renewal requests to continue the project for additional periods of time. Demonstrations must be “budget neutral” over the life of the project, meaning they cannot be expected to cost the federal government more than it would cost without the waiver. Importantly, Section 1115 waives the beneficiary freedom of choice provision allowing states to require eligible beneficiaries to participate in the waiver program.

State Examples: New York, Wisconsin

1915 (a): Section 1915(a) provides an exception to state plan requirements for voluntary managed care. Specifically, the Secretary is authorized to waive requirements under Section 1902(a) of the Act, including waiver from the requirement that the state plan be in effect in all political subdivisions of the state, waiver from the required list of covered services in the section, and waiver from the requirement that the state may not restrict the choice of Medicaid beneficiaries from obtaining medical assistance from any institution, agency, community pharmacy, or person qualified to perform the services by enrolling Medicaid-eligible beneficiaries in PCCM or Medicaid managed care. Section 1915(a) does not require an actual waiver or change to the state plan.

State Example: Minnesota

Waiver Authority (cont.)

Medicaid (cont.)

1915 (b): This waiver allows for, among other things, two-year renewable waivers for mandatory enrollment in managed care. Alternatively or in addition to managed care, a state may use selective contracting with providers on a statewide basis or in limited geographic areas. Section 1915(b) waivers must demonstrate their cost-effectiveness and must not substantially impair beneficiary access to medically necessary services of adequate quality. As opposed to the authority provided under Section 1932(a), this waiver option allows mandatory enrollment for dual eligibles in Medicaid managed care.

1915 (c): Section 1915(c) of the Social Security Act provides authority for Home- and Community-Based Services Waivers. This applies to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, the cost of which could be reimbursed under the state plan. Section 1915(c) waivers must be cost neutral and are renewable for five years after the initial three-year approval. States may opt to simultaneously utilize section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. By doing this, states can provide long term care services in a managed care environment or use a limited pool of providers.

State Examples (1915 b/c combos): New Mexico, Texas

Waiver Authority (cont.)

Medicaid

1915(i): Section 1915(i) of the Social Security Act provides for a State Plan Home and Community Based Services benefit option that allows individuals to access HCBS services through the State Plan instead of a waiver. Unlike 1915(c) waivers, individuals do not have to meet an institutional level of care to receive these services and States do not have to demonstrate that 1915(i) waivers cost the same or less than institutional services. This provision was designed to offer States an opportunity to offer services and supports before individuals need institutional care and provide a mechanism for States to provide HCBS services to individuals with mental health and substance abuse disorders. The original enactment prohibited states from targeting 1915(i) services to particular populations within the state and had a limit of financial eligibility not to exceed 150% FPL.

Section 2402 (see slide 66) of the PPACA permits States to continue to specify needs-based eligibility criteria but they are no longer permitted to limit the number of eligible individuals, establish a waiting list, or limit state-wideness. States are permitted to target specific 1915(i) waiver services to State-specified populations, and may modify the non-financial needs-based eligibility criteria without prior approval from CMS (60 day public notice; grandfathering of prior approved individual service plans who do not meet the new criteria as long as former needs-based criteria is met). States will be able to offer HCBS services without regard to comparability for specific populations. States will also be permitted to offer services that are different in amount, duration, and scope. Under this provision states may provide “any and all” services in 1915(c)(4)(b) of the Act including case management, homemaker/home health aide, personal care, adult day health, habilitation and respite care. In a direct attempt to address the Olmstead decision states may also offer day treatment, partial hospitalization, psychosocial rehabilitation, and clinic services to individuals with chronic mental illness. Self-directed plans of care may be included. States may request CMS approval for “other services” with the exclusion of “room and board.”

