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Health Care Strategies, Inc.

Medicaid-Funded Long- Term Supports and Services: *Snapshots of Innovation*

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Innovations in the Medicaid Continuum of Care Series

This report is part of CHCS' *Innovations in the Medicaid Continuum of Care* series, developed to help state and federal policymakers identify high-quality and cost-effective strategies for addressing the full range of clinical and long-term supports and services (LTSS) needs of Medicaid beneficiaries. The first three publications in the series, supported by the Robert Wood Johnson Foundation and Aetna, provide policy and technical resources to guide LTSS program development and implementation. Additional materials available at www.chcs.org include:

- **Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options** – Brief outlines initial federal policy suggestions for reforming the nation's Medicaid-funded LTSS system.
- **Systems of Care: Environmental Scan of Medicaid-Funded Long-Term Supports and Services** – National scan details the current publicly funded long-term care delivery system and broadly outlines opportunities and obstacles for LTSS reform.

Future materials will delve more deeply into specific options for transforming long-term care programs to support the full continuum of consumer needs.

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers and consumer groups to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity.

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Additional Interviewees

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Foreword

National policymakers and state Medicaid leaders across the country are paying greater attention to better management of long-term supports and services (LTSS). The reasons are obvious: aging of the baby boom population; severe fiscal pressures; the disproportionate share of costs absorbed by those with serious long-term conditions; an ongoing over-reliance on institutional forms of care; and the fact that LTSS remains almost entirely in the unmanaged fee-for-service system. This combination of factors presents state purchasers with significant opportunities to improve care and control costs by better coordinating and managing the full continuum of long-term care services.

To help states explore and understand emerging options, CHCS is launching a new publications series: *Innovations in the Medicaid Continuum of Care*. With support over the past several years from the Robert Wood Johnson Foundation and Aetna, CHCS has been working with states to design and test new approaches for organizing, financing, and delivering LTSS. This new series builds on this in-the-field work. This document offers highlights of innovative programs that are advancing the realm of possibilities for Medicaid-funded home- and community-based services. Future materials will delve more deeply into specific options for transforming long-term care programs to support the full continuum of consumer needs.

We thank all of those who have contributed to this series, especially Gretchen Engquist, Cyndy Johnson, and William Courtland Johnson; and the many state and program innovators interviewed along the way. I extend our gratitude to my colleagues at CHCS — Alice Lind, Lindsay Palmer Barnette, Melanie Bella, and Lorie Martin — and to all of the funders who have supported our efforts to inform national and state policymakers about emerging opportunities to improve LTSS.



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I. Introduction

Over the next two decades, analysts project that the states will collectively spend nearly \$1.6 trillion dollars for long-term care supports and services (LTSS) for elderly and disabled citizens and the federal government will contribute an additional \$2.1 trillion, for a total of \$3.7 trillion. Current estimates are that more than two-thirds of Americans age 65+ today will need long-term care with an average duration of need of about three years.¹ In light of this, cash-strapped states are seeking fresh approaches for delivering Medicaid-funded LTSS effectively and affordably, with an emphasis on reducing costly institutional care through home- and community-based (HCBS) “aging in place” initiatives.

This report provides snapshots of innovative initiatives across the country that we believe are deserving of enhanced attention and, perhaps, replication.

II. Long-Term Supports and Services: Provider Innovations

Aging Center Initiatives

The Martha Stewart Center for Living
The Martha Stewart Center for Living at Mount Sinai Medical Center in NYC (visit www.mountsinai.org) provides a home for the facility’s outpatient geriatrics services and offers a new model for the practice of geriatric medicine. Described as a “revolutionary new way to pass the torch,” Dr. Rosanne Leipzig, Vice Chair for Education of the Brookdale Department of Geriatrics and Adult Development, explains: “We’ve never had an older generation like this one, or the next one. People didn’t make it to this age, living a third of their lives in retirement.”

In response to these changing circumstances, Mount Sinai has implemented an innovative “geriatrics for the non-geriatrician” approach within its medical school. In fact, it is one of only a handful of medical schools in the country that require a month-long rotation in geriatric medicine for every student. The “Seniors as Mentors” program matches every incoming student with an older

SNAPSHOT: Martha Stewart Center for Living	
DESCRIPTION	Offers elderly individuals access to the full continuum of care delivered by an interdisciplinary team of trained professionals with broad experience in geriatric care
SERVICES	Comprehensive primary, preventive, acute, urgent, and behavioral health care as well as ancillary services like physical therapy. Staff members also coordinate care with HCBS providers and inpatient facilities.
LOCATION	New York City (there are a number of similar initiatives in other locales)
ELIGIBLE POPULATION	Medicare-eligible individuals age 65+
FUNDING	Medicare is the primary payer, with additional funding from Medicaid for the dually eligible as well as commercial insurance and private pay for non-duals
MOST INTRIGUING FEATURE	Access to a comprehensive range of acute care and LTSS in a single facility

¹ D.A. Shostak and P.A. London, PhD. “State Medicaid Expenditures for Long-Term Care, 2008-2027,” America’s Health Insurance Plans (September 2008).

patient in the Mount Sinai outpatient geriatrics program, which is housed within the Martha Stewart Center. That relationship continues all the way through the student's fourth year, constantly evolving to reflect the student's newly acquired skills as well as the senior mentor's health care needs and strengths. While other medical schools offer such programs as electives, Mount Sinai is one of the very few that requires every student to participate. The theory is that whether a student is training to become an ophthalmologist or a cardiologist, he/she will be seeing growing numbers of older patients.

The center primarily serves individuals residing in the local community, and the ethnic composition of its patients mirrors the diversity of its far Upper East Side location (i.e., 99th Street and Madison Avenue). Approximately 25 percent of the center's patients are African-American and another 30 percent are Hispanic (or identify themselves as primarily Spanish speakers). Nearly one third are dually eligible for Medicare and Medicaid. The center currently serves Medicare-eligible patients aged 65 years or older, but it is considering raising the age limit owing to the finite number of individuals they are able to serve (approximately 2,500 registered patients at any given time; the current average age is 87 years old). At present, there is a roughly three-month waiting period for new patients. However, once they become registered there is no problem accommodating patients on a timely basis. In fact, the center operates as a "mini" urgent care clinic with same-day appointments and walk-ins accepted.

Staffing: The center is committed to a multi-disciplinary care team approach and its staffing is reflective of this. Currently, there are four full-time-equivalent (FTE) physicians, 1.6 FTE nurse practitioners, 2.6 FTE RNs and 1.5 FTE social workers. There are also four medical assistants and four administrative employees. The classes (e.g., yoga, tai chi, Pilates, fall prevention) are taught by volunteers and open to any registered patient. New York Junior League volunteers support a variety of craft classes as well as a "Positive Images in Aging" series. Junior League volunteers also support a "telephone buddy" and hospital visit program to assist with socialization for the center's patients.

Services: The Coffey Geriatrics Associates Outpatient Practice is also housed in the Martha Stewart Center, caring for approximately 2,500 patients and completing about 11,000 office visits per year. The Visiting Doctors program, which brings medical care to homebound patients, is comprised of an additional 1,000 patients. Behavioral health services are integrated with physical health care through the geropsychiatry department, which assigns psychiatrists to treat patients at the center two days per week. If a patient is admitted for inpatient care at Mount Sinai, the Coffey practice's Mobile ACE (Acute Care for Elders) unit monitors the individual's progress and coordinates discharge planning and follow-up care. In addition, the center's licensed clinical social workers assist patients and their families in locating and accessing services available in the community, including home- and community-based long-term care services (e.g., personal care, home health, etc.).

The center has also implemented an electronic medical record (EMR) system that is in use throughout the Mt. Sinai system, which enables it to receive immediate notification if one of its patients visits the ER or is admitted to the hospital. While the center is not open on weekends or holidays, there is an on-call care team available 24/7.

The Hertzberg Palliative Care Institute's outpatient clinic within the center helps patients and family members to make critical decisions that will have long-term effects on the lives of their loved ones — as well as their own. One of its most important tasks is facilitating collaboration on these decisions among patients, family members, and care providers. Distinct from hospice, palliative care is not preparation for dying, but medical care focused on relieving pain, managing symptoms of multiple illnesses, detecting and reducing medication side effects, as well as education and advocacy. The palliative care team was recently expanded to include not only physicians and nurse practitioners, but also such disciplines as social work, massage therapy, and chaplaincy, among others. The professionals who deliver palliative care do not take over a patient's medical treatment, but instead serve in a consulting role.

Innovations: Collectively, the center has a large enough pool of patients to test new ideas and develop innovative initiatives in approaches for caring for the elderly. As an example, it provides a range of complementary and integrative therapies to patients and community members, including mindfulness-based stress reduction, tai chi, and yoga. As described by Dr. Patricia Bloom, the Director of Integrative Health for the center, “these therapies have a somewhat different philosophical basis . . . with the therapist serving as a partner in guiding the patient to utilize internal resources to aid in the healing process.” The center is also experimenting with group visits for patients with hypertension, congestive heart failure, and diabetes (on a voluntary, self-selected basis) and finds the peer group dynamic is having positive results.

A Replicable Model: The physical plant aspects of the center may be difficult to replicate, as it is housed in a “spa like” setting designed by C. C. Pei, the son of world-renowned architect I.M. Pei, and constructed with the assistance of a \$5 million donation by Martha Stewart, who also contributed her own significant design expertise. The result is a 7,800-square foot center with its own dedicated entrance that incorporates architectural and design features rarely found in traditional hospital settings. However, the essential elements of this type of medical home model for the elderly, coupled with the innovative teaching aspects of the program, should be replicable in other states and medical schools. In fact, the center’s leadership is actively promoting the concept and is willing to assist other institutions in developing similar programs.²

Adult Day (and Night) Care Services

“My Second Home” (Westchester County)

Family Services of Westchester County, NY operates a program known as “My Second Home.” The program is essentially an intergenerational social adult day service, which is not ordinarily a reimbursable Medicaid service. However, under New York’s Lombardi Program of Long-Term Home Health Care (LTHHC), which is also known as the “Nursing Home without Walls” program, the service can be reimbursed by Medicaid under a 1915(c) initiative for those enrolled in the program. The facility operates six days a week and serves 50 or so individuals a day, including door-to-door transportation using buses and vans, which is also reimbursable by Medicaid in New York State.

