PUBLIC CONSULTING GROUP

"Money Follows the Person" and Long Term Care System Rebalancing Study

August 8, 2008

Prepared For:

State of West Virginia

Department of Health and Human Resources

Office of the Ombudsman for Behavioral Health

Olmstead Office

List of Tables **Page**

I. INTRODUCTION

A. LONG TERM CARE IN THE UNITED STATES TODAY

By definition, "long term care" means a variety of services and supports utilized by individuals to meet their health and/or personal care needs over an extended period of time. The overall goal of long term care services is to help individuals maximize their independence and functioning. Often, the term "long term care" is associated with a population aged 65 and older. However, a person may require the assistance of long term care services at any age. In fact, 40 percent of people who currently receive long term care services and supports are adults aged 18 to 64 years old.[1]

Long term care (LTC) is often provided by paraprofessionals who assist individuals with Activities of Daily Living (ADLs). These include eating, bathing, dressing, using the toilet, transferring to or from bed or chair, and caring for incontinence.[2] Long term care services can also include support services that assist individuals to live a full life. These include support in developing and maintaining social skills, employment skills and community living skills.

The need for long term care services and supports in the US is increasing. In 2007 about 9 million Americans aged 65 and over will need long term care services. Estimates show that by 2020, that number will increase to 12 million.[3] There are several reasons for this:

- The population is aging.
- Individuals with cognitive and complex physical disabilities have a longer life expectancy and will require long term care services and supports for a longer period of time.
- Individuals with cognitive disabilities who have had the benefit of early intervention and an integrated and inclusive education have different expectations for living and working as adults and now require the support of states' long term care systems.

Many individuals develop the need for long term care as they age or as a chronic illness or disability becomes more debilitating. As an individual's need for long term care services and supports change over time, the setting selected for the provision of those services can change. In some cases, a person may need long term care for an acute illness or injury, and then may move back to their home or other community-based setting to receive home and community-based supports. Other individuals, whose needs can no longer be met at home, must move from home to a long term care facility for more extensive care or supervision.[4] If given a choice, most people prefer to delay or avoid extended stays in long term care facilities opting to stay in their own homes and communities with needed support services.

---

[1] www.longtermcre.gov/LTC/Main_Site/index.aspx. Accessed 2-16-07.
[2] Ibid.
[3] Ibid.
[4] Ibid.

A discussion of long term care services and supports must include a discussion of the financial reality: long term care is expensive. The National Clearinghouse for Long Term Care estimates a 2006 national average for one year of care in a nursing facility (NF) at over $62,000 for a semi-private room. One year of care at home, with only periodic personal support from a home health aide costs almost $16,000 a year.[5] While costs for long term care services vary greatly depending on the type and amount of services needed, geographic location, and the provider used, the trend is that costs will increase over time.

The variety of payers in the long term care arena further complicates finances. For example,

- Medicare and private insurance pay only for skilled services or recuperative care for a short period of time and do not pay for non-skilled assistance with ADLs;
- Medicaid pays only if financial and functional criteria are met; and
- Other federal programs such as the Older Americans Act and Veterans Affairs pay only for specific populations and in specific circumstances.

Therefore, even though there are an increasing number of private payment options that help to cover the costs of long term care services, such as long term care insurance and reverse mortgages, these are still uncommon forms of payment. As a result, most people end up paying for some or all of their long term care out of their own pockets.[6]

B. "MONEY FOLLOWS THE PERSON" INITIATIVE AND LONG TERM CARE REBALANCING

The July 1999 *Olmstead v. L.C.* Supreme Court decision serves as a catalyst for improving our country's LTC system. The decision requires states to administer services, supports, programs and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."[7] It guarantees that individuals with disabilities have equal access to public accommodations, employment, transportation, state and local government services, and telecommunications under an interpretation of Title II of the Americans with Disabilities Act (ADA).[8]

In 2001, the President Bush's New Freedom Initiative created a national effort to remove barriers to community living for all individuals with disabilities and chronic illnesses regardless of age. The goal of this ongoing Initiative is to put into action the decision and goals of *Olmstead v. L.C.* It is designed to ensure that all Americans have the opportunity to learn and develop skills, engage in productive work, choose where to live and participate in community life. The New Freedom Initiative continues to be implemented throughout the country's LTC system using a variety of approaches. Two of the approaches most frequently used as vehicles for system change are "Money Follows the Person" and "long term care rebalancing."

---

[5] Ibid.
[6] www.longtermcare.gov/LTC/Main_Site/index.aspx. Accessed 2-16-07.
[7] Olmstead v. L.C. (98-536) 527 U.S. 581 (1999).
[8] www.cms.hhs.gov/NewFreedomInitiative/01_Overview.asp. Accessed 3-1-07.

Enacted as part of the federal Deficit Reduction Act of 2005, Money Follows the Person (MFP) Rebalancing Demonstration is a grant program that is part of a comprehensive, coordinated strategy to assist states and their stakeholders to make widespread changes within their long term care support systems. "It is a market-based approach that gives individuals more choice over the location and type of services they receive [that] incorporate[s] the philosophy of self-direction and individual control in state policies and programs".[9] The goal of MFP is to reduce reliance on institutional care and develop community-based long term care services which support individuals' independence and full participation in the community.

MFP has two major components. One component is a financial system that promotes sufficient Medicaid funding of home and community-based services (HCBS). This often involves a redistribution of state funds between the LTC institutional and HCBS programs. The second component is a transition program that identifies individuals in institutional settings, including nursing facilities (NFs) and intermediate care facilities for people with mental retardation and developmental disabilities (ICFs/MR), who wish to live more independently in their own homes or more home-like settings and helps them do so.

Rebalancing of states' long term care systems has also become an important part of the federal New Freedom Initiative. The federal Centers for Medicare and Medicaid Services (CMS) has defined 'rebalancing' as "reaching more equitable balance between the proportion of total Medicaid long term support expenditures used for institutional services (i.e. NFs and ICFs/MR) and those used for community-based supports under its state plan and waiver options".[10] Under CMS' definition, a balanced long term care system offers individuals a reasonable array of options with adequate choices of community and institutional services without a financial and service bias for facility-based services and supports.

There are two key assumptions built into the concept of "rebalancing". First, any savings experienced as the result of transitioning people out of institutional settings are to be reinvested in community-based services. This is necessary to cover the cost of community-based services for those who had previously been in institutional settings. It is also important to use savings to expand access to community-based services to others in the community in order to delay or eliminate their need for institutional services. Second, it is assumed that even if there were no savings to be gained, it is morally and ethically more appropriate for people to live as long as possible within their communities rather than prematurely to be forced into institutional settings.

[9] CMS Letter to State Medicaid Directors, dated August 17, 2004.
[10] "Rebalancing Long term Care." www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp. Accessed 2-16-07.

National research has identified the following four components of long term care systems as important tenets of rebalancing.[11] As West Virginia looks to ensure an effectively rebalanced long term care system, it should fully incorporate these four components into its system.

Rebalancing Component	State Efforts
1. Equal Access to Institutional & Community Services	• Information/outreach to inform people about available options • Eligibility determination through an easily accessible entry point • Consistent assessment processes for institutional & community services • Mechanisms to quickly serve individuals at imminent risk of institutionalization
2. Financing of Programs and Services that Follows People into the Community	State legislatures have established budgetary changes that either allow funds allocated to one program to transfer to another as an individual moves within the system or creates a single long term care (global) budget instead of separating budgets between facility and community services.
3. Service Sufficiency and Provider Capacity	In addition to funding more services and supports, many states have also improved providers' capacity to provide new or underutilized services.
4. Quality Assurance and Improvement	States are incorporating mechanisms such as consumer-directed services, person-centered planning, obtaining participant feedback, and ensuring stakeholder involvement.

In 2006, CMS announced the availability of $1.75 billion in MFP rebalancing demonstration funding over five years. The funding is available to support state efforts to 'rebalance' the discrepancies between institution-based and community-based funding for long term care. The Money Follows the Person/Rebalancing Demonstration was created by section 6071 of the Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) and supports state efforts to:

- Rebalance long term support systems so that individuals have a choice of where they live and receive services;
- Transition individuals who want to live in the community from institutions; and
- Promote a strategic approach to implement a system that provides person-centered, appropriate, needs-based quality of care and quality of life services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions.[12]

[11] Crisp, Suzanne et al. Money Follows the Person and Balancing Long term Care Systems: State Examples. Medstat, September 29, 2003.

[12] CMS Program Announcement, www.cms.hhs.gov/NewFreedomInitiative/downloads/MFP_2007_Announcement.pdf. Accessed 4-5-07.

In 2007, CMS awarded MFP demonstration grants to 31 states. This funding will be used to transition 37,731 individuals out of institutional settings over the five-year demonstration period. [13] West Virginia applied for a MFP grant, did not receive funding, and is pursuing rebalancing through other initiatives.

C. PURPOSE AND METHODOLOGY OF THIS STUDY

In West Virginia, the Office of the Ombudsman for Behavioral Health assists the citizens of West Virginia who have concerns and grievances regarding the behavioral health care delivery system. This Office, which includes the Olmstead Office, provided oversight for this Rebalancing Study which includes a comprehensive review of the state's current long term care system and fiscal, regulatory and programmatic strategies to rebalance the West Virginia long term care system.

The State of West Virginia selected Public Consulting Group (PCG) to conduct this study and assist the Office of the Ombudsman for Behavioral Health to meet the study's goals, which are to:

- Conduct on-site interviews and public forums to gather information and obtain stakeholder input concerning West Virginia's long term care system;
- Analyze the West Virginia long term care system and provide recommendations for implementing specific Money Follows the Person and rebalancing initiatives;
- Provide fiscal projections for a conservative Money Follows the Person program;
- Provide fiscal projections for a more aggressive Money Follows the Person program;
- Provide projections for investment costs necessary for West Virginia to implement a Money Follows the Person program; and
- Detail cost savings, cost increases, and cost avoidance to implement recommended rebalancing initiatives.

To successfully achieve these goals, PCG followed a work plan that involved:

- Collecting and analyzing data to assess the state's current long term care system in the areas of access, services, financing and quality;
- Interviewing providers, state agency employees, consumers, advocates, and legislators to gain insight into system successes and gaps;
- Facilitating public forums throughout the state to obtain a variety of stakeholder input about the services and infrastructure of West Virginia's long term care system;
- Developing a draft report for the Office of the Ombudsman that includes a thorough analysis of the current system, puts forward options for implementing Money Follows the Person and rebalancing initiatives, and provides fiscal projections for a 10-year period regarding the implementation of recommended initiatives;

[13] CMS Money Follows the Person Fact Sheet, http://www.cms.hhs.gov/DeficitReductionAct/Downloads/MFP_FactSheet.pdf

- Finalizing the written report after a public feedback and input process; and
- Presenting the study findings to the Olmstead Council and the Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA).

II. ANALYSIS OF WEST VIRGINIA'S LONG TERM CARE SYSTEM

West Virginia's long term care system is integral to supporting the health and well-being of its citizens. As the result of the state's demographics, most West Virginians will come into contact with the long term care system at some point in their lives, either directly or indirectly. The state reportedly has "the highest rate of disability in the nation at 23% of the general population and 48% of senior citizens report having some type of disability."[14]

With 1.8 million people spread over 24,282 square miles of mountainous terrain, West Virginia's rural Appalachian geography provides a significant challenge to the capabilities of the long term care system. Many West Virginians live in remote communities with limited access to basic services such as adequate housing and transportation. Additionally, based on 2000 census data, West Virginia has the lowest median income in the nation at $16,477 and the highest median age at 38.9 years.[15] As such, many West Virginians depend on public assistance and funding to meet their basic living needs and Medicaid is the single largest source of funding for the long term care system.[16]

A comprehensive and detailed assessment of the current LTC system in West Virginia is critical in developing projections of the state's future needs and determining whether and how initiatives such as Money Follows the Person and system rebalancing could benefit the state. The following analysis covers the facility and community-based LTC services and supports administered and/or funded by West Virginia's Department of Health and Human Resources (DHHR) and other state agencies. Fundamental to this work is the assumption that a "rebalancing" of the system takes savings gained by transitioning individuals from institutional settings and uses those savings to increase and expand the availability of community-based supports.

Please note that the analysis is separated into the following sub-sections in order to demonstrate West Virginia's current ability and capacity to meet the important tenets of an effective LTC system that have been identified by national research:

- Service Delivery;
- Access;
- Financing; and
- Quality.

[14] MFP Demonstration Project Narrative.
[15] U.S. Census 2000.
[16] West Virginia Choice Case and Counseling Grant.

A. SERVICE DELIVERY

The analysis begins with an assessment of West Virginia's LTC service infrastructure: the facility-based and community-based services available to West Virginia residents and other factors that influence the LTC system. The analysis includes the presentation of data from a variety of sources as well as the opinions of stakeholders.

An effectively operating state LTC system supports two goals of long term care:

- To support people being able to live in their own homes within their home community for as long as possible; and
- To enable people to return to community living from institutional, facility-based settings as soon as possible. Today, institutional settings are defined to include nursing facilities (NFs) and intermediate care facilities for persons with mental retardation (ICFs/MR).

An effective LTC system must include a variety of flexible services that can be adapted to meet the unique needs of each person across their lifespan. Some individuals will need long term care throughout their lives while others tend to have need for supports during the later years of life. For most, the type and intensity of services they need will vary as the people age and experiences health-related changes.

Needs assessment is an important characteristic of an effective long term care system. A needs assessment determines the strengths, resources and needs of the individual. The needs assessment and discussions with the individual when planning services should focus on:

- The supports and services the individual needs to maximize independence and remain in their own homes and communities;
- The resources the individual can contribute; and
- Whether all of these resources as a whole result in the assurance of health and safety for the person.

When the needs and resources are understood, service options, including frequency and duration of service delivery and the availability of area providers, can be examined.

The second important element in a LTC system is the actual adequacy of the array of service options available. Are the services needed available at all? Are they available in the community where a person in need lives? Can the person gain access to those needed services soon enough to support improvement or at least maintenance of their health and wellbeing?

The third important element in a LTC system is service coordination. Once service needs are identified, service coordination is important in assuring that:

- Services meet the needs of the individual;
- Services are of good quality and comply with applicable standards and regulations; and
- Services achieve the intended outcomes.

Regularly-scheduled intervals for reassessment and quality monitoring are also important characteristics of an effective LTC system. This includes the capacity to reconvene the service

planning or assessment mechanisms should an individual's needs change for any reason. A system of long term care is only as effective as its ability to adapt to individuals' changing needs. This includes beginning services as well as ending services in a timely manner.

West Virginia's system of long term services and supports are shaped by a combination of federal and state initiatives. It is important to understand these initiatives in order to understand the West Virginia LTC system as a whole.

1. Federal Initiatives

Three federal initiatives influence West Virginia's LTC system infrastructure:

- The *Olmstead v. L.C.* decision;
- The New Freedom Initiative; and
- The Deficit Reduction Act of 2005 (DRA).

a. *Olmstead v. L.C.* and the New Freedom Initiative

As mentioned earlier, the Olmstead decision requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." The New Freedom Initiative is intended to remove barriers to community living options for people of all ages with disabilities and long term illnesses.[17] The announcement of the *Olmstead v. L.C.* decision and the resulting New Freedom Initiative directly influenced DHHR's long term care policies and procedures. One of the changes was the establishment of the Olmstead Coordinator position and Olmstead Office within DHHR in 2003, as directed by Governor Bob Wise.

As the result of the establishment of the Olmstead Office, West Virginia "has seen a positive influence on the long term care system", according to the West Virginia Mental Health Consumers' Association. The Olmstead Coordinator develops, implements, and monitors West Virginia's Olmstead activities and organizes the Olmstead Council, a forum comprised of people with disabilities, family members, advocates, providers and state officials selected through a statewide nomination process. The Council:

- Monitors the activities of the Olmstead Coordinator;
- Makes recommendations regarding the long term care system;
- Issues position papers to identify and resolve systemic issues; and
- Revises and updates the Olmstead Plan and any subsequent work plans.[18]

For the year 2008, the Olmstead Council has identified the following priority areas and issues:

[17] www.cms.hhs.gov Accessed 4-2-07
[18] Olmstead Office Brochure

- Implement the Olmstead Plan;
- Implement Money Follows the Person and Rebalancing Strategies;
- Increase availability of appropriate Home and Community-Based Services;
- Eliminate current and future Waiting Lists for Home and Community-Based Services;
- Enhance the service benefits offered by the Aged and Disabled Waiver Program; and
- Implement a Statewide Transition/Diversion Program.

The most important of the Olmstead Council's goals is the full implementation of West Virginia's Olmstead Plan. Once fully implemented, the plan, categorized into the following 10 key components, will positively influence the state's long term care system by supporting quality community-based living options and increased consumer choice. The 10 key components are as follows:

Informed Choice:	Establish a process to provide comprehensive information and education so people with disabilities can make informed choices.
Identification:	Identify every person with a disability impacted by the Olmstead decision, who resides in a segregated setting.
Transition:	Transition every person with a disability who has a desire to live and receive supports in the most integrated setting appropriate.
Diversion:	Develop and implement effective and comprehensive diversion activities to prevent or divert people from being institutionalized or segregated.
Reasonable Pace:	Assure community-based services are provided to people with disabilities at a reasonable pace.
Eliminating Institutional Bias:	Provide services and supports to people with disabilities by eliminating the institutional bias in funding long term care supports.
Self-Direction:	Develop self-directed community-based supports and services that ensure people with disabilities have choice and individual control.
Rights Protection:	Develop and maintain systems to actively protect the civil rights of people with disabilities.
Quality:	Continuously work to strengthen the quality of community-based supports and assure the implementation of the Olmstead Plan.
Community-Based Supports:	Develop, enhance, and maintain an array of community-based supports that are self-directed to meet the needs of all people with disabilities and create alternatives to segregated settings.[19]

[19] Olmstead Office Brochure.

b. The Deficit Reduction Act of 2005

The Deficit Reduction Act of 2005 (DRA) was signed into law on February 8, 2006 with the intention to reduce Medicaid spending. It impacts Medicaid eligibility, benefits and cost-sharing, provider payments, and program integrity. The federal government has mandated that state Medicaid programs implement parts of DRA while making implementation of other parts optional. [20]

The DRA makes several major mandated and optional changes to long term services policies in Medicaid. Key changes include the following:

Mandated changes

Asset Transfers:

- Requires that states lengthen from 3 to 5 years the look-back period for asset transfers to establish Medicaid's eligibility for NF coverage;
- Changes the start of the penalty from the date of the transfer to the date of Medicaid eligibility;
- Requires annuities to be disclosed and states to be named a beneficiary for cost of Medicaid assistance;
- Requires states to use the income first rule; and
- Excludes coverage for individuals with home equity in excess of $500,000 (or up to $750,000 at state option), with an exception when a spouse or child with a disability is residing in the home.

Long Term Care Partnership Programs:

- Lifts the moratorium on states expanding new partnership programs to increase the role of private long term care insurance in financing long term services;
- Requires that programs adopt National Association of Insurance Commissioners (NAIC) model regulations; and
- Requires the Secretary to develop standards for making policies portable across states.

Optional Changes

The Family Opportunity Act:

- Extends Medicaid "buy-in" coverage to children with disabilities whose family income is up to 300% of poverty;
- Phases in coverage for children up to age 6 in 2007 and increases it to age 19 by 2009;
- Permits states to charge income-related premiums; and

[20] Rudowitz, Robin and Andy Schneider. "The Nuts and Bolts of Making Medicaid Policy Changes: An Overview and a Look at the Deficit Reduction Act." The Henry J. Kaiser Family Foundation, August 2006. www.kff.org/medicaid/upload/7550.pdf. Accessed 4-5-07.

- Requires parents to participate in employer-sponsored insurance if the employer covers at least 50% of the premium.

Money Follows the Person Demonstration:

- Authorizes the Secretary to grant competitive awards to states to move people from an institutional to community setting;
- Provides for an enhanced Federal Medical Assistance Percentage (FMAP) for 12 months for each person transitioned from an institution to the community during the demonstration period (eligible participants must have resided in an institution for a period from 6 months to 2 years, as determined by the state); and
- Requires states to continue to provide community services after the demonstration period for as long as the individual remains on Medicaid and is in need of community services.

State Option to Provide HCBS Services:

- Gives states the option to provide all HCBS waiver services for seniors and people with disabilities up to 150% of poverty without the need for a waiver;
- Does not require that eligible beneficiaries be receiving an institutional level of care;
- Requires states to establish more stringent eligibility criteria for institutional services; and
- Permits states to cap enrollment, maintain waiting lists, and offer the option without providing services statewide.[21]

Cash and Counseling Option:

- Permits states to allow for self-direction of personal assistance services without a waiver;
- Includes consumer protections consistent with the cash and counseling demonstration;
- Prohibits individuals from participating in self-direction under the option if they live in a home or property owned or controlled by a services provider; and
- Does not require comparability or statewide application exclusively.[22]

2. State Long Term Care Elements

There are a variety of elements that make up West Virginia's long term care delivery system. The following is a description of these various elements and includes initiatives and directives stemming directly from the West Virginia Legislature as well as new initiatives from DHHR and other state agencies that have played major roles in the evolution of the state's long term services and supports delivery system.

[21] Bazelon Center for Mental Health Law, www.bazelon.org/issues/medicaid/stateplanoption.htm
[22] Crowley, Jeffrey S. "Medicaid Long term Services Reforms in the Deficit Reduction Act." Health Policy Institute, Georgetown University; April 2006.

a. West Virginia Legislative Initiatives

State legislation over the past decade has benefited the long term care system by:

- Creating the Ron Yost Personal Assistance Services (RYPAS) Program in 1998 to provide personal assistance services to individuals who do not qualify for Medicaid;
- Enacting Medicaid buy-in legislation in 2003;
- Enacting Personal Care Employment Support legislation in 2003 to allow access to personal care services in the workplace;
- Carrying over a study resolution of LOCHHRA's Medicaid Community Attendant Services and Supports Act in 2004;
- Initiating a study resolution for LOCHHRA to investigate MFP legislation (2006); and
- Authorizing the creation of a Comprehensive Behavioral Health Commission during the 2006 regular session to complete a comprehensive study of the state's behavioral health system, including expenditure of funds.[23]

b. Facility-Based Services

Over the years, West Virginia has made strides in moving individuals with disabilities and long term care needs from facility-based settings to community-based settings. West Virginia has closed nine state-operated facilities since 1977 and in 1998 became one of only six states to close all of its state-operated institutions for people with developmental disabilities. The state has made efforts to shift funding away from the institutions and toward the development of community-based supports. This has effectively reduced the number of state-operated beds from 4,140 in 1976 to 751 in 2006.[24] Additionally, West Virginia's Health Plan has established a capped number of 30 beds (33 with the state-operated facilities) per 1,000 residents aged 65 and older.[25]

Based on this information, one can see that West Virginia has made progress in shifting funding and service provision from facility-based to community-based programs. At the same time there is an opportunity to continue West Virginia's efforts to decrease institutional, facility-based long term care. Currently, the following facilities continue to provide care for a significant number of West Virginia residents:

- Nursing Facilities (NFs);
- Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR);
- State-operated LTC Facilities; and
- State-operated psychiatric hospitals.

---

[23] WV MFP Demonstration Project Narrative.
[24] WV MFP Demonstration Project Narrative.
[25] Manard, Barbara, Ph.D. "Nursing Facility Bed Supply and Need." September 2000.

Table 1 summarizes the number and capacity of long term care institutions in West Virginia. State psychiatric hospitals are included because in some cases they do provide long term care supports even though for a majority of their patients the hospital stays are short term.

Table 1. West Virginia Long Term Care Institutional Facilities

Facility Type	No. of Facilities in WV	Total Capacity	Avg. Occupancy Rate
Nursing Facilities	132	9,748	90%
Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)	63	502	N/A
State-Operated LTC Facilities (licensed beds)	5	535	85.3%
State-Operated Psychiatric Hospitals	2	240	98.8%

Source: "The State Long-Term Health Care Sector 2005: Characteristics, Utilization, and Government Funding." American Health Care Association, August, 2006. Data collected from BHHF, May 2007. OHFLAC website, Facility Lookup, Accessed 5-31-07.

1. Nursing Facilities

NFs are an important component of any state's long term care system infrastructure. They provide accommodations and nursing care 24 hours per day for persons who are elderly, ill or otherwise incapacitated. This holds true in West Virginia where NFs provide medical services and supports to nearly 16,000 new admissions per year. [26]

CMS uses the Long Term Care Minimum Data Set (MDS), a standardized, primary screening and assessment tool of health status, as a comprehensive assessment for residents in nursing facilities across the country. The Third Quarter, 2007 MDS data for West Virginia is documented in Table 2 and provides a good overview of NF utilization in West Virginia compared to the United States average. The following are identified trends from the MDS data presented in Table 2.

- On average, WV utilizes more Medicaid and Medicare dollars and less private pay for NF stays than the national average.
- West Virginians are admitted into NFs from homes without home health services being provided at a rate above the national average.
- The majority of NF residents come directly from their own homes without home health services or other community-based supports prior to NF admission.
- More than half of the current NF population has not spent time in a NF, residential setting, MH/psychiatric setting or MR/DD setting in the past 5 years.

[26] WV Health Care Association, LTC Facts 2006.

- A higher percentage of "independent" individuals are NF residents in WV than the national average.
- ADL functioning in NF residents is more likely to remain unchanged than in other states.
- On average, WV NF residents are less likely to have a support person who is positive towards discharge than in other states.
- It is less likely in WV than in other states for a NF resident, his/her family, or his/her significant other to participate in the assessment process.
- The highest percentage of NF residents in WV is in the age group from 75 to 84, while on average in the U.S., the age group of highest percentage in nursing facilities is 85 to 95.

Table 2: Selected MDS Data for West Virginia, Third Quarter, 2007

	Non-Medicaid	Medicaid	Total Stays
WV	38.3%	61.7%	9,663
U.S. Average	46.2%	53.8%	1,370,280
Medicare as Payment Source for NF Stays			
WV	73.0%	27.7%	9,663
U.S. Average	74.5%	25.5%	1,370,331
Payment Sources for NF Stays – Self or Family Pays			
WV	90.7%	9.3%	9,663
U.S. Average	85.9%	14.1%	1,370,283

Sources of NF Admissions								
	Private Residence without Home Health	Private Residence with Home Health	Assisted Living or Group Home	Other NF	Acute Care Hospital	Psychiatric Hospital or MR/DD Facility	Rehab Hospital	Other
WV	14.0%	4.5%	4.8%	11.9%	59.1%	1.6%	2.9%	1.1%
U.S. Average	11.3%	4.4%	6.2%	13.4%	58.9%	2.7%	1.7%	1.2%

Residential Stay at Same NF 5 Years Prior To Entry			
	No	Yes	Total
WV	83.9%	16.1%	9,793
U.S. Average	79.2%	20.8%	1,381,175
Residential Stay at Other NF 5 Years Prior To Entry			
WV	82.4%	17.6%	9,795
U.S. Average	78.3%	21.7%	1,381,181
Residential Stay at Other Facility 5 Years Prior To Entry			
WV	90.3%	9.7%	9,795
U.S. Average	85.0%	15.0%	1,381,202
Residential Stay at MH/Psychiatric Setting 5 Years Prior To Entry			
WV	97.8%	2.2%	9,795
U.S. Average	96.9%	3.1%	1,381,206
Residential Stay at MR/DD Setting 5 Years Prior To Entry			
WV	99.7%	0.3%	9,795
U.S. Average	99.6%	0.4%	1,381,212
No Residential Stay 5 Years Prior To Entry			
WV	40.8%	59.2%	9,793
U.S. Average	51.6%	48.4%	1,381,154

History of Mental Illness in NF Residents			
	No	Yes	Total
WV	88.3%	11.7%	9,740
U.S. Average	87.4%	12.6%	1,368,798

Cognitive Skills/Daily Decision Making of NF Residents					
	Independent	Modified Independence	Moderately Impaired	Severely Impaired	Total
WV	19.4%	20.2%	45.8%	14.6%	9,794
U.S. Avg	18.9%	22.4%	42.8%	16.0%	1,390,364

Resident Believes He/She is Capable of Increased Independence in at Least Some ADLs			
	No	Yes	Total
WV	84.0%	16.0%	9,663
U.S. Average	80.0%	20.0%	1,371,222
Direct Care Staff Believe Resident is Capable of Increased Independence in at Least Some ADLs			
WV	77.5%	22.5%	9,663
U.S. Average	74.7%	25.3%	1,371,297
Resident Able to Perform Tasks/Activities but is Very Slow			
WV	94.7%	5.3%	9,663
U.S. Average	89.7%	10.3%	1,371,301

Change in ADL Function				
	No Change	Improved	Deteriorated	Total
WV	66.7%	4.9%	28.4%	9,660
U.S. Average	63.9%	5.9%	30.2%	1,368,792

Resident Expresses/Indicates Preference to Return to the Community			
	No	Yes	Total
WV	79.8%	20.2%	9,794
U.S. Average	78.2%	21.8%	1,388,242
Resident Has a Support Person Who is Positive Towards Discharge			
WV	84.4%	15.6%	9,621
U.S. Average	82.1%	17.9%	1,367,236

Discharge Potential					
	No	Within 30 days	Within 31-90 days	Discharge status unknown	Total
WV	81.7%	3.1%	4.0%	11.3%	9,797
U.S. Average	78.1%	3.9%	4.1%	13.8%	1,388,432

Resident Participation In Assessment			
	No	Yes	Total
WV	13.5%	86.5%	9,663
U.S. Average	10.3%	89.7%	1,371,165

Family Participation In Assessment				
	No	Yes	No Family	Total
WV	62.3%	36.7%	1.0%	9,663
U.S. Average	53.2%	45.6%	1.2%	1,371,015
Significant Other's Participation In Assessment				
WV	72.8%	4.7%	22.6%	9,661
U.S. Average	61.1%	6.4%	32.5%	1,366,304

Age of Resident							
	1 to 30	31 to 64	65 to 74	75 to 84	85 to 95	> 95	Total
WV	0.2%	11.8%	14.1%	33.1%	36.5%	4.3%	9,817
U.S. Average	0.6%	13.1%	13.1%	30.8%	37.2%	5.1%	1,396,094

Source: CMS MDS "Active Residents" Data for West Virginia (September 30, 2007).

Individuals and the families of individuals who use the services of West Virginia's NFs are pleased with the care offered in the facilities. According to a 2005 Marshall University study of long term care, 94% of residents and families said they would recommend their facility to others looking for quality care.[27] In a report released in May, 2007, West Virginia NFs received nearly a 90% rating for overall satisfaction compared to a national average of 83%.[28]

Bases on an in-depth review of the operation of the state's nursing facilities, PCG found the following issues and challenges that need to be addressed:

- Statewide NF Capacity;
- Certificate of Need Process;
- Level of Care (LOC) Criteria;
- Availability of NF Specialty Care Units; and
- Medical vs. Psycho-Social Needs.

NF Capacity

The statewide capacity of NFs is considered adequate at the present time. This is the view of both the West Virginia Health Care Authority (WVHCA) and the Long-Term Care Ombudsman. At the same time, there are considerations that need to be taken into account when examining whether the NF needs of West Virginia residents are being met today and the prospects for the near future.

[27] WV Health Care Association, LTC Facts 2006.
[28] West Virginia Health Care Association, "Provider Perspective", Issue 2, 2007.

While the WVHCA states that NF capacity is adequate, there is concern about the current distribution of NF beds. There are geographic pockets in West Virginia that could use more NF beds and other areas that appear to have an oversupply. While redistribution of the existing statewide NF capacity may have merit, there are legal issues that come into play. NF beds cannot be reallocated geographically because of state statute and a moratorium that has been placed on NF beds since 1987. WVHCA confirmed that to date no changes to the state statute have been made and actions to try and amend the moratorium have not occurred.

BoSS qualifies their view that the current supply of NF beds is adequate. They indicated that the current supply would be adequate "if there were alternative options available, but without such options the current need for beds in many parts of the state is greater than there are available beds. Such options could include either waivers or increased state supplements for assisted living and other community-based reimbursements so that people could receive care in their homes. With current options, many individuals wanting to enter WV nursing facilities end up not entering either because the beds are not available or because they are refused entry due to their physical or mental condition."[29]

The West Virginia Mental Health Consumers' Association points out that NFs are sometimes the only option for individuals because community-based supports are simply not available or the services available through the state's Aged and Disability Waiver are not sufficient to meet their needs. Despite the fact that the eligibility criteria for NFs is quite restrictive, it is reasonable to assume that some residents of NFs do not require that level of care and are simply there because the supports they need to remain in the community are not available or the individual cannot afford the services. Individuals in acute care hospitals sometimes face the same challenge in that they are discharged to in-state and out-of-state NFs when their needs could be as appropriately met by a variety of community-based services and supports.

Certificate of Need Process

Across the United States, policymakers have used the Certificate of Need (CON) process for over 30 years to help direct health care delivery. The rationale has been that imposing market entry controls will result in a more appropriate allocation and distribution of health care resources. Thirty-six (36) states and the District of Columbia, including West Virginia, currently maintain CON programs with varying scope and focus. [30] In West Virginia, all healthcare providers, unless otherwise exempt, must obtain a CON before:

- Adding or expanding health care services;
- Exceeding the capital expenditure threshold of $2,000,000;
- Obtaining major medical equipment valued at $2,000,000 or more; or

[29] Letter from Larry Medley, State Long-term Care Ombudsman to Tina Maher, Office of the Ombudsman for Behavioral Health, September 12, 2007.
[30] "Certificate of Need." American Health Planning Assoc, www.ahpanet.org. Accessed 4-25-07.

- Developing or acquiring new health care facilities.[31]

In comparison with other states, West Virginia's CON system is fairly restrictive in regulating health care providers' ability to enter the state's long term care system. For example, Washington State requires only *certain* health care providers to obtain state approval before offering certain new or expanded services.[32]

While West Virginia's current system is effective in limiting unwanted growth in some areas of the long term care system, it unintentionally has a negative impact on the availability and access to other needed services and supports that are essential to people staying in or returning to community living. For example:

- The current CON law limits the provision of home health services to distinct service areas. By definition, this means the county or counties in which an application for a CON has been made or granted or in which a facility has expanded through a determination of non-reviewability.[33] As a result, the availability and capacity of home health services is limited.

The way in which the CON is administered for NF beds is intended to ensure that there is not overdevelopment of capacity. It unintentionally does not allow for the existing capacity to be appropriately redistributed within the state to better meet the changing demand of residents.

Level of Care (LOC) Criteria

In West Virginia, the LOC criteria that an individual must meet to qualify for nursing facilty services are restrictive. The LOC criteria requires that each Medicaid-eligible NF resident must meet the five (5) deficits on the Pre-Admission Screening Form (PAS):

- Decubitus, Stage 3 or 4.
- In the event of an emergency, the individual is either mentally unable or physically unable to vacate a building.
- Functional abilities of individual in the facility are as follows:
    1. Eating, Level 2 or higher (physical assistance to get nourishment, not preparation).
    2. Bathing, Level 2 or higher (physical assistance or more).
    3. Dressing, Level 2 or higher (physical assistance or more).
    4. Grooming, Level 2 or higher (physical assistance or more).
    5. Continence, bowel, Level 3 or higher (must be incontinent).
    6. Continence, bladder, Level 3 or higher (must be incontinent).

[31] www.hcawv.org/CertOfNeed/conHome.htm. Accessed 4-25-07.
[32] "Certificate of Need." Washington State Dept of Health, www.doh.wa.gov/hsqa/fsl/CertNeed/default.htm. Accessed 4-25-07.
[33] www.hcawv.org/CertOfNeed/Support/Home_Health_Services.pdf. Accessed 5-31-07.

7. Orientation, Level 3 or higher (totally disoriented, comatose).
8. Transfer, Level 3 or higher (one-person or two-person assistance in the facility).
9. Walking, Level 3 or higher (one-person assistance in the facility).
10. Wheeling, Level 3 or higher (must be Level 3 or 4 on walking in the facility to use Level 3 or 4 for wheeling in the facility).

- Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
- Individual is not capable of administering his/her own medications.[34]

West Virginia is more restrictive in its NF eligibility requirements than some neighboring states, such as Ohio. As the result, some individuals who desire NF care and do not meet West Virginia's LOC requirements seek services across the state border. Alan Cochrun of the Ohio Access Center for Independent Living noted that in 2006, 266 West Virginia residents were admitted to Ohio nursing facilities and receive Ohio Medicaid.[35]

The key to managing this situation is not for West Virginia to ease up its LOC requirements. The LOC requirements are reasonable in ensuring that people do not gain access to a more institutional and more expensive level of care when their needs could be met in a community-based setting that is more appropriate and less expensive. The challenge is increasing the availability of more community-based services, including assisted living services, for those individuals who are no longer able to live at home and who do not qualify for NF care.

Availability of NF Specialty Care Units

In speaking with stakeholders throughout the state, a consistent theme is that West Virginia's NFs lack units for specialty care. Specifically ventilator care units were mentioned as a needed resource within the facilities. In fact, West Virginia has fewer special care beds in NFs than any other state in the U.S.[36]

Because several neighboring states to West Virginia have the needed specialty NF units, some West Virginians who require specialty nursing care travel to these neighboring states, away from their home communities, families, and social network, in order to receive needed services In 2006, 16 West Virginia residents were admitted to NFs for vent care in Ohio alone.[37]

West Virginia State Code 16-2D-6 regulates nursing facilities in the state. One specific subsection of 16-2D-6 speaks specifically to ventilator beds and how they are to be treated by the nursing facilities. Subsection "f" states:

[34] Chapter 500, Nursing Facilities.
[35] Minutes of Vent Care Meeting, May 21, 2007.
[36] CMS OSCAR Form 671: F15 – F22, Current Surveys, June 2007, American Health Care Association – Health Services Research and Evaluation.
[37] Minutes of Vent Care Meeting, May 21, 2007

> "(f) In the case where an application is made by a hospital, NF or other health care facility to provide ventilator services which have not previously been provided for a NF bed, the state agency shall consider the application in terms of the need for the service and whether the cost exceeds the level of current Medicaid services. No facility may, by providing ventilator services, provide a higher level of service for a NF bed without demonstrating that the change in level of service by provision of the additional ventilator services will result in no additional fiscal burden to the state."[38]

This provision does not prohibit NFs from offering ventilator care. However, the practical result is that no NF has elected to provide such service in spite of a need. They simply cannot get paid the cost of the service. Many clients requiring ventilator services are therefore forced to look for out-of-state options for ventilator services.

It should be noted that HCBS have the potential for meeting specialty care needs in people's own homes rather than in an institutional setting. This potentially could be done for less cost than an individual needing to go to a NF.

Medical vs Psycho-Social Needs

During the April 2007 forums held in West Virginia to get public comments regarding the state's long term care system, a number of individuals indicated that there are minimal opportunities for recreational, spiritual, and social activities available for residents of the state's NFs. Availability to these activities varies widely among NFs and is also influenced by the extent to which an individual NF resident has family or community support. The fact is that Medicaid, which pays for the cost of most NF residents, is based on a medical model and pays for medically necessary services. While people's needs are not ignored, the resources available for addressing residents' psycho-social needs are limited. It is for this reason, among others, that creating more community-based options for individuals in meeting their health care needs is important.

2. Intermediate Care Facilities for Persons with Mental Retardation

As of May, 2007, there were 66 privately-operated Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) that provide care for individuals with developmental disabilities in West Virginia. These facilities are licensed for a total of 515 beds. [39] ICF/MR services vary according to individuals' needs, age, and level of mental retardation and developmental disabilities. In order to participate in the WV Medicaid Program and receive payment from BMS, each of the 66 ICFs/MR must:

[38] WV State Code 16-2D-6(f)
[39] May 19, 2008 phone conversation between Rose Lowther-Berman of OHFLAC and Tina Maher of the Olmstead Office.

- Meet and maintain all applicable state and federal licensing, accreditation, and certification requirements;
- Meet and maintain all BMS enrollment requirements; and
- Maintain a valid provider agreement on file that is signed by the provider and BMS upon application for enrollment into the WV Medicaid Program.[40]

As of August 1, 1989, there has been a moratorium on the construction or development of new ICF/MR facilities in West Virginia.[41] The moratorium was intended to assure that any new resources available to the state to be used to develop small, individualized residences and home-based programs for individuals.[42]

On average in West Virginia, there are eight individuals living in an ICF/MR facility. Eight individuals per ICF/MR facility does not reflect a home-like setting where individuals may exercise personal choice. Outside of facility-based settings such as college dormitories, you do not regularly witness eight unrelated adults living together. It is also unclear how much choice individuals have about who they live with (selection of house/roommates) and the compatibility of interests versus matching people based on staffing patterns and needs.

BHHF contracted with national experts to provide an independent review of the MR/DD Waiver Program in 2000. This is often referred to as the Cooper/Hill report.[43] This report addressed the utilization of ICFs/MR in West Virginia. The report stated:

- Given the substantial progress West Virginia has made in moving individuals into the community through the waiver, coupled with the significantly higher per ICF/MR participant costs, the state is well-positioned to begin to look at the role and utilization of non-state ICFs/MR.
- As has been clearly demonstrated, many individuals with similar needs are well served through the waiver.
- As a means to offer more choice and flexibility and achieve potential costs savings that could be used to add new individuals to the waiver, West Virginia may wish to review the role of these settings in the overall services system.

The Cooper/Hill Report made the following additional points[44]:

---

[40] Chapter 500–Covered Services, Limitations, and Exclusions for ICF/MR Services.
[41] Ibid.
[42] ICF/MR Moratorium, Civil Action No. Misc-81-585.
[43] "West Virginia Home and Community-based MR/DD Waiver Report", prepared for the West Virginia Bureau for Behavioral Health and Health Facilities, Robin Cooper, NASDDDS Inc. and Marilyn Hill, Hill Associates, July 10, 2000.
[44] "West Virginia Home and Community-based MR/DD Waiver Report", prepared for the West Virginia Bureau for Behavioral Health and Health Facilities, Robin Cooper, NASDDDS Inc. and Marilyn Hill, Hill Associates, July 10, 2000, pages 7 and 8.

- "The most common reasons cited (by other states) for the conversion of ICFs/MR to HCBS funding are: 1) Improving resident quality of life, 2) Potential cost savings, and 3) Deregulation leading to increased flexibility in services delivery."
- "As those who operate ICFs/MR are aware, using this funding authority comes with a fairly substantial overlay of federal (and sometimes additional state) regulations. While intended to assure the health and safety of those residing in ICFs/MR, many individuals, providers, and state personnel have found the regulations may unnecessarily constrain innovation and unintentionally restrict resident choice and opportunity."
- "Detailed habilitation requirements, clinical staff oversight and sometimes costly physical plant requirements all add to the cost of operating ICFs/MR without necessarily improving the individualization and life quality for some residents."
- "In situations where the ICF/MR provider offers all programming, individuals may not have the opportunity to be involved in other training such as supported employment, outside of the facility."
- "Staffing requirements may result in some individuals receiving more intensive – and therefore more costly – staffing ratios than they need or want. The requirements for clinical oversight can also add costs to the program, particularly for those individuals who have no need for nursing or other therapies."

Since 2000, DHHR has made improvements in the delivery of services to individuals with MR/DD. BMS has added members to the MR/DD waiver, received approval from CMS for MR/DD Waiver renewal, expanded quality management and expanded data systems. While these changes are noteworthy, many of the general points made in the Cooper/Hill Report are still relevant today.

In a report titled, "Proposed Redeployment of Two West Virginia ICFs/MR," dated February 13, 2006, DHHR noted that "elderly, frail individuals are often housed with younger, more aggressive consumers, putting them at risk of injury." The report also states that the ICFs/MR in West Virginia are "aging" and that most have been "constructed to require double rooms and roommates [which] often serves to increase behavioral problems and in some cases, the institutional flavor of the programs, neither of which are desirable outcomes." The report recommended the development of 2 four-bed ICFs/MR, newly built, in semi-rural areas of the state to make it easier to attract and maintain a higher quality of staff than is available in more competitive job markets such as Huntington and Charleston.[45]

West Virginia's ICFs/MR are an outdated model of service delivery that has been abandoned in many states. While ICFs/MR may be appropriate for a few older individuals with developmental disabilities who have significant medical needs, most ICFs/MR should be replaced by waiver services. This would result in the delivery of more appropriate and higher

[45] "Proposed Redeployment of Two West Virginia ICFs/MR." West Virginia Department of Health and Human Resources, February 13, 2006.

quality services for less cost and would provide individuals with a more desirable lifestyle. In addition, there is an opportunity to save significant sums of money that could be used to extend services to individuals in need of supports.

3. State-Operated Long Term Care Facilities

There are five (5) state-operated LTC facilities geographically dispersed throughout West Virginia:

- Pinecrest Hospital (Beckley, WV) in the past offered geriatric, long term and behavioral healthcare to those not served by traditional healthcare systems. In recent years the facility has shied away from taking the more difficult to care for residents and is primarily serving those traditionally served by other nursing homes.[46]
- John Manchin Sr. Health Care Center (Fairmont, WV) offers skilled/intermediate nursing, inpatient and outpatient clinical services and targets indigent residents unable to obtain services in the community.
- Hopemont Hospital (Hopemont, WV) provides services to geriatric residents of West Virginia requiring long term care and behavioral interventions.
- Lakin Hospital (Lakin, WV) provides nursing long term care services to West Virginians who have special placement needs due to behavioral, developmental and other complex problems and for whom community health will not or cannot provide services.
- Welch Community Hospital (Welch, WV) co-licensed as an acute care hospital and a long term care facility, offers acute inpatient and outpatient services to the rural population of southern West Virginia.

Because of the limited home and community-based options available in the state, many West Virginians who have long term care needs and no private insurance or financial resources, turn to the state's five LTC facilities for care. As such, the occupancy rates at these facilities typically are high, often with a majority of Medicaid funded individuals, as illustrated in Table 3.

For the period portrayed in Table 3, the occupancy rate for Lakin is low due to staffing challenges. Also, it should be noted that while Lakin is listed with a licensed capacity of 136, since 2005 that number has changed due to regulatory issues (room space) resulting in a reduction of licensed capacity to 114 beds.

Table 3: Occupancy in West Virginia's State-Operated Long Term Care Facilities

LTC Facility	Total Beds	Average Daily Census	Average Occupancy Rate
Hopemont	98	94.6	96.5%
Lakin	136	95.8	77.3%

[46] Letter from the State Long-term Care Ombudsman Program to Tina Maher, Olmstead Office, September 12, 2007.

LTC Facility	Total Beds	Average Daily Census	Average Occupancy Rate
Manchin	41	39.3	95.9%
Pinecrest	120[47]	113.2	94.3%
Welch	59	55.6	94.3%

Source: BHHF and Facility Data, May-June, 2007.

Our study of the five LTC facilities shows a weakness in accurate, consistent data collection and reporting. However, the state-operated LTC facilities are set to make some significant changes to ensure quality and reduce excess costs through the implementation of Medsphere's OpenVista electronic health records (EHR) system. Once fully implemented, the EHR system holds promise in DHHR's efforts to improve data collection and management, reduce duplication of efforts, and decrease documentation costs in the state-operated LTC facilities. For residents of the facilities, the accuracy promoted by the new records system will result in higher quality of care, and will promote patient safety. Overall, the implementation of OpenVista is a good step in committing to the improvement of long term care for West Virginians.

4. State Psychiatric Hospitals

During public forums in April of 2007, stakeholders noted that the psychiatric acute care hospitals—Sharpe Hospital and Bateman Hospital—have in fact become long term care facilities for some. Stakeholders mentioned that some individuals are admitted to the state acute psychiatric hospitals because their inability to access community-based services results in crisis situations.

Some individuals cannot access waiver services because of the waiting list (in the case of the MR/DD Waiver) or high level of care requirements, which individuals may not meet at the time they apply for waiver services. These admissions do contribute to the overcrowding at Bateman and Sharpe, resulting in a diminished quality and ability to provide effective treatment for hospital residents. Also, this situation contributes to the need for hospital diversions which will cost West Virginia approximately $9 million this year alone.

Efforts to investigate this issue further and quantify the extent to which this situation occurs were unsuccessful due to the lack of data. The new OpenVista electronic health records system will make this type of analysis possible in the future.

This growing, expensive problem within West Virginia's long term care and behavioral health systems would be eased by available and affordable HCBS services. Individuals and the state

[47] Pinecrest is licensed for 199 beds. However, some wings in the facility are closed. Vickie Parlier Jones, the Assistant Commissioner of BHHF's Office of Health Facilities, indicated in an email on 11/2/07 to Tina Maher of the Olmstead Office that "typically, they use 110-120 (beds)."

as a whole would benefit from increased opportunities and supports to transition from the state psychiatric hospitals to their homes and/or community-based settings of their choice.

3. Home and Community-Based Services (HCBS)

A range of Home and Community-Based services and supports are provided in a variety of settings. Examples of HCBS LTC include:

- Aged and Disabled Waiver Program (AD);
- Mental Retardation/Developmental Disabilities (MR/DD) Waiver Program;
- Home Health services;
- Hospice services;
- Medical Day Care; and
- Personal Care services.

West Virginia has made strides in providing an increased amount and variety of HCBS options for individuals needing long term care supports and services. Still, the state's community-based service infrastructure could be improved in the areas of scope, duration, funding and availability. The state's HCBS infrastructure could do better in supporting individuals who are aging and/or have a disability and who desire to stay in their own homes and communities.

General observations of West Virginia's system of HCBS reveal the need to:

- Create greater consistency across the state in the availability of services;
- Expand the variety of HCBS options;
- Emphasize HCBS rather than institutional settings, when appropriate; and
- Expand waiver services to more West Virginians and provide more appropriate services and supports.

Improving the existing network of HCBS in West Virginia would allow individuals to transition from institutional-based services back home or to a community-based support system more quickly and with greater success. Availability of services in the community would also decrease the number of individuals needing care in an institution. Analytical detail on the state's current HCBS options for long term care follows below.

a. Assisted Living Residences

As defined in West Virginia statute,[48] Assisted Living Residence is "any living facility or place of accommodation in the state, however named, available for four or more residents, that is … operated … for the expressed or implied purpose of providing personal assistance, supervision, or both, to any residents who are dependent upon the services of others by reason of physical or mental impairment, and which may also require nursing care at a level that is not greater than

[48] 64CSR14, Section 3.6.

limited and intermittent nursing care. A small assisted living residence has a bed capacity of four to sixteen. A large assisted living residence has a bed capacity of seventeen or more."

In general, assisted living residences provide housing, personal assistance services, and sometimes medical care. They can range in design from a luxury apartment building to a modest group setting. Assisted living residences are typically for those individuals who are too frail to live alone and do not need the 24-hour care provided in nursing facilities.

In recent years in a number of states, assisted living services have become a significant element in the mix of long term care services. They are typically less expensive and offer a more home-like environment than NFs. They are increasingly becoming the residential option of choice for both individuals who are paying for services on their own and states as they seek more appropriate and less expensive ways to meet people's needs.

As in many states, assisted living services in West Virginia are not regulated by the state's CON requirements. While this may make it easier for the assisted living provider to enter into the WV LTC system, the availability and affordability of assisted living services for West Virginians is still lacking. This was raised as a primary concern by stakeholders and state staff.

Stakeholders spoke of the large gap in services between those who need support with 4-5 ADLs and those who need support with 1-3 ADLs. They also discussed the need for more flexible and accessible assisted living services across the state. The current number of assisted living residents in West Virginia supports the opinions voiced by stakeholders. Table 4 shows data from a 2006 report released by AARP entitled, "Across the States Profiles in LTC" regarding assisted living residences in WV compared to the U.S. average.

Table 4: Assisted Living Resources in West Virginia Compared to the U.S.

HCBS Resource	WV total	U.S. total	WV Rank (Of 50 States)
Assisted living and residential care facilities, 2004	116	36,451	45
Assisted living and residential care beds, 2004	3,285	937,601	42
Assisted living and residential care beds per 1,000 age 65+, 2004	12	26	42

Source: AARP

The availability of assisted living resources in West Virginia is far behind other states. WV ranks in the bottom fifth of the country in total number of assisted living facilities (45th of 50) and beds (42th of 50). This ranking implies a straightforward conclusion: West Virginia needs to dramatically improve its statewide availability of assisted living residences. BoSS strongly agrees that assisted living is becoming an increasingly attractive and popular option and that this service setting should be available to more West Virginians.

Stakeholders also spoke with us at length about the lack of affordable assisted living options. It is difficult for people to access assisted living options when they depend on Medicaid or are not able to pay out-of-pocket to access assisted living options. In the public forums, participants urged the addition of Medicaid-licensed assisted living beds and changes to the state

supplement so that residents who receive only Social Security Income may afford assisted living services.

Assisted living is becoming an increasingly attractive and popular option in our country because it offers services between that of a NF and an individual's own home. This service setting should be available to all West Virginians, not just those individuals who can afford the option through private health insurance or by paying for it out-of-pocket.

b. Medical Adult Day Care Centers

The state licensing rule governing medical adult day care centers defines this setting as "an ambulatory health care facility which provides an organized day program of therapeutic, social, and health maintenance and restorative services and whose general goal is to provide an alternative to twenty-four hour long term institutional care to elderly or disabled adults who are in need of such services by virtue of physical and mental impairment."[49]

Although this licensing requirement is in place for Medical Adult Day Care Centers in West Virginia, there currently are no Medical Adult Day Care providers licensed in the state. However, there are 14 social model day care centers operating in the state, commonly operated by the county senior centers, that are not required to be licensed by the Office of Health Facilities Licensure and Certification (OHFLAC).

In general, our interviews and discussions with West Virginians familiar with the long term care system revealed a very positive opinion of the state's 14 social model adult day care centers. The centers appear to appropriately and efficiently blend the restorative, therapeutic, and social services and supports that individuals with long term care needs often seek.

With only fourteen social model adult day care centers and no medical adult day care centers, there are not enough services to meet the need. A report released by AARP in 2006 entitled, "Across the States Profiles in LTC" noted West Virginia's shortage in adult medical day care resources by comparing WV adult day care resources in West Virginia with the U.S. average:

Table 5: West Virginia Adult Medical Day Care Resources, 2006

HCBS Resource	WV	U.S.	WV Rank (Of 50 States)
Adult day facilities per 100,000 age 65+, 2001-2002	2	10	49

Source: AARP

West Virginia ranks second to last in the availability of medical adult day care resources and facilities in the US. The expansion of this particular type of HCBS in West Virginia—especially in the geographic regions that are presently underserved by social model adult day care centers—would greatly assist aging West Virginians and state residents with disabilities to stay out of

[49] Title 62, Series 2 of Department of Health Licensure Rules: Medical Adult Day Care Centers.

nursing facilities by having their needs met in a setting closer to their own homes and communities.

OHFLAC is currently re-writing the licensing rules governing medical adult day care centers in West Virginia and expects to begin licensing this type of facility under the new rules within a year or two. This may be a helpful step forward for the future of the LTC system in West Virginia.

c. Waiver Programs

As defined by CMS, waivers allow states flexibility in operating their Medicaid programs, as authorized by the Social Security Act. Out of the three types of CMS waivers—1115, 1915(b) and 1915(c)—the 1915(c) waiver program has the most significant impacts on states' long term care systems, as this type of waiver allows for long term care services to be delivered in community settings as an alternative to providing comprehensive long term services in institutional settings.[50]

West Virginia has two CMS 1915(c) HCBS waivers, one for individuals with mental retardation/developmental disabilities and another for individuals who qualify as aging or disabled that are important elements in West Virginia's long term care system. A third waiver for assisted living is not operational. The waiver programs are administered by DHHR. These waivers do make available an important variety of community-based services to individuals who qualify. While there are limits on eligibility and availability of services, many West Virginia residents benefit from these programs. At the same time, the waivers' limitations do mean that some individuals do not have access to these services which can jeopardize their ability to continue to live in the community. The MR/DD Waiver has a waiting list and the AD Waiver had a waiting list until recently when state funding was increased.

During April 2007 focus groups, individuals mentioned the following about the 2 waivers. These comments point out areas where the existing waiver programs might possibly be improved.

- "There is more choice in waiver service options in Parkersburg than in a more rural area, although there is not enough choice and self-direction in general. Waiver redesign was not fulfilling for the MR/DD Waiver individuals because people thought self-direction and individual budgeting would be part of the redesign." – Parkersburg
- "The MR/DD Waiver needs more staff to come into individuals' homes for less than 24/7 care, but there is also the problem of staff not showing up for their shifts." – Parkersburg
- "People are being placed into facilities much faster than into a waiver program or other types of HCBS. Sometimes it can take 90 days to become waiver eligible and then 1 to 2

[50] "Overview." The Centers for Medicare & Medicaid Services, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/. Accessed 5-17-07.

years to actually receive MR/DD Waiver services. There are almost 300 people on the waiting list [for MR/DD Waiver services] right now." – Parkersburg

- "Waiver slots are not filled if a person dies or drops out of waiver program." – Parkersburg
- "It seems like home modifications, adaptive housing, and assistive technologies are just too expensive and cannot be afforded within the waiver dollars right now, even though those are the services many people want." – Clarksburg/Bridgeport
- "A greater amount and wider array of respite services are needed for families. Respite services are limited to a maximum of 24 hours, which uses up families' respite hours very quickly. Respite care over the weekends for extended periods of time is also needed." –Martinsburg
- "West Virginia needs more than just 2 waivers to make the LTC system work."– Clarksburg/Bridgeport

1. MR/DD Waiver

BHHF's Division of Developmental Disabilities manages the MR/DD Waiver Program for BMS. The MR/DD Waiver Program currently serves almost 4,000 West Virginians across the state and provides the following types of services to enrollees:

- Residential Habilitation;
- Day Habilitation;
- Adult Companion;
- Respite;
- Pre-Vocational Services;
- Supported Employment;
- Environmental Accessibility Adaptations;
- Transportation;
- Service Coordination;
- Interdisciplinary Team Participation (to develop the Individual Program Plan (IPP);
- Therapeutic Consultative Services (such as skills and behavioral consultation);
- Nursing; and
- Extended Professional Services (such as services from a psychologist, dietician, physical therapist, occupational therapist, or speech therapist).

Individuals applying for the MR/DD Waiver must meet the following criteria prior to receiving services:

- Medical eligibility; and
- Financial eligibility as determined by the local DHHR office.

In order to be "medically eligible" for the MR/DD Waiver Program, an individual must:

- Have a diagnosis of mental retardation and/or a related condition(s) such as Autism, Pervasive Developmental Disability, NOS, Spina Bifida, Cerebral Palsy, Tuberous Sclerosis, or Traumatic Brain Injury and/or spinal cord injuries occurring during the developmental period;
- Require the level of care and services provided in an ICF/MR; and
- Have an assessment/evaluation that demonstrates the individual has a diagnosis of mental retardation and/or a related condition, which constitute a severe and chronic disability that is:
    - attributable to a mental or physical disability or a combination of both;
    - manifested before a person reaches twenty-two (22) years of age;
    - likely to continue indefinitely; and
    - substantially limiting on the functioning of the individual in three or more of the following areas of major life activities: self-care; learning (functional academics); mobility; capacity for independent living (home living, social skills, health, and safety, community use, leisure); receptive and/or expressive language; self-direction; economic self-sufficiency (employment).
        - "Substantially limiting" is defined on standard measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non-normative populations or in the average range or equal to or below the seventy-fifth (75) percentile when derived from MR normative populations.

The Office of Behavioral Health Services (OBHS) and BMS determine the level of care based on medical, psychological and social evaluations (DD-2A, DD-3, and DD-4). In order to qualify for MR/DD Waiver services, evaluations must demonstrate an individual's need for intensive instruction, services, safety, assistance and supervision to learn new skills and increase independence in ADLs.

The MR/DD waiver does have a waiting list. The number of individuals on the waiting list has risen steadily from 76 in January of 2005 to 482 in June of 2008. Of the individuals currently on the waiting list, over 78.8% have been on the waiting list for more than 90 days. Table 6 shows MR/DD waiting list data from January 2005 thru June 2008.

Table 6: MR/DD Waiver Waiting List Data from 2005 to 2008

2005	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Added to the Wait List	18	23	23	29	30	24	44	24	24	21	26	9
Total Wait List	76	99	122	151	181	136	180	204	231	252	96	105
Denied	29	18	28	20	37	30	32	42	25	30	30	15
Reviewed	47	41	51	48	67	54	76	66	49	51	57	24
2006	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Added to the Wait List	19	21	24	28	23	27	11	22	21	19	30	13
Total Wait List	124	151	175	203	226	253	98	116	136	155	186	198
Wait List - Over 90 Days	0	0	0	0	0	0	55	82	93	115	136	155
Denied	26	22	26	28	30	32	26	36	25	25	48	25
Reviewed	45	43	50	56	53	59	37	58	46	44	78	38
2007	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Added to the Wait List	35	31	24	31	30	27	26	24	28	37	42	29
Total Wait List	233	264	288	319	349	376	303	187	215	235	277	303
Wait List - Over 90 Days	185	198	234	266	294	326	250	136	162	198	235	275
Slots Released	0	0	0	0	0	0	140	0	0	17	0	3
Denied	40	24	21	40	42	62	38	44	40	21	50	35
Reviewed	75	54	45	71	72	89	64	69	68	58	92	64
2008	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**
Added to the Wait List	8	56	33	21	34	29						
Total Wait List	311	371	404	419	453	482						
Wait List - Over 90 Days	303	275	303	323	367	380						
Slots Released	0	1	0	6	0	0						
Denied	9	49	30	46	49	15						
Reviewed	17	105	63	67	81	44						

Source: BHHF Data

Several issues emerged while reviewing the components and aspects of the MR/DD Waiver program and its policies.

- While meeting with individuals to discuss the MR/DD Waiver, we heard multiple times that the program imposes unnecessary or unwanted services on program enrollees. When we talked with WV Advocates and discussed the MR/DD Waiver program, the group gave us the example that an individual enrolled in the waiver program but without medical problems will still need to have a nurse present at their treatment planning sessions and/or their medication management sessions because that is the program policy.

- WV Advocates also noted that waiver enrollees know they do not currently need the range of services given to them through the waiver program. However, the enrollees anticipate they will need these services in the future and believe it is better to be on the waiver and receiving too many services than to be shut-out from the waiver program and perhaps be unable to receive needed services in the future. There is a perception that the system is crisis-focused and that only people in dire need receive services, while others struggle until crisis occurs.
- Advocates noted that individuals who qualify for the MR/DD Waiver require 24-hour supports and receive a comprehensive package of services, while individuals who are not eligible for this comprehensive waiver receive significantly less or no services. Non-waiver services for individuals with MR/DD are limited and fragmented in their availability. A supports waiver would allow the LTC system to serve additional consumers who do not need the full gamut of services offered under the comprehensive waiver, but still need waiver services to support them in their home or community and assures that their health, safety and well-being needs are fully met. A supports waiver may be appropriate for some individuals currently enrolled in the comprehensive waiver but who could 'step down' to the supports waiver. Enrollment in any waiver occurs only after an objective assessment of need; after the individual chooses to participate in the HCBS waiver; and after there is an assurance by the state that the person's health and safety needs will be met. Having a fuller compliment of waiver options would make available a wider spectrum of supports and services and would help ensure that people would receive the appropriate services to meet their immediate needs.
- Another issue that we heard about in the public forums, and which was also noted in a 2005 Lewin Group analysis of the MR/DD Waiver, is the potential conflict of interest that exists between the needs of the waiver enrollees and the providers. Often the provider agencies complete the initial assessment, coordinate services, and provide waiver services.[51] This could create a potential conflict where it might be in the providers' best interest for the individual to receive a wider array of services than wanted or needed.
- Some consumers served by the MR/DD Waiver are receiving unwanted services or more services than desired and others are not receiving the level of care called for in their Individual Personal Program, or IPPs. The Lewin Group analysis from 2005 found that "77 percent of residential habilitation, day habilitation, and respite care services were delivered below levels authorized in the IPP. Respite care was provided an average of 73 hours (36 percent) less a month than IPPs authorized. Day habilitation was provided approximately 28 hours (46 percent) a month less." [52] Frequency of service delivery for MR/DD Waiver enrollees was also cited as an issue by stakeholders,

[51] Lewin Group's Assessment of WV MR/DD Waiver Program (March 30, 2005).
[52] Ibid.

who in meeting with us stated that sometimes the frequency of services can stray from IPP documentation so that service delivery frequency is "not appropriate."

2. AD Waiver

The AD Waiver Program is a CMS 1915(c) waiver that provides services to enable an individual to remain at or return home rather than receiving NF care. The AD Waiver provides the following HCBS services to individuals 18 years of age and older who are medically and financially eligible:

- Case Management;
- Consumer Directed Case Management;
- Homemaker Services;
- Medical Adult Day Care (however there are no service providers in West Virginia);
- Transportation; and
- Registered Nurse (RN) Assessment and Review.[53]

To be medically eligible for the AD Waiver, individuals must meet 5 or more of the following deficits:

- Decubitus, Stage 3 or 4.
- In the event of an emergency, the individual is either mentally unable or physically unable to vacate a building.
- Functional abilities of individual in the facility are as follows:
    1. Eating, Level 2 or higher (physical assistance to get nourishment, not preparation).
    2. Bathing, Level 2 or higher (physical assistance or more).
    3. Dressing, Level 2 or higher (physical assistance or more).
    4. Grooming, Level 2 or higher (physical assistance or more).
    5. Continence, bowel, Level 3 or higher (must be incontinent).
    6. Continence, bladder, Level 3 or higher (must be incontinent).
    7. Orientation, Level 3 or higher (totally disoriented, comatose).
    8. Transfer, Level 3 or higher (one-person or two-person assistance in the facility).
    9. Walking, Level 3 or higher (one-person assistance in the facility).
    10. Wheeling, Level 3 or higher (must be Level 3 or 4 on walking in the facility to use Level 3 or 4 for wheeling in the facility).
- Individual has skilled needs in one or more of these areas: (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
- Individual is not capable of administering his/her own medications.[54]

[53] WV AD Waiver Manual.

In comparison to other states and waiver programs, West Virginia uses a relatively high level of care threshold for medical eligibility for the AD Waiver. Stakeholders expressed the view that access to the AD Waiver from an eligibility perspective is an issue that needs to be addressed. They pointed out that by making the system difficult to access, it is not surprising that people who are aging or have changing health needs find themselves in need of community supports and end up falling through the cracks. These are individuals who have health needs that are not enough to qualify for available supports, or, if they do qualify, the scope and duration of services is not adequate to assure health and safety.

Stakeholders at public forums also expressed the opinion that there is inadequate quality monitoring and poor back-up/contingency planning built into the system to guarantee that authorized services are actually provided as specified in an individual's plan. BoSS takes issue with this opinion and pointed out the significant effort that has taken place in recent years to improve quality monitoring. Under current policy providers are reviewed by the state every 12 to 24 months.

For the first time since 1999, in 2007 the AD Waiver waiting list was reduced to zero as the result of additional funding from the Legislature. Additionally, the ability for individuals to self-direct their waiver services (called "Personal Options" and discussed later in this report) was added to the program. This allows participants to access an individualized budget based on their level of care and use the funds to purchase all waiver services, except for Medical Adult Day Care. There is also a savings option built into the Personal Options program designed to give individuals more flexibility. The addition of a self-directed option in the waiver expands the level of choice for those individuals enrolled in the AD Waiver. Self-directed case management is also a self-directed choice noted in the AD Waiver Policy Manual dated November 1, 2003.

These progressive changes have improved AD Waiver services as a component of HCBS for aging and disabled individuals. However, the waiver's service menu is still limited and, as a result, some people do not have adequate supports to remain in the community. This, in turn, can lead to NF placements that would otherwise not be necessary if people were able to stay in their own homes with adequate support.

Table 7 documents a comparison between the services provided under West Virginia's AD Waiver and the services provided under aging and disability waivers in eighteen other states. Of the twenty-five (25) waiver services compared, West Virginia includes fewer services than the large majority of comparison states, which points toward the needed addition of more services to the AD Waiver in order to better and more appropriately meet the needs of participants.

[54] Chapter 500, Nursing Facilities.

Table 7: Comparison of Nineteen States' Aging and Disabled Waivers

Waiver Name	State	Services																						
		Case mgmt	Homemaker	Respite	Personal care	Adult day care	Special med equip	PERS	Chore	Environmental adaptations	Attendant care	Assisted living	Skilled nursing	Companion services	Family training and counseling	PT/OT/SHL/RT	Home delivered meals	Risk reduction	Escort	Pest control	Rehab engineering evaluation	Adult res care	Transportation	Consultation	Prescription drugs	Consumer direction
Elderly and Disabled Individuals	AL	✓	✓	✓	✓	✓																				
Waiver for the Elderly and Disabled	DE			✓	✓	✓	✓	✓																		
Elderly and Physical Disabilities Waiver	DC	✓	✓	✓	✓			✓	✓	✓	✓	✓														
Elderly and Disabled Adults	FL	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓					
H&CB Waiver for Elderly and Disabled Individuals	GA			✓	✓	✓		✓	✓		✓		✓	✓		✓	✓	✓								
Aged and Disabled	ID	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓			✓					✓	✓	✓		
Aged and Disabled	IN	✓	✓	✓		✓	✓	✓		✓	✓	✓		✓	✓		✓	✓		✓		✓	✓			
H&CB Waiver for Elderly & Disabled Individuals	KY	✓	✓	✓	✓	✓				✓	✓															✓
Elderly and Disabled Adult Waiver (EDA)	LA	✓	✓		✓			✓		✓				✓												
Disabled & Elderly 18 and over	ME	✓	✓	✓	✓	✓		✓		✓	✓		✓			✓							✓			
Elderly & Disabled HCBS Waiver	MS	✓	✓	✓		✓					✓						✓		✓				✓			
Aged and Disabled Waiver	MO		✓	✓		✓			✓								✓									
Community Care Program for the Elderly & Disabled	NJ	✓	✓	✓		✓					✓												✓		✓	
Seniors and People with Disabilities	OR			✓		✓		✓	✓	✓	✓	✓	✓				✓					✓	✓			
Aged and Disabled	RI		✓		✓		✓	✓		✓			✓	✓			✓									
Waiver for Elderly and Disabled Individuals	SC	✓		✓	✓	✓	✓	✓		✓	✓			✓	✓		✓									
Elderly and Disabled Individuals	TN	✓	✓	✓	✓			✓		✓							✓									
Aged, Blind & Disabled	WA				✓	✓	✓	✓		✓	✓		✓		✓		✓						✓			
Aged and Disabled	WV	✓	✓			✓																	✓			✓

Source: CMS website, Accessed May 10, 2007.

d. Medicaid Personal Care Program

On behalf of BMS, BoSS administers the Personal Care Program for Medicaid-eligible individuals. It provides hands-on, in-home services to individuals through a number of agencies that have obtained a CON to provide this service. Services may include activities related to personal hygiene, dressing, feeding, nutrition, environmental support functions, and health-related tasks.[55] As of August 1, 2007, BoSS reported that over 4,000 people have utilized the Personal Care Option that assists individuals to stay in their homes and communities.

In West Virginia, personal care can only be provided in the person's home or for limited hours at the place of employment of the recipient. The state could change this policy so that individuals can receive personal care service outside of their homes. This would benefit a number of individuals

Stakeholders at public forums stated that the Personal Care Program has gaps in service coverage and the program should have expanded flexibility and availability. The NWVCIL noted that the Personal Care allocation is capped at a number of hours of service that is not sufficient to support continued community living for some, resulting in unwanted NF placement. At the same time, BoSS noted that the maximum hours of services available to an individual through the Personal Care program is 210 hours which is more than the 155 hours, the highest level of service under the LOC D offered in the ADW. Also, individuals can make a dual services request and potentially get both the Personal Care and ADW support hours.