Foundation of SNPs

“Enactment of the Medicare Modernization Act (MMA) in 2003 introduced a new type of coordinated care health plan, the Special Needs Plan, into the Medicare Advantage program. SNPs are unique in that they can target enrollment to ‘special needs’ beneficiaries identified as:

- Institutionalized beneficiaries
- Beneficiaries with severe or disabling chronic conditions
- Beneficiaries who are dually eligible for Medicare and Medicaid (dual eligibles).”

– CMS State Resource Center

SNP Legal Timeline

		2007	2008	2009	2010	2011	2012	2013	Implications
SNP Authority	<p>2005 Deficit Reduction Act creates PACE</p> <p>2006 Part D, SNPs Created</p> <p>2003 MMA Created SNPs authorized until Dec. 31, 2008</p>	<p>MM & SCHIP Extension Act of 2007 extended SNPs to Dec. 31, 2008, but put in place a moratorium on the designation of new SNPs after Jan. 1, 2008.</p>		Moratorium on SNPs	<p>MIPPA lifted moratorium through 2010. No more disproportionate SNPs. 90% of members must be special needs.</p> <p>3 Types: I-SNPs, C-CNPs, D-SNPs</p>	<p>PPACA, Section 3205, reauthorized through Dec. 31, 2012</p>	<p>Must be approved by National Committee for Quality Assurance (NCQA)</p>	<p>Must be reauthorized</p>	<p>2013 is an Important date</p>
Grant Structure		(Mass. Pilots? Others?/ Dates about scope)				<p>Duals Grants: CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, WI</p>			<p>Magellan should learn about state models and development opportunities</p>
Gain Share/ Risk Share	<p>2004: Massachusetts SCO used Medicare capitation payment using PACE program methodology - applying frailty adjuster</p>				<p>PPACA directs CMS to find innovative payment & service model</p>				<p>No Change</p>
Waivers	<p>Omnibus Budget Reconciliation Act of 1981 creates 1915(c) HCBS waiver</p> <p>Balanced Budget Act of 1997 enables PACE without waiver</p>				<p>HCBS FMAP Incentive</p> <p>PPACA waiver authority moves to Office of Innovation</p>				<p>Authority changes</p>
State Contracts	<p>2005: Washington state</p> <p>2006: MassHealth SCO, New York Medicaid Advantage Plus, Texas STAR+PLUS, and Arizona Long-Term Care System (ALTCSS), Wisconsin Partnership Program</p>		<p>New Mexico Coordination of Long-Term Services (CoLTS)</p> <p>Minnesota's Special Needs Basic Care program (SNBC)</p>		<p>PPACA: self directs attendant care, H&CB, MFD, Health Homes</p>		<p>D-SNPs must have state contract</p>	<p>SNPs must have state contracts</p>	<p>Medicaid only SNPs get flushed out, State Approval Required</p>
Rates						<p>PPACA Freezes, benchmark rates for 12 months</p>	<p>Medicare benchmark reinstated</p>		<p>Bench Marking Process, Nothing New</p>
Quality			<p>CMS contracted with the NCQA. Use of Healthcare Effectiveness Data and Information Set (HEDIS) Measures</p>		<p>MIPPA Creates model of care and reporting requirements</p>				<p>SNPs are required to report quality data</p>

SNP Type	Description
Chronic Condition SNPs (C-SNPs)	<p>Restrict enrollment to special needs individuals with specific severe or disabling chronic conditions defined in 42 CFR §422.2.</p> <p>Includes</p> <ul style="list-style-type: none"> ▪ Chronicalcohol and other drug dependence ▪ Autoimmune disorders limited to: ▪ Cancer excluding pre-cancer conditions or in-situ status ▪ Cardiovascular disorders limited to: ▪ Chronic heart failure ▪ Dementia ▪ Diabetes mellitus ▪ End-stage liver disease ▪ End-stage renal disease requiring dialysis ▪ Severe hematologic disorders ▪ HIV/AIDS ▪ Chronic lung disorders Asthma ▪ Chronic and disabling mental health conditions: ▪ Neurologic disorders Amyotrophic lateral sclerosis (ALS) ▪ Stroke
Institutional SNPs (I-SNPs)	<p>Restrict enrollment to MA eligible individuals who, for 90 days or longer, are expected to need the level of services provided in a long term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for the mentally retarded (ICF/MR), or an inpatient psychiatric facility.</p>