SNAPSHOT: My Second Home & Short-Term Nursing, Respite, and Night Care	
DESCRIPTION	Innovative approaches in the delivery of community-based adult day (and night) care institutional services
SERVICES	Traditional adult day care and overnight respite care
LOCATION	New York City region
ELIGIBLE POPULATION	Elderly individuals suffering from Alzheimer’s disease and related dementia
FUNDING	Medicare, Medicaid, commercial long-term care insurance, and private pay
MOST INTRIGUING FEATURES	<ul style="list-style-type: none"> ▪ Integrating adult and child day care to the mutual benefit of both ▪ Offering overnight respite care to provide informal caregivers with a good night’s sleep

One of My Second Home’s most interesting innovations is a combined child care and adult day health program with Mt. Kisco Child Care Center in which toddlers and the elderly participate together in various activities such as gardening, yoga, stories, songfests, and art projects, as well as special occasion celebrations. While many adult day programs invite young people to visit and perform with little or no intermingling, My Second Home is specifically designed for ongoing interaction between generations. According to Family Services, “by blending

² Interview with Dr. Audrey K. Chun, Medical Director, Martha Stewart Center for Living, March 11, 2010.

activities for older adults and children, both age groups acquire an understanding of shared values and respect for individuals at every stage of life.”

The results have been impressive. Elderly patients have responded well to their new-found “grandchildren,” helping them with art projects or working alongside each other in the home’s garden. Some of the frustration and agitation displayed by elderly persons with dementia seems to “melt away” when working with these young children who do not respond to them as being “unusual.”

In this respect, My Second Home represents an impressive adaptation of Dr. William Thomas’s Eden Alternative™ — a prescription for encouraging relationships among nursing home residents by improving the physical and social environment. Providing access to plants, animals and children are all key ingredients of nursing home “Edenization.” The idea is to provide seniors in nursing homes with the opportunity to give care instead of just receive it.³

In addition, My Second Home offers a home-like environment where personal care, nutrition, and wellness activities are provided to the elderly. Meals and snacks are prepared on-site and focus on locally grown, seasonal products. The program is staffed primarily with certified nursing assistants, a social worker, and a recreational activity supervisor, all of whom are overseen by a Program Director. The co-located facility was built specifically for My Second Home and the Mt. Kisco Child Care Center with private foundation funding. It is essentially a neighborhood-based physical plant built in a home-like style which is open so it is easy for staff to observe and monitor the activities of those in attendance.

The program also serves private-pay individuals, with the approximate difference between the private-pay rate and Medicaid reimbursement (through a contract with the LTHHC program) amounting to \$20 per day. By balancing its mix of patients, Family Services is able to operate the program with only a small operating loss.

Researchers at the Marilyn and Gordon Macklin Intergenerational Institute in Findlay, Ohio, found that preschoolers who interacted frequently with older adults showed advanced social development and improved manners over children in regular day care. Additional studies are underway in the hope of finding that children in intergenerational day care have enhanced language skills and self-confidence.⁴

Like the Martha Stewart Center for Living, My Second Home represents a worthy prototype for replication in other locations (The ONEgeneration Program in Van Nuys, CA operates a similar model). Having said this, issues related to Medicaid reimbursement for this type of social day (vs. medical) model need to be addressed, since many individuals who could benefit from this program will be dually eligible for Medicare and Medicaid.

Short-Term Nursing, Respite, and Night Care (Riverdale, New York)

The rebalancing trend toward home- and community-based service delivery has created a heightened demand for away-from-home family/caregiver respite services, especially among those caring for individuals with Alzheimer’s disease and related dementia (ADRD). As an example, ADRD often leads to disturbed sleep patterns, making it difficult for family members or caregivers to get the rest they need. In response, a number of skilled nursing facilities are offering short-term (i.e., 16 hours or less) respite services to provide caregivers a temporary reprieve from their demanding responsibilities.

To help alleviate this problem, the Hebrew Home in Riverdale, NY offers its “Eldercare at Night” program that arranges to have patients picked up from their homes in the early evening and brought to

³ National Center on Physical Activity and Disability, “An Eden Alternative: A Life Worth Living,” The University of Indiana (2003). <http://www.indiana.edu/~nca/ncpad/eden.shtml>

⁴ D.S. Hildebrand. “Intergenerational Day Care: Where the Older and Younger Generations Meet,” (June 2007). http://senior-leisure-activities.suite101.com/article.cfm/intergenerational_day_care

the area of the facility used by their adult day services program for dinner, therapeutic activities, socialization, and perhaps to rest or sleep, although if they do not wish to sleep there are activities to keep them occupied throughout the night. The facility’s staff also administers any needed medications and monitors vital signs, etc. In the morning, they receive personal care (e.g., a “shower and shave”) and are served breakfast prior to being transported home. In the interim, their family members/caregivers can enjoy a peaceful evening and restful night without the responsibility of maintaining constant vigilance over their loved one’s activities.

The 10-year old program employs 10 recreational therapists, nurses, and aides who attend to up to 40 individuals on a typical evening, few of whom are Jewish. Most participants are covered by Medicaid; the private fee is \$215 per night. The program is available from 7:00 pm to 7:00 am, 365 days per year.⁵

Nursing Home Culture Change: Green Houses

Pioneered by geriatrician Dr. William Thomas and supported by the Robert Wood Johnson Foundation and other organizations, the Green House nursing home model has garnered widespread interest across the nation. Green Houses are small group homes that use a social and habilitative model of care and staff empowerment to serve elders who need skilled nursing care. Conceived as part of a movement to change the culture of long-term care in America, they are designed to feel more like home than typical nursing homes and to blend into their community or surroundings. Designed to house and care for 10 to 12 elderly residents, Green Houses are organized around a self-managed team of staff who share in the tasks involved in caring for the residents — everything from housecleaning and cooking to medication management, delivered in ways completely different from those in an institutional setting.

SNAPSHOT: Green House Nursing Home Model	
DESCRIPTION	Green Houses represent a revolutionary approach to nursing home transformation
SERVICES	Skilled nursing facility services
LOCATION	Replicated in various locations throughout the nation
ELIGIBLE POPULATION	Individuals requiring skilled nursing facility services.
FUNDING	Medicaid, private long-term care insurance, and private pay are the primary funding streams
MOST INTRIGUING FEATURE	Green Houses make an institutional setting seem more like a home

Simple changes like these appear to improve seniors' behavior and health. For example, Green House residents are called "elders," not "patients." Unlike most nursing homes, residents can have pets and instead of mandated mealtimes, they have the flexibility of choosing when to eat. According to a recent University of Minnesota study, Green House residents have a higher overall quality of life and are better able to perform daily functions than people in regular nursing homes.⁶ Doctors report that they receive fewer urgent calls after hours because the staff interacts so closely with the residents every day that they can tell when there has been a significant change in a person's condition and can explain symptoms in greater detail. Preliminary research on Green Houses indicates that this more personalized approach may result in lower staff turnover and in residents with fewer complications spending less time bedridden.⁷

⁵ Interview with Daniel A. Reingold, President and CEO, The Hebrew Home at Riverdale. See also C. Buckley and J. Estrin. "All-Night Care for Dementia's Restless Minds," *New York Times*, June 12, 2009. http://www.nytimes.com/2009/06/14/nyregion/14cover.html?_r=1&hp

⁶ R.A. Kane, T. Lum, L.J. Cutler, H.B. Degenholtz, and A-C. Yu. "Resident Outcomes in Small-Group-Home Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program." *Journal of the American Geriatrics Society*, (2007):55 (6), 832-839.

⁷ J. Rabig, W. Thomas, R.A. Kane, L.J. Cutler, and S. McAlilly. "Radical Re-Design of Nursing Homes: Applying the Green House Concept in Tupelo, MS." *The Gerontologist*. (2006): 46 (4), 543-539.

The success of this model and the autonomy it provides its residents has led to the 50th Green House opening in the United States a full year earlier than anticipated. According to a recent article in *Parade Magazine*, about 30 percent of traditional nursing homes are beginning to adopt aspects of the Green House model, including creating smaller "households" within larger facilities.⁸

Larry Minnix, President and CEO of the American Association of Homes and Services for the Aging, says that the biggest criticism of Green Houses he hears is that it is not financially viable to run nursing facilities with only 10 or 12 residents.⁹ The Robert Wood Johnson Foundation continues to evaluate the model's financial sustainability and early indications suggest that it is financially doable. However, a recent analysis of the financial viability of the large-scale culture change initiative implemented by the large, for-profit nursing home chain Beverly Enterprises suggests that many hurdles lie ahead.¹⁰

⁸ S. Fine. "Reinventing America: Where to Live As We Age," *Parade Magazine* (May 31, 2009). <http://www.parade.com/health/2009/05/where-to-live-as-we-age.html>

⁹ L. Ellerman. "Green House = Better Alternative than Nursing Home," Legal Medicine Blog Posting (June 24, 2008). <http://legalmedicine.blogspot.com/2008/06/green-home-better-alternative-than.html>

¹⁰ L.A. Grant. "Culture Change in a For-Profit Nursing Home Chain: An Evaluation," The Commonwealth Fund (February 13, 2008). <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2008/Feb/Culture-Change-in-a-For-Profit-Nursing-Home-Chain--An-Evaluation.aspx>

III. New Directions for Managed Long-Term Care

While making only halting progress across most of the nation owing to state-level political opposition and provider resistance, managed long-term care is increasingly regarded by researchers and policymakers as a key solution for integrating and rationalizing the delivery of LTSS. At the same time, traditional fee-for-service models have recently introduced a number of important innovations in the delivery of home- and community-based services, including consumer-directed care and the patient-centered medical home. The sections that follow describe a number of approaches for incorporating these fee-for-service (FFS) initiatives into a managed care model.