Finally, many individuals noted their dislike of the fact that this program is a medical model of service delivery that requires a doctor's prescription to enroll. In fact, it is a federal requirement that services must be approved by a physician or by some other authority recognized by the state. [56]

e. Home Health Agencies

By CMS definition, a Home Health Agency (HHA) may be a public, nonprofit or proprietary agency or a subdivision of such an agency or organization which:

- is primarily engaged in providing skilled nursing services and other therapeutic services;
- has policies established by a group of professionals (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services which it provides;

---

[55] www.state.wv.us/seniorservices/wvboss_article2.cfm?atl=9B8412E9-BDE4-DB4F-142F1CC01F157 30A&fs=1. Accessed 5-18-07.

[56] http://www.cms.hhs.gov/HealthCareFinancingReview/Downloads/01summerpg155.pdf

- provides for supervision of above-mentioned services by a physician or registered professional nurse;
- maintains clinical records on all patients;
- is licensed pursuant to State or local law, or has approval as meeting the standards established for licensing by the State or locality;
- has in effect an overall plan and budget for institutional planning;
- meets the Conditions of Participation (CoPs) in the interest of the health and safety of individuals who are furnished services by the HHA; and
- meets additional requirements as necessary for the effective and efficient operation of the program.[57]

In West Virginia, Medicaid-eligible individuals can receive the following services in their homes through home health agencies: skilled nurse visits (SNV), physical therapy (PT), occupational therapy (OT), speech-language pathology (ST), home health aide (HHA), and medical social worker (MSW).

However, BMS will not pay for the following services as a home health benefit:

- For a dually eligible member (Medicare/Medicaid), any services denied by Medicare;
- Services in excess of those deemed medically necessary by BMS to treat consumer;
- Services not directly related to consumer's diagnosis, symptoms, or medical history;
- Duplicative services provided to consumers using the AD or MR/DD Waivers;
- Services provided to consumers receiving benefits of the Hospice program;
- Services provided to consumers receiving similar services from a behavioral health or community provider;
- Homemaker services;
- Respite care;
- Custodial care;
- Telephone consultations;
- Failed appointments, including canceled appointments and appointments not kept;
- Time spent in preparation of reports; and
- Experimental services or drugs.[58]

The provision of a heightened amount and variety of home health services throughout the state, including the more rural geographic areas, could assist these individuals to stay in their own homes and communities while receiving medical services and therapies that allow them to live in good health.

[57] www.cms.hhs.gov/manuals/downloads/som107c02.pdf
[58] WV DHHR Chapter 500.

f. Self-Directed Services

West Virginia has been progressive in embracing self-directed options for people. Implemented in 2001, the self-directed case management option within the AD Waiver allows participants to coordinate their own services rather than working through a case management agency.[59] In 2007, the Personal Options program was added to the AD Waiver, allows participants to direct their own supports, and has no limit on participation.

BoSS put together the following overview of the Personal Options program.

*"**Personal Options** is the self-directed service model within the WV Medicaid Aged and Disabled Waiver Program. To participate in **Personal Options** an individual must be assessed as being medically and financially eligible for the Medicaid Aged and Disabled Waiver Program. When an individual's eligibility has been determined and approved, they may select **Personal Options** as their service model.*

*Individuals who select **Personal Options** will be assessed at needing a certain level of care. The level of care is determined by the Pre-Admission Screening for medical eligibility. The individual may be assessed at Level A, B, C, or D. Each level has a monthly budget assigned to it.*

The levels and budgets are as follows: Level A = $812.54 a month

Level B = $1134.00 a month

Level C = $1455.47 a month

Level D = $1776.94 a month

The individual/participant may use their monthly budget to purchase needed Medicaid Aged and Disabled Waiver services. The services that may be purchased include Homemaker, Case Management, Transportation, Homemaker RN, and Participant Directed Goods and Services. Participant Directed Goods and Services is an optional service that allows the participant to save for equipment or service that promotes improved health/safety in the home, or reduces their need for Medicaid services.

(Note: A participant may only save $1000.00 annually for Participant Directed Goods and Services.) Homemaker Services are the only services required for an individual to purchase. All other services are optional.

*In **Personal Options** the individual/participant will become an employer. As an employer they will hire a homemaker or homemakers as their employee(s). A participant can purchase services from an agency, if the agency agrees to do so. (Example: A participant may choose to hire a homemaker or case manager from an agency.) Participants may hire friends or family as their employee. Spouses may **not** be hired as employees. All participant employees must meet the Medicaid Aged and Disabled Waiver Policy requirements. (Example: First Aid & CPR.) **Personal Options** participants have flexibility when determining their employee or employees' hourly wage. The hourly wage of a homemaker must be within minimum wage requirements and may not exceed the Medicaid reimbursement rate.*

[59] West Virginia Choice Cash and Counseling Grant.

*Participants in **Personal Options** will have the support of a **Resource Consultant** and a **Fiscal/Employer Agent**. The **Resource Consultant** will assist the participant with the responsibilities of self-direction, such as filing appropriate forms to become a registered employer with the state of WV and the IRS. **Resource Consultants** are also available to the participant for advice in developing a spending plan for their monthly budget that will meet the participant's needs. They can also advise the participant on how to hire, manage, and supervise employees. The **Resource Consultants** will monitor health and safety of participants and report any incidents accordingly.*

*The **Fiscal/Employer Agent** will perform payroll and tax functions on behalf of the participant. Because the participant will **not** handle any money directly, the **Fiscal/ Employer Agent** will mail or direct deposit paychecks to the employee on behalf of the participant/employer. They will also file state and federal taxes quarterly on behalf of the participant.*

***Personal Options** participants may transfer to traditional agency services at anytime."*[60]

g. Other Progressive Initiatives

West Virginia has taken the initiative to implement other options for individuals with long term care needs to direct the type of services and supports received. These self-directed options include the following.

- The Long Term Attendant Care Program, currently serving 20 individuals and administered by the WV Division of Rehabilitation Services (DRS), provides personal assistance services that help individuals with disabilities obtain and maintain employment. Participants are able to select, hire, and dismiss their own personal attendant(s) and are reimbursed for the cost of attendant services.
- The Ron Yost Personal Assistance Services (RYPAS) Program, established in 1999, provides personal assistant services for individuals with severe disabilities who are not eligible for services from any other program, including Medicaid. Twenty-two participants are currently served by the program and are able to select, hire, and dismiss their own personal attendant(s).

The state is in the process of implementing several initiatives to assist with the modernization of long term care service delivery by incorporating more choice, flexibility, and expanded community-based options.

- The West Virginia Transition Initiative, a pilot program serving 22 of the 55 West Virginia counties, will assist West Virginians with disabilities and seniors who reside in NFs to live and be supported in their communities. The Initiative will not replace current formal and informal transition/diversion processes, but will develop a statewide program to support future rebalancing and "MFP" strategies in the state. The Initiative, modeled after the Transition to Inclusive Communities (TIC) grant, will target at least 50

[60] Email from BOSS, 11/18/08

people in the first year to transition from NFs to community-based services, and will access the maximum amount of funding ($2,500 per person) for one-time costs such as: 1) a residential security deposit; 2) utility set-up fees; 3) moving expenses; 4) essential home furnishings; and 5) home modifications. This program seeks to assist people to "navigate" through the long term care system by adding a Transition Coordinator position and two Transition Navigator positions to the long term care system, and in addition, utilizing existing transition and diversion programs to target people for transition.[61]

- Since November, 2007, BoSS has been using a Nursing Home Diversion Grant from the U.S. Administration on Aging to establish the "Fair Plus" pilot project. BoSS is partnering with the Upper Potomac AAA and its new, state-funded Aging & Disability Resource Center (ADRC) to provide self-directed funds in the Family Alzheimer's In-Home Respite (FAIR) Program. BoSS will also collaborate with 15 predominantly rural county aging providers, the Alzheimer's Association, the state's Medicaid agency, and a fiscal intermediary to meet the program's goal of providing self-directed funds to 50 caregivers and to divert 50 care receivers from nursing facility placement and Medicaid spend-down. Objectives of this pilot are fourfold: to design, implement, and evaluate FAIR Plus, and to strengthen current state long-term care rebalancing efforts, by introducing a new diversion program, recommending systems change, educating policymakers, and empowering the ADRC to become fully functional. Outcomes of the program are the improvement of the quality of life for the client (caregiver) through supports, services, and goods; lengthening the time in the home and community for the care receiver; and recognizing the single point of entry role of the ADRC in the state's long-term care system. Products from FAIR Plus will include targeting, assessment, and quality tools; policies and procedures manual; articles for publication; required reports; and marketing materials, including a brochure.
- In September of 2006, WV received CMS funding for an urban/rural Program for All-Inclusive Care for the Elderly (PACE) pilot program for West Virginia's Kanawha Valley and its surrounding areas. The PACE program is a nationally-recognized model that provides an opportunity to integrate primary, acute and long term care services for frail elders. WV was going to use the funding to establish a geriatric health and wellness center, a geriatric education and research center, and PACE program.[62] However, the inability to negotiate an acceptable payment rate between BMS and community providers has prevented this program from going forward.

[61] Draft of WV Transition Initiative.
[62] WV Program for the All-Inclusive Care for the Elderly (PACE) Program.

4. Nurse Practice Act

Older adults and people with disabilities want to live as independently as possible in their homes and communities. Across the country, consumers are seeking more choices for long term care and more control in managing the services they need. This "consumer directed care" includes greater autonomy in directing care received from unlicensed assistive personnel (UAP) like "personal care attendants." This care may include "health maintenance tasks," such as bowel and bladder treatments for people with spinal cord injuries now living in the community, medication administration, and other care tasks that people needing long term care regularly require. State regulations that govern the practice of registered professional nurses often affect the extent to which consumer autonomy is permitted by the state boards of nursing, which are charged with the responsibility to protect the public's safety.

There are two broad statutory/regulatory options available to authorize UAP to perform health maintenance tasks, delegation and exemption. These two approaches are not mutually exclusive. The important distinction is where authority and responsibility rests in each.

a. The Exemption Approach

In the exemption approach, the consumer directing his or her own care is responsible for that care, not the nurse. The nurse can educate the consumer and the assistant, and monitor the services over time, but that nurse is not held responsible for the actual provision of the care. Most states include either a statutory or regulatory exemption from the provisions of the Nurse Practice Act (NPA), some of which are at least arguably related to consumer-directed care. Proponents of consumer-directed care often believe that the exemption approach is best, since it can carve out consumer-directed/personal care attendant programs.

Technically, an exemption from the NPA removes personal care from nursing regulation and makes delegation moot. This approach is consistent with the independent living movement's philosophy that consumers know what they need and can direct their own attendants without the "medical model" oversight of nursing or medical supervision. However, a well-designed framework for delegation, as found in Oregon, can support a consultative model for nurses to assist consumers to direct their assistants. In a practical sense, even in a state like New York which has a strong exemption model for consumer-directed care, actual practice and other regulations pertaining to personal care attendant programs call for involvement of nurses and/or physicians to assess the situation. The professionals certify that the consumer is able to direct his or her own health maintenance care tasks.

b. The Delegation Approach

Delegation is transferring the authority to perform a selected nursing task in a selected situation to someone who is competent to perform that task. Under the delegation approach, the nurse maintains responsibility for authorizing the delegation. Mechanisms for assessing the competence of the delegate range from the nurse's judgment to requirements for formal training

and testing. Although there is much variation across the states, most have explicit language in either the NPA or the implementing regulations, or both, to make it possible for nurses to legally delegate tasks to others. Many states also offer an explicit opportunity for nurses to delegate in home and community-based settings, or have language that is broad enough to support this delegation if consumers, nurses, providers, and policymakers seek such interpretations.

One of the biggest concerns for delegating nurses is the extent to which they will be held liable for the actions of those to whom they delegate. In the parlance of nurses, the concern is that these delegates are "acting on my license." A few states make nurses responsible for the delegation of the task, but not responsible for the actual performance of the delegated task. In other words, the nurse is responsible for determining that the task is appropriate to transfer to an unlicensed person who is capable of performing that task. The nurse is directly liable for the delegation process only. The nurse is not held responsible if that unlicensed person negligently harms the consumer (vicarious liability for the delegation outcome).

c. West Virginia's UAP (Unlicensed Assistive Personnel) Regulations

Consistent with most states, West Virginia's Board of Nursing (BON) policies permit registered nurses (RNs) to delegate tasks to competent individuals. In the broadest sense, the practice of registered nursing includes "the supervision and teaching of other persons with respect to such principles of nursing."[63] RNs are to implement the plan of care by delegating and supervising nursing care activities.[64] This broad policy direction would seem to enable RNs to work with and through families and unlicensed assistive personnel to support individuals in promoting, regaining and maintaining their health. However, further review of the BONs guidance raises concerns about limitations to this policy.

In West Virginia RNs are responsible and accountable for:

- Decision making regarding nursing care;
- Assuring care is safe and competent;
- Determining which acts in implementing care can be delegated or assigned; and
- Providing direction, assistance, periodic observation and evaluation of effectiveness of acts performed by those under supervision**.**

The rules do not limit delegation to certain settings, although there are different rules for delegation in schools, licensed residential facilities and with respect to dialysis care.[65]

---

[63] WV NPA (RN: Ch 30, Art 7; LPN: Ch 30, Art 7A), www.legis.state.wv.us.
[64] WV Code of State Rules for RN (Title 19), www.wvsos.com/csr/rules.asp.
[65] Telephone interview with the WV Board of Nursing on March 26, 2007 and response to questions sent by Cindy Hayes, Director of Education and Practice, April 6, 2007.

To offer guidance in how to do this, the "Purple Book" (PB)[66] provides a delegation/assignment decision model for RNs and Licensed Practical Nurses (LPNs).[67] The decision to delegate "must be made by a licensed nurse on the basis of the skill level of the caregivers, patient or client care needs, and other considerations."[68] Delegation depends on the complexity of the task to be delegated, care needs of the client, educational preparation, skills, ability of person to whom the task is to be delegated, availability and accessibility of supervision. In addition, "nursing judgment is the essential element in every delegation or assignment decision."[69]

Tasks that may be delegated to a UAP include basic nursing care services, such as taking vital signs, providing personal hygiene, comfort, nutrition, ambulation and environmental safety and protection.[70] Delegation of other more complex health maintenance tasks is not specified except in some settings. For example, UAP in residential care facilities can administer medication (except injections, parenteral medications, irrigations and debriding agents) if supervised by a professional nurse, provided they undergo training and retraining every 2 years, and follow guidelines.[71] RNs can also delegate medication administration to a dialysis technician once they have validated the technician's medication administration competencies.[72] Code of State Regulation (SR) §19-13-4.1 lists the medications that can be delegated (provided the technician follows the safety guidelines outlined in CSR §19-13-4.3). There are also provisions for school nurses delegate administration of injectable medication to school employees for students with a predisposition to an emergency health problem.[73]

Nurses cannot delegate tasks that require the "substantial, specialized knowledge, judgment, skill and decision-making" of an RN.[74] This is common language in NPAs across the country. On the one hand, this language offers nurses wide latitude to determine what can be delegated. On the other hand, nurses who fear liability often cite this provision as precluding delegation. West Virginia's NPA also states that UAPs are prohibited from performing any licensed nursing function that is specifically defined for licensed nurses in the NPA or rules, *except* where noted.[75] In addition, "the RN must not delegate professional functions to caregivers not

---

[66] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).
[67] Ibid.
[68] Ibid.
[69] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).
[70] Ibid.
[71] Medication Administration by Unlicensed Personnel in Specialized Health Care Facilities (§16-5O; 64CSR60), www.wvsos.com/csr/verify.asp?TitleSeries=64-60
[72] Ibid.
[73] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB)
[74] Ibid.
[75] Ibid.

qualified as professional nurses."[76] These cautionary provisions would appear to deter delegation.

The BON stipulates that RNs shall only delegate nursing tasks to a person that is prepared or qualified by training, experience or licensure to perform them.[77] It appears there is latitude for the nurse to delegate to UAP who have not obtained training and certification, as long as they have sufficient experience to assure the nurse that they are able to perform the specified task(s). RNs must supervise those to whom they delegate, but there appears to be discretion for the nurse to determine how often that occurs.[78]

West Virginia appears to be increasing its emphasis on accountability for delegation in ways that could discourage nurses from delegating in home and community care settings. An RN retains accountability for nursing care when delegating nursing interventions.[79] The BON's guidance document for scope of practice and delegation of decisions was changed between 1996 and 2005.[80] The definition of delegation was changed from one emphasizing each individual's accountability to the National Council of State Boards of Nursing definition, which emphasizes the nurse's accountability.

- Old definition: "Entrust to another: to assign responsibility; the act of empowering to act for another. Each person involved in the delegation process is accountable for his or her own actions or inaction and is potentially liable if competent, safe care is not provided."
- New definition: "Transferring to a competent individual the authority to perform a selected nursing task in a selected situation. The nurse retains accountability for the delegation."[81]

The new definition is a version of "strict liability," in which the nurse retains accountability for the outcome of the delegation, even if s/he follows all the correct delegation procedures and the UAP does not follow the directions. In addition, in 2002, a section on professional misconduct was added for RNs, which could also be viewed as a deterrent to delegation[82]. Acts constituting misconduct include committing acts that adversely affect patients, abandoning patients, permitting others to use one's license, *aiding unlicensed personnel in performing activities requiring a license, delegating responsibilities to someone "not qualified by training, experience or*

[76] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).
[77] WV Code of State Rules for LPN (Title 10, Series 3): www.lpnboard.state.wv.us/
[78] WV Code of State Rules for LPN (Title 10, Series 3): www.lpnboard.state.wv.us/
[79] Ibid.
[80] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).
[81] WV NPA and Regulations website for RNs: www.wvrnboard.com/default2.asp?active_page_id=74
[82] Ibid.

licensure…."[83] Of course, this definition of misconduct does not preclude delegation, but appears to dramatically emphasize the nurse's personal danger in doing so.

Like most states, West Virginia exempts family members, noting that: "The performance of nursing acts by the client for self-care or by the client's family members does not constitute delegation or assignment of nursing acts to unlicensed personnel for compensation…Nurses may teach and supervise the performance of activities by clients and family members who have demonstrated a willingness and an ability to perform the activity."[84] There is no specific exemption for consumer directed care in the NPA, although there could be provisions in other state laws and regulations that are not cited by the BON.

The WV NPA does include an exemption provision for LPNs that is relevant to UAP:

> §30-7A-9 specifies exemptions for LPNs in the following circumstance: *Nursing care of "sick, disabled, injured, crippled or infirm person by a member or members of such person's family, or by close relatives, or by domestic servants…whether employed regularly or because of emergency circumstances."*

An exemption that permits care by a "domestic servant" can be used to support consumer-directed care if the consumer hires an attendant to provide personal care that includes health maintenance tasks. However, this exemption was not found in the West Virginia's NPA and could be explored further.

B. ACCESS

In interviews with consumers, family members, providers and state staff, the point was made that there is room for improvement related to access to the LTC system in West Virginia. Access issues can be summarized into the following four areas:

- Availability of information;
- Eligibility determination processes;
- Un-served and under-served populations; and
- Institutional bias.

1. Availability of Information

One of the most significant and common problems facing health care systems across the country is the availability of and easy access to critical information regarding services, providers, and the cost of services. In general, the availability of information is inconsistent. As a result, consumers and their families lack information that would help them identify the services and providers that best meet their needs. Inaccurate and incomplete information can lead to

[83] Ibid.
[84] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).

individuals seeking services at a level of care that is not matched to their level of need, e.g. an individual receiving services in an institutional-based setting who would be better served in the community; or an individual being treated in the community who would be better served, even if only for a short time, in a more intense level of care.

Interviews with DHHR staff, consumers, family members, advocates and providers revealed that many individuals who seek long term care services are unable to obtain adequate information they need to make an informed choice about those services. The State ADA Coordinator noted that information about service options is not easily accessible. During an interview with the Northern West Virginia Center for Independent Living (WVCIL), we learned that individuals tend to approach long term care facilities, not community-based services, for information. This influences the decisions individuals and their families make regarding choice of services and creates a bias towards long term care facilities whether it is the best option for care or not.

In West Virginia, like most states, there is no single point or source to which consumers and family members can go for information on the variety of options available to meet their needs. The Center for Excellence in Disabilities at West Virginia University stated that there is a need for a single point of entry, especially given the complexity of the evaluation and eligibility processes for AD Waiver services. The ADRCs described below have the potential for meeting this important need.

The federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS), both part of the U.S. Department of Health and Human Services jointly sponsor the Aging and Disability Resource Center (ADRC) grant program. The program is intended to stimulate the development of state systems that integrate information and referral, benefits and options counseling services as well as facilitating access to publicly and privately financed long term care services and benefits.

AoA and CMS believe Resource Centers are a key component of an effectively managed, consumer-driven system of long term support. In many communities, long term support services are supported by numerous funding streams, administered by multiple agencies, and have complex, fragmented, and often duplicative intake, assessment, and eligibility functions. Figuring out how to obtain services is difficult for persons who qualify for publicly-funded supports and for those who can pay privately. These barriers can lead to institutional long term support as the default outcome. A single, coordinated system of information and access for all persons seeking long term support will minimize confusion, enhance individual choice and support informed decision-making. It will also improve the ability of state and local governments to manage resources and to monitor program quality through centralized data collection and evaluation.

Resource Centers will enable policymakers and program administrators to more effectively respond to individual needs, address system problems, and limit the unnecessary use of high-cost services, including institutional care. The strategy is not to add resources, but to ensure the

needs and preferences of consumers underpin all aspects of the system. Implementation of this approach may require some realignment or reorientation of a state's long-term care system, particularly the eligibility processes and resources.

States will be able to use the AoA and CMS Resource Center Program grant funds to better coordinate and integrate existing information, counseling and access functions that are associated with the multiple federal and state long term support programs and services available. Many states have already begun to establish one-stop entry points into their long term support systems. Such states will be able to utilize the funds to strengthen their programs by choosing to add functions, such as serving private-pay individuals, or to expand their program to parts of the state not currently served. Other states may choose to utilize the grant funds to begin to develop a single point of entry system.

In West Virginia, the ADRC was originally piloted in two counties of West Virginia, one rural and one urban. For SFY08 the Governor requested and the Legislature approved an additional $1 million to be divided among the AAA's that cover the four regions of the state. One of the existing ADRCs is expanding to cover 8 counties. BoSS plans to move the other ADRC and expand their coverage area. The AAA's used this year's funds to set up two new ADRCs in each of the other regions of the state for a total of eight offices in order to expand coverage areas to include all 55 counties. The new ADRCs were opened in November, 2007.

West Virginia's Centers for Independent Living are community-based organizations that provide advocacy, networking, and resources to persons with disabilities and their families. The centers are a place where people with disabilities are free to meet, share, learn and plan lives of greater independence and self reliance. There are four Centers for Independent Living (CIL) in West Virginia offering the core services of a CIL including the Appalachian Center for Independent Living, the Mountain State Center for Independent Living – Huntington, the Mountain State Center for Independent Living – Beckley, and Northern West Virginia Center for Independent Living. These Centers have collectively eight offices distributed across the state.

The ADRCs and CILs hold promise that the availability of information regarding LTC options will improve. To realize the potential, it is important to continue to coordinate efforts and improve communication among the various key participants in the state's LTC system, to achieve alignment on a common vision on how to get meet the information needs of the state's residents, and to provide adequate funding on a long term basis to maintain and expand current efforts.

2. Eligibility and Enrollment Processes

West Virginians find the processes of gaining eligibility for and enrolling in state LTC programs to be difficult. A clear entry point and process for receiving LTC services and supports would greatly assist those who need the services: the elderly, and individuals with mental health needs, developmental disabilities, substance abuse issues, and physical disabilities. These

populations are least able to navigate a complex and confusing system. A summary of eligibility and enrollment procedures can be found in Appendix D.

Regulations allow that eligibility for NF and ICF/MR placement can be presumed with the person admitted and then application made. As the result, eligibility for these services can happen much faster than eligibility for waiver services. This situation does influence and create a bias toward institutional placement.

A review of the BMS and BHHF websites shows limited information about the processes necessary to enroll in any of the programs listed above. This means that those seeking services must call BMS, BHHF, BoSS, APS Healthcare, Mountain Health Trust, etc. to find out how to enroll. This can be a time consuming and complex ordeal for individuals.

The ADRCs are playing an increasing role in providing enrollment information and support to WV seniors who are 60+ years of age and adults (18 years or older) with physical disabilities. This is being accomplished through both their web sites and through direct contact.

In addition, the inROADS website (wvinroads.org) assists individuals and their family members. A self-screening process on the site evaluates the user for possible eligibility and tells the user which benefits the members of the household may be eligible to receive. It then lets the user apply online for multiple DHHR benefits by completing one online application.

Another issue in the LTC system's enrollment and eligibility processes is that individuals who do not know how to apply for Medicaid services online or know to apply through BMS often show up at a provider site and apply for Medicaid with the provider's assistance. This creates a potential conflict of interest for providers, who assist individuals in completing their assessment forms to determine eligibility for services. There is the potential that the individual will be influenced to use the services offered by the provider. This situation also limits the range of information about comparative services that consumers receive.[85]

Finally, DHHR could review and revise the Pre-Admission Screening PAS 2000 document itself in order to better assess the individual's current personal, medical, social and living situations for transition and diversion purposes. The PAS is a 6-page assessment, 4 pages of which focus on the individual's medical needs. In order to better assess an individual's readiness to transition from facility-based services to community-based services or to better divert individuals from accessing facility-based services when they could be more appropriately served in their own home or by community-based services, the assessment form should record the setting in which the individual prefers to live and receive services. It follows that there should be time set aside in the assessment process to talk about an individual's preferences. Pairing up the PAS assessment process with the work of discharge planners, case managers, and System Navigators or Transition Counselors, as California and New Jersey do, would

[85] Saucier, Paul and Dr. Elise Bolda. "Progress and Potential in West Virginia's LTC System." Edmund S. Muskie School of Public Service, University of Southern Maine, February 2001.

significantly assist the transition and diversion efforts that WV needs to integrate into its LTC system.

3. Unserved and Underserved Populations

Stakeholders identified specific populations in West Virginia that are either un-served or under-served in the amount or type of LTC services available. Groups such as the BoSS, LTC Ombudsman, WV Advocates, the WV Mental Health Consumers' Association, the Fair Shake Network, the Office of the Ombudsman, the Center for Excellence in Disabilities at WVU, and participants in the public forums consistently identified the following populations were under-served or un-served by the LTC system:

- Individuals who are ventilator dependent;
- Individuals with Traumatic Brain Injury;
- Individuals with mental illness or mild MR or mild DD who do not meet the MR/DD Waiver requirements;
- Dually-diagnosed individuals, especially those individuals with mental illness and mental retardation (MI/MR) who do not receive adequate in-home services;
- Children and adults with Autism;
- Individuals with Alzheimer's Disease and Related Conditions; and,
- Individuals who are not waiver eligible and cannot afford private-pay services and supports.

Stakeholders placed particular emphasis on their perception that individuals with Traumatic Brain Injury (TBI) find it difficult to receive needed services and supports. A number of individuals with TBI struggle in the community without any formal supports or end up in NFs. If they have the financial means, individuals have secured services in private care settings outside of their communities. While some individuals who experienced their injury before they reached age 22 are able to receive services under the MR/DD Waiver, the majority of this population does not have access to adequate services. This has becomes a particularly poignant issue as veterans are coming home from Iraq with injuries and symptoms associated with TBI need services.

In addition to the population with TBI, those West Virginians listed above who have been identified as under-served or having unmet needs, need a wider array of services and supports so that they can continue to live their lives richly and fully within the borders of the state and preferably within their home communities.

4. "Institutional Bias" in West Virginia

One of the major impacts of the U.S. Supreme Court decision in *Olmstead v. L.C.* is the subsequent efforts by states to ensure the availability of adequate levels of non-institutional or community-based services for individuals who do not require institutional levels of care.

Despite significant steps taken by many states in this area, certain levels of "institutional bias" still exist. ("Institutional bias" as suggested by the Center for an Accessible Society, is typically considered a government policy or funding mechanism that perpetuates "…the forced segregation, isolation, or institutionalization of people with disabilities of any age."[86])

Both the experiences of consumers and the data can lead one to conclude that institutional bias does exists in the WV long-term care system. According to stakeholder comments made at public forums, there is "definitely" institutional bias in the services and supports provision of long term care services, "even when community services or supports would be less expensive to provide". A representative from the Center for Excellence in Disabilities at WVU stated that "over 2,000 people in institutional care have expressed an interest to move to the community."

BoSS noted that for years West Virginia residents have seen NFs as the only option for seniors as they age. As a result, there has been little interest and investment in assisted living residences and other community-based options including day care, respite and home health services. The availability of assisted living services varies by geographic region and, at the moment, is nearly all private pay. The state does pay for a limited number of beds with a state supplement. The absence of more state payment for this residential option significantly limits the ability of long term care consumers enrolled in Medicaid and Medicare to take advantage of this living arrangement. This results in consumers having to choose either NF or other institutional-based care or no care at all.

The presence of institutional bias is not limited to assisted living facilities. There also appears to be a degree of institutional bias when comparing institutional services and waiver services. Table 7 provides a summary of service requests in West Virginia for NF, AD Waiver, ICF/MR and MR/DD Waiver services in Calendar Years (CY) 2005 and 2006.

Table 8 shows that, when comparing requests for NF care and AD Waiver services, both the number and percentage of NF approvals are significantly larger. Without completing a thorough record review of the accepted and denied requests, it is difficult to determine if this disparity is attributable to specific issues related to the needs and medical status of the individuals requesting approval. However, this data indicates the presence of higher approval rates for institutional care. The data shows there is a higher likelihood that individuals will be admitted to a NF than to community-based services. There was a substantial decline in the percentage point difference in approval rates between 2005 and 2006. It is difficult to determine whether this represents a long-term trend or an anomaly.

Table 8 also shows that more than 50% of the requests for MR/DD Waiver services were declined, while all requests for ICF/MR placement were approved. The number of people requesting community-based services was significantly higher than requests for institutional

[86] Quoted from "Institutional Bias in Long-Tem Care Policy", The Center for an Accessible Society, www.accessiblesociety.org/topics/persasst/instbias.htm.

care. At the same time, the percentage of denials indicates that the need for services is not being met.

Table 8: CY 2005 & CY 2006 Prior Authorization Annual Report: Summary of the Number of Approvals and Denials for Institutional and Waiver Services.

Service Setting	CY 2005	CY 2006
Nursing Facilities		
Total Requests	14,783	15,490
Approved	13,048	9,150
Denied	843	278
AD Waiver Services		
Total Requests	7,235	7,755
Approved	4,484	4,007
Denied	913	1,671
ICF/MR Facilities		
Total Requests	30	30
Approved	30	30
Denied	0	0
MR/DD Waiver Services		
Total Requests	631	607
Approved	295	258
Denied	336	349

Source: Data was provided by State of West Virginia, BMS

In addition, as mentioned earlier, there is a presumption of eligibility for NF and ICF/MR services that allows for much faster placement in these settings than establishing eligibility for and gaining access to waiver services. As the result, institutional placements rather than securing community-based services are more likely to occur when the need requires the securing of services within a short timeframe.

Both the experiences of consumers and the data can lead one to conclude that there exists in the WV behavioral health long term care system, a level of institutional bias significant enough to effect the lives of West Virginians. One suggested solution from the West Virginia Mental Health Consumers' Association is to ensure that sufficient reimbursement rates be available to long term care community-based providers. Doing so would:

- Attract more long term care providers to the business of providing community-based services; and
- Increase the capacity of the community-based system.

Based on an analysis of payment systems contained within this report and in the BHHF strategic plan conducted in 2005, it appears that the current payment system for services is geared towards nursing and state facilities and not to community-based services and providers.

In interviews with consumers, family members, providers and state staff, the point was made that there is room for improvement related to access to the LTC system in West Virginia. The state needs to improve how people get information about services, enter the LTC system, and begin to receive LTC services and supports. We heard in Parkersburg that more people would be interested in home and community-based services if information was more prevalent. In the Clarksburg/Bridgeport area of the state, we heard that it takes too much time to access services and that the eligibility process is complicated and difficult for consumers and their family members to navigate.

The approach West Virginia uses to develop and deliver LTC services often limits consumers' access to services as well as their choice and control. We have previously discussed in this report the issues with the CON process, which have a deep impact on access. In general, the state has an inadequate supply of qualified providers to meet the needs of the LTC population requesting community-based options. The state needs to make a concerted effort to recruit qualified providers into the state, especially into the more rural areas. One solution for this challenge is to develop a set of standards that ensure adequate availability of providers and then embark on a process to achieve those standards. The state also needs to engage in a discussion about the appropriateness and pros/ cons of provider competition. This should include consideration of how increased competition may enhance consumer choice and access to services. Experiences in other states have proven that social service systems can operate as market-driven entities when providers are responsive to consumer needs and feedback.

C. FINANCING

Financing is a crucial component of any LTC system. As West Virginia investigates the rebalancing of the LTC system and implementing a MFP approach to long term care, financing will be an important issue to address. Funding for the LTC system must be available so providers receive reimbursement for services in the individual's setting of choice. WV will first need to assess the availability of funds for improving the LTC system. Then the state will need to develop a budget for a balanced system that allows for funds to be spent based on the services and supports an individual prefers.

1. A National Look at Medicaid Costs

In order to gain a better perspective on the current LTC environment in West Virginia, it is useful to first look at this environment on a wider, national scope. Table 9 below shows Medicaid enrollment and beneficiaries for selected years between 1975 and 2006. From 1990 to 2006, unduplicated annual aged beneficiaries increased from 3.2 million in 1990 to 6.1 million in 2006: an increase of nearly 91 percent. Unduplicated annual blind and disabled enrollment rose 162 percent in this time period, from 3.7 million in 1990 to 9.7 million in 2006.

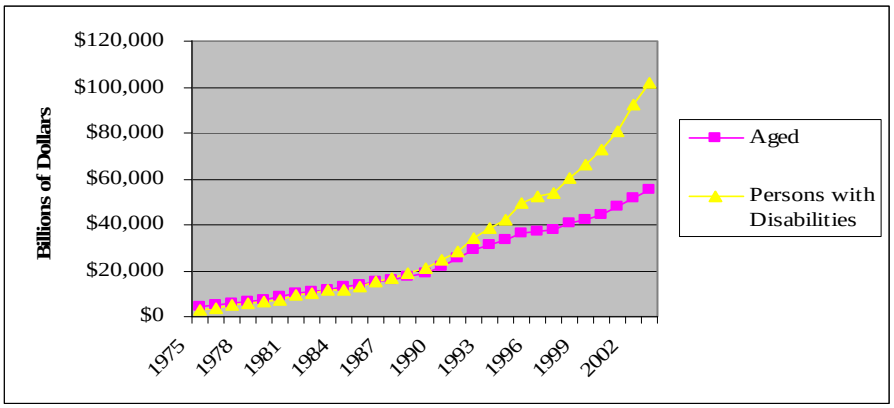
Table 9: Average U.S. Monthly and Unduplicated Medicaid Enrollment Selected Years 1975-2006

	1975	1980	1985	1990	1995	1999	2000	2001	2002	2003	2004	2005	2006
Average monthly enrollment in millions													
Total	NA	NA	NA	22.9	33.4	32.6	33.6	37.7	39.9	41.9	45.0	46.9	49.3
Aged	NA	NA	NA	3.1	3.7	3.9	3.7	4.0	4.2	4.3	4.5	4.6	5.2
Blind/Disabled	NA	NA	NA	3.8	5.8	6.6	6.7	7.2	7.5	7.8	7.9	8.1	8.8
Children	NA	NA	NA	10.7	16.5	15.9	16.2	17.5	18.4	19.3	22.1	23.1	23.9
Adults	NA	NA	NA	4.9	6.7	6.2	6.9	8.9	9.8	10.5	10.5	11.0	11.4
Other Title XIX	NA	NA	NA	0.5	0.6	NA	NA	NA	NA	NA	NA	NA	NA
SCHIP	NA	NA	NA	NA	NA		2.1				4.3	4.3	4.4
Unduplicated annual enrollment in millions													
Total	22.4	21.6	21.8	25.3	42.5	NA	43.3	NA	NA	NA	57.6	60.1	63.2
Aged	3.7	3.4	3.1	3.2	4.4	NA	4.3	NA	NA	NA	5.2	5.4	6.1
Blind/Disabled	2.4	2.8	3.0	3.7	6.5	NA	7.5	NA	NA	NA	8.8	9.0	9.7
Children	9.8	9.3	9.8	11.2	21.3	NA	20.9	NA	NA	NA	28.7	30.0	31.1
Adults	4.7	4.8	5.5	6.0	9.4	NA	10.6	NA	NA	NA	15.0	15.7	16.2
Other Title XIX	1.9	1.5	1.2	1.1	0.9	NA	NA	NA	NA	NA	NA	NA	NA
SCHIP	NA	NA	NA	NA	NA	NA	3.3				6.8	6.8	6.9

Source: CMS 2006 Data Compendium, Population file.