CMS Uses 5 Terms to Describe D-SNPs

SNP Type	Description
All-Dual Eligibles D-SNPs	<p>Includes all categories of dual eligibles, including those with comprehensive Medicaid benefits as well as those with more limited cost-sharing such as Qualified Medicare Beneficiary without other Medicaid Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiary without other Medicaid (SLMBs), and Qualifying Individual (QIs).</p>
Full-Benefit D-SNPs (FBDE)	<p>42 CFR §400.202; 42 CFR §400.203; 42 CFR §423.34</p> <p>A full-benefit D-SNP enrolls individuals who are eligible for:</p> <p>(1) Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the State plan or comprehensive benefits under a demonstration under section 1115 of the Act ; or</p> <p>(2) Medical assistance under section 1902(a) (10) (C) of the Act (Medically Needy) or section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.</p>
Medicare Zero-Cost-sharing D-SNP	<p>42 CFR §400.202; 42 CFR §400.203</p> <p>This type of D-SNP limits enrollment to QMBs only and QMBs with comprehensive Medicaid benefits (Qualified Medicare Beneficiary with Comprehensive Medicaid Benefits, QMB+)—the two categories of dual eligibles beneficiaries who are not financially responsible for cost-sharing for Medicare Parts A or B. Because QMB-only individuals are not entitled to full Medicaid benefits, there may be Medicaid cost-sharing required.</p>

<p>FIDE SNPs:</p>	<p>FIDE SNPs are described in section 1853(a) (1) (B) (iv) of the Act and at 42 CFR §422.2. FIDE SNPs are CMS-approved SNPs that:</p> <ul style="list-style-type: none"> (1) Provide dually eligible beneficiaries access to Medicare and Medicaid benefits under a single MCO ; (2) Have a contract with a State Medicaid agency that includes coverage of specified primary, acute, and long term care benefits and services, consistent with State policy, under risk-based financing; (3) Coordinate the delivery of covered Medicare and Medicaid health and long term care services, using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) Employ policies and procedures approved by CMS and the State to coordinate or integrate enrollment, member materials, communications, grievance and appeals, and quality assurance. <p>This definition is awaiting approval as a published final rule, CMS-4144-F.</p>
<p>Dual eligibles subset D-SNPs</p>	<p>MA organizations that offer D-SNPs may exclude specific groups of dual eligibles based on the MA organization’s coordination efforts with State Medicaid agencies. CMS reviews and approves requests for coverage of dual eligibles subsets on a case-by-case basis. To the extent a State Medicaid agency excludes specific groups of dual eligibles from their Medicaid contracts or agreements, those same groups may also be excluded from enrollment in the SNP, provided that the enrollment limitations parallel the structure and care delivery patterns of the State Medicaid program. Enrollment coordination with State Medicaid agencies is described in detail in §50.6.2 of this chapter.</p>