Consumer Direction in Managed Long-Term Care

Two noteworthy trends are simultaneously emerging across the Medicaid long-term care landscape:

- **Consumer Direction** – in which individuals eligible for LTSS are given the choice of determining the services and supports they need and the ability to hire, train, supervise, and fire the direct care workers who provide the services.
- **Managed Long-Term Care (MLTC)** – in which states contract with managed care organizations (MCOs) to oversee and assume financial risk for the delivery of LTSS to eligible individuals.

SNAPSHOT: Consumer Direction in Managed Long-Term Care	
DESCRIPTION	Allows MLTC beneficiaries (or their surrogates) to manage HCBS services
SERVICES	Typically personal care and homemaker services
LOCATION	Arizona, Hawaii, and New York, among others
ELIGIBLE POPULATION	Medicaid-eligible LTSS beneficiaries in select states
FUNDING	Budgeted allocations within the MCOs' capitation payments
MOST INTRIGUING FEATURE	Garnering the benefits of managed care while allowing beneficiaries to exercise control over the delivery of services

At first blush, the two trends would seem contradictory, as more than one expert has observed: “In managed care, there’s clearly tension [because it] takes the control out of the hand of the consumer and puts it in control of the risk bearer, the provider.” Others express concern that managed care would have a negative impact: “You have a problem that you have to overcome with managed care before you can get to the issue of consumer direction; that it is a medically dominant model and they don’t consider . . . consumer direction to be very important, period.”¹¹

However, upon closer scrutiny, the two trends appear to be more harmonious than originally envisioned inasmuch as MCOs can provide a layer of structure and oversight over consumer direction that other “cash and counseling” models often lack. First and foremost, through regularly scheduled and ongoing monitoring and assessment activities, the MCOs continuously reaffirm the capability of members (or surrogates) to perform the responsibilities inherent in consumer direction and can provide additional training and counseling as needed. Such oversight activities also provide an added degree of protection against fraud and abuse. And perhaps most importantly, the MCOs provide a convenient avenue for conducting quality oversight over the direct care workforce, which is a deficiency that most consumer-directed programs have yet to address.

¹¹ M.R. Meiners, et al. “Consumer Direction in Managed Long-Term Care: An Exploratory Survey of Practices and Perceptions,” *The Gerontologist* 42 (February 2002): 32–38.

State Medicaid programs that incorporate consumer direction within their MLTC programs include Arizona, Hawaii, New Mexico, and Wisconsin, among others.

Integrating Long-Term Care within Medical Homes

The “patient-centered medical home” (PCMH) model is gaining increased traction throughout the health care continuum, with numerous pilot programs either underway or in the planning stage in Medicare, commercial, and Medicaid programs across the nation. However, thus far no models have fully integrated LTSS, although North Carolina’s “Community Care” enhanced PCCM medical home program, in which regional networks of self-governing primary care physicians organize as PCMHs, is expanding to include the aged, blind, and disabled (ABD) population. This includes individuals who may be receiving home- and community-based long-term services and supports. The state commenced the program with eight pilots two years ago and expanded it further during fiscal year 2009. Enrollment in the program is currently mandatory for non-duals and voluntary for duals.¹²

SNAPSHOT: Community Care Patient-Centered Medical Home	
DESCRIPTION	A patient-centered model that integrates comprehensive long-term supports and services within medical homes
SERVICES	Full continuum of primary, acute, and long-term care supports and services
LOCATION	North Carolina
ELIGIBLE POPULATION	Medicaid-eligible individuals in need of LTSS
FUNDING	Medicaid and Medicare FFS reimbursement with an additional PMPM payment to the PCP and the regional network
MOST INTRIGUING FEATURE	Incorporating LTSS into an enhanced primary care case management model of care

However, even though the non-dual ABD population (i.e., no Medicare) has been ostensibly required to enroll in the Community Care program, many of these individuals obtained temporary exemptions that continued for a significant period of time. To address this, in 2008 the state began auto-assigning the non-dual ABD population to medical homes based on their historic utilization patterns with providers. Beneficiaries were sent letters informing them of their medical home assignment and were offered the option of selecting an alternative medical home if they wished.

Starting in January 2010, the state similarly began auto-assigning the dually eligible population residing in the counties participating in the state’s Medicare 646 “shared savings” demonstration, which encompasses approximately one-third of the state’s geographic area. Because of Medicare’s freedom of choice provision, these individuals can elect to “opt out” of the Community Care program, but to-date less than five percent have done so. Accordingly, about one-third of North Carolina’s dually eligible population is now enrolled in Community Care. The remainder of the state’s counties was scheduled to be “rolled out” in the spring of this year.

To assist in enrolling the dually eligible, the state expects to receive Medicare claims data from CMS to help identify patterns of service use (where Medicare is the primary payer) that appear inconsistent with a medical home model (i.e., no coordination of care). In those cases, the state will conduct outreach and education with these individuals to stress the importance of their medical home and the benefits it can provide. However, owing to federal requirements, beneficiaries will still be free to access care with a provider of their choice, whether or not the provider participates in the Community Care program.

¹² Interview with Denise Levis and Jeffrey Simms of North Carolina Medicaid; Bailit Health Purchasing, LLC, “A Feasibility and Cost Effectiveness Analysis: Expanding Managed Care for Aged, Blind, and Disabled Populations to Rural and Urban Counties Without Managed Care,” Texas Health and Human Services Commission (December 2008): 22-3.

To prevent duplication, individuals enrolled in the program can only have one case manager at a time. The case manager may be a behavioral health case manager (for those with comorbid physical and behavioral health conditions) or a waiver case manager (for those co-enrolled in HCBS waiver programs). However, high-risk individuals who do not have a case manager or care plan in place at the time of enrollment will be assigned a Community Care case manager. In either situation, all of these individuals will receive care that is coordinated across the full continuum of services in a manner consistent with their plan of care. (We should note that at this time the institutionalized population is excluded from Community Care.)

To ensure the viability of the program for this vulnerable population, the state is considering increasing the PMPM rates paid to both primary care practices as well as the regional networks in which they are organized to reflect their greater needs. Each regional network will have a “chronic care champion” to provide leadership in appropriately caring for the ABD/LTSS population and educate PCPs about the available long-term supports and services within the community. The nine networks are also developing clinical protocols and promoting an understanding of what is involved in coordinating services for this population (e.g., ancillary services, therapies, home health, pharmacy, etc.).

Finally, the regional networks will assist PCPs in developing transitional care plans, disease management initiatives, and a behavioral health integration effort and the networks will be expanded to include additional internists, geriatricians, home health providers, and other ancillary providers. At present, the state has four experienced clinicians on staff to provide assistance to the regional networks.¹³

Primary Care for Low-Income Seniors

The Geriatric Resources for Assessment and Care of Elders (GRACE)¹⁴ program is a new model of primary care designed specifically to better meet the health care needs of low-income seniors. The GRACE model involves a geriatrics team to help recognize and treat common geriatric conditions, while assisting in coordinating care between physicians and hospitals and community-based services providers. Coordination and continuity of care among all health care professionals and sites of care is a key component of GRACE.

GRACE was designed to serve low-income seniors aged 65 and older who have an annual household income of less than 200 percent of the federal poverty level. The core of the GRACE program is the support team, which is made up of a nurse practitioner and social worker employed by the primary care practice. Following enrollment, the support team meets with

SNAPSHOT: Geriatric Resources for Assessment and Care of Elders	
DESCRIPTION	Primary care model designed to improve the quality of care for low-income seniors by providing comprehensive assessment/care management in an interdisciplinary team setting
SERVICES	Primary care, care coordination/case management
LOCATION	Indianapolis, Indiana; Southern California
ELIGIBLE POPULATION	Low-income seniors age 65 and older
FUNDING	Health systems, managed care organizations, Medicare, Medicaid
MOST INTRIGUING FEATURE	Development of a web-based tracking system that monitors care plan implementation, and provides electronic medical record prompts to providers to contact GRACE for information and assistance with care coordination

¹³ Interview with Denise Levis, North Carolina Medicaid, February 16, 2010.

¹⁴ For more information, visit <http://medicine.iupui.edu/IUCAR/research/grace.asp>.

patients (and family members if possible) to conduct a comprehensive geriatric assessment, including a medical and psychosocial history, medication review, functional assessment, and review of social support and advance directives. In addition, the team performs a home safety evaluation. After the assessment, the support team meets with an interdisciplinary team that includes a geriatrician, pharmacist, mental health social worker, and community-based services liaison, to develop an individualized care plan. The care plan is based on program-specific protocols that have been adopted by GRACE to address key areas of relevance to elderly populations: advance care planning, health maintenance, medication management, difficulty walking/falls, malnutrition/weight loss, visual impairment, hearing loss, dementia, chronic pain, urinary incontinence, depression, and caregiver burden.

Once the care plan has been developed and approved by the patient's primary care provider, the support team provides ongoing care coordination across conditions, providers, and sites of care through the support of an EMR. This is done using both face-to-face and telephone contacts with patients, family members/caregivers, and providers. During calls and visits, the team encourages goal setting and self-management, teaches problem-solving skills, provides education related to each GRACE protocol, prepares patients and physicians to address problems during office visits, and assists with transportation as necessary.