Table 10 shows that at the federal level, spending on the aging and disability population was approximately similar in 1975 to 1990.[87] After 1990, the spending patterns diverged sharply: since 1990, CMS has been increasing its spending on the senior population by 8.21% each year and by 12.08% for persons with disabilities. The higher caseload growth of persons who are blind and have disabilities is one factor accounting for the higher rate of spending.

Table 10: U.S. Medicaid Spending on the Aged and Persons with Disabilities, 1975 – 2003

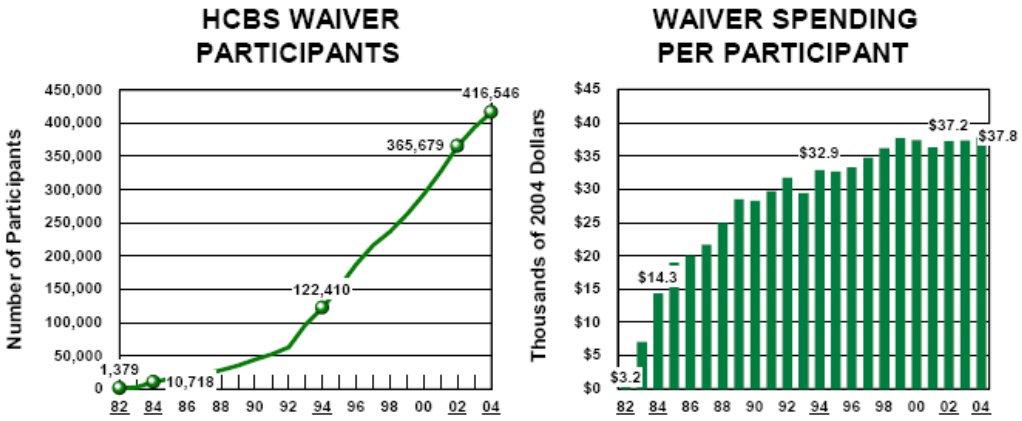


Source: CMS Medicaid Statistical Supplement 2006, Table 14.10

[87] CMS Medicare and Medicaid Statistical Supplement, Table 14.10 Medicaid Payments, by Eligibility Group: Fiscal Years 1975-2003.

National trends in MR/DD spending and participation also show significant increases in the number of individuals served and the cost per person. Table 11 illustrates these upward trends.[88]

Table 11: US MR/DD Waiver Participants and Spending, 1982-2004



Source: Braddock, Hemp & Rizzolo, Coleman Institute and Dept of Psychiatry, University of Colorado, 2005.

2. West Virginia's LTC Spending

West Virginia's Medicaid spending on the LTC population has tended to mirror national trends. In general, more funding is spent on institutional care (including NFs and ICFs/MR) than on community-based services. Also, Medicaid spending for HCBS for individuals with developmental disabilities exceeds HCBS spending for older people. This leaves the delivery system much more institutionally focused for people age 65 and older.[89]

The WV Health Care Authority collects yearly financial information on hospitals, NFs, home health agencies, and other regulated health care providers. In Table 12, the Authority's data for NFs shows that in Fiscal Year (FY) 2005, Medicaid was the largest payor of NF services. Medicaid's payments comprise 65.89% of total revenue, followed by Medicare, then private pay.

[88] D. Braddock et. al. (2005) State of the States in Developmental Disabilities 2005, Coleman Institute for Cognitive Disabilities, University of Colorado, Boulder, Colorado.
[89] Weiner, J. (2006). It's not your Grandfather's Long-Term Care Anymore. *Public Policy & Aging Report* 16, 28-35.

Table 12: West Virginia NF Consumer Revenue, FY 2005

West Virginia NF Patient Revenue	Patient Days	Revenue	% of Revenue
Medicare	389,630	$ 129,648,000	20.93%
Medicaid	2,451,379	$408,691,000	65.98%
Private Pay and Other Sources	433,879	$ 81,043,000	13.08%
Total	3,274,888	$619,382,000	100.00%

Source: WV Health Care Authority Annual Report 2006 Tables 25-28.

NFs provide more days of service to individuals who pay for their own care than for individuals covered by Medicare, despite the fact that the average Medicare rate is higher than the average private pay rate. Table 13 shows that in 2005 the average rate for a West Virginia NF day was $187 compared to the national average of $203.

Table 13: Daily Private Pay NF Costs in West Virginia vs. the U.S., 2006

NF Costs per Day	Charleston Area	U.S. Average
Semi Private Room (Average)	$179	$176
Private Room (Average)	$187	$203

Source: MetLife Survey of Nursing Home & Home Health Costs September 2006, p. 11

The West Virginia Health Care Authority's Annual Report for 2006 shows that Medicare margins are substantially higher than margins on Medicaid: Medicare margins averaged 18.8% versus an average of 1.6% for Medicaid margins. In keeping with national trends, WV NFs are gradually expanding the amount of Medicare business they do, as Medicare days comprised 10.5% of total patient days in FY 2003 and 11.89% in FY 2005.

The Health Care Authority also keeps track of Home Health and Hospice expenditures. Home Health expenditures are reported for five types of agencies: county, proprietary, proprietary hospital-based, non-profit hospital based, and non-profit. In FY 05, the 73 home health agencies received approximately $86,912,000—a loss of $919,000 for the year, although 37 of the 73 agencies reported a profit. During FY 2005, the state's 20 hospice programs received $52,168,000 and made an 11% profit on their revenue.

Table 14 shows West Virginia Medicaid Home Health expenditures to be $3,496,420 in State Fiscal Year (SFY) 2006 for services to 2,405 persons. LTC services are also paid for through the Medicaid Personal Care program. In 2006, Medicaid paid $33,871,328 for Personal Care services for 5,724 individuals. The number of individuals paid for and amount paid for Personal Care have increased during the last four years.

Table 14: West Virginia Medicaid Expenditures on Home Health, Personal Care, and Targeted Case Management, SFY 2003 - 2006

Persons Served	SFY 2003	SFY 2004	SFY 2005	SFY 2006
Home Health	2,076	2,108	2,078	2,405
Personal Care	4,739	5,143	5,218	5,724
Targeted Case Management	19,256	20,246	19,070	17,728
Medicaid Expenditures	SFY 2003	SFY 2004	SFY 2005	SFY 2006
Home Health	$3,025,617.96	$3,278,493.57	$3,089,831.55	$3,496,419.74
Personal Care	$24,246,337.66	$28,612,352.82	$28,189,145.19	$33,871,327.79
Targeted Case Management	$7,137,320.35	$8,420,523.81	$6,975,330.09	$5,537,744.62

Source: State of West Virginia, Bureau for Medical Services

DHHR also administers programs that provide long term care services to persons who are above Medicaid income eligibility requirements. DHHR pays for adult residential care for persons who are unable to function independently. In SFY 2006, approximately $1,135,382, including a $628,435 Temporary Assistance to Needy Families (TANF) transfer, was paid for such residential services. [90]

a. Bureau of Senior Services

BoSS is a cabinet-level, state government agency that acts as the lead advocate for programs serving older West Virginians. BoSS oversees services provided through over 140 local organizations. Services are both Medicaid and non-Medicaid-funded and include meals and transportation, in-home care, Alzheimer's respite, wellness, long term care advocacy, senior employment, and Medicare counseling.[91] Some of the programs administered by BoSS include: [92]

- Legislative Initiative for the Elderly (LIFE). In 2006, this lottery-funded program provided 350,000 hours of services similar to Older Americans Act services to about 17,000 persons.
- Alzheimer's Disease Demonstration Grant. A three-year program to help families of persons with Alzheimer's, and increase the amount of hospice and respite care available.
- Family Alzheimer's In-Home Respite. A state-funded respite care program.

---

[90] State Of West Virginia, (2005, May), *Report On Intended Expenditures For The Title XX Social Services Block Grant July 1, 2005 - June 30, 2006,* Department of Health and Human Resources, Office of Planning and Quality Improvement, Charleston, WV

[91] State of WV, BoSS, "Lighthouse Program" brochure, 7/07.

[92] State of WV, BoSS 2006 Annual Report. www.legis.state.wv.us/Reports/Agency_Reports/Agency_Reports_Docs/S05_CY_2006_45.pdf

- Non-Medicaid Community Care. In 2006, this program provided personal care services to 400 persons who were not eligible for Medicaid.
- Resource Center Demonstration Grant. This grant from the federal Administration on Aging originally supported two Aged and Disabled Resource Centers (ADRCs) in Marion and Ohio counties. Recently the state invested an additional $1 million and there are now four ADRCs covering the entire state.
- The Lighthouse Program, initiated in 2007, is a state funded program that provides up to sixty hours of in-home assistance to individuals over sixty who qualify. Supports are provided in the areas of personal care, mobility, nutrition and environment. There is a sliding fee schedule based on the eligible individuals' income.
- Personal Options is available in the AD Waiver and allows a person to manage their own services. This program was described in more detail earlier in the "Self-Directed Services" section of this report.

BoSS, as contracted by BMS, assists in the administration of the Medicaid AD Waiver and the Medicaid Personal Care program. BoSS has also collaborated with the Robert Wood Johnson Foundation's Cash & Counseling Project. This program option within the AD Waiver began in 2007 and encourages persons to direct their own services.

In 2006, the BoSS received funding from four sources: State General Funds, Lottery Funds, Federal Funds, and Special Revenue Funds. The amounts BoSS received from each of these sources are listed in Table 15.

Table 15: Funding Sources for West Virginia Bureau of Senior Services SFY 2006

Funding Source	Amount
State General Funds	$ 873,415
Lottery Funds	$ 39,189,503
Federal Funds	$ 12,295,891
Special Revenue Funds	$ 1,360,561
TOTAL	$ 53,719,370

Source: Bureau of Senior Services Annual Report 2006

b. NF Reimbursement Methodology

West Virginia NFs are regulated under the authority of CON laws at WV 16-2D and licensure and certification laws at WV 16-5C. Aside from the restrictions on ventilator beds found at 16-2D-6(f), the WV code does not mention how NFs are to be reimbursed. Administrative law, as described in the State Code of Rules, is also without information on the subject of NF

reimbursement. Regulations for the licensure of nursing facilities are further described in Title 64, Series 13. The State Code of Rule at 78-10-2 incorporates the WV State Plan for Medicaid as a legislative rule. Reimbursement methodologies for non-governmental NFs are specified under Attachment 4.19 D-1 of the West Virginia State Plan. NF reimbursement procedures have been in place for almost two decades. This is a stable, well established reimbursement policy.

Every six months NFs submit cost reports. The state uses these to establish the per-diem cost of providing what it calls "standard and mandated services". Standard services are dietary, laundry and housekeeping, medical records and administration. Mandated services include activities, maintenance, utilities, and taxes and insurance. Costs for these specific services are converted to per-diem costs, assuming 100% occupancy, by dividing the allowable costs by the number of licensed bed days times the number of days in the year.

These per-diem costs are arrayed and per-diems greater than plus or minus one standard deviation are excluded from the array. In a normal distribution, about 68% of all values are found within plus or minus one standard deviation from the average of the distribution. This process removes about 32% of the facilities that have the higher and lower per-diems. This methodology is a way of controlling for the effects of a few scores which are very high or very low. The average of this truncated distribution is then divided by either the facility's actual occupancy rate or 90% occupancy, which ever is higher. The resulting cost per day is the allowed amount per-diem for that cost center.

Although the Medicaid State Plan uses the terminology of standard appraised value (SAV), capital reimbursement uses a fair rental value approach in which providers are reimbursed the mortgage and equity costs of operating the property. The State is phasing in capital reimbursement rule changes which take into account the fluctuation of capital percentage costs. The rules also now permit non-profits to have an equity component.

The Medicaid State Plan uses "case mix" factors to reimburse nursing services. Table 16 shows that in the base amount before adjustments, Medicaid will pay for 2.5 hours a day of nursing care and .40 hours a day of restorative care per person. [93] These numbers were arrived at some years ago by using a case mix assessment instrument, finding the average score was about 2.5 and translating that average into an estimation of the number of hours needed. These hours are then multiplied by allowable per hourly costs to arrive at a per-diem rate. Hourly nursing-related costs are arrived at by taking the actual hourly costs of homes, ranking them, and then identifying the costs at the 70th percentile and using those cost to create cost limits, or "ceilings", above which the state will not pay.

Facilities where residents have a higher average score on the MDS than the 2.5 base component have the chance to receive an additional per-diem add-on to their nursing per-diem. The additional add-on may not reimburse the facility for all of its nursing service costs but does provide some additional funding on top of the base amount of 2.5 hours a day.

[93] Attachment 4-19 D- 1, p. 11

Table 16: Nursing Services Hours in Medicaid State Plan

4. Nursing Service and Restorative Servies

Nursing and related service costs, including restorative services, will be determined on a facility-by-facility basis by applying the allowable cost formula and case mix adjustments Nursing service reimbursement will consist of an adjusted base component and allowable case mix add-on.

The base nursing services component will reflect minimum staffing patterns for nursing personnel, plus a factor to account for restorative services, and amounts reflecting Director of Nursing costs and the costs of supplies and services. Basic nursing staffing is established at a case mix score of 2.5, which reflects nursing and restorative staffing hours per patient day as follows:

# of Beds	Position	Nursing	Restorative	Total
1-90	R.N.	20	.00	20
	L.P.N	.50	35	.85
	Aides	1.80	.05	1.85
TOTAL		2.50	40	2 90
91+	R.N.	.20	00	20
	L.P.N	.50	30	80
	Aides	1.80	.05	1.85
TOTAL		2.50	35	2 85

TN No. 05-10
Supersedes
TN No. 96-15

Approval Date MAY 23 2006

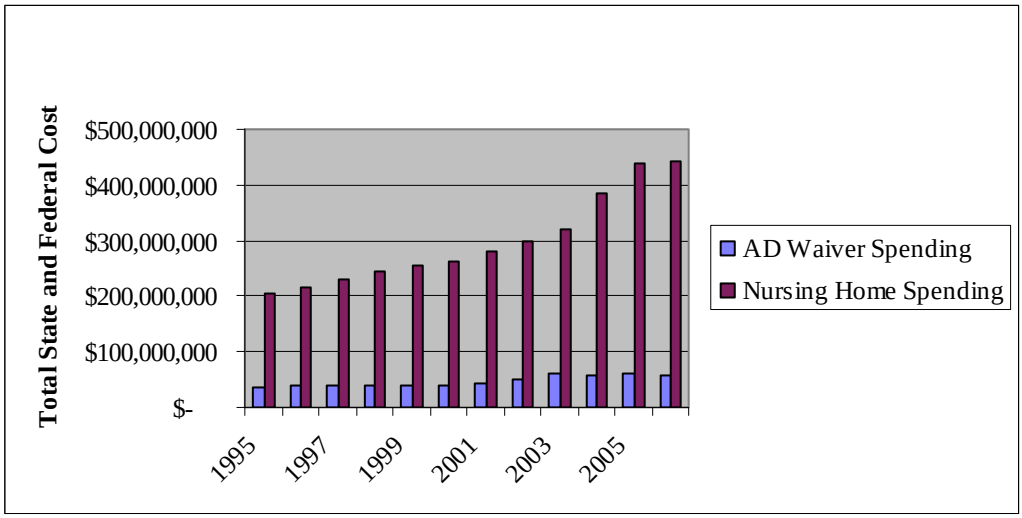
Effective Date OCT - 1 2005

Of note is that the statewide average score in this MDS assessment process is now close to 3.00. Do West Virginia nursing facilities now take care of more acute persons than they did 10-15 years ago? Should the base component in the nursing services rate be updated to reflect current MDS scores? Updating the base 2.5 score to recognize changes would have a fiscal impact on NF reimbursement. Reimbursement would reflect higher nursing costs for facilities that are providing higher levels of nursing service to their residents.

In general, NF reimbursement appears to be an established system with tight controls that reimburses providers close to cost, and produces gradual year-to-year expenditure trends, as shown in Table 17 below. As cited elsewhere in this report, the West Virginia Health Care

Authority data shows the average NF made a 1.6% margin on their Medicaid revenue and 47 facilities lost money on Medicaid.[94]

Table 17: Medicaid AD Waiver and NF Spending, 1995 - 2006



Source: West Virginia Department of Health and Human Resources, 2007

c. ICF/MR Reimbursement Methodology

Like NFs, the reimbursement methodology used with ICF/MR facilities is also based on cost reports, has a "case-mix" like adjustment for individual residents, and uses standard appraisals to reimburse a property component.[95] Unlike NFs, whose costs are rebased every six months, the rebasing of ICF/MR rates is less specific. The State Plan says, "Individual specific rates are established on a prospective basis, considering costs to be expected and allowable during the rate period. The rate is not subject to retrospective revision. The State will provide for periodic re-basing of rates on the most recent cost report filings."[96] Because of software problems, in the last two reimbursement cycles, the previous year's rate was advanced by an inflation factor rather than being rebased.

As of May, 2007 there were about 66 ICFs/MR operating in West Virginia. ResCare[97] and REM[98] are the two largest chain operators of ICFs/MR in the state. About two thirds of all

[94] State of West Virginia, West Virginia Health Care Authority, (2006), *Annual Report for 2006, Table 26*
[95] ICFs/MR reimbursement is described in the Medicaid State Plan at Attachment 4.19 D-2.
[96] State of West Virginia, State Medicaid Plan.
[97] www.rescare.com. ResCare operates in about 27 states and provides services to about 18,000 persons with MR/DD.
[98] REM has facilities in 16 states, including WV. www.reminc.com/

ICFs/MR in West Virginia are operated by ResCare, while REM's programs are generally located in the northern part of the state.

The funding methodology for ICFs/MRs divides costs into six types: direct care, medical and other costs, day programming, room and board, administration, and property. The direct care component is the largest part of the rate and also has a level of care component. Since its adoption in December of 1998, each resident in the facility is assigned a score based on answers to questions contained in the Inventory for Client and Agency Planning (ICAP). The score reflects the needs/resources of the person rather than directly measuring acuity. Based on these scores, residents are assigned to one of four reimbursement levels: intermittent, limited, extensive, and pervasive, with pervasive being the highest level of needed care. The higher the level of care needed, the higher the direct care per-diem.

Facilities are "peer grouped" by size. For example, in 2005, 65 ICFs/MR received Medicaid reimbursement. Of the 65, 16 had fewer than eight beds, 47 had eight beds and two had more than eight beds. The amount paid for persons in each level varies by size of the facility. Within ICAP levels, the smaller the facility is the larger the ICAP payment. A number of hours is assigned for each type of nursing staff depending on the ICAP and peer group. The rate per hour paid for the various types of nursing staff is based on the cost reports for the peer group.

Medical and other costs, day programming, room and board, and administration are based on costs reported in the cost reports. For example, the costs of each facility within the peer group are arrayed and a cost standard is calculated at an average percentile. Each facility within the peer group is reimbursed at the peer group standard for that particular cost. Property is reimbursed using what could be called a "fair rental" approach. Facilities are appraised and allowable percentages of appraised value are reimbursed for the property component. These allowable percentages are weighted averages of selected bond rates.

ICF/MR reimbursement is similar to NF reimbursement in the following ways:

- Both are prospective;
- Providers are placed into peer groups based on the size of the facility;
- Nursing services are case- mixed based on residents' scores on a questionnaire; and
- Property is reimbursed using a standard appraised value methodology which is similar to what is called a fair rental model.

The West Virginia Health Care Provider Tax Act of 1993, W. Va. Code § 11-27 et seq., imposes a tax of 1.75% to 5.5% on the gross receipts of various categories of health care providers in West Virginia. ICFs-MR are subject to this tax, which will be at the rate of 5.50% in SFY 2008.

ICF/MR reimbursement is different from NF reimbursement in the following ways:

- Each ICF/MR resident has a different reimbursement rate depending on the ICAP level and peer group of the facilities, whereas Medicaid reimburses nursing facilities the same per-diem for each resident.

- NF reimbursement takes into account the occupancy of the facility, whereas no occupancy provisions are found in the ICF/MR Medicaid State Plan reimbursement methodology.

d. MR/DD Waiver Reimbursement Methodology

MR/DD Waiver reimbursement rates were updated on October 1, 2006 using wage labor data from the Department of Labor, plus inflation, fringe benefit and administrative percentages derived from cost reports.

The reimbursement methodology is straightforward, easy to explain, and covers all of the approximately 50 procedure codes used to reimburse MR/DD Waiver services. For example, procedure code T2015 Individual Supported Employment, is based on the assumption that hourly help equivalent to the skill of a psychiatric aide is necessary. In 2005, West Virginia established average costs for psychiatric aides at $7.77 based on Department of Labor figures. This base amount included fringe benefits, administration and inflation added on to bring the 2006 announced rate to $12.31.

3. Expenditures and Caseloads for NFs and the AD Waiver

The Medicaid program is authorized in section 1915(c) of the Social Security Act to offer services that are not in the Medicaid State Plan to persons who would otherwise be at risk of institutionalization in a NF. The West Virginia AD Waiver provides in-home services to those persons who choose to remain at home rather than go to a NF. The waiver began in 1982 and has been periodically renewed.

The federal On-Line Survey and Certification Report (OSCAR) requires nursing facilities to submit information as part of the conditions of participation in the Medicare program. OSCAR data for West Virginia show that since December 2001 the number of facilities in the state has decreased from 138 to 131 in December 2006. West Virginia facilities tend to be smaller than the average facility nationally. During the last six years the average number of residents per facility is about 75 persons which is lower than the national average of 90 persons per facility.

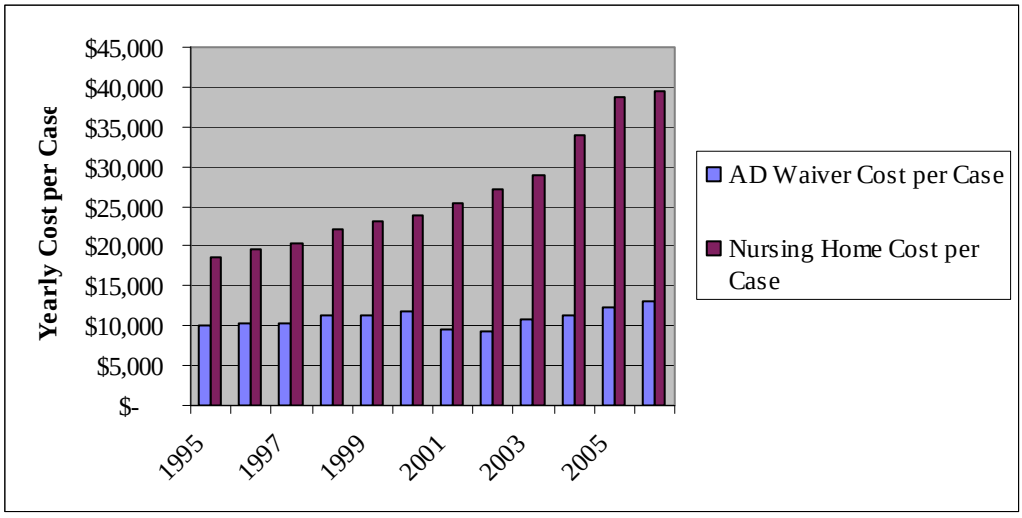
In keeping with the decline of the number of nursing facilities, the number of beds in nursing facilities has decreased slightly from 11,214 in December 2001 to 10,924 in December 2006. State-wide average occupancy rates of nursing facilities have varied from 92% to 89% during the period December 2001 through December 2006 and have averaged 90.28% during this period. About 65% of West Virginia's nursing facilities are run by for-profit companies, exactly the same percentage as the national average for the country. West Virginia has a slightly higher percentage of government-operated facilities, about 10% versus 6% nationally, and a slightly lower percentage of non-profit facilities, 23%, versus 28% nationally. National statistics show that 20% of West Virginia facilities are hospital-based while nationally about 10% of facilities are hospital-based.

West Virginia Code 11-27-11 imposes the health care provider tax on NF services in West Virginia. The tax will be at a rate of 5.50% in SFY 2008. Table 15 shows the amount of state and federal funds used to pay for AD Waiver services and NF services.

State and federal NF expenditures have grown from $204 million in 1995 to $385.1 million in 2006, an average increase of about 5.95% a year. Waiver expenses have been growing at a rate of 5.09% from $35.4 million in 1995 to $59 million in 2006.

Table 18 graphs changes in the NF and waiver cost per case. While expenditures have been increasing at approximately a 6% rate, the number of Medicaid dollars paid for individuals served in nursing facilities has increased from $11,036 in 1995 to $11,142 in 2006. Table 16 also shows the AD Waiver cost per case has been flat from 1995 to 2003 and has risen in the last three years while the caseload has gone up from 3,493 persons in 1995 to 4,537 persons in 2006. In 2006, the cost per case on the AD Waiver was $13,012 and the cost per case in NFs was $34,569, which does not include the residents' share of the cost.

Table 18: West Virginia Medicaid AD Waiver and NF Cost per Case, 1995-2006

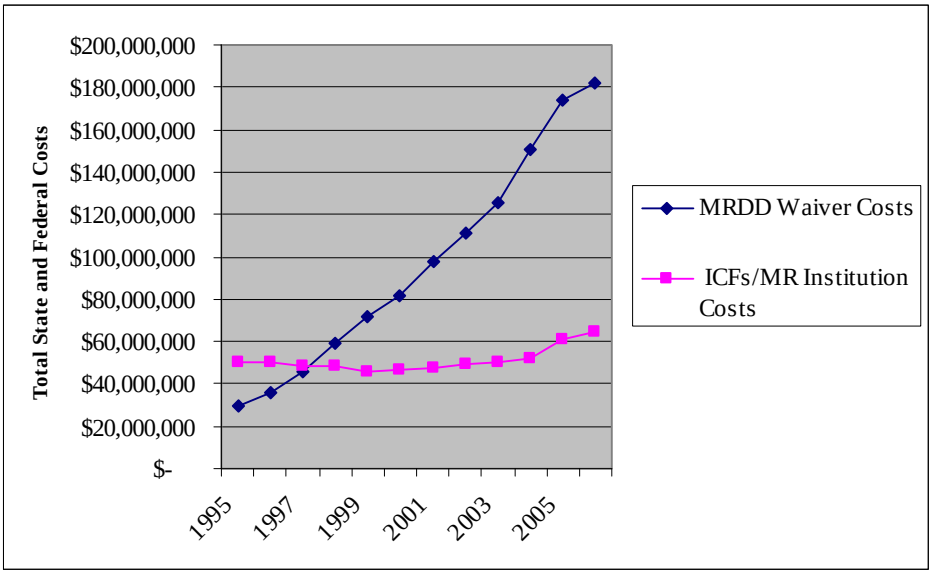


Source: West Virginia Department of Health and Human Resources, 2007

4. Expenditure and Caseloads for ICFs/MR and the MR/DD Waiver

Table 19 compares state and federal costs of institutional care and waiver services for West Virginians who have mental retardation and/or a developmental disability. West Virginia does not have large publicly-operated institutions for persons with mental retardation. Rather the state pays for care for persons who have mental retardation in 66 privately-operated ICF/MR facilities. The cost of these institutions has grown approximately 2.46% a year from $50.3 million in 1995 to $64.3 million in 2006. Waiver expenses have grown approximately 18.05% a year from $29.9 million in 1995 to $182.1 million in 2006.

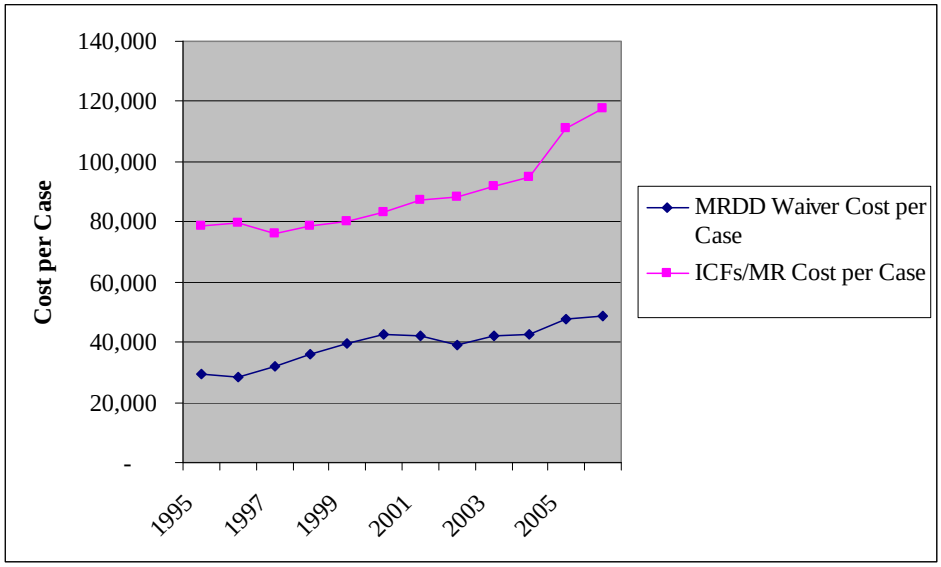
Table 19: West Virginia Costs of the MR/DD Waiver versus ICFs/MR, 1995-2006



Source: West Virginia Department of Health and Human Resources, 2007

Table 20 shows the cost per case for persons receiving services in ICF/MR institutions versus the cost per case for persons receiving in-home waiver services. The cost per case for institutional services has increased from $78,582 in 1995 to $117,620 in 2006 while the number of persons served has declined from 640 persons in 1995 to 547 persons in 2006. The cost per case for waiver services has increased from $29,652 in 1995 to $48,687 while the number of persons receiving waiver services has increased from 1,007 persons in 1995 to 3,741 persons in 2006.

Table 20: West Virginia MR/DD Waiver and the ICFs/MR Cost per Case, 1995-2006



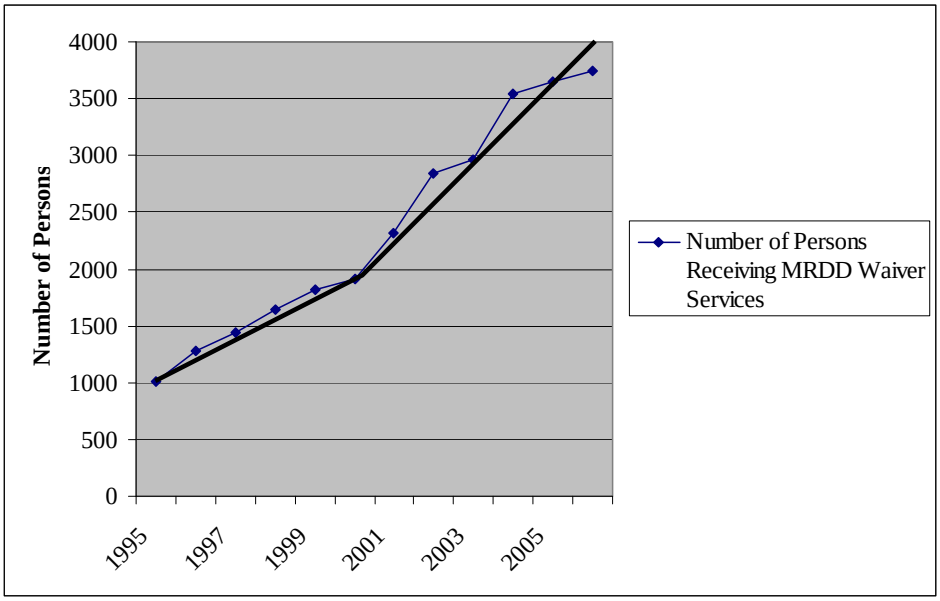
Source: West Virginia Department of Health and Human Resources, 2007

The dramatic increase in MR/DD Waiver slots can be partially explained by the court decisions that have periodically reshaped West Virginia programs. The *Medley vs. Ginsburg* decision, filed in 1978 and settled via consent degree in 1981, ordered the discharge of persons with mental retardation who were under 23 years of age from state-operated institutions and the provision of services in the community. The Hartley Consent Decree, (*E.H., et al. vs. Matin, et al.*), a 1981 action brought by four residents of Huntington Hospital addressed the need to provide active treatment in facilities and to identify residents in state-run, long term care facilities with mental health or MR/DD diagnoses who are appropriate for community placement. The state closed its last large MR/DD institution in 1998. The Hartley and Medley consent decrees are still in effect and being monitored by the courts.

The *Benjamin H. vs. Ohl* case was brought in 1999 in the U.S. District Court for southern West Virginia and was settled in 2002. This class action complaint alleged that West Virginia had violated federal Medicaid law and the ADA by failing to provide Medicaid long term services with reasonable promptness to eligible individuals. In July 1999, the District Court granted the plaintiffs' motion for a preliminary injunction based on its conclusion that the plaintiffs were likely to prevail at trial based solely on the requirements of federal Medicaid law. The Court upheld the complaint and ordered the state to develop a plan to eliminate waiting lists and make other improvements to administrative procedures for accepting, reviewing and making decisions as to who shall receive waiver services. For example, prior to the *Benjamin H.* case, providers who accepted MR/DD applications for waiver services only forwarded applications to the state that the provider thought would be accepted. After *Benjamin H.*, all applications were forwarded to the State MR/DD Waiver Office for eligibility determinations.

As a result of the case, West Virginia agreed to increase the number of individuals with developmental disabilities who receive home and community-based waiver services by 875 over a five-year period. Table 21 shows enrollment in the MR/DD Waiver program and slope lines have been added to the graph to show the impact of the *Benjamin H.* case. The caseload lines are steeper after the decision than before the decision.

Table 21: Rate of Growth in West Virginia MR/DD Waiver Caseload 1995-2006



Source: West Virginia Department of Health and Human Resources, 2007

BMS requested and received CMS approval for 140 additional MR/DD Waiver slots for a total of 3,964 slots as of July 1, 2007. Increasing caseloads and the increase in rates created by the November 2006 rate changes, implies that MR/DD Waiver costs will continue to rise.

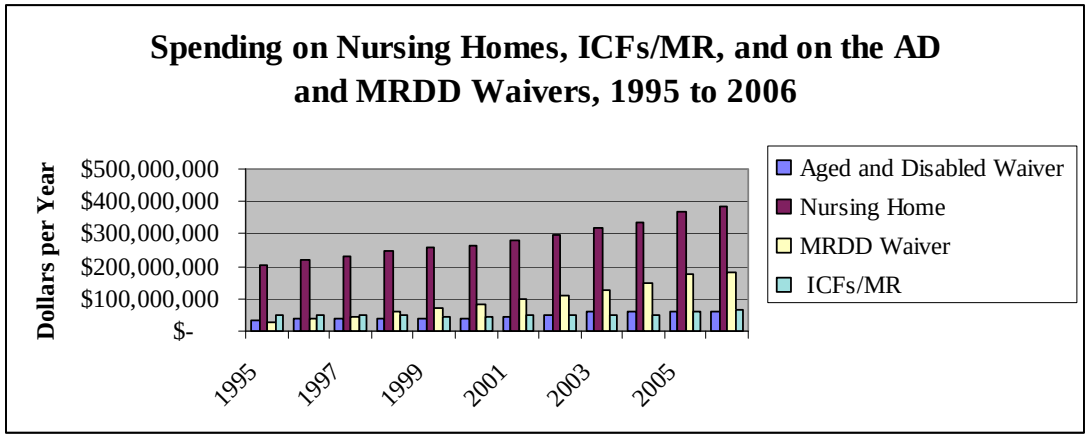
a. Caseload Comparison

Different programs have had different trends over the past ten years.