Evidence-based Care Transition Models • Page 1 of 2

	BOOST Better Outcomes for Older (adults through) Safe Transitions	Bridge	Care Transitions (CTI) "Coleman Model"	Transitional Care Model (TCM) "Naylor Model"	GRACE Geriatric Resources for Assessment and Care of Elders	Guided Care
TYPE	Hospital to Home Transition Model	Hospital to Home Transition Model	Hospital to Home Transition Model	Hospital to Home Transition Model	Practice-based coordination models with Care Transitions elements	Practice-based coordination models with Care Transition elements
AGE	<input type="checkbox"/> Age 18+, with focus on older adults.	<input type="checkbox"/> Age 60+	<input type="checkbox"/> Age 65+ (may apply to younger adults)	<input type="checkbox"/> Adults age 65+	<input type="checkbox"/> Age 65+	<input type="checkbox"/> Age 65+
RISK FACTORS	<input type="checkbox"/> If dementia is present, then a reliable caregiver is required.	<input type="checkbox"/> Two or more of the following <ul style="list-style-type: none"> <input type="checkbox"/> Discharged with home health referral <input type="checkbox"/> Live alone <input type="checkbox"/> Hospitalized in the past six months <input type="checkbox"/> Caregivers stressed or overburdened <input type="checkbox"/> Determination of Need 29+ 	<input type="checkbox"/> Should be community dwelling adults with a working telephone. <input type="checkbox"/> Have at least one of 11 diagnoses. <input type="checkbox"/> Appropriate for persons with depression or dementia, provided they have willing and able family caregivers.	<input type="checkbox"/> Two or more risk factors, including: <ul style="list-style-type: none"> <input type="checkbox"/> Poor self health ratings <input type="checkbox"/> Multiple chronic conditions <input type="checkbox"/> History of recent hospitalizations <input type="checkbox"/> Cognitively intact (current testing among cognitively impaired hospitalized older adults and long-term care recipients)	<input type="checkbox"/> Low-income <input type="checkbox"/> May include adults at high risk of hospitalization (probability of repeated risk admission screen).	<input type="checkbox"/> Persons with medically complex health conditions. <input type="checkbox"/> At high risk of using health services heavily during the following year, as estimated by the daim-based Hierarchical Condition Category (HCC) predictive model.
POINT OF ENTRY	<input type="checkbox"/> Loose structure	<input type="checkbox"/> Hospital (with integrated Aging Resource Center)	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hospital (at admission)	<input type="checkbox"/> Primary care physicians' office	<input type="checkbox"/> Primary care physicians' office
GOALS	<input type="checkbox"/> Improve the care of patients as they transition from the hospital to home. <input type="checkbox"/> Provide resources to optimize the hospital discharge process. <input type="checkbox"/> Reduce 30-day hospital readmission rates. <input type="checkbox"/> Promote patient empowerment. <input type="checkbox"/> Improve information flow between hospital and outpatient physicians. <input type="checkbox"/> Improve patient satisfaction. <input type="checkbox"/> Ensure high-risk patients are offered specific interventions to reduce risk. <input type="checkbox"/> Improve patient and family education practices to encourage use of the teach-back process around risk specific issues.	<input type="checkbox"/> Reduce caregiver stress. <input type="checkbox"/> Increase consumer safety. <input type="checkbox"/> Reduce ED visits. <input type="checkbox"/> Reduce re-hospitalizations. <input type="checkbox"/> Improve adherence to the medical plan of care. <input type="checkbox"/> Increase older adult and caregiver satisfaction.	<input type="checkbox"/> Reduce rates of rehospitalization. <input type="checkbox"/> Increase patient confidence during transition and beyond. <input type="checkbox"/> Empower the patient and caregiver to assert a more active role during care transitions. <input type="checkbox"/> Develop lasting self management skills. <input type="checkbox"/> Use a patient-centered health record to guide patients through the care process. <input type="checkbox"/> Coordinate primary care provider and specialist follow-up. <input type="checkbox"/> Promote patient understanding of "red flags" and appropriate next steps.	<input type="checkbox"/> Reduce rates of rehospitalization. <input type="checkbox"/> Reduce ED visits for primary and co-existing conditions. <input type="checkbox"/> Prepare patients and caregivers to more effectively manage changes in health associated with multiple chronic illnesses. <input type="checkbox"/> Reconcile and manage medications. <input type="checkbox"/> Improve health outcomes after discharge. <input type="checkbox"/> Enhance patient and family caregiver satisfaction. <input type="checkbox"/> Reduce total (i.e., physician, hospital, and home health) health care costs.	<input type="checkbox"/> Improve quality of care. <input type="checkbox"/> Reduce acute care utilization among a high-risk group.	<input type="checkbox"/> Provide intensive transitional care. <input type="checkbox"/> Uses motivational interviewing to promote self-management. <input type="checkbox"/> Provide continuing education, resources, and support for family caregivers. <input type="checkbox"/> Address complex chronic conditions. <input type="checkbox"/> Employ a rigorous curriculum to ensure that RNs possess necessary skills. <input type="checkbox"/> Utilize Electronic Health Record.
STAFFING	<input type="checkbox"/> No explicit care coordinator. <input type="checkbox"/> Team orientation, including clinical nursing staff, MDs, primary care physician, Social Workers, case managers, pharmacists, medical records personnel, hospital informatics, data analyst, nutrition/dietary staff. <input type="checkbox"/> Family caregivers <input type="checkbox"/> Optional: ED staff	<input type="checkbox"/> Social Workers	<input type="checkbox"/> Nurse/Transition Coach (model is open to person not being a nurse). <input type="checkbox"/> Someone with strong interpersonal skills, the ability to make the shift from doing things for patients to facilitating skill transfer so that the patients can do more for themselves.	<input type="checkbox"/> Transitional Care Nurse (in the study, this was an advanced practice nurse with a MSN degree and advanced knowledge and skills in serving older adults. Currently evaluating outcomes with bachelors-prepared nurse.)	<input type="checkbox"/> Program utilizes nurse practitioner and social worker who work with the primary care physician, geriatrician, and other relevant health professional in a team-based approach	<input type="checkbox"/> Must be a registered nurse, ideally with experience in home care, case management, community health and/or equivalent gerontologic nursing
LENGTH OF INTERVENTION	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> 30 days	<input type="checkbox"/> On call seven-days per week. <input type="checkbox"/> Home visits and telephone access for one to three months of home follow-up (two months on average)	<input type="checkbox"/> Long term/definite. <input type="checkbox"/> Contact with patient in evaluation was two years.	<input type="checkbox"/> Long term/usually for life.