While the number, content, and timing of follow-up visits and calls varies from patient-to-patient depending on individual needs, each patient will receive a minimum of one phone contact per month. These monthly contacts provide an opportunity for the support team to address any new problems, such as changes in medications, social supports, and/or living arrangements. Face-to-face home visits occur automatically after major events such as hospitalizations. In addition, providers in the primary care and specialty clinics, emergency department, and hospital receive automated prompts via an EMR to contact the GRACE support team for information and assistance with follow-up and coordination of care.

GRACE has been shown to improve the quality and cost-effectiveness of care in low-income seniors in Indianapolis, Indiana. Research has demonstrated improved quality of care, better health-related quality of life, and reduced emergency department visits for patients receiving care within the GRACE program, compared to a control group receiving care as usual.¹⁵ For the sickest patients, or for those at high risk of hospitalization, GRACE reduced hospital admission rates. A recent cost analysis showed that for high-risk patients, GRACE is cost-neutral in the first two years because costs of the program were offset by reductions in hospital costs.¹⁶ In the third year, GRACE led to cost savings among high-risk patients stemming from continued lower hospital utilization rates and hospital costs. There is further potential for cost savings by using the GRACE model to prevent or delay nursing home placement in patients at risk for long-term institutionalization. As a result of its success, GRACE is being replicated in the Healthcare Partners Medical Group in Southern California and in the VA health system.

¹⁵ S.R. Counsell, C.M. Callahan, D.O. Clark, W. Tu, A.B. Buttar, T.E. Stump, G. D. Ricketts. "Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial." *Journal of the American Medical Association*. 2007 Dec 12;298(22):2623-33.

¹⁶ S.R. Counsell, C.M. Callahan, W. Tu, T.E. Stump, G.W. Arling. "Cost Analysis of the Geriatric Resources for Assessment and Care of Elders Care Management Intervention." *Journal of the American Geriatrics Society*. 2009 Aug;57(8):1420-6.

IV. Administrative and Financing Solutions

Consistent with the oft-repeated assertion that in health care “everything is interrelated,” the following sections describe a number of innovative “fixes” to problems associated with certain Medicaid policies and benefits. These include processes to: (1) ensure that HCBS providers are fulfilling their obligations; (2) streamline and expedite financial and level of care eligibility determinations; (3) prevent “medically needy” Medicaid beneficiaries from experiencing interruptions in the continuity of care; and (4) establish capitation rates based on an individual’s actual needs and anticipated expenditures rather than unrelated factors such as agency bias and geographic location.

Electronic Verification and Quality Management in HCBS Programs

Many states seek an efficient way to monitor and verify that HCBS providers are fulfilling their responsibilities as prescribed in a beneficiary’s care plan. In most cases, this process is accomplished by requiring direct-service workers to sign a daily activity log to certify the number of hours they worked in the beneficiary’s home. However, reports frequently surface about problems with providers leaving early, arriving late, or not providing the service at all and beneficiaries often feel pressured to fill in the scheduled hours on the time sheet.

To address this issue, in 2003 the South Carolina Division of Community Long-Term Care (CLTC) implemented a real-time electronic monitoring system called “Care Call.” Care Call is an electronic database system that requires HCBS providers to call a toll-free number and identify themselves by entering a unique provider identification number as soon as they enter and again when they leave a beneficiary’s home. When the provider calls in, the Care Call system automatically verifies that the telephone number that he/she is calling from matches the home telephone number listed for that beneficiary and then records the visit’s start and end times. For other in-home services and services not provided in a beneficiary’s home, providers call a toll-free number or log onto the Care Call website to document service delivery. In all cases, documented services are compared with prior authorization records to confirm that the service was provided appropriately.

Each week the data is automatically transferred to the state’s MMIS system and serves as the providers’ claim information, which makes invoicing easier since providers no longer have to bill themselves. At the same time, the system allows the state to identify any improper billing. The system also supplies provider agencies with weekly logs of their claim so that they can verify the information with their staff. The system may be accessed electronically at any time by the provider through the Care Call website.

Finally, the Care Call database also functions as a quality monitoring system. Case managers can track and make sure providers are in the home on schedule and for the entire period of time called for in the beneficiary’s care plan. Case managers can access the website at any time and quickly detect

SNAPSHOT: Care Call

DESCRIPTION	Automated system for conducting oversight of HCBS providers
SERVICES	Oversight of in-home support services such as personal care and homemaker services
LOCATION	South Carolina (a number of additional states and localities have implemented this type of program)
ELIGIBLE POPULATION	Medicaid-eligible individuals in need of LTSS
FUNDING	Medicaid
MOST INTRIGUING FEATURE	Replacing cumbersome paper sign-in sheets with a simple phone call

circumstances that may indicate poor care or diminished quality of life for the beneficiary (e.g., provider arriving at the wrong time of day). As a requirement of the waivers, case managers contact each enrolled beneficiary a minimum of once per month and review a beneficiary’s Care Call report within five days prior to the contact. Any unusual pattern requires the case manager to consult the beneficiary and follow up on any complaints with the provider. Case managers also call in to Care Call to document that the contact was made.¹⁷

Washington State, New Mexico, Tennessee, Oklahoma, Louisiana, New York City, and Miami-Dade County are either currently using or planning to adopt a similar system.¹⁸

Streamlined Eligibility in the Arizona Long-Term Care System (ALTCS)

Arizona’s nationally recognized ALTCS program took several steps to streamline the eligibility process for long-term care and Supplemental Security Income (SSI). From the time of ALTCS’ inception in 1988, Arizona understood the importance of ensuring that the two components of eligibility determination — medical and financial — were timely and that neither unduly delayed the final determination and thereby increase an individual’s risk of further deterioration. To this end, the state implemented three key policies under its 1115 demonstration waiver:

- Conducted financial eligibility determinations in-house for medical assistance only (MAO) applications for long-term care;
- Scheduled the preadmission screening (PAS) for medical eligibility determination within 39 days of the initial application (timeframe established to ensure its completion before the financial eligibility determination); and
- Provided prior period coverage only for periods subsequent to completion of the PAS.

In order to further expedite enrollment, in the late 1990s ALTCS sought and received approval to use the preadmission screening in lieu of the SSI disability determination, which can take 90 days or longer to complete.

In addition, in 2001 Arizona received approval to use the determination of serious mental illness (SMI) in lieu of the Social Security disability determination for the SSI MAO acute program. For individuals who are a danger to self or others, the SMI determination of disability is verified on a sample basis. For other individuals determined SMI, the applicant is considered presumptively eligible for disability and

SNAPSHOT: Streamlined Eligibility in the Arizona Long-Term Care System	
DESCRIPTION	Policies and procedures designed to expedite financial and medical eligibility determinations for Medicaid-funded LTSS
SERVICES	All Medicaid-funded LTSS
LOCATION	Arizona
ELIGIBLE POPULATION	Medicaid-eligible frail elderly and disabled individuals
FUNDING	Medicaid capitation payments
MOST INTRIGUING FEATURE	Allowing the state to use its pre-admission screening tool in lieu of an SSI disability determination

¹⁷ <http://www.dhhs.state.sc.us/dhhsnew/insidedhhs/Bureaus/BureauofLongTermCareServices/Care%20Call.asp>

¹⁸ Sandata Technologies, Inc., “Telephone-Based Time and Attendance Improves Efficiencies and Reduces Fraud and Abuse in the Home Healthcare Industry” (September 2009). <http://www.sandata.com/pdf/TelephoneBasedTimeAttendance.pdf>

the disability determination is reviewed for consistency by the Disability Determination State Agency (DDSA) in all cases.

Hawaii “Spend-Down” for the Medically Needy

Prior to implementing its Quest Expanded Access (QExA) managed long-term care program in February 2009, Hawaii understood the unique challenges presented by medically needy populations with a “spend down” and/or share of cost in a managed care environment. The typical method for collection of spend down is to determine the amount on a monthly basis and allow unpaid claims to accrue until it is reached. However, when beneficiaries are receiving home- and community-based services, unpaid claims can lead to a discontinuation of services, which places individuals at constant risk of facility placement. Moreover, if the state plan allows payment for HCBS such as personal assistance for individuals with spend down who are not yet at the nursing facility level of care, they similarly risk deterioration and facility placement. Both situations arise in fee-for-service states with medically needy programs and/or states that impose a share of cost for home- and community-based services under waiver programs.

HIGHLIGHTS: Hawaii “Spend-Down” for the Medically Needy	
DESCRIPTION	Program to ensure that the medically needy with spend-down maintain continuity of care
SERVICES	All Medicaid-funded LTSS
LOCATION	Hawaii
ELIGIBLE POPULATION	Low-income individuals who meet the state’s level-of-care criteria
FUNDING	Medicaid capitation payments plus spend-down amounts constitute the two funding streams
MOST INTRIGUING FEATURE	Simplifying an often complex process while avoiding disruptions in care

In Hawaii, a 209(b) state, the ABD population is eligible for acute and long-term care services under five income categories, as follows:

- 100 percent SSI (whether or not the individual is actually receiving SSI);
- The State Supplemental Payment (SSP) income level;
- 100 percent of the federal poverty level (FPL) under the OBRA 1986 optional income category;
- Medically needy individuals who do not meet the state’s nursing facility level of care criteria and have income above 100 percent FPL, but incur qualified medical expenses that reduce income to the Medically Needy Income Level (MNIL) under §17-1721-22 (the MNIL level in Hawaii is roughly 50 percent FPL); and
- Medically needy individuals at the nursing facility level of care who have income above 100 percent FPL and less than 300 percent of SSI who incur a share of cost.

Individuals in the last two categories must spend down to the MNIL and the 100 percent FPL income level respectively to receive medical assistance. In Hawaii, the medically needy category has outpaced growth in all other ABD income categories.