- The number of persons in nursing facilities has increased slightly, approximately 1% from 11,036 in 1995 to 11,142 in 2006.
- The number of persons in ICFs/MR has declined approximately 14.5% from 640 to 515.
- On the other hand, enrollment in the AD Waiver has increased approximately 30% from 3,493 in 1995 to 4,537 in 2006.
- Enrollment in the MR/DD Waiver has increased approximately 270% from 1,007 in 1995 to 3,741 in 2006.

Table 22 shows a comparison of Medicaid spending on the four programs. Spending on nursing facilities continues to be the largest state program followed by the MR/DD Waiver. Spending on the AD Waiver and ICFs/MR tends to be similar and both are noticeably smaller than the two largest programs.

Table 22: Comparison of Spending for West Virginia Facilities and Waivers 1995-2006



Source: West Virginia Department of Health and Human Resources, 2007

In West Virginia, the MR/DD waiver serves 8 times as many people at only 3 times the cost of ICFs/MR.

West Virginia appears to be successful in accommodating the growth of persons needing a NF over the last ten years in that NF caseloads are essentially flat while waiver enrollment has gone up 30 percent. This implies that all of the growth that would have gone into nursing facilities has been accommodated in the waiver programs.

The state still spends 4.4 times more on nursing facilities than on home and community alternatives to nursing facilities, approximately $385 million for NFs in 2006 to $86 million for community-based alternatives. The state also pays for about 2.4 times more persons in nursing facilities than in community alternatives, 11,142 in nursing facilities in 2006 to 4,537 persons receiving in-home waiver services.

D. QUALITY

In general, the quality of a state's long term care system can be largely attributed to the success of three critical components: workforce, housing and transportation. In meeting with WV Advocates, we were told that these three areas within the state's LTC system are fragmented and lacking coordination, leading to a level of overall quality in the system that needs improvement.

The LTC Ombudsman's Office characterized the overall quality of LTC services in West Virginia as currently "mediocre." At the same time, they feel that NFs provide good medical

care while having concerns about both the medical model and the lack of meaningful quality of life initiatives in NFs. The medical model has inhibited many NFs from recognizing and/or implementing practices which demonstrate the importance of residents having greater say over their own care. There is also concern about the lack of meaningful efforts to address mental health issues, such as depression or aggressive behaviors, in ways other than the use of anti-depressants or psychotropic medications. In addition, there is sensitivity to the disparity in the quality of services for lower income individuals in assisted living and other smaller residential long-term care homes compared to the assisted living homes for those with good incomes which are of very high quality.

West Virginia's workforce, housing, and transportation strengths and areas for improvement are each analyzed below in order to provide an account of the long term care system's current components of service quality and to document the quality of life perspectives of current long term care consumers in the state.

1. Workforce

In almost all interviews and discussions, stakeholders commented about the LTC system's difficulty with hiring and retaining qualified and reliable staff. The shortage of staff is far-reaching and includes nurses and physicians, direct service workers, administrators, case managers, and data processing staff. WV Advocates may have said it best when they stated that staffing needs to be the top priority in the system because without a stable, effective, and reliable workforce, the demand for services simply cannot be met. The end result is a poor quality of life for consumers.

Low pay, inadequate training, and lack of on-the-job support were cited as reasons for the state's LTC workforce shortages. Stakeholders told us that a career ladder for direct care workers needs to be created because currently, direct care jobs are "minimum wage and dead-end." One particular area of concern is the position of waiver service coordinators—there is a high turnover rate for this position and not enough training, particularly in clients' rights. There is also a coverage issue for the waiver programs regarding staff capacity on evenings, weekends, and for emergency backup.

The Center for Excellence in Disabilities at WVU noted that workforce development issues are particularly problematic in the northern and eastern panhandles of the state because of the employment pull from bordering states. This is particularly true for the Martinsburg area, where public forum participants told us "neighboring states pay more in salary," "a number of physicians have left this area of the state because of the more attractive salaries in other states and malpractice insurance rates," and "property taxes are getting so high here that it is more difficult to live here than in other areas of West Virginia, particularly for direct care workers." In fact, by court order, Martinsburg Child Protective Services (CPS) workers have to be paid higher salaries than other areas of the state in order to actually have a stable number of CPS workers, because the cost of living is so much higher there.

BoSS is identifying workforce strategies and looking at collaboration opportunities with vocational schools. This is a positive step in dealing with the immense workforce shortages the state's LTC system is facing and the resulting detriment this shortage has on the system's level of quality. However, with the increasing demand for long term care services and supports and an aging population in the state, this is a problem that will continue to persist and expand if significant actions are not taken to prevent the drought of LTC professionals in West Virginia.

2. Housing

WV Advocates stated that affordable, appropriate, and safe housing is a real need for individuals with mental illness. Others indicated that there is simply is not enough affordable, accessible housing currently available in the state for all populations. Still another example cited during interviews was that often people with physical disabilities are living in senior high rises because of the state's housing shortage. From all of these interviews and conversations, it became apparent that affordable, accessible, and safe housing stock is a commodity that is simply not readily available to people with a variety of disabilities and very limited fiscal resources.

The term "accessible housing" includes living options that are safe, affordable, and barrier free. If all three aspects cannot be in place, then individuals are unable to call a living situation 'home.' One particular challenge exists when individuals are able to find and purchase appropriate housing through home-ownership assistance programs, yet they cannot obtain assistance with housing maintenance costs that routinely arise or with emergency housing problems.

West Virginia may want to support a statewide initiative to develop more affordable, accessible housing stock. It is unlikely that there is one single or easily achievable approach for remediation of the housing problem. A combination of efforts will produce a workable solution for the state.

One program that is already available in West Virginia and could be improved upon is better use of the federal Housing and Urban Development (HUD) Section 8 housing vouchers. These could help address the shortage of housing experienced by the underserved populations. In addition, an inventory of current housing stock across the state that is affordable, accessible, and safe for individuals with disabilities or for the elderly would be a starting point in completing the needs assessment for housing. It would also serve as a resource when assisting individuals who want to return to or remain in the community.

The construction of houses using Universal Design would also increase accessibility. Some features of Universal Design include:

- lower light switches and temperature controls (no more than 48");
- higher outlets (no less than 15");
- wider doorways (32" of clear passage);

- at least one no-step entrance into the home;
- entry level bathroom and bedroom;
- maneuvering space throughout the living area, especially in bathroom and kitchen; and
- adequate lighting.

Another potential resource is the HOME program. The HOME Program is a federally-funded housing program offered by the WV Housing Development Fund for low and very low-income individuals and families. It provides affordable financing for home repair, home purchases, and rental development. Participants apply through an approved nonprofit housing provider. This is a program that is lowering the barriers to accessible housing within the state and it should be expanded.

Finally, the United States Department of Agriculture (USDA) offers many programs that assist with the construction, rehabilitation, or relocation of a dwelling and related facilities for low - or moderate-income rural individuals. These should be further investigated by West Virginia. They include:

- Home Ownership Direct Loans. These guaranteed and direct loans provide financing, with no down payment and at favorable rates and terms, either through a direct loan with RHS (Rural Housing Service) or with a loan from a private financial institution that is guaranteed by RHS.
- Home Improvement and Repair Loans and Grants. These enable low-income rural homeowners to remove health and safety hazards from their homes and to make homes accessible for people with disabilities. Grants are available for people 62 years and older who cannot afford to repay a loan.
- Housing Subsidies**.** RHS can help subsidize monthly mortgage and rental payments, limiting these costs to no more than 30 percent of the adjusted monthly income of the applicant. These subsidies can be used for home ownership, rural rental and farm labor programs." [99]

3. Transportation

Transportation plays a critical role in the delivery of quality long term care services and supports. When an individual cannot physically access service providers, his or her support plan of LTC cannot be appropriately implemented.

Stakeholders of the WV LTC system told us there were many obstacles to receiving transportation services. Staff in the LTC Ombudsman's Office told us there are problems with transportation services for individuals with behavioral health needs and socialization desires, as there simply are not enough transportation resources to meet the needs. Additionally, they told

[99] Northern WV Center for Independent Living Housing Committee. "A Guide to Housing in West Virginia." December 2004.

us that Medicaid reimbursement issues interfere with the ability of individuals to access the frequent transportation needed for dialysis care. The NWVCIL also noted that transportation is a huge area of need within the LTC system and cited the limited number of public transportation hours and routes, especially in the more rural areas of the state.

An example of the transportation challenge faced by individuals comes from the Charleston area. Individuals utilizing KAT (accessible bus) services must make appointments way in advance to use these services. There is no consideration for spontaneous travel needs.

The state's ADA Coordinator told PCG that the state's regulations for transportation are restrictive and only provide for rides to medical appointments, which limit individuals' abilities to attend social, recreational and spiritual events. This, in turn, restricts overall quality of life. This restriction does not apply to people receiving services through the AD Waiver.

The State of West Virginia has recognized that there is a gap in transportation services provided for individuals with long term care needs. The West Virginia Transportation Alliance project was created to develop grassroots coalitions similar to those in the Commonwealth of Pennsylvania for the purpose of working together to advocate for statewide transportation services. Their efforts have been ongoing for 3 years. Additionally, the Southern Highlands Initiative received a $498,900 grant to coordinate transportation in a 6-county area of Southern West Virginia. The grant was awarded to the Southern West Virginia Community and Technical College by HUD.[100]

While these efforts show that West Virginia is making strides towards ameliorating its transportation gaps, there is still a lot of collaborative effort and innovation that could occur to assist individuals to attend medical, social, recreational and spiritual events and appointments. Particularly as the Baby Boomers age and seek unrestricted travel, transportation will remain an issue.

4. Quality Assurance and Rebalancing Efforts

The implications and effects of quality assurance policies and procedures within state health and human services agencies have garnered national attention and have been a primary focus of CMS. While there is support to financially and programmatically rebalance LTC services from facilities to HCBS, it is imperative that the quality of services and supports are maintained at the highest standard when those shifts occur. If the levels of service quality and consumer satisfaction suddenly drop after an individual moves from a facility to community-based services, the overall improvement in the individuals' expected outcomes will be lost.

A report in 2001 stated that West Virginia's LTC quality assurance structure "relies heavily on traditional licensing and certification activities, which historically have focused on facilities and are not entirely appropriate or adequate for community-based care settings. In order to

[100] www.marshall.edu/ati/shi/

maintain quality services in the face of rapid growth, the State should make this an area of immediate focus."[101] Comments from LTC system stakeholders in the Spring of 2007 reinforced the claims from the 2001 report, indicating that quality assurance activities vary significantly across the state and that the variance in quality assurance measures is frustrating for providers as the amount of paperwork can be duplicative and overwhelming. Attendees to the public forums stressed that consistency in the state's quality assurance processes and reports would assist the overall quality of long term care services and supports.

West Virginia has made many strides to enhance the quality of services delivered to LTC consumers and their families; however, there remain several challenges apparent within the system that hamper the provision of high-quality services and supports. The sub-sections below detail the progress made in the state to date, as well as the hurdles that will confront the LTC system in the future, in providing quality long term care services and supports in the most integrated and appropriate setting possible.

a. Beneficial QA Initiatives and Activities

In 2003 the West Virginia Medical Institute (WVMI) spearheaded a new federal initiative funded by the American Health Quality Association and U.S. Department of Health and Human Services (DHHS). The initiative's goal was to provide facilities and community-based LTC programs with the materials and technical support needed to upgrade clinical and organizational systems to improve care for consumers who often experienced pain, delirium, depression, pressure ulcers, and loss of everyday functions.

WVMI is serving as a Local Area Network of Excellence (LANE) for the Home Health Quality Improvement National Campaign 2007, a collaborative quality improvement effort among the home health community and healthcare leaders, to improve the quality of care in the home health setting. Home health agencies participating in the campaign are working to reduce the number of avoidable hospitalizations while improving clinical outcomes and patient satisfaction. As a LANE, WVMI encourages home health agencies to enroll and participate in the national campaign and to become leaders in the home care industry. WVMI also distributes monthly resources to agencies and communicates with other LANEs in the state about best practice interventions and resources.

WV's MR/DD Waiver Program is currently establishing the "Quality System Plan," a standardized and comprehensive set of procedures for assessing the quality of MR/DD Waiver care and services." The Plan will meet quality assurance standards as issued by CMS and will focus on the fact that States have the first-line responsibility for quality assurance in their waiver programs. The "Quality System Plan" will provide for a full range of quality assurance activities and will involve consumers, providers, state agencies, and other stakeholders. The

[101] Saucier, Paul and Dr. Elise Bolda. "Progress and Potential in West Virginia's LTC System." Edmund S. Muskie School of Public Service, University of Southern Maine. February 2001.

implementation of the Plan should assist the MR/DD Waiver program in improving quality as it incorporates the philosophies of the CMS Quality Framework.

The AD Waiver is also using the CMS Quality Framework. The AD Waiver established the QAI Advisory Council in 2003 made up of stakeholders including five members/family members or legal guardians and ten people who have a direct interest in the AD Waiver program such as providers, Ombudsman, and community members. The tools and methods are based on "The Quality Framework for Home and Community–Based Services" recommended by CMS in 2002. After comments from stakeholders and collaboration with the National Association of State Medicaid Directors, the National Association of State Units on Aging, and the National Association if State Developmental Disability Directors, CMS updated and improved the Quality Framework in 2004.

"A Vision Shared" was a collaboration of business and economics organizations and groups that issued a report in 2007. The report included recommendations to change the health and human services system in West Virginia and enhance the quality of life for all citizens in the state. Legislation was introduced based on the group's recommendations and was not enected.

"A Vision Shared" included a Long Term Care Focus Area Team that "envisions a comprehensive statewide system of public and private services and supports for West Virginians with long term care needs and their families that enhances the quality of life of all citizens; preserves the vitality of local communities; and contributes to the revitalization of West Virginia's economy."[102] The LTC Focus Area Team articulated a system of public and private long term care that:

- Promotes the health and wellness of individuals with LTC needs and their families;
- Preserves the dignity and respect of individuals with LTC needs and their families;
- Honors the preferences of individuals with LTC needs to reside in settings of their choice, including their own homes;
- Promotes personal responsibility for planning, financing and coordinating LTC services and supports;
- Supports self-determination of individuals with LTC needs based on the principles of freedom, authority, autonomy, responsibility, and confirmation; and
- Is transparent, open, accessible, coordinated, individualized, seamless, integrated, financially secure, flexible, and sustainable.[103]

The Office of the Ombudsman for Behavioral Health often fields concerns and grievances from West Virginians utilizing the state's long term care system and provides a well-documented and advertised grievance process to resolve issues. This process allows consumers and family members an effective entryway into the quality assurance practices and procedures of BHHF

[102] A Vision Shared Overview.
[103] Ibid.

and other state agencies when other QA activities do not address their concerns. Similarly, the Office of the Olmstead Coordinator assists with quality in the LTC system by fielding questions, concerns and grievances related to community transitions and the availability of community supports and services, and all other Olmstead-related issues.

BoSS successfully completed the first year of a 3-year Alzheimer's Disease demonstration grant that:

- Provides a Continuum of Contact for up to 500 families of individuals with Alzheimer's Disease;
- Identifies roles/activities of Hospice regarding palliative care and providing grief and bereavement counseling for persons with Alzheimer's Disease and their families; and
- Supports, enhances, and expands respite care.

Additionally, BoSS continues to operate the WV Call Center for the Medicare Prescription Drug Program (Medicare Part D), in collaboration with other state agencies and with funding from special grants obtained through the WV Primary Care Association/Access to Benefits Coalition, AARP, and the AARP Foundation. The call center provides assistance to thousands of West Virginians in understanding, comparing, and enrolling in Medicare prescription drug plans.[104]

b. QA Initiatives and Activities that Need Improvement

West Virginia's Office of Health Facility Licensing and Accreditation (OHFLAC) could play a stronger role in quality assurance. According to WV Advocates, neglect and abuse instances are sent directly to OHFLAC for resolution, but OHFLAC does not collaborate enough with advocacy agencies and self-advocates during this process and relies heavily upon administrative rules.

BoSS, using tools developed in conjunction with the BMS Office of Quality and Program Integrity (OQPI), completes quality assurance activities for the AD Waiver Program by completing site visits every twelve (12) to twenty-four (24) months, with more frequent visits as needed. BoSS makes completed reports available to the provider agency within sixty (60) days of the review and expects responses to any corrective action within sixty (60) days after receipt of the completed report.[105]

A Medicaid Aged and Disabled Provider Certification Application is now required by BoSS of each provider every 12 to 24 months which includes a statement of assurances and compliance with policies signed by the provider Administrator. Monitoring of all AD Waiver providers is now automated and has a reporting function that reviews each provider site and reports on all providers as one in relation to compliance with policies.

---

[104] WV BoSS 2006 Annual Report.
[105] ADW Manual.

The WV Participant Experience Survey (PES) was developed to evaluate the participants' experiences with the AD Waiver program and includes people who participate in both the Traditional and Personal Options programs. The surveys are conducted in the person's home face to face and entered into a data base for reporting. A successful pilot of the PES was conducted with 216 AD Waiver participants from throughout the state. Implementation of the PES includes the goal that ten percent of the AD Waiver participants are surveyed.

The PES is now part of the provider review process. When a provider is monitored, two people receiving services from that provider are selected randomly are surveyed as part of the process.

BHHF contracts with APS Healthcare, Inc. to monitor the quality of services delivered throughout the behavioral healthcare system, which overlaps with the long term care system. However, the quality assurance processes and procedures completed by APS Healthcare in collaboration with providers and BHHF are often duplicative and the reports produced from these quality monitoring activities are not regularly distributed to the public and the consumers of the LTC system.

DHHR has tried to implement the use of telemedicine (MDTV) into the state's LTC system to improve access for individuals residing in geographically diverse areas of the state. Although MDTV has been in place in West Virginia for over five years, the system is under-utilized, as expansion of the network has been inhibited by both the cost of maintaining the infrastructure and payment for the services. Additionally, under-utilization of MDTV in West Virginia may be occurring due to the fact that stakeholders do not have knowledge of and/or training in using the technology. MDTV is a critical resource to expand and support because of the tremendous beneficial impacts the operation of telemedicine can have on the consumer population utilizing the technology.

c. Rebalancing Efforts

West Virginia has also made the following efforts towards moving the LTC system from facility-based to HCBS.

- Transition to Inclusive Communities (TIC) Grant, which ended in 2004, demonstrated promising practices in NF transition and diversion, as it assisted over 84 individuals to transition from NFs to the community and assisted over 180 individuals to remain in community settings of their choice. TIC developed and implemented a creative 'Navigator' program that provided coordinators at dispersed Centers for Independent Living to assist individuals through transition and diversion processes.[106]
- Community-Integrated Personal Assistance Services and Supports (C-PASS) developed the model for Personal Options, researched PAS workforce issues and created a directory of personal assistance services and supports.

[106] MFP Demonstration Project Narrative.

- West Virginia Real Choice System Change Grant accomplished the following:
  - Creation of an information and referral system and online web-based resource directory which is affiliated with the WV 2-1-1 collaborative for families, professionals and communities;
  - Development of a series of Real Choice Consumer Workgroup white papers;
  - Demonstration projects and approaches that can be replicated or sustained in areas as housing, transportation, youth leadership and transition, fine arts and recreation and self-determination; and
  - Presentations to stakeholder groups regarding policies and procedures.
- Aging and Disability Resource Center grant coupled with a state appropriation established four ADRCs to provide information and access to LTC support services; and supported the development of marketing, outreach materials and presentations for the general public.
- Quality Assurance and Improvement Project accomplishments include the establishment of a Quality Improvement Team that oversees the implementation of the QAI Project and coordinates the quality management initiatives of both the AD & MR/DD Waivers; and establishment of Quality Assurance & Improvement Advisory Councils for each Waiver.
- People's Advocacy Information and Resource Services (PAIRS) Project has developed and implemented training on self-directed supports, trained 20 peer-to-peer coordinators, and established a WV Family Links Network of advocates.
- The Cash & Counseling Grant from the Robert Wood Johnson Foundation was awarded to the BoSS in 2004 to provide funding and technical assistance to finalize the design and develop the infrastructure (financial management, supports brokerage, and quality management) for Personal Options, the self-directed model within the A/D Waiver Program.[107]
- The Transition Initiative, which was initiated in March 2008, is funded and managed by the Olmstead Office in collaboration with the BMS and BoSS. The purpose of the Initiative is to assist West Virginia citizens with disabilities and seniors who reside in nursing facilities to live and be supported in their communities. The Initiative will enable individuals with disabilities and seniors to experience increased independence, dignity, choice, and flexibility to access home and community-based supports.
- Nursing Home Diversion Modernization Grant was awarded to West Virginia by the AoA in November 2007. The grant will allow the state to go forward with its "Fair Plus" pilot project in which BoSS) will partner with the Upper Potomac AAA and its new, state-funded ADRC to provide self-directed funds in the Family Alzheimer's In-Home

[107] MFP Demonstration Project Narrative

Respite (FAIR) Program. BoSS will also collaborate with 15 predominantly rural county aging providers, the Alzheimer's Association, BMS, and a fiscal intermediary to meet the program's goal of providing self-directed funds to 50 caregivers and to divert 50 care receivers from nursing home placement and Medicaid spend-down.

These programs have all shown promise in attempts to improve the overall quality of the West Virginia's LTC system. However, "rebalancing" the LTC system is no easy task and will take time and financial investment. To be effective, initiatives need to be sustained and supported over the long run. While there are signs of encouragement, it will take a concerted effort and a great deal of cooperation and coordination of effort to produce lasting and meaningful results.

Consumers and their family members rely on innovative programs and initiatives like the rebalancing efforts noted above in order to remain appropriately supported in their homes and communities. Accordingly, it is important that WV ensures continuing adequate funding and leadership for rebalancing efforts and transition initiatives.

III. RECOMMENDATIONS

At the beginning of this report, we noted four components of a rebalanced long term care system:

1. Service Sufficiency and Provider Capacity
2. Equal Access to Institutional and Community Services
3. Financing of Programs and Services That Follows People Into the Community; and
4. Quality Assurance and Improvement.

Accordingly, this study's recommendations have been categorized according to these four components.

In reviewing these recommendations, please note the following:

- The scope of this study did not allow for an in-depth examination of all the issues, including financial considerations, involved in making significant adjustments to the existing long term care system. Further analysis of recommendations should be considered prior to implementation to ensure that unintended consequences do not occur.
- Every recommendation that follows is sound on its own merits and has been successfully implemented in one or more states.

SERVICE SUFFICIENCY AND PROVIDER CAPACITY

1. **Create an action plan for increasing the availability of home health, adult medical day care, and assisted living services in West Virginia through a review of the existing CON program and Medicaid payment rates.**

To meet West Virginians' long term care needs, the availability of home health, adult medical day care, and assisted living services must be increased with sensitivity to geographic distribution. This is the case from both private pay and Medicaid perspectives. With limited options, West Virginia residents do not have access to services that would allow them to continue to live in their own homes as long as possible and give them a range of residential options when the need arises. The availability of a broad array of quality services is also fundamental to state "rebalancing" efforts. The need for this breadth of services is more important than ever in order to meet the needs of the state's aging population.

This effort must include a review of the existing CON program. The review should examine the current process, scope, and language of West Virginia's CON program and adjust it to ensure it supports service flexibility and the sufficient availability of services across the state.

Medicaid payment rates must be examined since they do influence the availability of certain types of services. If Medicaid rates are not sufficient to cover the cost of services, the service will

not be made available unless there is sufficient demand from people paying privately to "subsidize" the loss from Medicaid clients. This is particularly important in West Virginia where a significant number of residents qualify for services through the Medicaid program

Adult Day Care is a service that is paid at a low rate by the Medicaid program. BMS began reporting Adult Day Care services on the FY 2004 CMS-372 report for the AD Waiver. As evidenced in the CMS-372 report data, Adult Day Care is rarely provided in West Virginia.

Assisted living s a very important residential option that is currently not covered by the West Virginia Medicaid program. In other states, assisted living plays an important role in allowing people to live more independently in a less expensive living arrangement. This is an option that should be made more readily available.

2. Expand the AD Waiver to provide a wider variety of services to more individuals and continue to support the self-directed option under the waiver.

West Virginia is a state with one of the highest populations of individuals aged 65 and older and also one of the poorest states in the country. As a result, many residents do and will rely on the state's Medicaid program. Therefore, it is important that Medicaid services be comprehensive and inclusive in order to meet the needs of West Virginia citizens.

While many of the state's residents needs are being addressed currently, there is room for improvement. A number of stakeholders during the course of this study pointed out that some services that would help people continue to live at home longer and help reduce the cost of services over the long run are simply not available. Additionally, the AD Waiver has a high medical threshold for eligibility as compared to other states and results in people in need not being eligible for services.

In order to improve the current AD Waiver and better meet the needs of the state's aging and disabled Medicaid-eligible populations, BMS and BoSS should work together in order to: (1) review the current waiver requirements and regulations; (2) assess the variety of services provided under the waiver; (3) study consumer satisfaction with the waiver program and its services; and (4) review how other states have implemented their AD Waivers to identify additional opportunities to use the WV AD waiver to appropriately support people who prefer to live in the community as opposed to a NF. In this effort, they should consider:

- Adding waiver slots for individuals who would become eligible with a lower medical eligibility threshold in place;
- Expanding transportation services;
- Adding respite services;
- Expanding adult medical day care;
- Adding transition assistance;
- Adding assisted living; and

- Increasing the availability and frequency of service delivery to reflect a realistic alternative to NF services.

The self-directed Personal Options component of the AD Waiver has been very successful as the result of BoSS' and BMS' efforts. Further expansion of this program will improve consumer and family satisfaction with the AD Waiver by enhancing the program's flexibility and people's competency in managing their needs in the most integrated and least expensive environment possible.

3. Replace ICFs-MR with Waiver Homes and Apply for two new Medicaid waivers to incorporate into the West Virginia long term care system: a Traumatic Brain Injury waiver and an MR/DD Supports waiver.

West Virginia's ICFs/MR are an outdated model of service delivery that has been abandoned in many states. While ICFs/MR may be appropriate for a few older individuals with developmental disabilities who have significant medical needs, most ICFs/MR should be replaced by waiver homes. This would result in the delivery of more appropriate and higher quality services for less cost and would provide individuals with a more desirable lifestyle. In addition, there is an opportunity to save significant sums of money that could be used to extend services to individuals in need of supports by restructuring the existing MR/DD Waiver.

The structure of the current MR/DD Waiver provides up to 24 hour supports and a comprehensive package of services for those who qualify for this waiver, while individuals who do not qualify for this comprehensive waiver receive significantly less or no services. With limited and fragmented non-waiver HCBS, many individuals rely on West Virginia's waiver program and many other Medicaid-eligible individuals who desire and need waiver services remain un-served or under-served.

To address this situation, it is recommended that West Virginia pursue the addition of two new CMS waivers: a Traumatic Brain Injury (TBI) Waiver and a Supports Waiver.

It is important to note that we recommend adding these new waivers instead of expanding state plan services. In doing so, we have considered the impact of the federal Deficit Reduction Act of 2005. According to the Kaiser Family Foundation, the DRA will produce "net reductions of $4.8 billion over the next five years and $26.1 billion over the next ten years from Medicaid, the program that partners with states to provide health coverage and long term care assistance to over 39 million people in low-income families and 12 million elderly and disabled people, to fill in gaps in Medicare coverage, and to support safety-net providers. Many of the policy changes in the DRA would shift costs to beneficiaries and have the effect of limiting health care coverage and access to services for low income beneficiaries.[108]"

[108] "Deficit Reduction Act of 2005: Implications for Medicaid." www.kff.org/medicaid/upload/7465.pdf. Accessed 6-5-07.

Kaiser and several other organizations have openly stated that the impacts of activities initiated by the DRA will result in a decrease in the number of services and supports that Medicaid-eligible individuals will be able to receive. One of these activities is the ability under the DRA that the states now have to offer HCBS as an optional Medicaid benefit instead of requiring a waiver. This also allows states to cap the number of people eligible for HCBS. PCG believes that moving West Virginia's current network of HCBS from under the two current waivers to the Medicaid state plan is a change that will cause individuals to receive fewer services, when these individuals already face a large service needs gap. In order to better begin to address this needs gap, West Virginia critically needs to pursue the addition of a TBI Waiver and Supports Waiver to its current network of LTC services.

Traumatic Brain Injury (TBI) Waiver

West Virginia is not addressing the LTC needs of those individuals with traumatic or acquired brain injury (TBI/ABI) in the current system. The addition of a TBI/ABI Waiver is important in improving the service gaps in the system.

More than half of the country's 50 states have applied for and successfully implemented TBI/ABI waiver programs through a Medicaid waiver from CMS.

In Kansas, the HCBS Waiver for Individuals with a Traumatic Brain Injury serves individuals age 16 through 65 who have residual deficits and disabilities resulting from a traumatic brain injury acquired as a result of external head trauma, and who meet criteria for inpatient care in a head injury rehabilitation hospital. The overall goal of the TBI waiver, the first of its kind in the country, is to provide rehabilitation for those with a traumatic brain injury and to assist individuals in reaching their highest level of independence.

Kansas has structured its TBI waiver a bit differently than its other HCBS waivers, building upon the fact that TBI waiver services should be more short term and rehabilitative in nature. Individuals are monitored for progress in independent living skills and in reaching his or her highest level of independence. If an individual is on the TBI waiver for four years, his or her progress is reviewed by a committee, which makes a recommendation for continued TBI waiver services or for a transition off of the waiver. When an individual transitions off of the TBI waiver, he or she may receive services through a different CMS waiver program in Kansas or may need no services at all and return to work.

This waiver is also unique because case management services are provided through Centers for Independent Living and Home Health Agencies in Kansas and a self-directed option has been incorporated into it by law. Kansas's TBI waiver is currently serving 174 individuals, has no waiting list, and has an average monthly service cost of $3,127 or $37,524 per year.[109]

[109] "Special Committee on Medicaid Reform: HCBS Waivers, ICFs/MR, and NFs for Mental Health." October 3, 2005. www.srskansas.org. Accessed 6-5-07.

In Vermont, individuals with moderate to severe TBI are diverted from hospitals and facilities to community-based settings or return to community-based settings following a stay in a hospital or institution. This rehabilitation-based, choice-driven program is intended to support individuals to achieve their optimum independence and help them return to work. Emphasis is placed on utilizing a "Team Approach" of professionals experienced in brain injury, and practicing daily skills and routines based on the physical, cognitive, emotional and social needs of the individual through a holistic approach.

Prior to the development of this waiver, individuals were placed in expensive out-of-state facilities and often resided there for years, with little hope of returning to their home communities. The waiver and initial pilot program has demonstrated that individuals with a moderate to severe traumatic brain injury can be appropriately served in community placements.

Vermont's Traumatic Brain Injury Program offers the following services: case management, rehabilitation services, community supports, environmental and assistive technology, crisis support, respite, employment supports, and ongoing long term services for those individuals with special needs. Vermont also has a TBI Advisory Board, consisting of 20-25 members including consumers, family members, providers, advocates, and state agency representatives as well as a TBI Steering Committee acting as the working group of the Advisory Board.

The state's 2002 Annual Report on the TBI Waiver stated that the program saves Vermont $2,000,000 each year, as the average cost per person utilizing the Vermont TBI Waiver is $5,000 per month versus an out-of-state cost of $12,000 per person per month. The Annual Report was also proud to announce the success of the 13th Annual TBI Conference, which was well-attended by over 380 consumers, caregivers, and professionals.[110]

Services provided under New York's HCBS Waiver for Individuals with TBI began in 1995. Under this waiver, Medicaid funding is used to provide supports and services to assist individuals with a traumatic brain injury to move toward successful inclusion in the community. TBI waiver participants may come from a NF or choose to participate in the waiver to prevent institutionalization.

The waiver's philosophy centers around the participant's right to choose where to live, who to live and socialize with, and what goals and activities to pursue. Waiver services are based on the participant's unique strengths, needs, choices and goals. The individual is the primary decision-maker and works in cooperation with providers to develop a plan for services. This process leads to personal empowerment, increased independence, greater community inclusion, self-reliance and meaningful and productive activities.

Regional Resource Development Centers (RRDCs) across the state serve as the initial point of contact for accessing TBI waiver services and assisting individuals in determining their

[110] "Traumatic Brain Injury (TBI) Program." http://ddas.vermont.gov/ddas-programs/programs-tbi-default-page. Accessed 6-5-07.

eligibility for the waiver. Eligibility criteria include: 1) being a Medicaid recipient; 2) having a diagnosis of traumatic brain injury (TBI) or experiencing deficits similar to a TBI; 3) being between the ages of 18 and 64 upon application to the waiver; 4) having a documented need for NF level of care as a direct result of the TBI; 5) electing to participate in the waiver rather than reside in a NF by signing the Freedom of Choice form, Application for Participation form and Service Coordination Selection form; 6) identifying a residence in which to receive waiver services; and, 7) completing an Initial Service Plan and Application Packet in cooperation with a Service Coordinator and approved by the RRDS; and 8) completing a Plan for Protective Oversight (PPO).[111]

MR/DD Supports Waiver

Many states, including Virginia, Pennsylvania and Indiana currently utilize MR/DD supports waivers in addition to their comprehensive MR/DD Waivers. A supports waiver in West Virginia would allow the LTC system to serve more individuals with identified MR/DD needs who do not need the full gamut of services offered under the comprehensive MR/DD Waiver but still need some waiver services. This new MR/DD supports waiver would support individuals in their home or community and would assure that their needs for health, safety and well-being are fully met. As mentioned above, a supports waiver may be appropriate for those individuals currently enrolled in the comprehensive waiver but who could 'step down' to the supports waiver. Enrollment in any waiver only occurs after an objective assessment of need, after the individual chooses to participate in the HCBS waiver and after there is an assurance by the state that the person's health and safety needs will be met. As always the individual has appeal rights.

Developing a supports waiver will require DHHR with assistance from BHHF to make several key decisions, including: identifying the target population for whom the supports waiver and objective assessment process will be used; the types of services and supports to be provided under the supports waiver; identifying the number of individuals waiting for waiver services who could have their needs appropriately met through a supports waiver; and determining the number of individuals on the comprehensive waiver who may be able to have their needs met more appropriately through a transition to the supports waiver.

Several positive outcomes and implications could result from the addition of a MR/DD supports waiver:

- It could provide individuals with the opportunity to transition from larger congregate care settings to smaller, more individualized service settings;
- It could better meet the needs of individuals with MR/DD who seek community-based services through the waiver program; and

[111] "Home and Community-based Services: Medicaid Waiver for Individuals with Traumatic Brain Injury, Program Manual." NY DOH, June 2006. www.health.state.ny.us/health_care/medicaid/reference/tbi/docs/tbiprovidermanual.pdf. Accessed 6-11-07.

- It could give the state the opportunity to add self-direction of services to individuals with MR/DD allowing them more flexibility in service and provider options.

4. Boost the existing ACT program and expand telemedicine services.

Assertive Community Treatment (ACT) is an evidence-based approach to service provision that includes highly individualized services provided directly to consumers. ACT teams are comprised of multidisciplinary, round-the-clock staff that can provide behavioral intervention services within an individual's own home and community. ACT teams typically include staff trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. ACT teams are available where and when needed. The use of ACT teams in many states has helped to divert consumers from institutional care settings.

West Virginia currently has two ACT programs in place. However, WV Advocates stated that more ACT programs are needed in order to adequately meet the demand for services, and that the defined areas currently covered by the two current ACT programs need to be expanded.