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Evidence-based Care Transition Models • Page 2 of 2

	BOOST Better Outcomes for Older (adults through) Safe Transitions	Bridge	Care Transitions (CTI) "Coleman Model"	Transitional Care Model (TCM) "Naylor Model"	GRACE Geriatric Resources for Assessment and Care of Elders	Guided Care
DESCRIPTION	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Use team approach to assess patients' risk for re-hospitalization. <input type="checkbox"/> Plan and execute risk-specific discharge planning activities. <input type="checkbox"/> Tailor communications. <input type="checkbox"/> Provide outpatient providers and receiving sites with a discharge record. <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Use "teach back" for discharge education. <ul style="list-style-type: none"> o Simple lay language, with explanation and/or demonstration. o Asks patient/caregiver to repeat in his or her own words. o Identifies/corrects misunderstandings. o Repeats steps until convinced that patient/caregiver comprehends information and safety is ensured. <p>Follow-up (for high-risk patients)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Outpatient follow-up visit is scheduled, and/or <input type="checkbox"/> A 72 hour follow-up call with the patient and/or the caregiver is conducted. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Identify patients for participation (at Rush University Medical Center, hospitalized clients are identified through a risk screen integrated into the Electronic Health Record). <input type="checkbox"/> Meet with patient and/or caregiver in hospital room or in the hospital's Aging Resource Center. <p>Identify unmet needs:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Set up services prior to discharge. <input type="checkbox"/> Provide discharge information (i.e., a patient-friendly, one-page "Patient PASS" containing all vital information for successful transition (e.g., test results, diagnoses, MD contact info, warning signs, follow-up appointments, medication regimen). <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Call participant within 48 hours of discharge to assess their situation. <input type="checkbox"/> Make additional calls or schedule face-to-face visits to resolve identified problems. <input type="checkbox"/> Utilize consumer-driven health record to relay critical information to care providers involved with an older adult's post-discharge care. <p>Follow-up</p> <ul style="list-style-type: none"> <input type="checkbox"/> At 30 days post-discharge, track patient's progress and address emerging needs. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Transition coach conducts hospital visit <input type="checkbox"/> Uses tools such as the Personal Health Record (PHR) <p>Post-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts one home visit 24-72 hours post discharge <input type="checkbox"/> Actively engages patients in medication reconciliation. <input type="checkbox"/> Uses role-playing and other tools to transfer skills. <input type="checkbox"/> Reviews any "red flags" that indicate a worsening of conditions and strategies for how to respond to these red flags should they manifest. <p>Follow-up</p> <ul style="list-style-type: none"> <input type="checkbox"/> Performs three follow-up phone calls reinforcing coaching <input type="checkbox"/> Discusses encounters with health care professionals <input type="checkbox"/> Reinforces importance of maintaining/sharing the PHR & supports patient's self-management role. 	