Under the Hawaii QExA program, which includes both acute and long-term care, managed long-term care health plans are responsible for spend down and share of cost. Hawaii was able to negotiate a

different methodology with CMS for medically needy individuals who have health and long-term care needs that exceed the spend-down amount (and are expected to do so for at least three months) or a share of cost for their long-term care services. The special term and condition in the state’s 1115 waiver reads as follows:

Members of Aged, Blind, or Disabled Medically Needy State Plan groups whose spend-down liability is expected to exceed the health plans’ monthly capitation payment will be eligible under the Demonstration subject to subparagraph (d) and an enrollment fee equal to the medically needy spend-down amount or, where applicable, the amount of patient income applied to the cost of long-term care. This group will receive all services through the QExA health plans.

In the sub-paragraph (d) referenced by CMS, it specifies that medically needy individuals who are expected to incur expenses sufficient to satisfy their spend-down obligation for less than a three-month period will not be enrolled in a QExA health plan and will be subject to an enrollment fee equal to the medically needy spend-down and receive services on a fee-for-service basis. This category might include, for example, persons who become medically needy for a short period due to catastrophic injury or illness, or persons who incur high medical expenses sporadically and thus will not meet their spend-down obligations every month.

Spend-Down for Acute Care Services and Long-Term Care

Under the QExA program, Hawaii provides its contracted health plans with the required spend-down amount and share of cost for each medically needy family unit (which may be an individual, couple, or family). If the member meets the "three months or more" criteria for spend down and/or share of cost, he/she can pay a premium at the beginning of each month. This method ensures continuity in the delivery of HCB services, which is critical for maintaining individuals in their homes or in the community. Providers submit reports to the MCO detailing spend down amounts and share of cost collected.

The MCOs manage the share of cost for nursing facility services by converting the amount to a per diem, which is the same methodology that most states have adopted.

Per-Case Rate-Setting Initiative: Louisiana Office of Citizens with Developmental Disabilities

Across the nation, HCBS expenditures for people with developmental disabilities exceed the amount spent for the frail elderly and physically disabled both on a per-capita basis as well as in the aggregate. Moreover, many states have patterns of spending for the developmentally disabled which they suspect are not based on need, but instead reflect location, agency bias, or even funding by county.

In response, a number of states (e.g., Colorado, Georgia, Louisiana, Oregon, and Wyoming, among others) are considering or have adopted rate-setting systems that establish case rates or individual funding

SNAPSHOT: Louisiana Per-Case Rate-Setting Initiative	
DESCRIPTION	Program ensures that Medicaid payments reflect an individual’s needs rather than unrelated factors
SERVICES	All Medicaid-funded LTSS
LOCATION	Louisiana
ELIGIBLE POPULATION	Medicaid-eligible individuals with developmental disabilities
FUNDING	Medicaid fee-for-service payments
MOST INTRIGUING FEATURE	Generating significant cost savings while maintaining beneficiary satisfaction

levels based on regression analyses which define the important relationships between groups by need as well as by anticipated expenditures or needs. Most programs for the developmentally disabled that use funding level systems have adopted the American Association on Intellectual and Developmental Disabilities' Support Intensity Scale (SIS) assessment instrument with supplemental questions added by each state. States must purchase the instrument and have the option of including their data in a nationwide data set. To date, long-term care case rate systems have not been applied to the elderly and physically disabled on a widespread basis, although Florida is in the process of doing so. In part, this is because there is no widely accepted assessment tool that parallels the SIS with a national database and national norms. The minimum data set is an exception; however, the tool is completed by nursing facilities and it has not gained acceptance for HCBS.

In developing funding levels for developmentally disabled clients, the Louisiana Office for Citizens with Developmental Disabilities was unable to rely on expenditure data because of the influence of factors unrelated to need (e.g., age, region, case management agency, and inadequate standards for case managers). To address this, the state adopted a three-pronged approach:

- Defining a service package of supports for each of seven levels of need derived from the SIS, based on professional expertise and independently developed service plans;
- Clinically validating a sample of cases to confirm the SIS assignment and the appropriateness of services/guidelines; and
- Consolidating all three sources of data — expenditures, clinical validation, and independently developed service plans — into a product the state wanted to purchase.

After completing this exercise, Louisiana published a tool titled, “Guidelines for Support Planning,” that provides support coordinators/case managers with step-by-step instructions on the entire care planning and budgeting process, including tips for planning within the guidelines and the mechanism to request exceptions.

Louisiana initially applied its guidelines to 2,000 individuals on the waiting list and will gradually phase-in the application of the guidelines to existing waiver participants. The preliminary results are very encouraging: (1) the state has not had a single appeal; and (2) the state has been able to closely estimate expenditures under the funding levels. Based on the completion of 472 service plans, the average annual service cost is \$47,083 compared to a previous average of \$65,000 (adjusted down from over \$70,000 owing to additional cost-saving measures). The average annual savings per service plan equals \$17,917.

V. Emerging Telehealth Technologies

During the past three or four years, a host of promising technological solutions for managing the care of individuals with complex and/or chronic health conditions or those in need of post-acute discharge monitoring and/or long-term care services have been introduced, including devices for remotely monitoring and communicating with patients in their homes or assisted living facilities.

Home care agencies that have implemented telehealth systems report that their two biggest goals are to improve overall quality and reduce unnecessary hospitalizations and emergency room visits. A full 88.6 percent of these agencies report that telehealth improved the overall quality of services provided to their patients; 76.6 percent generated a reduction in unplanned hospitalizations; 77.2 percent achieved a reduction in emergency room visits; and 42.8 percent report that their telehealth program has led to a reduction in cost.¹⁹

There are a number of barriers to the widespread adoption of the technology (see below), with the most daunting being reimbursement, although some states have recently implemented waiver programs to compensate HCBS providers for telehealth services. The following sections provide an overview of the technology and its potential benefits, including the results of a pilot program conducted by the Veterans Administration, and a description of state initiatives to provide Medicaid reimbursement for telehealth services.

Telehealth Technology Overview

Telehealth enables providers to service more patients in a given day across a broader catchment area. As an example, nurses who previously conducted three to five physical home visits during a given day can conduct virtual visits to many more patients during that same day, with an additional savings in travel time and costs. While such virtual visits cannot and should not completely replace in-person visits, they provide a valuable supplement that has a proven benefit for patients.

Telehealth Products

An impressive number of companies are producing an array of telehealth products that can be categorized into three primary categories, as follows:

- **Remote Patient Monitoring:** These interactive devices are primarily designed for patients suffering from chronic diseases such as heart failure, COPD, and diabetes. They typically engage patients through personalized daily interactions and questionnaires while collecting vital signs and transmitting the information directly into a database. Besides collecting vital sign data, the devices also have the ability to serve as a communicator between the care provider and the patient and can be configured to ask symptomatic questions and provide patient reminders. A number of them can also be configured to verbalize what is on the screen using compressed audio files.
- **“Smart Homes”:** These products function as 24/7 early detection and monitoring systems that enable caregivers/family members to identify problems and intervene before they become emergent. Much like a security monitor, they utilize small wireless sensors to monitor the elderly individual in his/her home and transmit the information to a base station. The base station gathers this information, develops a baseline template on the individual’s routine living habits (e.g., wake/sleep cycles, bathroom habits, opening the refrigerator, etc.) and regularly transmits

¹⁹ W. Engle. “The Approaching Telehealth Revolution in Home Care,” *Telemedicine and Telehealth Articles* (March 2009). http://tie.telemed.org/articles/article.asp?path=articles&article=telehealthRevolution_wengle_tie09.xml

the data to a remote server. If the senior's habits change in any significant way, the system alerts caregivers/family members to intervene.

- **Remote Medication Management:** The most noteworthy example of this genre is the EMMA® remote medication management device from INRange Systems that consists of a medication delivery unit and wireless two-way web-based software that allows a physician, pharmacist, or other practitioner to remotely manage prescriptions stored and released by the unit. The remote-controlled device identifies each medication automatically and dosing changes can be made remotely. The device emits an audible and visual alert when it is time for the patient to take their medication. When activated by the patient, the specific medications are selected and released into a delivery tray.

Barriers to the Widespread Adoption of Telehealth

Despite more than 15 years of increasingly sophisticated technological advances and impressive study results, the benefits of telehealth remain largely untapped throughout the health care continuum. The reasons for this are not easily identifiable, having as much to do with culture and resistance to change as with more tangible factors like reimbursement. The factors that researchers most commonly cite include:

- **Reimbursement:** Medicare and Medicaid offer little in the way of reimbursement for telehealth, which in turn hampers its widespread adoption among providers and health plans. There are compelling reasons to reform these policies. To cite one example, state Medicaid programs could generate enormous savings from a simple reduction in transportation costs through the use of telehealth technology, not to mention reduced ER visits and inpatient utilization. Moreover, Medicare only reimburses for telehealth services for some patients in rural areas, when the technology also offers enormous improvements in caring for chronically ill patients in urban areas as well. Even more importantly, because the dominant reimbursement strategies reward providers for performing procedures and seeing patients, they have a strong disincentive against embracing telehealth.
- **Cross-State Licensure:** States vary greatly in their policies relating to out-of-state practitioners treating patients across state lines through telehealth, which highlights the need for a national solution that will permit physicians, nurses, and other licensed practitioners to expand their practices across state boundaries.
- **HIT Infrastructure:** The sophisticated telehealth products currently being introduced require reliable broadband service. Telehealth advocates are lobbying for the introduction of an interconnected national digital network that will provide virtual links between hospitals, physicians, first responders, health educators, public health, and homeland security to support all aspects of health care and health care communications.
- **Liability:** Providers are understandably reluctant to expose themselves to the enhanced risk of litigation when making health care decisions from a remote location without benefit of face-to-face contact. To address this, the telehealth industry must continue its efforts to develop standardized, evidence-based treatment protocols and quality standards.
- **Resistance to Change:** Providers, health plans, home health agencies, and other stakeholders are typically resistant to altering established work flows and routines or to make needed changes to their existing IT systems to incorporate new technology.