Factors affecting the availability of the ACT program are upfront costs of developing the service, the rate of payment for services and the fact that reimbursement does not reflect the added cost of providing the service in rural areas. The current rate of payment of $23 per day is not sufficient to cover the cost of delivering the service, including the costs involved in developing the service. Also, in the event rates are adjusted, the added cost of providing services in rural areas needs to be taken into account.

In order to ensure that West Virginians have uniform access to ACT services as an alternative to institutional care, we recommend that:

- BHHF establish a minimum of one ACT program in each DHHR service region.
- BHHF develop six new ACT programs, each of which is assigned to a DHHR service region. The two existing ACT programs should be realigned so that each one serves its own distinct DHHR region.

BHHF should review the staffing of the ACT programs on an annual basis to ensure that the staff-to-consumer ratio is clinically appropriate. If the ratio is found to be inadequate, necessary adjustments should be made.

ACT programs that follow the fidelity model standards should include a minimum of 10 to 12 full time equivalent (FTE) clinical staff persons, one program assistant, and at least 20 hours of psychiatrist time per week for 60 clients and 26 hours for 80 clients. At least 60% of the total non-MD, direct care staff (including the team leader) shall be mental health professionals with degrees in one of the core mental health disciplines with clinical training that includes internships and other supervised practical experiences in a clinic or rehabilitation setting, and clinical work experience with persons with serious mental illness. If WV is to adhere to these standards, the expected program cost would be approximately $800,000.

Expanded use of telemedicine would enhance the ACT programs in West Virginia's long term care system. West Virginia has limited, but positive, experience with telemedicine.

Telemedicine should accompany each ACT program in the DHHR regions in order to provide ACT team staff and consumers with technology that allows for quick communication and delivery of clinical care. Telemedicine allows care to be provided across distances, which is a beneficial approach given WV's mountainous and rural geography and lack of access to services in many parts of the state.

Currently, physician consultations via interactive video teleconferencing are the only telemedicine services recognized by BMS. These telemedicine consultations are reimbursed under a fee-for-service methodology, in the same manner as a conventional, face-to-face consultation, with the slight difference that both the "hub" and "spoke" sites are reimbursed for the telemedicine services. The reimbursement methodology for telemedicine uses consultative Current Procedural Terminology codes with a "TV" modifier and is limited to physician consultations.

The Charleston Area Medical Center (CAMC) Center for Telehealth is a collaborative effort between CAMC and West Virginia University. CAMC and WVU serve as the main service centers for an interactive video network in the state. The network includes 19 rural sites made up of hospitals, community health centers and Veterans Administration Hospitals. This network allows for patients in rural areas to receive inpatient and outpatient clinic-style consultations in dermatology, neurology, ENT, rheumatology, and hematology from physicians at CAMC or WVU.[112] The CAMC Center for Telehealth is also currently part of demonstration projects looking at telemedicine use in both adult and juvenile correctional facilities.

As states look to expand telemedicine, one of the main issues to consider is that of licensure. States must decide if only those physicians licensed in the state are allowed to provide telemedicine services or if licensed physicians from outside the state can furnish the services. This determination takes on greater importance for reimbursement purposes. Most states, including Texas and Michigan only recognize telemedicine services furnished by physicians licensed in the state. Conversely, Minnesota allows for out-of-state providers to furnish telemedicine services but will only reimburse the provider if they have a Minnesota license.[113]

WV would likely fund telemedicine through the Medicaid program. As such, BMS should consider expanding the types of services eligible for reimbursement and look to increase the reimbursement rate for telemedicine. Because WV is a rural state with limited access to services in some geographic areas, telemedicine could make community-based care more effective and efficient for certain populations.

The use of ACT programs in conjunction with telemedicine would provide West Virginia with a two-pronged approach for delivering clinically–appropriate, timely care across the state. Such an approach would allow consumers to receive long term care services in the community and

[112] http://www.camcinstitute.org/telehealth/consultation.htm
[113] http://www.ichp.ufl.edu/documents/Telemedicine%20in%20Medicaid%20and%20Title%20V%20Report.pdf

would provide the state with a cost-effective option for reaching out to the rural parts of the state.

5. Continue and expand options for self-direction and individualized budgeting into statewide LTC programs and services.

As discussed earlier, West Virginia's current long term care system has made significant progress in promoting self-direction of long term services. Most recently the Personal Options program within the AD Waiver was initiated with an excellent response. At the same time, there are opportunities to continue to pursue more options for individuals to utilize flexible approaches to service delivery within the AD Waiver, the MR/DD Waiver and the State Medicaid Plan. Examples include participant self-direction and individualized budgeting, both of which give consumers more control and responsibility over the services that meet their long term care needs. These options, it is important to note, have the full support and encouragement of CMS and other federal agencies such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and allow the consumer increasing flexibility in areas such as who, what, when, where, and how services are provided. Also, these programs ensure that individuals receive the services they actually need, not just given what is available. This capability can, in fact, realize cost efficiencies for the state.

We understand that the use of individualized budgets and self-direction initiatives require adequate safeguards and quality measures while they address issues such as lack of choice, provider shortages, and flexibility. However, there are many states in the country that have very successfully implemented statewide, large-scale individualized budgeting and self-direction programs, including Oregon and New York. Therefore, as West Virginia develops its own statewide program for increased consumer flexibility and choice, it can look to the lessons learned by these other states, which have used these tools to effectively support people in the community.

6. Improve access to community-based services for underserved and un-served populations by expanding HCBS.

Comments made at public forums noted that there are a number of individuals in West Virginia who need special care and whose needs are not being met by currently available services. This includes:

- Individuals who are ventilator dependent;
- Individuals with Traumatic Brain Injury;
- Individuals with mental illness or mild MR or mild DD who do not meet the MR/DD Waiver requirements;
- Dually-diagnosed individuals, especially those individuals with mental illness and mental retardation (MI/MR) who do not receive adequate in-home services;
- Children and adults with autism;
- Individuals with Alzheimer's Disease and related conditions;

- Individuals who are not waiver eligible and cannot afford private-pay services and supports.

With the state's population getting older and more intensive health needs becoming prevalent, it is critical that West Virginia meet the needs of those who must have access to special care. Stakeholders noted that the gap in meeting the needs of individuals using a ventilator as especially important for the state to address.

We recommend that the state expand services available through the HCBS waiver to meet unmet special care needs. We also recommend a comprehensive inventory of the 46 existing special care beds, with the assistance of OHFLAC representatives, in order to determine the geographic locations that have the highest need for special care services.

EQUAL ACCESS TO INSTITUTIONAL AND COMMUNITY SERVICES

7. Expand the Transition Navigator Program.

The purpose of this program is to assist West Virginia citizens with disabilities and seniors who reside in nursing facilities to live and be supported in their communities. Currently, two full time Transition Navigators, employed by community agencies, provide coverage for 22 of the 55 counties.

Transition Navigators assist participants in "navigating" the long term care system to establish necessary community-based supports. The average time to transition an individual from a nursing facility to a community-based setting is six (6) months. Transition Navigators target people that need more assistance than the current system can support. The number of Transition Navigators should be increased by three in order to provide coverage to the 33 counties currently not served by this program.

Each participant of the Transition Navigator Program is eligible to receive up to $2,500 to pay for reasonable and appropriate start-up costs to support their transition from an institutional setting. These costs are one-time in nature and are not intended to support on-going needs of the participant. One-time costs can include: security deposit for housing and utilities, moving expenses, home furnishings, home accessibility modifications, and assistive technology equipment and/or devices. Funding should be provided to increase the number of people from 50 to 125 who will be able to receive assistance with start-up funding.

8. Continue to Develop a Single Point of Entry system through the ADRCs with other community services for improved information accessibility and a streamlined eligibility and assessment process.

The ADRC grant program, a cooperative effort of the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS), was developed a few years ago to assist states in their efforts to create a single, coordinated system of information and access for individuals seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. The target populations of the effort are seniors who are 60+ and adults with

physical disabilities who are 18+. The goal of the ADRC initiative is to support states as they develop "one-stop shop" programs at the community level, which serve as the entry point into the long term care system. Since 2003, 43 states including West Virginia have received ADRC initiative grants and have used ADRC funds to better coordinate and/or redesign their existing systems of LTC information, assistance and access through strong state and local partnerships. In West Virginia, ADRC grant funding was used initially to set up 2 ADRCs in the state, one in Wheeling and one in Fairmont.[114] The state legislature provided $1 million in additional funding to develop two additional ADRCs and to expand coverage by the ARDC to be statewide.

The Lewin Group released a report on the initial outcomes of the federal ADRC grant program in November 2006 that found the ADRCs had established themselves as visible, trusted places in the community and had served a large numbers of individuals to find information about and access into the LTC system. The report also noted that "ADRCs built and enhanced the information technology infrastructure for information, referral, assistance, and eligibility" and that state grantees had made "significant progress in streamlining access to services."

The ADRC program is a collaborative effort mobilizing both public and private sector resources. It provides states with opportunities to effectively provide resources for providers and consumers in a single coordinated serviced delivery system consistent with the goals of long term care rebalancing initiatives taking place at all levels. In addition to their role as change agents in producing enduring systems change, the initial experience of the initiative also shows that ADRCs provide the community and state levels capable of playing a critical role in implementing national programs, such as Medicare Part D, and assisting consumers in times of crises, such as responding to the devastation of Hurricanes Katrina and Rita."[115]

Because of the beneficial impacts and outcomes of the ADRC single point of entry model, West Virginia should continue its efforts in using this model as a foundational structure for the long term care system. ADRCs or ADRC-like entities distributed throughout the state, expanding on the two that currently exist, would assist elderly West Virginians and residents with physical disabilities to enter and navigate the system smoothly, with full information on the choices and options available to them for receiving LTC services and supports. Additionally, if these ADRCs or ADRC-like entities could be co-located with the entry point into or information source for other community, health, and human services, the concept of a "one-stop-shop" or single point of entry would be promoted to an even greater extent and would allow West Virginians to easily access a range of needed and desired health and support services through one visit to one physical location, website, phone number, or other accessible means.

There is some concern that the ARDCs may be more successful in serving seniors than individuals with disabilities and children. This should be monitored. While it is desirable that

---

[114] "Aging and Disability Resource Centers." http://aoa.gov /prof/aging_dis/aging_dis.asp. Accessed 6-12-07.
[115] "ADRC Demonstration Grant Initiative: Interim Outcomes Report." The Lewin Group. Nov, 2006.

ADRCs successfully serve all whom seek long term care services, it is equally important that individuals with disabilities have improved access to service opportunities and eligibility information.

9. **Change the current assessment process for long term care consumers to: a) ensure providers are not completing individuals' assessments (remove the apparent conflict of interest); b) ensure that options / benefits counseling is occurring at the time of potential facility admission; and c) utilize a presumptive eligibility process or fast track initiative.**

Our evaluation and analysis of the assessment tools and methods utilized in West Virginia's current long term care system revealed the following obstacles to the delivery of progressive, strengths-based assessments that are focused on diverting and transitioning individuals from institutional to community-based settings.

- Providers of LTC services and supports often complete individual's assessment forms, which creates a potential conflict of interest in delivering an assessment process that includes full disclosure of the range of service options and providers available to the individual.
- Assessments completed in the state's nursing facilities often do not include participation by the resident, the resident's family, or the resident's significant other.
- The Pre-Admission Screening/PAS 2000 (6-page assessment document) focuses on the individual's medical needs and does not properly evaluate the availability or desire for community-based services and supports.
- Options and benefits counseling is not available for every individual at the time of potential facility admission.
- West Virginia does not practice presumptive eligibility, which increases the time it takes for individuals to begin receiving services and supports.

These are barriers to improve long term care assessment tools and processes that the State of West Virginia can and should address. In order to address these barriers:

- Providers, including providers of NF services, should cease their participation in the assessment processes. It is critical that an individual's need assessment for LTC services is completed by an independent, third party representative who can discuss all available service options and area service providers with the individual, so that the individual can make a choice as to the most appropriate and desired service setting and provider.
- The Pre-Admission Screening PAS 2000 tool needs to be reviewed and redesigned in order to focus less on the individual's medical needs and more upon his/her social and support needs. Additionally, the form needs to better describe the transition and diversion efforts that could assist the individual being evaluated by the tool.
- The LTC assessment processes, PAS-2000, could be improved by including options/benefits counseling at the time of each individual assessment. Options/benefits counseling is currently available in many states to inform individuals and family

members who apply for NF admission about the community services that are available to help them remain at home. As such, this service could be particularly helpful in West Virginia's LTC system to ensure that individuals who are better served in the community as opposed to a facility know and understand their options for staying at home or in their home community.

- Lastly, West Virginia needs to include a presumptive eligibility process or fast tracking initiative within its long term care system. Presumptive eligibility allows eligibility workers, case managers, nurses, or social workers who are responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible, based on decided criteria, and to initiate services before the official Medicaid eligibility determination has been made by Medicaid staff. Fast track initiatives, such as HCBS and NF service eligibility staff requesting sufficient documentation of income, bank accounts, and other assets to allow for financial eligibility to be evaluated, accelerate the eligibility process and address the factors that are most likely to cause delays.

Incorporating presumptive eligibility or fast tracking is important to the LTC system, as delays in determining Medicaid eligibility often affect an individual's decision about where services may be available. Additionally, without these initiatives incorporated fully into the LTC system, institutional bias is perpetuated because NFs are more willing to admit individuals while their Medicaid application is pending than community-based supports. This occurs because NFs are more capable of measuring an individual's income and resources and judging whether they will become a Medicaid beneficiary or remain private pay. Additionally, NFs can mitigate the risk of not being paid for services delivered, as they can charge for services rendered to residents who are found ineligible.

Incorporating presumptive eligibility or fast tracking into the LTC system would require state funds to pay for services in the few instances in which the applicant is found ineligible since FFP is not available for services delivered if the applicant is not eligible for Medicaid. However, many other states have incorporated presumptive eligibility and fast tracking into their health and human services system with limited risk and in fact have even realized savings by serving more people in community versus institutional settings. For instance, officials in the State of Washington have determined that clients presumed eligible save Medicaid an average of $1,964 per person per month by authorizing community services for people who would have entered an institution if services were delayed.

Presumptive eligibility and/or fast tracking have proven to be important components to an improved long term care system in other states and would significantly benefit the assessment, eligibility and service delivery aspects of West Virginia's LTC system.

10. Modify the Nurse Practice Act.

West Virginia's nurse practice policies do not adequately respond to consumer demand for community-based supports, even when that care involves assistance with health maintenance tasks.

To remedy this, DHHR should engage the nursing community in removing barriers to consumer direction and home and community-based care of persons with disabilities. While there are specific changes to statutes and regulations that could help with this situation, the most difficult barrier is a lack of understanding. Most boards of nursing are comprised of nurse educators and nurses in acute care settings, and their experience in home care is usually post-acute care, not long term care or long term services and supports. These practitioners are unfamiliar with the independent living movement and worry about patient safety and are not attuned to consumer choice, dignity of risk, or health maintenance that includes bladder catheters or tube feedings, and the like.

Given this context, West Virginia is like many states. However, several states have made substantial progress and West Virginia can do the same. States that have made changes in the last decade have taken idiosyncratic approaches to this issue. There is no one way to proceed. For example, there is disagreement about how useful it is to have broad language versus more specific guidance on delegation. On the one hand, broad language permits the greatest discretion for the nurse in delegating tasks, and allows the nurse to use judgment in determining the ability of the UAP to perform tasks like wound care or the administration of medications. On the macro level, this kind of policy framework permits consumer direction of services with nurses included as consultants to consumers and their attendants. On the other hand, the absence of detailed requirements or guidance for delegation leaves room for varied interpretations. Program administrators and nurses themselves often seek more detail to protect themselves from charges of "violating the nurse practice act." In the absence of detailed language, they frequently call their state BON for "permission" to delegate specific tasks in specific circumstances.

West Virginia has taken the broad approach option. However, we are concerned about several provisions and believe they should be altered:

- Registered nurses are allowed to teach activities to family members who have the willingness and ability to perform them, but "must not delegate professional functions to caregivers not qualified as professional nurses."
- Are health maintenance activities like tube feedings, bladder catheters, and medication administration (to name a few) considered "professional functions"?

We recommended that the guidelines (or statutory exemption) make it clear that nurses can delegate these care tasks, or that they be exempt from the NPA.

Other state examples could help West Virginia develop its own approach:

- Nebraska takes a sophisticated approach by exempting "health maintenance activities" by a designated care aide for a competent adult, "at the direction" of such adult or at the direction of a caretaker for a minor child or incompetent adult. Arkansas adopted similar language in 2005.
- Kansas' statute offers a laundry list of tasks enumerated in another section of state public health law (65-6201) that defines "health maintenance activities" including, but not limited to, medication administration, wound care, catheter irrigation, and enemas—and requires the opinion of a physician or nurse to determine if such activities can be performed safely.
- North Carolina exempts caretakers who provide personal care to individuals whose health care needs are "incidental to the personal care required," a definition that many people with chronic health maintenance needs would embrace.
- New York exempts persons under the instruction of a patient, family, or household member determined by the nurse to be self-directing and capable of providing such instruction. In practice, nurses are involved early in the situation to confirm that consumers are knowledgeable about their self-care needs (including complex procedures), are proficient in the processes involved, and capable of instructing and supervising unlicensed personal assistants in performing specific tasks. The nurse is viewed as a consultant to the consumer and is not delegating to the assistant.
- Montana details a statutory exemption for personal assistants performing health maintenance activities that include urinary systems management, bowel treatments, administration, and wound care—if that person is acting on the direction of a person with a disability and the physician or other health professional determines the procedure could be safely performed in the home.
- Illinois and Ohio exempt attendants in private homes.
- Maine's unusual statutory language defines nursing in part as "teaching ADLs to care providers designated by the patient and family."
- Alaska allows broad discretion caring for persons with "routine, repetitive needs" and provides examples that are consistent with the needs of persons who seek consumer-directed care (urinary catheterizations, suctioning, and gastrostomy tube feedings).

Specific consumer-directed care exemptions are also found in Connecticut, Florida, New Mexico, South Dakota, Texas, and Vermont.

West Virginia's "Guidelines for Assigning Tasks to Unlicensed Personnel" includes a statement that should be removed, or at least qualified, in order to state that this regulation does not apply to consumer-directed care in HCBS settings. If West Virginia intends to pursue consumer-directed care, its BON cannot stipulate that UAP should be assigned to nurses and not directly to consumers.

There is a need and a place for competent, appropriately supervised, unlicensed assistive personnel in the delivery of affordable, quality health care. However, it must be remembered

that unlicensed assistive personnel are to assist - not replace - the nurse. Thus, unlicensed assistive personnel should be assigned to the nurse to assist with patient care rather than be independently assigned to the patients.[116]

West Virginia should adopt more progressive liability provisions to reduce barriers to delegation and nurse consultation in consumer direction. A few states (HI, ND, OR, WA) offer some tried and tested language that addresses liability with more specific language but without holding the nurse legally responsible for all actions of the delegate. These states hold the nurse accountable for following the guidelines related to the process of delegation .[117]

- Oregon's statute states that a delegating nurse "shall not be subject to an action for civil damages for the performance of a person to whom nursing care is delegated unless the person is acting pursuant to specific instructions from the nurse or the nurse fails to leave instructions when the nurse should have done so."
- Washington's statute stipulates "nurses acting within the protocols of their delegation authority are immune from liability for any action performed in the course of their delegation duties." The regulations hold the nurse and the assistant accountable for their own individual actions.
- Hawaii states "the nurse shall be accountable for the adequacy of nursing care to the client, provided the UAP performed the special task as instructed and directed by the delegating nurse."
- North Dakota holds the nurse accountable for individual delegation decisions and the evaluation of the outcomes, not the outcomes themselves.

Even in states that have made substantial progress in resolving the issue of nursing regulation and consumer-directed care, there is a need to educate nurses, consumers, and policymakers. Continuing education courses for practicing nurses are needed and curriculum development for undergraduate and graduate nursing programs is another need, with clinical experiences designed for students to work with consumers in a more consultative framework. New Jersey has recognized this issue and is currently developing "orientation" programs for nurses, aides and their employers in home settings to help them understand the state's policies about delegation and consumer direction.

Members of boards of nursing are sincerely interested in performing their duties. If they can see people with disabilities who are managing complex health maintenance tasks in community settings with personal care attendants, they begin to understand how different these issues are from acute care. It helps to hear from boards of nursing in states that have wrestled with these issues, developed polices to advance more flexible, cost-effective services, and found no problems in doing so. However, if resistance to consumer direction is strong, it is possible to

---

[116] Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as "The Purple Book" or PB).
[117] Another term is "direct liability" for the process only.

use the "domestic servant" provision to support consumer-directed care if the consumer hires an attendant to provide personal care that includes health maintenance tasks. That option could be explored. In addition, states can also create policy through laws other than the NPA and its implementing regulations, memoranda or agreements, and attorney general decisions.

11. Modify current policies and practices that reinforce institutional bias.

As discussed earlier in this report, stakeholders indicated that institutional bias exists in the West Virginia LTC system. Our analysis also indicates that there is a certain level of institutional bias. In order to have a long term care system in place that effectively and efficiently meets the needs of West Virginia consumers, there must be an emphasis on and investment in community-based services that appropriately meet the needs of individuals who would not choose or require institutional services. Based on interviews with numerous stakeholders, a review of the current system, and our experiences in other states, the following steps should be considered in order to continue the reduction of institutional bias:

- Review all eligibility determination processes to ensure that there is no institutional bias inherent in the evaluation and eligibility determination process. The state should make sure that consumers are not being inappropriately screened into institutions when their needs could be better met in a community setting. Also, the state should review referral policies and procedures used by the state and other long term care providers to make sure that consideration is given to the appropriateness of community-based services in lieu of institutional services.
- Review the current waiver eligibility determination process and monitor the percentage of individuals being denied AD and MR/DD Waiver services. The state should determine why such as higher percentage of requests for NF services are approved while a substantially lower number of waiver requests are approved. If needed and where necessary, the state should consider amending the current State Plan to make community-based services easier to obtain for eligible individuals.
- In conjunction with the Office of the Ombudsman, DHHR should establish benchmarks over the next 5 years to reduce the reliance on institutional levels of care and increase the placement of individuals in community-based services. These benchmarks may need to include a plan to increase incentives for providers, increase in the level of capacity, and the development of new service setting options that currently do not exist but could improve long term care provision for West Virginians.
- Establish a payment system that provides incentives for providers to increase and expand community-based services provision. The state should review the rates paid to long term care providers and determine what level of payment would facilitate expanded provision on services in the community. Furthermore, the state should review service settings paid for with public funds to ensure that public insurance consumers have access to community-based settings such as assisted living that otherwise are only accessible to private-pay or self-pay consumers.

12. Review the medical records of and discuss HCBS options with current LTC facility residents to identify those more appropriately served in / ready for transitioning to the community.

Recommendation #8 of this report suggests the utilization of a new assessment tool because the PAS 2000 tool currently used by the LTC system simply does not collect enough information about the desire or readiness of individuals to transition from facility-based care into HCBS. Accordingly, for those individuals who are currently residing in LTC facilities and had an assessment process completed that applied the PAS 2000 tool, efforts need to be made to identify those residents who want to and could successfully transition back home or to a community-based setting.

We recommend that providers, advocates, and state agency staff undertake outreach, education, and identification efforts such as the following to ensure those individuals who ought to or would like to transition back into the community or their own home have the chance to do so:

- Organize group discussions in the facilities about the availability of community-based options;
- Have one-on-one conversations with residents about their living setting of choice;
- Review facility-based residents' medical records to identify individuals who could be more appropriately served in their own home or in a community-based setting; and
- Have discussions with residents' family members about the individual's support options.

Additionally, programs and projects within the state that have the expressed intent of transitioning individuals from facility-based to community-based services and supports when appropriate, like the new "Transition Initiative", should be championed by the providers, advocates, consumers and state agency staff of the LTC system. These efforts should emphasize state agency collaboration, consumer choice in living and service delivery arrangement, and family participation in decision-making. These programs should also be expanded for statewide coverage.

However, for any of these transition efforts and complementary diversion efforts to be successful, the State of West Virginia and DHHR must make the enhancement and expansion of LTC HCBS a top priority amongst the state's health policy needs and issues to be resolved. Without this commitment from the State and in particular DHHR to boost the HCBS resources of the state, the West Virginia long term care system will continue to inappropriately serve individuals in facility-based settings when they could be more appropriately and more cost effectively served at home or in community-based settings, with better outcomes and a higher level of satisfaction.

FINANCING OF PROGRAMS AND SERVICES THAT FOLLOWS PEOPLE INTO THE COMMUNITY

13. Expand the amount of funding resources set aside for assisted living services so that Medicaid and Medicare recipients can access assisted living more equitably.

Assisted living services are not currently funded by the Medicaid program in West Virginia. Assisted Living services can provide a more economical alternative for Medicaid patients than costly NF care, if delivered with other AD Waiver services. PCG recommends that BMS consider covering the service as you move forward with transition initiatives. The West Virginia Assisted Living Association provided a quote of approximately $2,500 per month as the cost of this care. The annual cost for an individual in an assisted living setting would be approximately $30,000. PCG has built these figures into financial models of Section V of the report.

14. Expand the variety of services and the number of recipients utilizing Personal Care Services by allocating more state-only dollars toward these services.

Personal care services are currently covered by BMS as an optional State Plan service and homemaker services are available under the AD Waiver. These services are performed by direct care staff who must have basic training to provide support with eating, bathing, grooming, dressing, ambulation, transporting and other activity of daily living functions before rendering care or unsupervised service to an eligible member. The current cost to Medicaid (per recipient) is close to $6,000 per year. BoSS and BMS should look to cover personal care and homemaker services for those individuals who do not meet the Medicaid qualifying requirements but meet service need requirements. The Lighthouse Program initiated in 2007 may address this need.

15. Continue to apply for Federal Grants to increase funding for LTC services and supports.

DHHR has been successful in the past in applying for and receiving federal grant funds made available from agencies such as the AoA and CMS. Grants have been received through the Real Choices Systems Change Grant Program and Medicaid Transformation Grant Program. Most recently a NF Diversion Modernization Grant was received. These grants may be helpful as the state continues to refine its LTC programs and services. DHHR should continue its efforts to take advantage of federal grant opportunities.

QUALITY ASSURANCE AND IMPROVEMENT

16. Promote affordable and accessible housing.

Individuals in the long term care system and their families stated that affordable, appropriate, and safe housing is a real need in West Virginia. In order to build up this resource for older West Virginians and residents with disabilities, the state could embark upon any or all of the following collaborative activities:

- Launch a statewide initiative that develops a stock of more affordable, accessible housing for the elderly or individuals with disabilities. This will require a large amount of collaboration by organizations and agencies such as BoSS, DHHR, HUD, housing authorities, area developers and construction companies, etc. This collaboration could improve the way individuals identify themselves as needing housing resources when returning to or desiring to remain in the community; the way individuals acknowledge the types of housing modifications they need in order to best live their lives; and could improve the amount of information available to consumers and their family members about the types of housing and financial resources for housing that are available to them. Combining the efforts and strengths of these groups through communication and collaboration in working towards a common goal could help to provide a workable solution for the state.
- Improve upon and expand the current utilization of the HUD Section 8 housing vouchers.
- Emphasize the need for new construction and remodeling of existing structures that utilize the principles of Universal Design.
- Look into securing federal dollars for housing programs. Grant programs such as the USDA's Home Ownership Direct Loans, Home Improvement and Repair Loans and Grants, and Housing Subsidies could substantially increase the financial resources available for safe and accessible housing in the state.
- Consider expanding the HOME Program, currently offered by the WV Housing Development Fund through federal funding.
- "Exempt" the income normally paid to a NF for up to 6 months to allow residents to maintain or establish a home in the community. The exempt income could then be used to cover rent, mortgage, property taxes, insurance, and utilities.
- Cover the funds to re-establish a home in the community as a transition service under its HCBS waivers through a waiver amendment.

17. Work with the Department of Transportation to provide more affordable and accessible transportation that allows individuals to access recreational, social, medical and spiritual events.

Improving the transportation resources available for elderly West Virginians and West Virginians with disabilities, particularly in the more geographically isolated regions of the state, will dramatically increase the level of quality and consumer satisfaction achieved by the state's long term care system. Providing seniors and people with disabilities the means for increased participation in recreational, social, and spiritual events through improved transportation greatly assists in creating inclusive, supportive communities. Some of this need can be met through homemaker services under the AD Waiver which does include member transportation

without a service limit for both essential errands and activities related to the Service Care Plan and community activities.

Transportation was brought up as a source of frustration many times during our interviews with stakeholders as well as during the public forums. West Virginia can and should improve its current transportation situation by continuing to support the work of the West Virginia Transportation Coordinating Council (WVTCC), a state level council appointed by the Governor to study issues pertaining to the effective and efficient use of transportation resources in the state.[118] Support for activities and initiatives under the Council's administration of the state's federally-funded "United We Ride" grant is also critical for improving transportation in West Virginia. Implementing the recommendations from the Council's 2005 study and final report is also important. They include, among others:

- Educating public and human service transportation providers about the benefits of coordination;
- Providing technical assistance/peer-to-peer assistance to local officials for improving transportation coordination;
- Developing a statewide strategic approach to better utilize federal funds allocated for transportation programs and initiatives;
- Developing transportation coordination demonstration programs;
- Promoting and financially participating in local transportation coordination studies;
- Adopting procedures to ensure better coordination of funding decisions by State Agencies on local transportation grants;
- Formation of a working group amongst state agencies to establish uniform approaches to local transportation project reporting on service delivery; and
- Council support of the WV DOT Division of Public Transit's efforts to develop required FTA coordination plans and key local agencies' participation in the planning process.[119]

In addition, a collaborative effort between the long term care system and WV DOT should seek to secure a Capital Grant for Transportation for Elderly and People with Disabilities (Section 5310) or a Rural Transit Formula Grant (Section 5311), if not already secured. These federal grants could provide financial resources to innovative solutions to the transportation barriers elderly West Virginians and West Virginians with disabilities currently face.

18. Tackle the state's critical workforce shortage by increasing direct care workers' salaries and implementing new methods for recruitment, retention, training and credentialing.

---

[118] "West Virginia Coordination Study." www.wvdot.com/2_buses/download/WV-Coordination-Study-FinalReport.pdf, November 25, 2005. Accessed 6-4-07.

[119] Ibid.

The quality of the state's long term care system is highly dependent on the workforce that it employs, which is why the nation's current shortage of direct care workers in long term and behavioral healthcare is so critical.

This is an issue that is deeply impacting the quality of care received by consumers of West Virginia's long term care system. During our interviews and discussions with stakeholders throughout the state, we heard multiple times the system is having extreme difficulties in hiring and retaining staff because the rate of pay for direct care workers is lower than rates available at other local employers, such as gas stations, fast food restaurants and large retail stores. Stakeholders living near the state's borders next to Ohio, Maryland, and Virginia voiced particular frustration at the fact that many potential direct care employees in West Virginia are driving over the border for work because of the more appealing salaries. These stakeholder perspectives were verified upon reviewing the most recent U.S. Department of Labor statistics. Table 23 compares hourly and annual average direct care worker wages with workers in the food industry, retail employees, and gas station attendants in WV, Maine (a state with a comparable population and rural geography), Ohio and the District of Columbia.

Table 23: Comparison of Hourly and Annual Average Direct Care Wages with Other Industries

Job Title	State			
	WV	ME	OH	DC
Home Health Aide				
Avg Hourly	$7.41	$10.14	$9.39	$9.50
Avg Annual	$15,410	$21,100	$19,530	$19,770
Nursing Aide / Attendant				
Avg Hourly	$8.99	$10.63	$10.98	$12.62
Avg Annual	$18,690	$22,110	$22,840	$26,250
Psychiatric Aide				
Avg Hourly	$7.68	$13.69	$10.40	$14.24
Avg Annual	$15,790	$28,460	$21,620	$29,610
Personal and Home Care Aide				
Avg Hourly	$6.97	$10.12	$10.06	$14.79
Avg Annual	$14,490	$21,040	$20,920	$30,760
Food Preparation / Serving				
Avg Hourly	$7.58	$9.38	$8.25	$11.25
Avg Annual	$15,760	$19,510	$17,150	$23,410

Job Title	State			
	WV	ME	OH	DC
Fast Food Service				
Avg Hourly	$6.44	$8.90	$7.38	$10.94
Avg Annual	$13,390	$18,500	$15,360	$22,760
Gas Station Attendants				
Avg Hourly	$7.03	$8.08	$8.60	N/A
Avg Annual	$14,620	$16,800	$17,880	N/A
Retail Salespersons				
Avg Hourly	$9.93	$11.75	$11.02	$11.54
Avg Annual	$20,650	$24,440	$22,920	$24,010

Source: U.S. Dept of Labor, Bureau of Labor Statistics. "May 2006 State Occupational Employment and Wage Estimates," www.bls.gov. Accessed 6-5-07.

The comparative statistics above clearly indicate a need to improve the wage rates of direct service workers in West Virginia's long term care system. Particularly in the West Virginia border towns and cities near Ohio and the District of Columbia, where the cost of living is generally higher, a low wage for direct care workers draws employees and potential employees out of West Virginia and hurts the level of quality that can be delivered by the system.

In addition, as reported by the Annapolis Coalition, a not-for-profit organization focused on improving workforce development in the mental health and addiction sectors of the behavioral health field, nationwide "there is a pronounced shortfall in the current workforce of providers with expertise in geriatrics, and this deficit is expected to worsen.[120]" This is another issue that impacts West Virginia's long term care system. In an effort to combat recognized workforce development barriers, the Annapolis Coalition released a report in 2007 entitled "An Action Plan for Behavioral Health Workforce Development," which put forward several recommended objectives and strategies for health care systems to consider implementing for improved workforce recruitment and retention, to enhance system quality:

- Increase the employment of consumers within the LTC system where appropriate;
- Increase the employment of family members as paid staff in LTC provider organizations;
- Increase the workforce competency in building community capacity/collaboration;
- Provide wages & benefits commensurate with education, experience and responsibility;

[120] "An Action Plan for Behavioral Health Workforce Development." The Annapolis Coalition, 2007. www.annapoliscoalition.org.

- Implement a comprehensive public relations campaign to promote direct care work as a career choice;
- Develop career ladders;
- Increase the cultural and linguistic competence of the workforce;
- Adopt evidence-based training methods that have been demonstrated as effective through research;
- Use technology to increase access to and the effectiveness of training and education;
- Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce; and
- Increase the use of data to track, evaluate, and manage key workforce issues.[121]

West Virginia's long term care system should consider initiating several or all of these strategies in order to improve the LTC workforce of the state. This will, in turn, promote higher quality service and support within the system.

19. Continue to increase consumer and family involvement in the development of policy and the development or redesign of quality improvement / quality assurance activities and processes.

There are a variety of opportunities for consumer and family involvement in the development of policy by DHHR and quality assurance activities. Each waiver program has an Advisory Council which includes at least 5 current or former recipients of services. Each Advisory Council has as part of its mission a commitment to stakeholder involvement. The MR/DD Waiver uses National Core Indicator (NCI) data. The AD Waiver uses Personal Experience Survey (PES). Each program utilizes public forums for input and open comment periods during quarterly council meetings.

At the same time, stakeholders at the public forums and during interviews expressed their dissatisfaction with the way DHHR solicits input and feedback into its programs and program changes. Stakeholders may have the chance to comment and they do not have the sense that they are being heard.

DHHR should continue its efforts to provide for stakeholder input. It should review its existing policies and procedures in this area and look for ways for stakeholders to participate that gives stakeholders more of a sense of having participated meaningfully.

Quality improvement (QI) and quality assurance (QA) activities are important aspects of a long term care system as they ensure effective evaluation and subsequent improvement of service delivery processes and practices. Regular consumer input is paramount to a LTC system's QI and QA efforts, as consumers are the stakeholders who are directly impacted by the level of quality delivered. In short, the quality of a long term care system cannot be defined, assessed, or

[121] Ibid.

improved without input from consumers and families. The system exists to meet their needs, but their needs cannot be understood or acted upon without an active effort to communicate with them.[122]

We recommend that the providers and state agencies of West Virginia's long term care system reassess the QI and QA tools and methods currently utilized to ensure that consumers are involved in meaningful ways.