<p>Pre-discharge</p> <ul style="list-style-type: none"> <input type="checkbox"/> Assessment in hospital room (including details of patient's functional status). <input type="checkbox"/> Daily visits. <input type="checkbox"/> Collaborate with care team members to reduce adverse events and prevent functional decline. <input type="checkbox"/> Develop a streamlined evidenced-based plan of care. <p>Home visit (within 24 hours of discharge):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Evaluate ADLs/iADLs/safety. <input type="checkbox"/> Recommend adaptations. <input type="checkbox"/> Refer to other services. <p>Follow-up:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Accompany patient to post-discharge MD visit and subsequent visits, as needed <input type="checkbox"/> Facilitate MD-RN collaboration across episodes of acute care <input type="checkbox"/> Conduct weekly home visits for one month. <input type="checkbox"/> Make phone contact for each week if in-person visit not scheduled. <input type="checkbox"/> On-call seven days per week for home visits and telephone access. <input type="checkbox"/> Provide active engagement of patients and family caregivers with focus on meeting their goals. <input type="checkbox"/> Facilitate communication among patient, family caregivers, and health care professionals. 	<p>Nurse or Social Worker</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts home visit <input type="checkbox"/> Meets with GRACE interdisciplinary team <input type="checkbox"/> Meets with primary care physician <input type="checkbox"/> Implements individualized care plan <input type="checkbox"/> Arranges additional home visits and phone calls, as necessary. <input type="checkbox"/> Supports transition from hospital to home 	<p>Guided Care Nurse:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Conducts in-home assessment <input type="checkbox"/> Creates a care guide and an action plan for patients <input type="checkbox"/> Provides monthly monitoring and self-management coaching <input type="checkbox"/> Provides smooth transitions into/out of hospitals and other institutions <input type="checkbox"/> Coordinates care by all providers <input type="checkbox"/> Provides family caregiver education/support <input type="checkbox"/> Facilitates access to community based services.
STAFF TRAINING	<ul style="list-style-type: none"> <input type="checkbox"/> Day long training sessions (fee-based) <input type="checkbox"/> Year-long coaching/mentoring program (free, courtesy of grant from the John A. Hartford Foundation). 	<ul style="list-style-type: none"> <input type="checkbox"/> Bridge Training Module 	<ul style="list-style-type: none"> <input type="checkbox"/> Recognition as an official CTI adoption, and model fidelity, requires one-day training for the Transition Coach, delivered by CTI staff on-site or in Aurora (Denver), CO. 	<ul style="list-style-type: none"> <input type="checkbox"/> U of Penn Web-based training modules prepare nurses to become Transitional Care Nurses, plus training on the clinical information system. It takes an average of one month to orient a new TCN. 	<ul style="list-style-type: none"> <input type="checkbox"/> Nurse Practitioners and Social Workers complete a 12-session training program (with meetings held once a week) on GRACE protocols and interdisciplinary teamwork). 	<ul style="list-style-type: none"> <input type="checkbox"/> All candidates must complete the Johns Hopkins 5-week, 40 hour web-based course, pass an on-line exam, and earn a Certificate in Guided Care Nursing from the ANCC.
COST	<ul style="list-style-type: none"> <input type="checkbox"/> Unknown, but includes tuition (\$26,000 per site) 	<ul style="list-style-type: none"> <input type="checkbox"/> Unknown 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$74,310 (\$196 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$115,856 (\$982 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention costs for high risk patients: \$310,040 (\$1,432 per patient) 	<ul style="list-style-type: none"> <input type="checkbox"/> Per research study, total annual intervention cost was \$95,900 (\$1,743 per patient)
WEB	<ul style="list-style-type: none"> <input type="checkbox"/> www.boscitalmedicine.org/BOOST 	<ul style="list-style-type: none"> <input type="checkbox"/> http://hmcrg.org/programs/projects/transition-care-consortium/ 	<ul style="list-style-type: none"> <input type="checkbox"/> www.caretransition.org 	<ul style="list-style-type: none"> <input type="checkbox"/> www.transitionalcare.info 	<ul style="list-style-type: none"> <input type="checkbox"/> http://medicine.jhu.edu/LUCAS/research/grace.htm 	<ul style="list-style-type: none"> <input type="checkbox"/> www.guidedcare.org