- **Unfamiliar Technology:** Studies show that only one-third of Americans over the age of 65 use the Internet and many have never been online and are exceedingly uncomfortable with electronic gadgetry like computers, smart phones, and, of course, in-home monitoring devices. Studies similarly reflect that many older Americans actually look forward to doctor visits as an opportunity to socialize. These phenomena are much less apparent among Baby Boomers, which suggests that widespread acceptance of telehealth may unfold gradually rather than dramatically.

Veterans Administration Telehealth Initiative

The Veterans Administration (VA) has been conducting intensive evaluations of “technology-enabled connected care” or “Telehealth” for close to a decade, with very impressive results. Candidates for the VA’s “Chronic Care Home TeleHealth” (CCHT) program undergo a comprehensive battery of assessments to determine which technology is best suited for managing his/her condition(s) based on an algorithm of the individual’s health needs, complexity of condition(s), and ability to use technology. The various types of technology include one or more of the following: videophones, messaging devices, biometric devices, digital cameras, and telemonitoring devices. Some of the latest products integrate all of these functions into a single device.

SNAPSHOT: Veterans Administration Telehealth Initiative	
DESCRIPTION	Pilot program to evaluate the effectiveness of telehealth technology in caring for chronically ill individuals
SERVICES	VA-covered home health services, including telehealth devices
LOCATION	Florida and other select locations
ELIGIBLE POPULATION	Eligible veterans needing home health services
FUNDING	Veterans Administration
MOST INTRIGUING FEATURE	Generating significant cost savings without compromising care

Once enrolled in the program, the VA conducts a daily risk stratification of all patients that generates color-coded alerts to identify anyone with significant changes in vital signs, symptoms, health knowledge, and other indicators that may require intervention. A care manager typically oversees a panel of between 100 and 150 individuals with physical health conditions or approximately 90 individuals with associated behavioral health symptoms. During the four-year study period, the number of patients enrolled in CCHT increased from 2,000 to 31,570 and generated a 20-percent reduction in hospital admissions; a 25-percent reduction in patient days; and a patient satisfaction rate of 86 percent. The annual cost per patient was calculated to be \$1,600, which is significantly less than the VA’s home-based primary care service program’s cost of \$13,121 per annum.²⁰

²⁰ A. Darkin, et al. “Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions,” *Telemedicine and e-Health* (December 2008): 1118-1126.

Pennsylvania and New Mexico Medicaid Telehealth Reimbursement Program

Pennsylvania is one of the first states in the nation to provide reimbursement for home telehealth technology through a Medicaid waiver for older adults ages 60 and older. On September 1, 2007 the state’s Office of Long-Term Living implemented a demonstration reimbursement policy to cover a range of services provided by home health, durable medical equipment providers, pharmacies, or hospitals through contracts with local county Area Agencies on Aging (AAAs).

Reimbursement not only covers remote patient monitoring technology, but also “Smart Home” technology by which a family member can access a website and determine the patient’s activity status, such as the time of awakening in the morning, the number of times the refrigerator opens, how many times the bathroom is used, when/if medications are taken, and whether an individual suffers a possible fall. The initial reimbursement rates are as follows:²¹

- Health status measuring and monitoring: \$10 per day;
- Activity and sensor monitoring: \$200 for installation: \$79.95 per month;
- Medication dispensing and monitoring: \$50 per month; and
- Personal Emergency Response System: \$30 per month.

In 2007, New Mexico also implemented a policy allowing Medicaid to reimburse providers for telehealth services. Dr. Dale Alverson, Medical Director of the Center for Telehealth at the University of New Mexico, explained that “New Mexico Medicaid has begun one of the nation’s most comprehensive reimbursement programs for telehealth services and provides a model for the country. The Human Services Department recognizes the value of using telehealth to enhance access to covered services for its clients, and now eligible providers using telehealth will be reimbursed at the same rate as a physical face-to-face encounter.”²²

Other states that are considering or are in the process of implementing telehealth reimbursement policies include Arkansas, Colorado, Kansas, Minnesota, New York, Pennsylvania, South Dakota, and Utah.²³

SNAPSHOT: Medicaid Telehealth Reimbursement Programs	
DESCRIPTION	Program to reimburse Medicaid providers for telehealth services
SERVICES	In-home monitoring and communications from a remote location
LOCATION	New Mexico and Pennsylvania
ELIGIBLE POPULATION	Medicaid-eligible individuals in need of LTSS
FUNDING	Medicaid; within both a fee-for-service and capitated managed care model
MOST INTRIGUING FEATURE	Eliminating a bureaucratic obstacle to the use of potentially life-saving technology

²¹ S. Peifer. “The State of Technology in Aging Services in Pennsylvania,” American Association of Homes and Services for the Aging, Center for Aging Services Technologies and the Pennsylvania Association of Nonprofit Homes for the Aging (October 2008).

<http://www.aahsa.org/uploadedFiles/providers/conferences-education/State%20of%20Technology%20in%20Pennsylvania%20FINAL.pdf>

²² Newsletter from New Mexico Human Services Department, “Telehealth Services Now Available for Medicaid Recipients,” (Sept. 5, 2007).

²³ “Medicaid Pays for Home Telehealth,” Information for Tomorrow (2007).

<http://www.informationfortomorrow.com/community/MedicaidPaysforHomeTelehealth.htm>

VI. Additional Promising Innovations

The initiatives described above have all been implemented to a greater or lesser degree and they are included in this report in the hope that policymakers and other stakeholders will evaluate their potential for replication elsewhere. This final section consists of brief descriptions of four additional promising initiatives, including:

- Naturally Occurring Retirement Communities (NORCs) with a more flexible Program of All-Inclusive Care for the Elderly (i.e., PACE-like model);
- Federally Qualified Health Centers (FQHC) that are certified as “Federally Qualified Aging Centers (FQAC);”
- Pay-for-performance (P4P) programs for HCBS providers; and
- Forward-looking state-level planning activities to enhance the states’ ability to anticipate and address future needs (both short and long-term).

Naturally Occurring Retirement Communities and PACE-Like Programs

Overview

NORCs are communities, housing developments, apartment buildings, and neighborhoods of single-family residences with high concentrations of older residents. NORC Supportive Services Programs (NORC-SSPs) are NORCs that have implemented programs to assist eligible residents with a variety of health and social services designed to delay or prevent institutionalization and promote “aging in place.” Distinctive characteristics of NORC-SSPs include:

- Providing a range of health care and social services that match the needs and interests of seniors, whether they are well and active, frail or ill.
- Making services available to all seniors in the given community regardless of income or health.

SNAPSHOT: NORC PACE-Like Programs

DESCRIPTION	Approach capitalizes on the “synergies” between two programs designed to assist elderly individuals to “age in place”
SERVICES	All PACE-covered services as well as any additional services and supports provided through the NORC
LOCATION	Any qualifying NORCs could potentially participate in this initiative
ELIGIBLE POPULATION	Participants residing in or near qualifying NORCs who meet NF-LOC criteria or are at-risk for institutional placement in the absence of some basic support services
FUNDING	Medicare and Medicaid capitation payments ²⁴ plus additional NORC-funding streams
MOST INTRIGUING FEATURE	Combining a variation of the PACE concept with NORCs to develop a flexible yet comprehensive program of long-term supports and services

²⁴ Medicare and Medicaid capitation payments will be based on the number of NORC residents who are dually eligible and meet the clinical eligibility criteria for the program. The use of capitation funding is likely to require some type of relationship with a risk-bearing entity.

- Offering services both on the housing site and in seniors' homes.
- Encouraging frequent, informal contact between residents and professionals, which helps build trust and familiarize seniors with available services. NORC program staff can observe changes over time and suggest services that might prevent health emergencies from occurring.
- Encouraging residents to take an active part in designing, developing, and coordinating the services offered.
- Having neighborhood associations, housing corporations, and health and social service providers work in collaboration with one another and share responsibility for ensuring the success of these programs.
- Operating flexibly and modifying or augmenting services in response to the changing needs of the community.
- Drawing isolated residents out of their homes to interact with neighbors they might never have met. The end result is often the creation of cohesive communities.

In contrast to most federal and state entitlement programs, eligibility for services and programs is based on age and residence in the NORC-SSP rather than on functional deficits or economic status, and the mix of services available is resident-specific, not program-specific. At present, NORC-SSPs do not replace or supplant existing categorical or entitlement programs (e.g., Medicaid, Medicare), but instead use them as tools. These categorically funded services are indispensable to NORC program clients who qualify, but by themselves leave significant gaps and are inadequately coordinated with one another, let alone connected to the community. The NORC-SSPs identify the gaps and develop services and programs to fill them.

There are now approximately 300 self-identified NORCs across the country. They are located in areas with heavy concentrations of seniors and are "natural" in the sense that they are not brick-and-mortar retirement complexes that seniors move into (as opposed to "Deliberately Occurring Retirement Communities" or "DORCs"). Programs exist in densely populated cities, suburbs, and even rural areas. Some have high-income members who pay hefty fees for self-supporting programs that emphasize discounted merchant services, and others, like one in St. Louis, are centered in more modest neighborhoods. Owing to its sheer size and unique housing environment, New York City's 34 NORCs represent the largest concentration in the nation by far.

NORC-SSP Services

The NORC-SSP basket of services (the key program elements) consists of four main categories:

- Case management, case assistance, and social work services;
- Health care management and health care assistance, including assessments, disease prevention and health promotion, and assistance with managing chronic conditions;
- Education, socialization, and recreational activities; and
- Volunteer opportunities for project participants and other interested community members.