[122] "System Reform: Consumer and Family Involvement." www.naminc.org/Tab2.htm. Accessed 6-11-07.

IV. FISCAL PROJECTIONS AND IMPACTS

As part of West Virginia's request PCG was asked to model and provide financial estimates for the implementation of a MFP initiative. While the concepts of MFP can be applied to all individuals with disabilities regardless of age, PCG's model was developed based on those populations that are most often covered by Medicaid waiver programs: older adults, persons with physical disabilities and persons with MR/DD. The model developed by PCG shows projections for the 10-year period from 2007 through 2017. PCG also developed "high" and "low" models for the estimated savings from implementing a MFP program in West Virginia. The process of developing a model to illustrate the estimated savings from the implementation of MFP consisted of 3 parts:

- A baseline to estimate expenditures for the AD Waiver, the MR/DD Waiver, NFs, and ICFs/MR in the absence of enhanced diversion and transition efforts;
- A low model to implement a conservative MFP program including potential cost savings, cost increases, and cost avoidance"; and
- A high model to implement a more aggressive MFP program including potential cost savings, cost increases, and cost avoidance.

The first step in the process is to establish a baseline of what expenditures would be like in the absence of enhanced diversion and transition efforts. This was done by examining the state's data and preparing projections of expenditures for the period 2007 through 2017 for the AD Waiver, the MR/DD Waiver, NFs, and ICFs/MR.

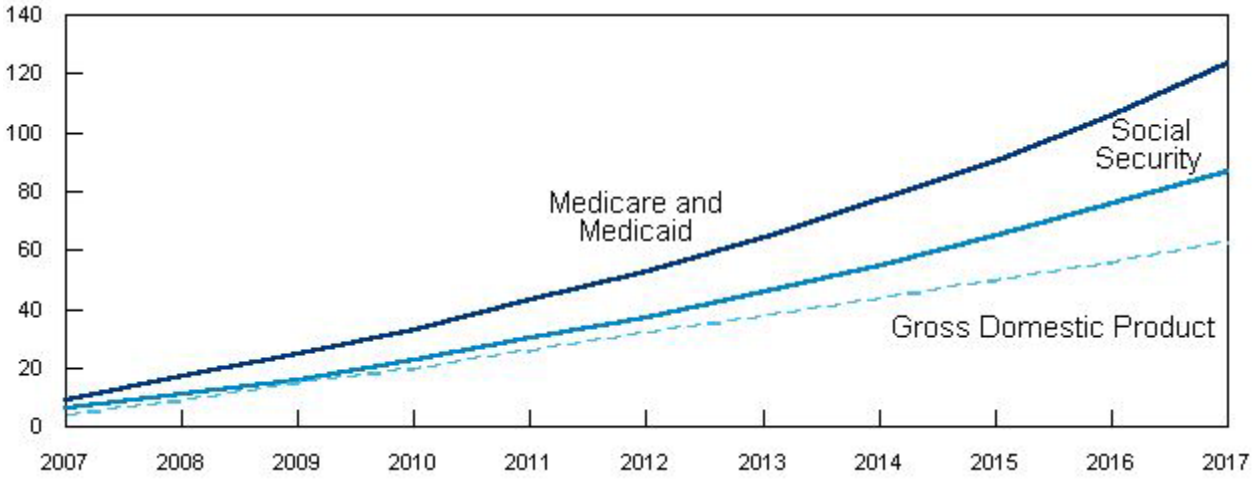
The next step in the process is to define what a "low" model is and what a "high" model is. This was accomplished by reviewing the experience of other states as well as West Virginia's previous experiences with diversion and transition programs. The caseload and cost changes of using these models are then compared to the baseline expenditures.

A. NATIONAL LOOK AT FUTURE MEDICAID COSTS

In order to provide a context within which the analysis of West Virginia can be understood, it is useful to see the bigger national picture before focusing specifically on West Virginia**.** The Congressional Budget Office makes frequent projections of Medicaid and Medicare spending and their latest ten-year projections covering 2007 to 2017, illustrated in Table 24 below, show that spending on these large federal health programs is projected to grow at annual rates of seven to eight percent, well above growth in domestic gross product.[123]

[123] Congressional Budget Office (2007, March). www.cbo.gov/ftpdoc.cfm?index=7731&type=0

Table 24: Projected Growth of Medicare and Medicaid U.S. Spending 2007 to 2017



Source: Congressional Budget Office. www.cbo.gov/ftpdoc.cfm?index=7731&type=0

The Congressional Budget Office makes these general projections based on how the subparts of Medicaid are growing. Its projections for caseload growth in both the aged programs and programs for blind persons and persons with disabilities are that both programs are growing about 2.5% a year and will have a little less than 30% growth over the ten year period from 2007 through 2017.

Table 25: Federal Medicaid Caseloads and Cost per Case for the U.S., 2006 through 2017

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
	ENROLLMENT BY ELIGIBILITY CATEGORY (MILLIONS OF PEOPLE)											
Aged	5.5	5.8	6.1	6.2	6.4	6.5	6.7	6.8	7.0	7.2	7.3	7.5
Blind and disabled	9.8	10.3	10.8	11.2	11.5	11.7	11.9	12.2	12.4	12.7	12.9	13.2
Children	29.5	29.8	30.6	30.9	31.1	31.5	31.9	32.3	32.9	33.3	33.8	34.3
Adults	16.0	16.2	16.6	16.6	16.8	17.0	17.2	17.3	17.5	17.6	17.8	17.9
Total	60.9	62.2	64.1	65.0	65.8	66.7	67.6	68.7	69.8	70.8	71.8	72.9
	AVERAGE FEDERAL SPENDING ON BENEFIT PAYMENTS PER ENROLLEE											
Aged	$6,630	$6,570	$6,750	$7,050	$7,430	$7,830	$8,220	$8,670	$9,140	$9,630	$10,170	$10,730
Blind and disabled	$7,360	$7,590	$7,980	$8,460	$9,050	$9,680	$10,370	$11,040	$11,750	$12,510	$13,320	$14,180
Children	$1,070	$1,130	$1,200	$1,290	$1,380	$1,470	$1,570	$1,670	$1,780	$1,900	$2,020	$2,160
Adults	$1,310	$1,380	$1,430	$1,530	$1,620	$1,710	$1,820	$1,930	$2,040	$2,170	$2,310	$2,450

Source: Congressional Budget Office, March 2007 Medicaid Fact Sheet, www.cbo.gov/budget/factsheets/2007b/medicaid.pdf

As Table 25 indicates, there are differences in the rate of increase in the cost per case amounts for the aged population and the blind and disabled population. The Congressional Budget Office is projecting that the aged cost per case will increase at a 4.4% annual rate while the cost per case for blind persons and persons with disabilities will increase at a 6.5% rate. Against this national backdrop, we turn to a look at possible ten-year projections for West Virginia's programs.

B. Establishing Baselines

The first step in this process is to establish a baseline of what institutional and waiver expenditures in West Virginia would be like in the absence of enhanced diversion and transition efforts. As a starting point, BMS provided twelve years of CMS 372 data covering the period of 1995 through 2006. This data set is a main component of establishing a baseline. The CMS 372 reports are filed by every state annually to report waiver expenditures for the federal fiscal year (FFY). The report includes annual expenditures, line item costs by waiver service, the number of unduplicated recipients, per capita expenditures, and the waiver's cost-neutrality formula.

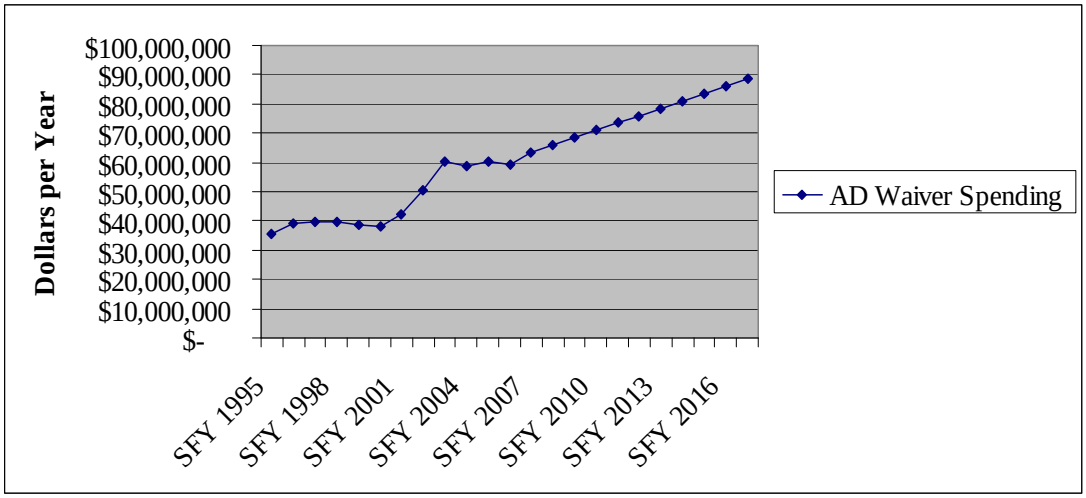
The CMS 372 data for the AD Waiver contains both waiver caseload and costs and NF caseload and costs by year. Similarly, the CMS 372 for the MR/DD Waiver contains both waiver caseload and costs and ICF/MR caseload and costs. This data analysis excludes the costs of acute care services and only contains waiver and institutional costs. A review of reported acute care costs shows they are subject to sizeable year to year changes due to administrative actions. These acute care costs are therefore considered in separate analysis.

1. Projected Medicaid AD Waiver Spending

We examined the ten years of historical data that BMS supplied and observed that the amount of state spending on the AD Waiver was roughly $39 million between 1995 and 2000 and then gradually increased until 2003, where it was approximately $60 million. State spending has remained constant around the $60 million dollar figure from 2003 to 2006. The projection captures the gradual increase and assumes a constant increase of about $2.5 million per year in AD Waiver spending. The average percentage increase in AD Waiver spending over the ten year period is 3.77%.

Based on projections of cost per person and waiver enrollment, Table 26 shows the projected annual Medicaid AD Waiver spending from SFY 1995 to SFY 2017. The projection methodology is based on using the linear regression projection of total spending. The per person AD Waiver cost is projected by assuming that the rate of increase in AD Waiver spending from 1995 through 2006 will continue. The average rate of increase during this period is 2.67%. Projected waiver enrollment was calculated by dividing projected spending by projected per person waiver costs.

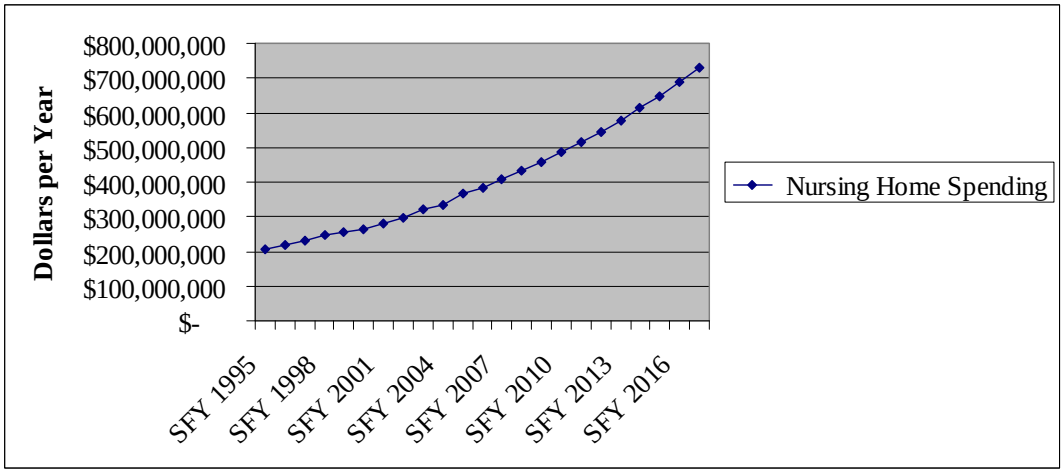
Table 26: Projected Medicaid AD Waiver Spending for WV, 2007 to 2017



2. Projected Medicaid NF Spending

Table 27 below shows the results of the analysis of NF spending. The graph was constructed from actual data for the period 1995 through 2006 from West Virginia's CMS 372 reports. Per person NF costs increased at a rate of 5.87% from 1995 through 2006 while the number of persons served gradually increased about .09% per year. The following graph is constructed assuming these same trends continue into the future.

Table 27: Projected Medicaid NF Spending in WV, 2007 to 2017



3. Projected Medicaid MR/DD Waiver Spending

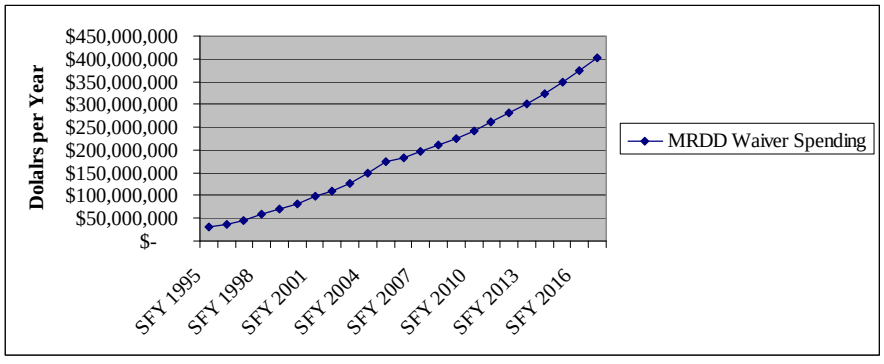
As noted elsewhere in this report, MR/DD Waiver services have been growing at a rate of 18.5% per year. Unlike NF expenditures and the AD Waiver, it does not seem reasonable to assume that past trends will continue for another ten years.

Total expenditures can be broken down into increases due to eligible persons and increases due to cost per case. From 1995 to 2006, MR/DD Waiver enrollment grew an average of 12.97% per year from 1,007 persons in 1995 to 3,741 in 2006. It is not reasonable to assume that this rate of increase will continue. The major impact of court settlements and changed eligibility processing appears over time. For the last two years waiver population growth has been 2.5% to 3%, more closely reflecting projected national average increases.

Annual MR/DD Waiver cost per person increases averaged 4.85%, from a cost per case of $29,652 in 1995 to $48,687 in 2006. These increases in the cost per person are below projected national average increases. It should also be noted that individuals identified for transition will likely have high physical/medical support needs and the cost per person may be higher than the current average. The actual cost of the higher acuity model is unknown at this time so the tables and charts have been developed using historical averages. Assuming a 2.5% average increase in MR/DD Waiver enrollment and a 4.85% increase in cost per case, the results are displayed in Table 28.

In late 2006, 140 waiver slots were added and there was a rate increase in MR/DD Waiver services. This represents an increase that is slightly greater than what was assumed in projecting future costs thru 2016. At the same time, we think that the assumptions underlying the projections are reasonable as a long term trend.

Table 28: Projected Medicaid MR/DD Waiver Spending for WV, 2007 to 2017



4. Projected Medicaid ICF/MR Spending

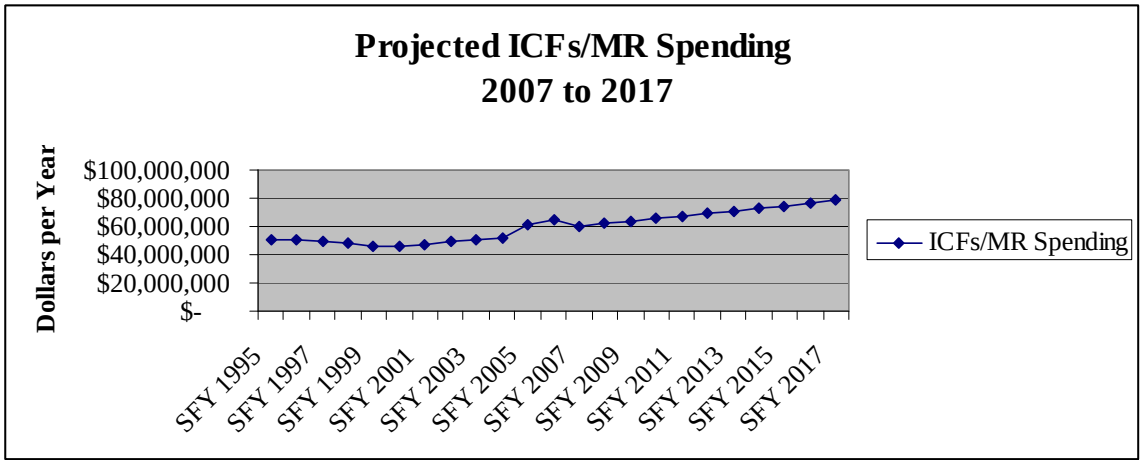
ICF/MR spending increased at a rate of 2.42% from 1995 to 2006. However, this was not a smooth increase, since in 2005 there was an unexplained jump of 18%. When asked about the

increase, state staff said that it was not inflation related and must be due to a case mix change. Given normal inflation rates of 2-4%, changes in case mix must have accounted for approximately 15% of the increase. State staff had no explanation as to why, all of a sudden, in one year there was such a dramatic and expensive increase in the ICF/MR costs. It should be noted that this increase should be further studied by Medicaid staff.

The number of residents in ICFs/MR has been stable since 1998 and the projections of ICF/MR caseload assume no increase in this population. From 1995 to 2006, the cost per person in ICFs/MR increased at an average, annual rate of 3.85%. At this time, there is no knowledge of policy changes or administrative actions that would impact this trend. The number of facilities has been stable over the years and the number of persons in the facilities has gradually declined.

The resulting projection of total spending assuming a flat case load and a 3.85% trend in the cost per case is shown in Table 29.

Table 29: Projected Medicaid ICFs/MR Spending for WV, 2007 to 2017



C. The Transition Process

Having projected future spending, the next step in the analysis is to consider the effect of transition programs upon this future spending.

Beginning and growing successful transition programs is hard work. Fortunately, earlier this year, a new initiative was established that has the potential to play a major role in West Virginia's rebalancing efforts. In January 2007, the Olmstead Office in collaboration with the BMS and BoSS began the development of a formal transition program, called the West Virginia Transition Initiative (the Initiative). The purpose of the Initiative is to assist West Virginia citizens with disabilities and seniors who reside in nursing facilities to live and be supported in their communities. The Initiative will enable individuals with disabilities and seniors to

experience increased independence, dignity, choice, and flexibility to access home and community-based supports.

A Transition Coordinator and two grant funded Transition Navigators are being hired to facilitate and coordinate transition efforts. The Navigators role is to identify those individuals who wish to leave institutional settings and return to community living arrangements and help those individuals achieve the transition. The program is being piloted in two regions covering 22 of the 55 counties in WV. The future goal of the Initiative is to have Transition Navigators throughout 4 to 6 regions. Depending upon how many individuals are interested in moving out of institutional settings, the number of Navigators can be adjusted.

When thinking about transition, it is also important to recognize that there will be some "start-up" expenses. The Initiative will provide up to $2,500 per participant for reasonable and necessary transitional start-up costs. This includes one-time costs for: 1) security deposit for housing; 2) set-up fees for utilities; 3) moving expenses; 4) essential home furnishings; and/or 5) home accessibility adaptations.

Based on the current system structure in West Virginia, it is reasonable to project that the greatest number of individuals transitioned to the community would likely come from a NF setting. For that reason, the conservative MFP analysis will focus primarily on nursing facilities. The more aggressive MFP analysis will focus on nursing facilities, ICFs/MR and State Facilities.

D. Low Model - Conservative Initiatives

Having established baseline expenditure projections, the next step in the analysis is to identify the parameters of a "low model" and calculate its fiscal impact. Transition models have five key parameters in the estimation of fiscal impact: how many persons can be transitioned; where do persons go when they leave the institution; what additional state Medicaid costs do persons incur because they now receive Medicaid waiver services; what is the impact of provider taxes; and, what are the administrative and other transition costs.

1. First Key Parameter – Number of Individuals to Transition

What is a Low Model? There is no agreed on definition of what a "low" or non-aggressive level of effort is regarding NF transition programs. For example, there is nothing in state or federal law that distinguishes a low effort from a high effort. These are not federal Medicaid concepts. However, actual experience of transition programs can provide a rough metric for classifying programs.

With a few exceptions such as Oregon and Washington, states did not begin NF transition programs until the late 1990's and early 2000's.[124] While some states such as New Jersey began

[124] O'Keeffe, J., (2006, July) *Money Follows the Person Initiatives of the Systems Change Grantees Final Report*, U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Washington, DC, pp. 58ff.

their program in the late 1990s, most did not implement programs until CMS funded NF transition programs.

The largest comparative study of NF transition programs was done on eighteen states that received a CMS grant in 2001 and 2002.[125] Many of the states split the money between independent living councils and state agencies so the 18 states had about 33 different programs as shown in Table 30 below. The study collected data on the numbers of persons transitioned by state by year for 2002-2004.

Table 30: Persons Transitioned by CMS NF Transition Grantees, 2002-2004

Transition Grantees, 2002-2004				
State (Grant Type: SP = state program, ILP = Independent Living Council)	Number Transitioned			
	2002	2003	2004	Total
Alabama (ILP 2001)	2	13	16	31
Alabama (SP 2002)	–	n/a	n/a	n/a
Alaska (SP 2001)	2	12	47	61
Arkansas (SP 2002)	–	n/a	n/a	n/a
California (ILP 2002)	–	20	4	24
Colorado (SP 2001)	17	93	124	234
Connecticut (SP 2001)	1	31	40	72
Delaware (ILP 2002)	–	5	4	9
Delaware (SP 2002)	–	0	4	4
Georgia (ILP 2001)[1]	30	20	63	113
Georgia (SP 2001)[1]	n/a	8	n/a.	8
Indiana (SP 2001)[2]	0	0	4	4
Louisiana (SP 2002)	–	44	0	44
Maryland (ILP 2001)	n/a	n/a	n/a	0
Maryland (SP 2001)	23	78	65	166
Massachusetts (SP 2001)[3]	n/a	6	13	19
Michigan (SP 2001)	88	146	66	300

[125] Siebenaler, K., O'Keeffe, J., Brown, D., O'Keeffe, C. (2005, June) Nursing *Facility Transition Initiatives of the Fiscal Year 2001 and 2002 Grantees: Progress and Challenges.* Report prepared under CMS Contract No. 500-00-0044, TO #2, RTI International, Research Triangle Park, NC

Transition Grantees, 2002-2004				
State (Grant Type: SP = state program, ILP = Independent Living Council)	Number Transitioned			
	2002	2003	2004	Total
Minnesota (ILP 2002)	–	43	49	92
Nebraska (SP 2002)	–	147	86	233
New Hampshire (SP 2001)	n/a	1	4	5
New Jersey (ILP 2002)	–	11	27	38
New Jersey (SP 2002)	–	98	94	192
North Carolina (SP 2002)	–	13	37	50
Ohio (SP 2002)	–	n/a	3	3
Rhode Island (SP 2002)	–	16	156	172
South Carolina (SP 2002)	–	2	24	26
Texas (ILP 2001)	n/a	n/a	n/a	n/a
Utah (ILP 2002)	–	28	62	90
Washington (SP 2001)	12	209	1178	1,399
West Virginia (SP 2001)	0	15	32	47
Wisconsin (ILP 2001)	36	69	No Report	105
Wisconsin (SP 2001)	159	127	116	402
Wyoming (SP 2002)	–	13	47	60
Totals	**370**	**1268**	**2365**	**4003**

Source: Exhibit B-1 NF Transition Initiatives of the Fiscal Year 2001 and 2002

Table 31 shows yearly increases as the programs gained experience over the three-year period. However, the number of persons transitioned was generally small. By the third year, only four of the 33 programs, or 12%, helped more than 100 persons. The remaining 88%of the programs helped fewer than 100 persons, with ten of them reporting that they served fewer than 25 persons.[126] Other studies also report a small number of persons participating. For example, a study of Michigan's diversion program showed that it worked with 118 persons over a three-

[126] Descriptions of state NF transition activities are provided at www.pascenter.org/systemschange and in the Real Choice Systems Change Grants Compendium 4th Edition. www.cms.hhs.gov/RealChoice/downloads/compendium.pdf

year period.[127] A Delaware study looked at data from six states, compared the number of persons transitioned as a percentage of the NF population, and found the following results.[128]

Table 31: Percentage of NF Residents Helped by Transition Efforts

State	First Year	After First Year
Texas	1.00%	5.00%
New Jersey	1.00%	4.00%
Pennsylvania	1.00%	na
Utah	3.00%	3.00%
Colorado	1.00%	na
Indiana	5.00%	na

West Virginia, like so many states, had low participation rates in its first NF transition program. These low rates nationally exist for multiple reasons. The majority of states did not have historical experience with NF transition programs. Many states have not consolidated long term care activities into a single agency and were not able to coordinate programs effectively across agencies. Inter-agency cooperation on innovative long term care programs was limited or lacking. States did not have a single point of entry, a system of local administering agencies experienced in NF transition work, statewide telephone numbers, or other program features to expedite enrollment in home and community-based programs. States did not make diversion and transition programs a priority in the state's philosophy of what long term care is. States lacked strong consumer and advocacy pushes from aging and disability representatives. Finally, state staff and researchers in LTC are familiar with anecdotal references to the political influence of NF providers. In some states, the Medicaid agency was not involved in transition program activities and this disconnect compounded the difficulty of putting on effective transition activities.[129]

The increasing use of transition approaches has represented a change in emphasis by state Medicaid agencies. For the past 25 years, the overwhelming focus has been on "diversions" (preventing admissions to NFs), not discharging residents from NFs.[130] For example, neither

---

[127] Supiano, K. Carroll, A. & Blomquist, A. (2004, September) *Nursing Facility Diversion:*

Mobilizing Residents, Families and Resources to Facilitate Return to Community Living The Geriatrics Center, University of Michigan Health System, Ann Arbor, MI

[128]Lewin Group, (2006, February), *Money Follows the Person* Report prepared for the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities, State of Delaware, Dover, DE.

[129] For description of development of HCBS during the 1990's see Murtaugh, C. et al (1999, September) *State Strategies for Allocating Resources to Home and Community-Based Care.*Center for Home Care Policy and Research, Visiting Nurse Service of New York, New York, NY.

[130] Weiner, J. (2006). "It's not your Grandfather's Long term Care Anymore." *Public Policy & Aging Report* 16, 28-35.

state pre-admission screening workers nor staff of local agencies such as the AAA staff, were trained to undertake transition tasks. States did not understand how to use existing assessment data to identify persons who might be helped by transition activities and did not systematically change state regulations, e.g. shelter allowances, to support transition activities. The result of these historical national trends is that most state programs do not have aggressive transition programs.

Based on interviews with West Virginia persons who worked on the state's first transition program and PCG's understanding of the organizational capacity of West Virginia to support transition activities, it seems reasonable to assume that a "low" model would envision working with about 75 persons a year. This would represent about two-thirds of one percent of all West Virginia NF residents in 2006.

2. Second Key Parameter – Where do persons go when they leave the institution?

There is little information available about where persons go when they leave the institution. PCG has done a review of national literature which shows very few states publish information about what services persons receive after they are transitioned. General trends have not been established. Much of the results are not published in national journals. Rather, for example, they are PowerPoint demonstrations prepared for conferences, or partial data is contained in evaluations or reports prepared for state agencies. Some of the information indicates that extensive use of waivers is made by persons who leave nursing facilities but insufficient data is presented to understand the full picture of where all persons go. For example,

> "During the first 18 months, more than 200 people transitioned from nursing facilities to waiver services. After one year, the proportion of persons entering HCBS waivers from either a NF or a hospital increased from less than five percent to more than thirty-five percent."[131]

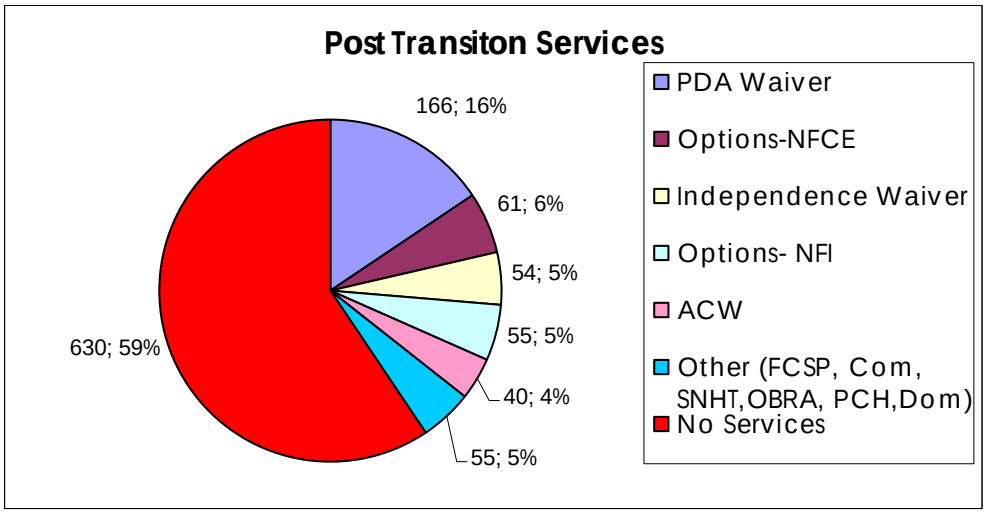
There are at least two studies that have published detailed data on what services persons receive. Michigan's 2005 evaluation of its NF transition project found that 41% of the persons transitioned received only transition services and nothing else, 38% were served by a Medicaid waiver program, 12% were served by another state program and 8% returned to a NF.[132] Pennsylvania has transitioned approximately 1,000 persons in the last year and collects extensive data on the persons it helps. A recent study of these persons shows that

---

[131] Justice, D., *Promising Practices in Long Term Care Systems Reform: Vermont's Home and Community-based Service System*, MEDSTAT, Report prepared for the Centers for Medicare and Medicaid Services Disabled and Elderly Health Programs Division, Washington, DC. p. 8.
[132] Youngs, D. (2005), *Michigan NF Transition Initiative Project Evaluation Report Transition Component*. DYNS Services, Inc., Report prepared for the Michigan Department of Community Health, Ann Arbor, MI. Table 11

approximately 59% of them did not use any state services after they returned to the community.[133]

Table 32: Post Transition Services Received in Pennsylvania 2006-2007



Source: Office of Governor Edward G. Rendell Health Care Reform

New Jersey's NF transition programs have been well studied. In SFY 2005, New Jersey staff reported that approximately 40% of the persons it helped leave did not use further state services after they left. [134] For SFY 2006 New Jersey staffs report that 65% of persons discharged through the state's Global Options program did not receive further state services.[135] A study of 859 New Jersey persons who had been transitioned identified where they were living but did not identity what services they were receiving. The study found:

> "For most of the respondents, the consumer still lived at home and was satisfied with his or her living arrangement. Most consumers (77 percent) lived in an apartment, their own home, or someone else's home. Four percent of consumers lived in nursing facilities, and another 17 percent lived in assisted living, boarding homes, or other community residential settings. Almost half (47

---

[133] Burnett, J. (2007, April 11), *NF Transition in Pennsylvania.* PowerPoint Presentation to the Medical Assistance Advisory Committee Long term Care Subcommittee. Office of Governor Edward G. Rendell Health Care Reform, Harrisburg, PA

134 Reinhard, S. & Petlick, N. (2005, December). *Sustaining New Jersey's Evolving Community Choice Counseling Program.* New Brunswick, NJ: Rutgers CSHP/NASHP: Community Living Exchange. http*://www.cbo.gov/budget/factsheets/2007b/medicaid.pdf*

135 Perriello T. (2006). Personal Interview. July 20, 2006. New Jersey Department of Health and Senior Services, Trenton, N.J.

> percent) of home-based consumers lived with a spouse or child, and another 14 percent lived with other people such as friends, other relatives, and paid caregivers.[136]

Unpublished data from Alaska shows that 16 of the 130 persons or 12.3% receiving transition services from August 1, 2002 through July 11, 2006 did not receive any Medicaid waiver or personal care services after they were transitioned.[137]

Interviews with Texas staff reported that a substantial proportion of people leave the NF went to live in their own homes or with family.[138] Indiana data indicates that almost 60% of the persons lived alone post-transition, while a little more than 30% lived with spouses or other family. Most of the Indiana persons receiving diversion or transition waivers stay enrolled in the waiver program for at least nine months and after one year about 15% of the persons transitioned returned to a NF.[139]

These studies and fragments of studies provide some indication of what might happen in a NF transition program in West Virginia. For those leaving nursing facilities, PCG conservatively assumes that 90% of them will receive services on the AD Waiver and ten percent will be able to function in the community without receiving state services. It is also reasonable to assume that about ten percent will return to the NF after one year.

3. Third Key Parameter – Additional State Medicaid Cost Incurred

The CMS 372 reports also show the amount of acute care costs generated by persons on the AD Waiver and by Medicaid residents of nursing facilities. These acute care costs represent all other

---

[136] Howell-White, S., (2003, June). "Current Living Situation and Service Needs of Former Nursing Home Residents: An Evaluation of New Jersey's Nursing Home Transition Program" Center for the Study of State Health Policy, Rutgers University, New Brunswick. www.cshp.rutgers.edu/cle/products/CurrentLivingSituationNJsNHTprogramWEB.pdf. See also Eiken, S., (2003, December 22) "Community Choice: New Jersey's Nursing Home Transition Program." MEDSTAT. Report prepared for U.S. Dept of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP), Washington, D.C.
State Health Policy, Rutgers University, New Brunswick. www.cshp.rutgers.edu/cle/products/CurrentLivingSituationNJsNHTprogramWEB.pdf. See also Eiken, S., (2003, December 22) "Community Choice: New Jersey's Nursing Home Transition Program." MEDSTAT. Report prepared for U.S. Dept of Health and Human Services, Office of Disability, Aging and Long-Term Care Policy (DALTCP), Washington, D.C.
[137] Walker, R. Alaska Dept of Health and Social Services. Personal Communication. December, 2006.
[138] Eaton, M., Kafka, B., Telge, J., & Klein, J. (2004 March) "Money Follows the Person: The Texas Experience," www.hcbs.org/files/29/1414/Money_Follows_the_Person.doc
[139] Reinhard, S. & Farnham, J. (2006, February) *Indiana's Efforts to Help Hoosiers Prevent Unwanted Nursing Home Residence*. Center for the Study of State Health Policy, Rutgers University, New Brunswick, pp. 10-11. www.cshp.rutgers.edu/cle/Products/MichiganNHTfinalWEB.pdf

Medicaid costs incurred by these persons outside of waiver and nursing facilities. In the table below data for acute care costs for persons on the AD Waiver are incomplete for SFY 2003 and are overstated for SFY 2004 due to administrative changes in the recording of pharmaceutical costs.

Excluding SFY 2003 and SFY 2004, the average acute care cost for the years, 2000, 2001, 2002, 2005, and 2006, for someone on the AD Waiver, was approximately $1,500 higher than the acute care costs of a person in a NF. This difference needs to be factored into the costs attributable to a person who leaves a NF and then receives waiver services. The trend shows that the average amount since 2000 is lower than the difference prior to 2000.