Source: Department of Health and Human Services, Administration on Aging, <http://www.aoa.gov>

Waiting List Priority Levels

Community Choices Priority Levels

- Priority 1
 - Incomplete assessment (phone or in-home)
- Priority 2
 - In-home assessment (complete or incomplete)
 - Level of care is Medically Ineligible
- Priority 3
 - Phone assessment
 - Level of care is Medically Ineligible
- Priority 5
 - No assessment
 - Medicaid eligibility **NOT** verified
- Priority 7
 - No assessment
 - Medicaid eligibility verified
- Priority 8
 - Phone assessment
 - Level of Care is intermediate or skilled
 - Medicaid eligibility **NOT** verified
- Priority 9
 - Phone assessment
 - Level of Care is intermediate or skilled
 - Medicaid Eligibility verified
- Priority 10
 - In-home assessment
 - Level of Care is intermediate or skilled
 - Medicaid eligibility **NOT** verified
- Priority 12
 - In-home assessment
 - Level of Care is intermediate or skilled
 - Medicaid Eligibility verified
 - Waiting for a slot

Waiting List Status

- Normal – no slot assignment has been made
- Flagged – all criteria for enrollment has been met; applicant can be enrolled in the waiver
- Dormant – all criteria has been met but the person was not enrolled in 30 days; applicant can be enrolled in the waiver

09/10/10

08/01/11 Community Choices Waiting List Priorities

Area Office	Priority 12	Priority 10	Priority 9	Priority 8	Priority 7	Priority 5	Priority 3	Priority 2	Priority 1
1	13	104	14	103	5	7	0	0	0
2	6	25	29	234	2	2	24	0	0
3	1	19	56	161	0	1	16	0	0
4	6	53	29	85	8	15	27	1	1
5	5	34	116	319	2	7	43	0	0
6	4	13	21	63	1	0	18	0	0
7	0	18	79	200	0	4	12	1	0
8	2	9	107	183	15	9	64	0	0
9	9	68	83	263	1	4	74	0	0
10	3	12	33	317	0	0	51	1	0
11	2	14	26	128	3	4	14	0	0
13	5	17	3	50	3	3	39	0	0
14	1	10	54	161	1	4	12	0	0
15	0	0	4	6	0	0	1	0	0
Statewide	57	396	654	2,273	41	60	395	3	1

*Sumter → Mass
Florence to be
down
nurses*

Source - Phoenix Data
File Name - Waiting List Census
Report Provided By - Community Long Term Care
Report Printed - 8/1/2011

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End Notes

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