Structure and Governance

In contrast to traditional service delivery models, NORC programs are comprised of unlikely partnerships, including:²⁵

- A social service provider, which is often the lead agency (the lead agency, which is the government contractor, is responsible for facilitating the partnership and building community relationships; in most instances it manages the site and program finances and coordinates and integrates the services offered);
- A housing corporation (NYC NORCs require their financial participation as well as the provision of rent-free space for program staff and activities);
- A health provider — typically a nearby medical center, home health agency, or nursing home — that often supplies dedicated nurses or geriatric nurse practitioners; and
- The residents.

Each entity plays a critical role in shaping the program and bringing to the program the resources it can best contribute. The actual governing structure can take a number of forms, including:

- **Housing Partner Structure:** In NYC, several housing entities have established separate non-profit 501(c)(3) organizations to oversee their NORC-SSPs. Their boards of directors are made up of representatives from the boards of the housing cooperative and other interested residents.
- **Shared Partnership Structure:** A number of NORC-SSPs rely on an advisory committee or board consisting of representatives from all the partner constituencies (including government and philanthropy) to coordinate and integrate the partnership. The designated lead agency is responsible for organizing and facilitating the meetings and managing the annual budget that reflects the consensus on policy direction of the group.
- **Resident Advisory Committee Structure:** Other NORC-SSPs have established resident advisory committees that are organized and coordinated by the lead agency. These committees typically meet monthly or quarterly to share ideas and discuss problems or issues that participants may be experiencing. Although this type of structure satisfies requirements that a NORC-SSP have an advisory committee with resident representation, if it is the only mechanism used by a program, it does little to advance the reality of the partnerships.

Funding

NORC-SSPs receive funding from a combination of sources, including government, philanthropies, housing corporations and/or tenant associations, and participants, among others. As an example, the St. Louis program's expenses are about \$300,000 a year, costing roughly \$500 per member. Members pay only a small portion — approximately \$30 per person or \$45 per couple annually. Most funds are raised from public and private sources, including a \$127,000 Missouri state grant this past year.²⁶

²⁵ F. Vladeck. "A Good Place to Grow Old: New York's Model for NORC Supportive Service Programs," United Hospital Fund (2004).

²⁶ P. Moeller. "NORCs: Unique Havens for an Aging America." US News and World Report, October 7, 2009.

Evaluations

Nearly all evaluations of NORCs reach conclusions similar to a study completed by a graduate student at Miami University of Ohio, which states: “NORC residents were more likely to feel connected to their community, be age-integrated, and have higher assessments of their health. NORC residents had a high level of knowledge of available services and were satisfied with the services. Overall it was found that NORCs are important communities for older adults and the services are beneficial to its participants.”²⁷

What the Future May Hold

As previously stated, at present NORC-SSPs do not receive funding from government-sponsored entitlement programs, although residents who are eligible for these programs can access services through the normal channels available in their state (e.g., traditional Medicare, Medicare Advantage, Medicaid fee-for-service, Medicaid managed care, HCBS Waiver Services, etc.). Having said this, NORCs may well represent an as-yet-untapped opportunity to accomplish a number of important goals, including:

- Advancing efforts to “rebalance” long-term care services from a reliance on institutional care in favor of home- and community-based services;
- Expanding on the PACE program model to include a much more robust and flexible program for integrating Medicare and Medicaid funding streams and rationalizing the delivery of long-term care services;
- Solidifying NORC funding streams to ensure long-term viability and enable program sponsors to focus on the delivery of services rather than constant fund-raising;
- Promoting the movement toward consumer-directed care by allowing participants to purchase, manage, and pay for services and supports of their choosing (NORCs are often able to negotiate significant discounts from local merchants and service providers); and
- Delaying or averting ER visits, inpatient hospital utilization, and nursing facility admissions by not restricting participation to individuals who already meet the nursing facility level of care criteria.

The precise details of how this might be accomplished have yet to be fully fleshed out, but the table on the following page highlights a number of the “synergies” that a combined “NORC-PACE-Like” model might offer.

What is clear is that both NORCs and DORCs offer opportunities to deliver support services to the elderly on a shared basis, thus making them more efficient and affordable while reducing the isolation of the elderly in their homes. At present, most retirement communities fail to take advantage of this opportunity and instead fund support services on a case-by-case basis, which is ultimately not financially sustainable for either the consumer or the government.

²⁷ E.C. Coppinger. “NORC vs. Non-NORC: Evaluation of Profiles and Impact of Naturally Occurring Retirement Communities,” Miami University, Gerontology (2006). Available at <http://etd.ohiolink.edu/view.cgi?miami1145474961>.

Potential Synergies of a NORC-PACE-Like Model

Program Feature	NORC-SSP	PACE	NORC-PACE-Like Model
Services	Variable and flexible depending on residents' needs and preferences over time, but typically includes personal assistance, transportation, health assessments, disease management, meal preparation, social and educational activities, and other needed services and supports.	All Medicare and Medicaid-covered services, including institutional care and other home- and community-based and adult day care services determined necessary by the interdisciplinary team for the care of the PACE participant.	All services (except institutional services) currently included in NORC-SSPs and PACE programs, but the "NORC-PACE-Like" program would retain the flexibility to adjust service offerings to meet the needs and preferences of the participants.
Physical Setting	A rent-free location within the NORC housing complex or neighborhood.	A "bricks and mortar" facility for the delivery of primary and acute care, adult day care, and other PACE-sponsored activities like personal care, occupational therapy, recreational activities, etc.	A rent-free "bricks and mortar" facility within the NORC site for the delivery of primary and acute care, adult day care, and other PACE-sponsored activities.
Eligibility	At least 60 years old and reside in the NORC complex or neighborhood.	At least 55 years old, dually eligible for Medicaid and Medicare, reside in the PACE service area, and be certified as eligible for nursing home care by the appropriate state agency.	At least 55 years old and reside in (or near) the NORC-PACE complex/service area. No NF LOC requirement. To qualify for the program, the NORC must have a "critical mass" of dually eligible residents (e.g., 50 percent or more) in sufficient number to spread financial risk.
Funding	A combination of government, philanthropies, partner contributions, and private pay.	Medicare and Medicaid risk-based capitation payments.	A combination of current NORC-SSP funding sources and Medicare and Medicaid capitation payments based on the number of dually eligible participants. Non-duals (i.e., Medicare only, private insurance, uninsured) will be required to pay a sliding scale premium based on income. With certain restrictions (e.g., limits on administrative expenditures), the NORC-PACE model would have the flexibility to combine all of its funding, from whatever source, to provide appropriate services to all of its participants.
Governance	A partnership of housing corporations, health care providers, social service providers, and residents, with one entity (usually the health care provider) assuming day-to-day management responsibilities.	Typically a non-profit provider organization such as a nursing facility or home health agency with the appropriate experience and financial backing to handle risk.	Flexible, but the "NORC-PACE" health care partner must play a prominent role in the staffing and management of licensed physicians, nurses, therapists, and other key personnel. It may also be beneficial to allow the health care partner to participate in multiple programs in densely populated urban areas like NYC. At least one of the program partners must also have the ability to handle financial risk.

Federally Qualified Aging Centers (FQAC)

FQHC Overview

An FQHC is a type of provider defined by the Medicare and Medicaid statutes that includes all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC “look-alikes” (i.e., an organization that meets all of the eligibility requirements but does not receive Section 330 grant funding). The goal of the FQHC program is “to maintain, expand, and improve the availability and accessibility of essential primary and preventive health care services and related ‘enabling’ services provided to low-income, medically underserved, and vulnerable populations that traditionally have limited access to affordable services and face the greatest barriers to care.”²⁸

SNAPSHOT: Federally Qualified Aging Centers	
DESCRIPTION	Expansion of existing federally qualified health centers and rural health centers (RHC) service offerings to include LTSS
SERVICES	Full continuum of medical, behavioral, and LTSS
LOCATION	Nationwide
ELIGIBLE POPULATION	Medicaid-eligible individuals residing in proximity to an FQHC or RHC
FUNDING	Federally mandated FQHC/RHC reimbursement
MOST INTRIGUING FEATURE	Making LTSS medical home services widely available

RHC and FQHC core services include those services provided in the office, another medical facility, the patient's place of residence (including nursing homes), or elsewhere. Medicare does not recognize care provided in hospitals (either inpatient or outpatient) as RHC or FQHC services to be paid for on the basis of cost. Medicaid coverage of hospital care for both an RHC and FQHC varies from state to state and may be based upon the Prospective Payment System rate or some other methodology, depending on the state plan.

FQHC Reimbursement

Unlike most other entities in the American health care system, FQHCs can bill the government for their costs rather than for market prices or negotiated fees. By law, state Medicaid programs “shall provide for payment for such services in an amount (calculated on a per-visit basis) that is equal to 100 percent of the average costs of the center or clinic of furnishing such services.” Medicare also pays FQHCs “an all-inclusive per visit payment amount based on reasonable costs as reported on its annual cost report.”²⁹

In 2000, the Benefits Improvement and Protection Act changed the way FQHCs are reimbursed under Medicaid. The previous cost-based reimbursement system was replaced by a Prospective Payment System methodology, which varies by state. States also have the option of reimbursing FQHCs under an alternative methodology other than the Medicaid Prospective Payment System, but each individual FQHC must agree to the new methodology prior to state implementation.

Under Medicaid, the FQHC-covered core services include services provided by physicians, physician assistants, nurse practitioners, clinical nurse specialists, psychologists, and social workers. Thus, while

²⁸ <http://bphc.hrsa.gov/policy/pin0321.htm>

²⁹ National Association of Community Health Centers, Inc. *Understanding the Medicaid Prospective Payment System for Federally Qualified Health Centers*. Medicare/Medicaid Technical Issue Brief #69 (January 2001). Available at <http://www.nachc.com/client/documents/publications-resources/69.pdf>

states may choose not to cover psychologists and licensed clinical social worker services in their state plan, they must nonetheless cover these services in an RHC or FQHC because they are core services.

RHC and FQHC Medicaid reimbursement for “other ambulatory services” (i.e., case management, social services, transportation, pharmacy, dental, and advanced nursing care) provided for in the state plan can be either paid for under the PPS methodology or some alternative methodology established by the state.

Researchers and policymakers have conducted a number of studies to evaluate the cost effectiveness of FQHCs by comparing the overall cost of caring for individuals who receive FQHC services and those who do not. Nearly all such studies conclude that FQHCs are indeed cost effective and their patients incur lower total per-member-per-month Medicaid costs than similarly situated non-users.³⁰ In fact, the National Conference of State Legislatures reports that community health centers can cut Medicaid costs by 30 percent by regularly addressing chronic illnesses and thus lowering hospital admission rates.³¹

FQACs

Using the Martha Stewart Center for Living and the North Carolina LTSS medical home initiative (described on pgs. 7-9) as possible templates, the federal government could encourage the existing 1,200 FQHCs as well as the many FQHC “look-alikes” and rural health centers (RHCs) to also serve as a comprehensive source for long-term services and supports, or FQACs.

Under this scenario, FQHCs, “look-alikes,” RHCs, and other interested providers could seek a designation from the Secretary of Health and Human Services as an FQAC and would work collaboratively with state waiver programs, Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs), and community-based organizations to identify and enroll eligible individuals who could potentially benefit from the program. Each enrolled elderly patient would have an interdisciplinary care team composed, at a minimum, of a physician and case manager (nurse or social worker) to provide and/or coordinate the full continuum of medical, behavioral, and long-term services and supports. The FQAC would function as the individual’s medical home and would be responsible for making and coordinating all necessary referrals for specialty care and services that cannot be provided within the center.

Ideally, these aging centers would have geriatricians on staff or, at a minimum, internal medicine and family practice physicians as well as nurses and/or social workers with training in geriatric medicine. Urgent care and same day appointments should be required, as elderly patients often need to be seen quickly in order to forestall an avoidable emergency room visit. Similarly, diagnostic services such as laboratory and basic radiology should be available on-site. FQACs should also be required to offer preventive care services and health education appropriate to an elderly population (e.g., fall prevention programs).

FQACs would receive reimbursement in the same manner as FQHCs currently do for state plan services. Importantly, under recently adopted health reform legislation, states also have the option (beginning in January 2011) of amending their state plans to fund medical home services, components of which include case management, care coordination, and health promotion, among others. The precise details of this provision await further clarification, but it may provide states with an opportunity to work with

³⁰ For example, see T. McRae and R.D. Stampfy. “An Evaluation of the Cost Effectiveness of Federally Qualified Health Centers Operating in Michigan,” The Institute for Health Care Studies (IHCS) at Michigan State University (October 2006).

³¹ M. Mahar. “Medicaid: Issues of Eligibility and Enrollment,” Blog Posting on Health Beat (October 15, 2008).

<http://www.healthbeatblog.com/2008/10/medicaid-issues.html>; Proser M. “Deserving the Spotlight: Health Centers Provide High-Quality and Cost-Effective Care.” *Journal of Ambulatory Care Management*, (October-December 2005): 28(4):321-330.

CMS to offer these services under the FQAC model outlined above while still maintaining control over aggregate HCBS expenditures.

HCBS Pay for Performance Programs

Pay-for-performance (P4P) programs are widespread among Medicaid managed care organizations, including MCOs that manage long-term care services. Some states also participate in the Medicare nursing facilities pay-for-performance pilot program (i.e., the Medicare Nursing Home Value-Based Purchasing demonstration, launched in 2009) or conduct their own P4P programs. However, P4P programs for home- and community-based services are in their infancy, even though they could assist states in improving care management/ service coordination in FFS environments and achieving quality and access objectives.

Owing to a host of factors, Medicaid agencies have traditionally assumed that FFS provider payments — including payments to case management providers that are outside of the administrative claims process — must be claim- and/or encounter-related. They further assume that payments must be tied to an established fee schedule and deviations are not allowed, which renders P4P all but impossible.

However, there is precedence under which CMS has explicitly permitted states to make performance incentive payments to providers under both a state plan as well as HCBS waivers. In 2006, CMS issued its “Quality Improvement Roadmap” and subsequently its “Value-Based...Results Driven...Healthcare: The Medicaid/CHIP Quality Initiative,” that articulates CMS’ formal position on Medicaid P4P initiatives, which it defines as: “a quality improvement and reimbursement methodology aimed at changing the current payment structure which primarily reimburses based on the number of services provided regardless of outcome.” CMS further specifies that P4P programs must be:

- Data driven;
- Beneficiary-centered;
- Transparent;
- Developed through partnerships; and
- Administratively flexible.

As a result of growing interest across states in quality-based payment strategies, in April 2006 CMS published a letter including the following guidance concerning the use of P4P incentives in the FFS environment:³²

SNAPSHOT: HCBS Pay for Performance Programs

DESCRIPTION	Incentivize HCBS providers to deliver high-quality services
SERVICES	All Medicaid-funded home- and community-based services
LOCATION	Participating states and localities
ELIGIBLE POPULATION	Medicaid-eligible individuals in need of HCBS
FUNDING	Medicaid-funded incentive payments
MOST INTRIGUING FEATURE	Allowing states the flexibility to implement common-sense programs that enhance quality

³² Center for Medicaid and State Operations, Centers for Medicaid and Medicare Services. State Health Official Letter #06-003. April 6, 2006.

Can pay-for-performance be accomplished through a Medicaid or SCHIP State Plan or is a demonstration or request for waiver necessary? The method by which a state may choose to accomplish its quality-based purchasing program can vary greatly because of the variety of approaches available to a state to administer its Medicaid and SCHIP programs. In general, states have broad flexibility, within established Federal regulations, to decide on medically necessary services that will be covered and rates that will be paid to providers or plans. CMS may review these plans through a State plan or a Medicaid demonstration project application or amendment, and through various other mechanisms.

In general, if the pay-for-performance program is a part of a fee-for-service delivery system, a state may include its initiative in its State plan. While the requirements for payment for managed care are somewhat more complicated, CMS will work with States to determine the proper method to implement such an initiative. A waiver under Section 1115, 1915(b), or 1915(c) of the Social Security Act (the Act) may be necessary when the initiative will not be statewide; will impact the amount, duration, and scope of benefits; will affect the comparability of benefits across the eligible population; or will restrict beneficiary freedom of choice of provider.

In the same letter, CMS advises states that P4P incentives that are implemented through HCBS waivers must be considered within the overall cost-effectiveness test.

Types and Examples of Financial Performance Incentives for HCBS

Financial performance incentives fall into six general categories:

- **Withholds from reimbursement repaid if performance standards are met:** For example, a state could withhold five percent of the reimbursement fee and if a provider meets pre-established performance targets (e.g., update plans of care at least annually and conduct quarterly on-site visits), states could then release the withheld amount.
- **Differential reimbursement rates for providers who meet performance standards:** To continue the previous example, in lieu of a withhold, states could add five percent to the reimbursement rate for providers who meet pre-established standards or for service providers that lower avoidable hospitalizations and ER visits.
- **Periodic bonus payments:** States could provide bonus payments to a provider with exceptionally high member satisfaction rates, a reduced incidence of bed sores, higher than expected discharge rates to the home, and/or members achieving established plan of care goals, among others.
- **Grants:** States could provide supplemental grants to providers that meet performance standards for HCBS, such as low turnover rates.
- **Penalties:** States can apply penalties for longer than expected lengths of stay, failure to discharge to home, never events, etc.
- **Preferential referrals to providers meeting performance standards:** Providers meeting performance standards could be allowed the right of first refusal for new members.

In light of the important benefits that an effective HCBS P4P program could generate in enhanced health outcomes and reduced expenditures, states are likely to soon begin taking advantage of the

options that CMS has put in place. To help guide resulting state activities, the recently formed Long-Term Quality Alliance (<http://www.ltqa.org>) is currently developing guidelines and recommendations.³³

State-Level Planning Activities

Most state-level planning for long-term care is now driven by population demographics and incident rate methodologies. However, state Medicaid agencies need to conduct “planning” that is much more specific and includes both short- and long-term horizons. At the very least, these planning activities should include:

- Tracking nursing facility admissions for the dually eligible (Minnesota now does this);
- Tracking nursing facility Medicare admissions for individuals with incomes likely to qualify for home- and community-based and/or nursing facility services under Medicaid once assets are depleted;
- Tracking assisted living center capacity and admissions for individuals with incomes likely to qualify for Medicaid-funded HCBS once assets are depleted;
- Identifying aging communities (e.g., measured by reductions in the number of school-aged children, increases in average age, population density, etc.) that will be important targets for developing community-based capacity;
- Tracking the aging of individuals served by other state agencies (e.g. individuals with mental illness and developmental disabilities) who may transition to the general long-term care system; and
- Community-level tracking of chronic conditions.

SNAPSHOT: State-Level Planning Activities

DESCRIPTION	A process to enable states to proactively anticipate and address future needs over the short- and long-term
SERVICES	All Medicaid-covered LTSS
LOCATION	Participating states
ELIGIBLE POPULATION	Medicaid-eligible individuals in need of LTSS
FUNDING	NA
MOST INTRIGUING FEATURE	Intelligently anticipating and rationally planning to meet future needs

Tracking and trending this information will provide states with the invaluable ability to anticipate and address their future long-term needs in a rational, orderly manner.

³³ See D.J. Lipson and S.Simon. “Quality’s New Frontier: Reducing Hospitalizations and Improving Transitions in Long-Term Care,” Mathematica Policy Research, Inc. (March 2010); CMS Disabled and Elderly Health Programs Group, “Advancing Quality in Community-Based Long-Term Care Services,” Centers for Medicare and Medicaid Services (March 2009).