Table 33: Acute Care per Person Costs, 1995-2006

	Acute Care Per Person Costs for Persons on AD Waiver	Acute Care Per Person Costs for Persons in NFs	Difference in Per Person Costs
SFY 1995	$ 6,601	$ 2,231	$ 4,369
SFY 1996	$ 5,444	$ 2,561	$ 2,882
SFY 1997	$ 5,435	$ 2,903	$ 2,533
SFY 1998	$ 5,998	$ 3,683	$ 2,316
SFY 1999	$ 4,154	$ 2,435	$ 1,719
SFY 2000	$ 4,859	$ 2,941	$ 1,918
SFY 2001	$ 4,867	$ 3,500	$ 1,367
SFY 2002	$ 5,427	$ 3,756	$ 1,672
SFY 2003	$ 953	$ 4,292	$ (3,339)
SFY 2004	$ 10,432	$ 4,599	$ 5,833
SFY 2005	$ 7,982	$ 6,488	$ 1,494
SFY 2006	$ 6,170	$ 5,135	$ 1,035

Source: West Virginia Department of Health and Human Resources

4. Fourth Key Parameter – Impact on Provider Taxes

Effective October 31, 2007, West Virginia code at 11-27-11 imposes a gross receipts tax of 5.5% on NF providers. This cost is incorporated in the reimbursable costs of NFs and savings from NF transition programs need to adjust to take into account the loss of revenue incurred when a person is transitioned. The provider tax is not a factor in making the projections of future spending and cost per case increases since the tax was in existence prior to 1995.

5. Fifth Key Parameter –Administrative and Other Transition Costs

Administrative costs include the costs of running transition programs. These costs cover the use of transition assistance to persons being helped, personnel costs of staff working in transition programs, transition program operations such as the creation of a website and the development of marketing and outreach material, and the necessary computer and information systems that need development or revision to support transition activities.

In the late 1990's states used state general funds to pay for transition related expenses such as buying furniture, a refrigerator, moving costs, buying a bed, etc. The federal Medicaid agency, CMS, recognized the necessity of these expenses as part of helping persons live outside of institutions and issued Medicaid Director Letters identifying federal reimbursement for them.[140] Transition assistance expenditures by states have also been studied nationally.[141]

States can request modifications to their Medicaid waivers that would permit them to obtain federal reimbursement for transition activities. West Virginia has not yet taken advantage of this federal support.

Program administration costs associated with a MFP approach varies significantly across states. Some states like New Jersey and Texas have programs with vastly different administrative structures. On the one hand, New Jersey has taken an approach that utilizes many counselors to educate their aged and disabled clients on their options for community-based care. This approach has reportedly cost the state $250,000 in administration costs in its first year of the Community Choice program.[142] In contrast, Texas uses a more simple approach in their MFP program with minimal administrative costs.

As discussed earlier, the West Virginia Transition Initiative is the appropriate vehicle for facilitating the targeted transitions from NFs and ICFs/MR. In its first year, a Transition Coordinator and two Transition Navigators are being hired. This is considered the administrative cost associated with the Low Model. Next year the goal is to hire an additional four Navigators. A full compliment of a Transition Coordinator and six Transition Navigators comprise the anticipated administrative expenses associated with the High Model. In addition, it is anticipated that transition start-up funding will average $2,500 per person.

---

[140] State Medicaid Director's Letter #02-008, May 9, 2002, www.cms.hhs.gov/smdl/downloads/smd050902a.pdf and State Medicaid Directors Letter #03-006, July 14, 2003, www.cms.hhs.gov/smdl/downloads/smd071403.pdf

[141] Eiken, S., Holtz, D. & Steigman, D. (2005, January). *Medicaid HCBS Waiver Payment for Community Transition Services: State Examples.* Washington, DC: Medstat. www.hcbs.org/files/67/3306/HCBS_Transition_Services.pdf

[142]Eiken, S. Community Choice: New Jersey's Nursing Home Transition Program. U.S. Department of Health and Human Services. December 23, 2003. http://aspe.hhs.gov/daltcp/reports/NJtrans.htm.

On this basis it is assumed that the administrative and start-up costs in West Virginia for the low model will be $300,000 in SFY 2008 with inflationary adjustments for subsequent years. The estimated costs for the high model are $1,000,000 in SFY 2009 with annual inflationary adjustments thereafter. Assuming that transition costs are built into the AD and MR/DD Waivers therefore qualifying for federal matching funds, the administrative costs are shown in Tables 34 and 35.

Table 34: Administrative Costs in the Low Model

Low Model	Total Cost	Federal Funds	State Funds
SFY 2007	$ 215,587	$ 139,407	$ 76,180
SFY 2008	$ 300,000	$ 193,992	$ 106,008
SFY 2009	$ 307,500	$ 198,842	$ 108,658
SFY 2010	$ 315,188	$ 203,813	$ 111,375
SFY 2011	$ 323,067	$ 208,908	$ 114,159
SFY 2012	$ 331,144	$ 214,131	$ 117,013
SFY 2013	$ 339,422	$ 219,484	$ 119,938
SFY 2014	$ 347,908	$ 224,971	$ 122,937
SFY 2015	$ 356,606	$ 230,595	$ 126,010
SFY 2016	$ 365,521	$ 236,360	$ 129,161
SFY 2017	$ 374,659	$ 242,269	$ 132,390

Table 35: Administrative Costs in the High Model

High Model	Total Cost	Federal Funds	State Funds
SFY 2007	$ 300,000	$ 195,434	$ 104,566
SFY 2008	$ 1,000,000	$ 651,445	$ 348,555
SFY 2009	$ 1,025,000	$ 667,731	$ 357,269
SFY 2010	$ 1,050,625	$ 684,424	$ 366,201
SFY 2011	$ 1,076,891	$ 701,535	$ 375,356
SFY 2012	$ 1,103,813	$ 719,073	$ 384,739
SFY 2013	$ 1,131,408	$ 737,050	$ 394,358
SFY 2014	$ 1,159,693	$ 755,477	$ 404,217
SFY 2015	$ 1,188,686	$ 774,363	$ 414,322
SFY 2016	$ 1,218,403	$ 793,723	$ 424,680
SFY 2017	$ 1,248,863	$ 813,566	$ 435,297

6. NF Costs

State staff have pointed out that costs of NFs are rebased twice a year and that in a cost-based system money does not follow the person. Allowable costs remain even though occupancy drops and the rebasing simply raises the rate on the remaining residents. This is partially

correct. National studies of this do not exist.[143] Two significant qualifications to be considered are the percentage of Medicaid and Medicare residents in the state's nursing facilities and the existence of any occupancy regulation which lowers reimbursement of cost when occupancy falls below a given level such as 85% or 90%.

The care for about 73% of the residents in West Virginia NFs is paid for by Medicaid, thus a dollar of cost is not a dollar of cost to Medicaid. The West Virginia NF regulations also contain a 90% occupancy regulation for some costs so that if occupancy drops below 90% the facility does not receive all of its costs back.

There is also the continued impact of declining enrollment upon state costs. Total expenditures drop as the occupancy percentage and paid Medicaid days drops. In the last year, there has been considerable discussion of potential state strategies to "rightsize" NF capacity.[144]

7. Cost Savings and Cost Avoidance

In the context of MFP, a state avoids spending money by diverting persons from entering a higher cost institutional setting to a lower cost waiver or community setting. In other words, cost avoidance is avoiding the expenditures. Cost savings occurs when the state is already spending money and finds alternative methods of care for which less is spent. These models analyzed below are primarily concerned with cost savings.

8. Fiscal Analysis of the Low Model

What is a low model? The level of effort and policy context assumed in the low model is close to what the state is now undertaking. The current policy context assumes no expansion of the AD Waiver to include residential options, no use of a TBI waiver, and no expansion of home health or personal care. The low model assumes a modest effort with a small group of staff that takes place within the current services offered by the state.

The fiscal analysis of the low model is based on the following parameters:

- Seventy-five persons per year will be helped;
- Transition will be phased in with an equal number of persons transitioning each month throughout the year;
- Ten percent will return to the NF after one year;

---

[143] L. Hendrickson & S. Reinhard, (2006, September). *Money Follows the Person: State Approaches to Calculating Cost Effectiveness*. Center for State Health Policy, Rutgers University, New Brunswick, NJ. Available at http://www.cshp.rutgers.edu/cle/Products/MFPCalcCostEffectivenessWEB.pdf

[144] Morris, M. (2007, February) *Reducing Nursing Home Utilization and Expenditures and Expanding Community-Based Options.* Center for State Health Policy, Rutgers University, New Brunswick, NJ. Available at http://www.cshp.rutgers.edu/cle/Products/NursingHomeAlternatives%20FEB2007%20--FINAL.pdf

- An additional $1,500 in acute care costs will be incurred by persons who transition (the $1,500 is a conservative estimate since the long-run trend in the difference between acute care costs for wavier versus NF persons has been narrowing);
- Ten percent of the persons transitioned will not use any Medicaid services after transition; and
- A 5.5% adjustment to savings is made to account for provider taxes.

The fiscal analysis shown in Table 36 makes one additional assumption that addresses the question: how long into the future should we project the savings for an individual? The national literature does not contain any standard by which this important projection can be gauged.[145] Nor do states routinely publish information on how long persons stay on waivers. There is a MFP study about Delaware that suggests a three-year assumption.[146]

The data in Table 36 takes the per person cost projections and applies the projected per person costs of NFs with the assumptions that 75 persons will be helped and 10% will return to the NF after one year. The table shows savings before costs.

Table 36: Savings Before Costs from a Low Model of Transition Activities, 2008-2017

Low Model Savings before Costs	# Persons Transitioned	# 12-mth. Persons Counted for this Year	Per Person NF Cost	NF Savings before Costs	Provider Tax Adj.	NF Savings after Adj.
SFY 2008	75	38	$38,745	$1,452,931	$79,911	$1,373,020
SFY 2009	75	106	$41,018	$4,327,428	$238,009	$4,089,419
SFY 2010	75	173	$43,425	$7,512,544	$413,190	$7,099,354
SFY 2011	75	207	$45,973	$9,504,953	$522,772	$8,982,180
SFY 2012	75	207	$48,671	$10,062,676	$553,447	$9,509,229
SFY 2013	75	207	$51,527	$10,653,125	$585,922	$10,067,203
SFY 2014	75	207	$54,550	$11,278,219	$620,302	$10,657,917
SFY 2015	75	207	$57,751	$11,939,993	$656,700	$11,283,293
SFY 2016	75	207	$61,140	$12,640,597	$695,233	$11,945,364
SFY 2017	75	207	$64,727	$13,382,311	$736,027	$12,646,284

We assume 75 people will transition each year. However, the number of yearly full-time equivalent persons phased in the first year is only 38 since they will be phased in throughout the year with equal numbers transitioned each month. In the second year the equivalent of 106

[145] There is some national data showing the average length of stay in an assisted living facility is 27 months. See Byala, G., (2006). *2006 Overview of Assisted Living*, Acclaro Growth Partners, Reston VA.
[146] Lewin Group, (2006, February), *Money Follows the Person* Report prepared for the Governor's Commission on Community-Based Alternatives for Individuals with Disabilities, State of Delaware, Dover, DE. p. 61

persons will be served for a full twelve months including 38 full-year equivalents from the second year of transition and 68 persons from the first year's transition work. The analysis assumes a 10% return rate to the NF so that 68 of the persons from the first year's group of 75 will still be in waiver program the second year.

The third year of work will see a total of 173, 12-month equivalent persons: 38 full year persons from the third year, 68 from the second year and 68 from the first year. The fourth year will see 38 full year persons from the fourth year of work, 68 from the third year, 68 from the second year and 34 full year persons from the first year as they phase out at the end of their three-year assumed stay on the waiver. At the fourth year, the model is in a steady state mode as an equal number of people come on and an equal number drop off.

Table 37 shows the costs associated with the transitioned persons and includes the projected per person AD Waiver costs developed earlier and the assumption that 10% of the persons transitioned will not use any services. The assumption is that persons transitioned will go on the AD waiver and that $1,500 in additional acute care costs will be generated per year by the persons transitioned. These costs are based on the assumption that the state continues to use the AD Waiver in its current form.

Table 37: Costs from a Low Model of Transition Activities, 2008-2017

The Low Model	Number of Persons who Receive Waiver Services	Per Person AD Waiver Cost	Waiver Costs	Added Acute Care Costs	Administrative Costs	Total Costs
SFY 2008	34	$ 13,716	$ 466,327	$ 50,625	$ 215,587	$ 732,539
SFY 2009	95	$ 14,082	$ 1,337,811	$ 142,425	$ 300,000	$ 1,780,236
SFY 2010	156	$ 14,458	$ 2,255,481	$ 233,550	$ 307,500	$ 2,796,531
SFY 2011	186	$ 14,844	$ 2,761,030	$ 279,113	$ 315,188	$ 3,355,330
SFY 2012	186	$ 15,240	$ 2,834,640	$ 279,113	$ 323,067	$ 3,436,820
SFY 2013	186	$ 15,647	$ 2,910,342	$ 279,113	$ 331,144	$ 3,520,599
SFY 2014	186	$ 16,065	$ 2,988,048	$ 279,113	$ 339,422	$ 3,606,584
SFY 2015	186	$ 16,494	$ 3,067,829	$ 279,113	$ 347,908	$ 3,694,850
SFY 2016	186	$ 16,934	$ 3,149,724	$ 279,113	$ 356,606	$ 3,785,443
SFY 2017	186	$ 17,386	$ 3,233,822	$ 279,113	$ 365,521	$ 3,878,456

Table 38 summarizes the savings and costs of a low transition model using the assumptions identified. The net savings to West Virginia under this model is over $57,000,000 over a ten year period.

Table 38: Net Savings from Low Model of Transition

The Low Model	NF Savings before Cost	Total Costs	Net Savings
SFY 2008	$ 1,373,020	$ 732,539	$ 640,481
SFY 2009	$ 4,089,419	$ 1,780,236	$ 2,309,183
SFY 2010	$ 7,099,354	$ 2,796,531	$ 4,302,823
SFY 2011	$ 8,982,180	$ 3,355,330	$ 5,626,850
SFY 2012	$ 9,509,229	$ 3,436,820	$ 6,072,409
SFY 2013	$ 10,067,203	$ 3,520,599	$ 6,546,604
SFY 2014	$ 10,657,917	$ 3,606,584	$ 7,051,333
SFY 2015	$ 11,283,293	$ 3,694,850	$ 7,588,443
SFY 2016	$ 11,945,364	$ 3,785,443	$ 8,159,921
SFY 2017	$ 12,646,284	$ 3,878,456	$ 8,767,828
Total	$ 87,653,263	$ 30,587,388	$ 57,065,875

E. HIGH MODEL – MORE AGGRESSIVE INITIATIVES

What is a "high", more aggressive model of transition? As discussed above, some states have managed to implement important tenets of rebalancing. These states have made the changes in mission and organization needed to implement larger scale transition programs. These larger scale programs are not possible without the shared vision, organizational and regulatory restructuring, budget commitment and financing mechanisms, development of community alternatives, and hard work over multiple years by numerous persons. When these factors come together, both large and small states are capable of more aggressive transition work.

Oregon and Washington steadily rebalanced their programs from the early 1980's and NF diversion and transition activities have been a normal part of state operations for two decades. The states of Wisconsin, New Jersey, Texas, Indiana, and Pennsylvania all work with sizeable numbers of people a year while other states such as Alaska, Vermont, Utah, Arizona, New Mexico, and Minnesota have also put on significant transition programs.

For example, New Jersey's sizeable transition program occurred after the state's long term care programs were consolidated into a single agency, assisted living was expanded by 10,000 beds, other home and community-based programs were created, a statewide telephone number for seeking long term care assistance was created and local answering capability and case management was developed in the AAAs.

1. An Appropriate "High" Model for West Virginia

The AD Waiver, as currently structured, does not contain sufficient alterative home and community choices to support sustained, aggressive NF diversion and transition programs. PCG's analysis of the state's LTC system has offered recommendations for expanding the continuum of care provided under West Virginia's waiver programs such as adding assisted living to the services currently provided through the AD Waiver. The average assisted living

cost in West Virginia is $2,500 a month and an assisted living placement would be cost effective compared to average NF costs.[147]

PCG's high model presupposes working with double the number of people and assumes that the state has encouraged and adopted policy changes that provide more residential options, other waiver expansions and expanded state plan services. These policy assumptions create the need for a different analysis to look at costs and savings of a more "aggressive" model. PCG has prepared the following analysis based on the hypothesis of where persons might go if they left nursing facilities, and the cost of those alternatives. The methodology for determining the costs by service for each of these alternatives is described below.

a. Home Health Agency (HHA)

In West Virginia, approximately $1,500 has been spent per member per year on HHA services since FY 2002. The table below illustrates the per member cost on an annual basis from 2002 through 2006.

Table 39: Home Health Agency Cost Per Member, Per Year, 2002-2006

Fiscal Year	Members	Amount Paid	Per Member Cost
2002	2,072	$ 3,189,902	$ 1,540
2003	2,076	$ 3,025,618	$ 1,457
2004	2,108	$ 3,278,494	$ 1,555
2005	2,078	$ 3,089,832	$ 1,487
2006	2,405	$ 3,496,420	$ 1,454
Avg. % Change Per Year	4.0%	2.7%	-1.3%

WV were to expand the coverage of HHA services to more clients, $1,500 per member per year would seem to be a reasonable cost estimate. PCG used this estimate to forecast rebalancing costs related to HHA services.

b. Adult Day Care

Adult Day Care is reimbursed minimally within the state. BMS just started reporting Adult Day Care services on the FY 2004 CMS-372 report for the AD Waiver. As the chart below illustrates, Adult Day Care services are rarely provided in West Virginia.

[147] Nancy Cartmill, West Virginia Assisted Living Association, Personal Communication, June 11, 2007.

Table 40: Adult Day Care Cost Per Member, 2002-2006

Fiscal Year	Members	Amount Paid	Per Member Cost
2002	-	$ -	N/A
2003	-	$ -	N/A
2004	8	$ 27,270	$ 3,409
2005	3	$ 20,750	$ 6,917
2006	3	$ 4,010	$ 1,337
Avg. % Change Per Year	-31.3%	-52.3%	11.1%

During interviews with the provider community, providers noted that "nobody" was providing Adult Day Care services because they could not "break even" on the services. OHFLAC identified the few providers who do provide these services and they provide it under a social support model and not a medical model.

If West Virginia wishes to expand the use of Adult Day Care as a supplement service to community care, the Adult Day Care eligibility and reimbursement system must be reengineered. A recent study looked at the reimbursement strategy, amount, and whether or not transportation was included as a service for seventeen states. Most states contacted based reimbursement on a per diem rate, ranging from $17.50 per day to $192.38 per day. A day typically consisted of 4 to 5 hours of service.[148] West Virginia reimburses for Adult Day Care services in a range of $4 per day to $18 per day, far below the range indicated in the study. PCG supports the idea of increased funding (on a demonstration basis) for Adult Day Care.

For the purposes of calculating an annual cost to the State of West Virginia for increased Adult Day Care Services, PCG estimates that the annual cost per member per year would be $18,250 or $50 per member per day. This estimate of $50 per day easily falls in the per diem range of $17.50 to $192.38 seen in other states.

c. Assisted Living

The annual cost of assisted living in West Virginia was calculated based on an assumption of a $2,500 per month that was provided by the West Virginia Assisted Living Association. At $2,500 per month, the annual cost for an individual in an assisted living setting would be $30,000.

d. Traumatic Brain Injury Services

West Virginia's DHHR and advocacy organizations have been discussing the creation of Traumatic Brain Injury (TBI) services since the early 1990's.149 Since the late 1990's, advocates have raised the issue legally and the provision of traumatic brain injury services has been

[148] http://www.cshp.rutgers.edu/PDF/AdultDaycareLitRev.pdf
[149] There is a 1991 report titled "Report of the West Virginia Task Force on Traumatic Brain Injury" which was commissioned and completed under the during the tenure of Secretary Taunja Willis Miller.

studied by the court.150 Under the auspices of a Court appointed mediator, negotiations were conducted and a potential settlement was proposed in 2007. This settlement would require the state to pay $1,000,000 to create a system of TBI services. It also calls for the development of formal and comprehensive plan to develop TBI services including the decision about whether or not to develop a TBI waiver by March 2008. Accordingly, PCG prices the fiscal impact of creating TBI services at $1,000,000 since this may be the court ordered settlement of the litigation.

Parties to the negotiations have collected fiscal information on the FY 2001 cost per person of TBI Medicaid waivers for Iowa, Idaho, New Hampshire, Kansas, and Vermont. As part of its research on this recommendation, PCG looked at the total expenditures of the twenty-two states that had brain injury waivers in FFY 2005 and called five of them to obtain current data on the average cost per person served on these brain injury waivers.

The states were picked based on the proximity to West Virginia in population size and whether they were one of the five states discussed in the court documents. The results are shown in Table 41. New Hampshire was excluded from the analysis because of its unusually high cost per case is not representative of most programs. The average cost in 2006 of the five programs was $20,256.

Table 41: Average TBI Waiver Costs for Selected States

State	Year	Unduplicated Person Count	Per Person Cost per Year
Utah	SFY 2006	91	$22,847
Iowa	SFY 2006	700	$19,800
Idaho	FFY 2006	19	$12,406
Kansas	SFY 2006	269	$23,379
Nebraska	SFY 2006	26	$22,847
Average			$20,256

These are modest programs and a TBI program would be less expensive on a per person basis than nursing facilities, the MR/DD Waiver, and ICF/MR. The court settlement requires West Virginia to make a determination whether a TBI waiver or amendments to the State Medicaid Plan will be the vehicle for providing comprehensive TBI services. A program using 100% state general funds should only be used to provide services to persons who are not eligible for Medicaid.

150 See Office of the Court Monitor, (1999, March 5), *Traumatic Brain Injury: Formal Recommendations*. Office of the Court Monitor, Charleston, WV.

e. Telemedicine

Telemedicine in West Virginia, compared to some states, is in its development stage. For that reason, data was not easily available to project program usage and cost. PCG therefore used a conservative estimate of $1,000 per year per individual receiving telemedicine services.

f. Personal Care Services

Personal care services are currently covered by the BMS as an optional State Plan service. AD Waiver recipients can receive personal care services if meet eligibility criteria and only if they qualify for "Level D" resources. Personal Care Services are performed by direct care staff who must have basic training of eating, bathing, grooming, dressing, ambulation, transporting and other activity of daily living functions before rendering care or unsupervised service to an eligible member. Table 42 identifies BMS spending on PCS services from FY 2002 to FY 2006 for state plan services.

Table 42: West Virginia Spending on Medicaid Personal Care Services, 2002-2006

Fiscal Year	Members	Amount Paid	Per Member Cost
2002	1,723	$ 7,483,570	$ 4,343
2003	4,739	$ 24,246,338	$ 5,116
2004	5,143	$ 28,612,353	$ 5,563
2005	5,218	$ 28,189,145	$ 5,402
2006	5,724	$ 33,871,328	$ 5,917
Avg. % Change per Year	48.7%	65.2%	8.3%

Medicaid is currently paying close to $6,000 per year on Personal Care Services for eligible Medicaid recipients. This annual cost was utilized to project the high model of reimbursement for rebalancing initiatives.

g. MR/DD Waiver

Based on the programmatic recommendations presented earlier in this study, PCG calculated the annual cost for an individual in two distinct levels of MR/DD Waiver programs. The first of these levels, which closely mirrors the mix of services covered by the MR/DD Waiver as it exists now, is called the MR/DD Waiver- Comprehensive. The annual cost for this level of waiver care of $48,687 is based on the FY 2006 cost for the current MR/DD Waiver as illustrated by the CMS-372 data. It should be noted that individuals identified for transition may have high physical/medical support needs and the cost per case may be higher than the current average. The actual cost of the higher acuity model is unknown at this time so the tables and charts have been developed using historical averages. Future analyses could identify these costs discretely.

The second level of MR/DD Waiver care, called MR/DD Waiver- Supports, mirrors the MR/DD Waiver- Comprehensive with the major difference being that the "supports" level of

waiver care does not include a residential habilitation component. Based on the same FY 2006 CMS-372 data used to calculate the MR/DD Waiver- Comprehensive less the residential component, the annual cost for an individual on the MR/DD Waiver- Supports is estimated to be $34,420.

h. AD Waiver

In the programmatic recommendations, it is suggested that West Virginia explore the possibility of changing the current structure of the AD Waiver. Current AD Waiver services include case management, RN assessment, homemaker services, chore services, adult day care services, and transportation services. Under the restructured AD Waiver only services such as transportation, chore, case management, and homemaker would be covered. Based on this recommendation and the CMS-372 data from FY 2006, the annual cost for the AD Waiver (Other) is estimated to be $12,634.

2. Costing Methodology

With the annual cost for an individual in each service defined, it is necessary to determine a blended annual rate for services based on the institutional setting from which an individual is being transitioned. In order to calculate these blended rates, PCG made assumptions as to the number of people transitioned from each institutional setting and what services these individuals would receive in the community. As illustrated in the table below, it was assumed that there would be 100 people transitioned from a NF setting, 100 people from an ICF/MR setting, and 80 from State LTC settings. Within each of these settings, Table 45 shows the primary setting or service that an individual would receive as well as any secondary services that would be received.

For example, of the 100 residents transitioned from a NF setting, it was assumed the 55 would receive services in an Assisted Living setting, 5 in a TBI setting, 30 in their own homes with AD Waiver supports and 10 at home with no services. The 100 individuals would also receive additional, "ancillary" services that include home health services, adult day care, telemedicine, and personal care services. The number of residents that would require these services is illustrated in the table below.

A similar method was used in projecting service settings for individuals transitioned from ICFs/MR, and State LTC facilities. The number of individuals that will receive services in each community setting is illustrated in Table 43 below with the primary service setting being shown in bold and the secondary services being shown in regular numbers.

Table 43: Number of Residents Transitioned by Program

Transition Service Type	Per Year	NF (100 Residents)	ICF/MR (100 Residents)	State LTC (80 Residents)
Assisted Living	$ 30,000	**55**		**45**
A&D Waiver (Other)	$ 12,634	**30**		**25**
TBI	$ 20,256	**5**		**10**
Home with No Services **	$ -	**10**		
Personal Care	$ 6,000	30	20	30
Adult Day Care	$ 18,250	25		25
Home Health	$ 1,500	20		20
Telemedicine *	$ 1,000	10		10
MR/DD Comprehensive	$ 48,687		**70**	
MR/DD Supports	$ 34,420		**30**	
Total Bed Counts		11,153	515	400+

To calculate the blended rate for individuals transitioning from each of the institutional settings, the annual cost of each service was multiplied by the number of transitioned individuals receiving that service in the community. For example, with 40 individuals being transitioned from a NF to an Assisted Living setting at a rate of $30,000 a year per individual, the total cost would be $1.2 million. When the total cost for each service for an institutional setting was calculated, the total cost for transitioning individuals from the institutional setting to the community was calculated. The blended rate was then calculated by dividing the total cost by the number of individuals transitioned. Table 44 illustrates these costs.

Table 44 Cost of Transition by Program

Transition Service Type	Per Year	NF (100 Residents)	ICF/MR (100 Residents)	State LTC (80 Residents)
Assisted Living	$ 30,000	$ 1,650,000	$ -	$ 1,350,000
A&D Waiver (Other)	$ 12,634	$ 379,020	$ -	$ 315,850
TBI	$ 20,256	$ 101,280	$ -	$ 202,560
Home with No Services **	$ -	$ -	$ -	$ -
Personal Care	$ 6,000	$ 180,000	$ 120,000	$ 180,000
Adult Day Care	$ 18,250	$ 456,250	$ -	$ 456,250
Home Health	$ 1,500	$ 30,000	$ -	$ 30,000
Telemedicine *	$ 1,000	$ 10,000	$ -	$ 10,000
MR/DD Comprehensive	$ 48,687	$ -	$ 3,408,090	$ -
MR/DD Supports	$ 34,420	$ -	$ 1,032,600	$ -
Total Cost		**$ 2,806,550**	**$ 4,560,690**	**$ 2,544,660**
Per Person/Per Year Transition Cost		**$ 28,065.50**	**$ 45,606.90**	**$ 31,808.25**

3. NF Transition – High Model

The analysis of NF costs uses the same methodology as used with the low model. Applying the same cost assumptions identified in the analysis of the low model results in the following savings.

Table 45: Savings before Costs from a High Model of Transition Activities 2008-2017

The High Model Savings before Costs	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person NF Cost	NF Savings before Costs	Provider Tax Adj.	NF Savings after Adj.
SFY 2008	150	75	$ 38,745	$ 2,905,863	$ 159,822	$ 2,746,041
SFY 2009	150	210	$ 41,018	$ 8,613,838	$ 473,761	$ 8,140,077
SFY 2010	150	345	$ 43,425	$ 14,981,663	$ 823,991	$ 14,157,671
SFY 2011	150	413	$ 45,973	$ 18,963,932	$ 1,043,016	$ 17,920,916
SFY 2012	150	413	$ 48,671	$ 20,076,681	$ 1,104,217	$ 18,972,464
SFY 2013	150	413	$ 51,527	$ 21,254,723	$ 1,169,010	$ 20,085,713
SFY 2014	150	413	$ 54,550	$ 22,501,889	$ 1,237,604	$ 21,264,285
SFY 2015	150	413	$ 57,751	$ 23,822,234	$ 1,310,223	$ 22,512,012
SFY 2016	150	413	$ 61,140	$ 25,220,054	$ 1,387,103	$ 23,832,951
SFY 2017	150	413	$ 64,727	$ 26,699,894	$ 1,468,494	$ 25,231,400

Table 46 takes PCG's analysis of where persons might go if they left the NF and assumes that the state develops a reasonable array of services for them. The major difference is shown in the average cost of the alternatives. Based on the analysis of alternatives illustrated above, PCG estimates the average SFY 2007 cost of a blended array of home and community-based alternatives might be approximately $28,066 for individuals transitioning from a NF to the community. This is greater on average than the cost of the existing AD Waiver and reflects the higher costs of residential care, especially assisted living which has a cost of approximately $30,000 per year. Table 46 shows the costs, assuming that ten percent of the persons transitioned out of nursing facilities will not incur state waiver costs. For example, in 2008, the equivalent of 75, 12-month persons will be transitioned out of NFs, but only 68 of them will receive waiver services.

Table 46: Costs from a High Model of Transition Activities, 2008-2017

The High Model	# of Persons Receiving AD Waiver Services	Per Person AD Waiver Cost	AD Waiver Costs	Added Acute Care Costs	Administrative Costs	Total Costs
SFY 2008	68	$ 26,897	$ 1,815,525	$ 101,250	$ 300,000	$ 2,216,775
SFY 2009	189	$ 27,615	$ 5,219,198	$ 283,500	$ 1,000,000	$ 6,502,698
SFY 2010	311	$ 28,352	$ 8,803,334	$ 465,750	$ 1,025,000	$ 10,294,084
SFY 2011	371	$ 29,109	$ 10,806,762	$ 556,875	$ 1,050,625	$ 12,414,262
SFY 2012	371	$ 29,886	$ 11,095,303	$ 556,875	$ 1,076,891	$ 12,729,068
SFY 2013	371	$ 30,684	$ 11,391,547	$ 556,875	$ 1,103,813	$ 13,052,235
SFY 2014	371	$ 31,504	$ 11,695,701	$ 556,875	$ 1,131,408	$ 13,383,985
SFY 2015	371	$ 32,345	$ 12,007,977	$ 556,875	$ 1,159,693	$ 13,724,545
SFY 2016	371	$ 33,208	$ 12,328,590	$ 556,875	$ 1,188,686	$ 14,074,150
SFY 2017	371	$ 34,095	$ 12,657,763	$ 556,875	$ 1,218,403	$ 14,433,041

Table 47 summarizes the savings and costs from using a high model of transition. A comparison of the low and high model shows that the high model does not produce twice the savings of the low model even though the number of persons transitioned is double and the same per person NF costs are used. The reason is the cost per person is higher with a blended array of home and community services. The table below shows that considerable savings are available with an aggressive model of transition despite the higher per person cost of a blended array of home and community services.

Table 47: Net Savings from High Model of Transition-NF

The High Model Savings - Nursing Facility	Number of Persons Transitioned	Number of 12 - mth. Persons Counted for this Year	Per Person Nursing Facility Cost	Per Person Transition Cost	Total Nursing Facility Cost	Total Transition Cost	Net Savings
SFY 2008	150	Varies	$ 36,614	$ 33,432	$ 2,746,041	$ 2,216,775	$ 529,266
SFY 2009	150	Varies	$ 38,672	$ 31,409	$ 8,140,077	$ 6,502,698	$ 1,637,379
SFY 2010	150	Varies	$ 41,037	$ 31,009	$ 14,157,671	$ 10,294,084	$ 3,863,587
SFY 2011	150	Varies	$ 43,392	$ 31,665	$ 17,920,916	$ 12,414,262	$ 5,506,654
SFY 2012	150	Varies	$ 45,938	$ 32,468	$ 18,972,464	$ 12,729,068	$ 6,243,396
SFY 2013	150	Varies	$ 48,634	$ 33,294	$ 20,085,713	$ 13,052,235	$ 7,033,478
SFY 2014	150	Varies	$ 51,487	$ 34,141	$ 21,264,285	$ 13,383,985	$ 7,880,300
SFY 2015	150	Varies	$ 54,509	$ 35,010	$ 22,512,012	$ 13,724,545	$ 8,787,467
SFY 2016	150	Varies	$ 57,707	$ 35,903	$ 23,832,951	$ 14,074,150	$ 9,758,801
SFY 2017	150	Varies	$ 61,093	$ 36,819	$ 25,231,400	$ 14,433,041	$10,798,359

4 . ICF/MR Transition – High Model

The number of residents in ICFs/MR has been stable since 1998 and the projections of ICFs/MR caseloads assume no increase in their population. PCG has used a caseload count of 515 ICF/MR residents to project `per resident spending for each of the next 10 fiscal years. PCG also assumed that 10 residents per year could be transitioned into the community for each of the

next 10 years. Based on these assumptions, the net savings associated with transition from ICF/MR level care to community-based care could reach over $10 million per year by SFY 2017.

Table 48: Net Savings from High Model of Transition- ICF/MR

The High Model Savings - ICF/MRs	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person ICF/MR Cost	Per Person MR/DD and Other Cost	Total ICF/MR Transition Cost	Total MR/DD and Other Transition Cost	Net Savings
SFY 2008	10	10	$ 124,106	$ 44,235	$ 1,241,059	$ 442,350	$ 798,709
SFY 2009	10	20	$ 127,482	$ 45,438	$ 2,549,631	$ 908,764	$ 1,640,868
SFY 2010	10	30	$ 130,949	$ 46,674	$ 3,928,472	$ 1,400,223	$ 2,528,249
SFY 2011	10	40	$ 134,511	$ 47,944	$ 5,380,435	$ 1,917,746	$ 3,462,690
SFY 2012	10	50	$ 138,170	$ 49,248	$ 6,908,479	$ 2,462,386	$ 4,446,093
SFY 2013	10	60	$ 141,928	$ 50,587	$ 8,515,668	$ 3,035,235	$ 5,480,433
SFY 2014	10	70	$ 145,788	$ 51,963	$ 10,205,176	$ 3,637,426	$ 6,567,750
SFY 2015	10	80	$ 149,754	$ 53,377	$ 11,980,294	$ 4,270,130	$ 7,710,164
SFY 2016	10	90	$ 153,827	$ 54,828	$ 13,844,427	$ 4,934,562	$ 8,909,865
SFY 2017	10	100	$ 158,011	$ 56,320	$ 15,801,106	$ 5,631,980	$ 10,169,126

5. State Facility LTC – High Model

PCG also calculated the potential savings through a transition of residents from the state-operated long term care facilities to the community. PCG utilized the average per diem cost for all 5 state facilities (Hopemont, Lakin, Manchin, Pinecrest , and Welch's Unit) in SFY 2004 as the basis for the "per person/per year" state facility amount. An inflation rate of 4.4% was applied to both the state facility and the transition side. The "per person /per year" transition cost was garnered from Table 47 above. PCG also assumed that 10 residents per year could be transitioned into the community for each of the next 10 years. Based on these assumptions, the net savings associated with transition from State Facility LTC level of care to community-based care could reach over $6.6 million by SFY 2017.

Table 49: Net Savings from High Model of Transition State Facility – Long Term Care

The High Model Savings - State Facility LTC	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person State Facility LTC Cost	Per Person Transition Cost	Total State Facility LTC Cost	Total Transition Cost	Net Savings
SFY 2008	10	10	$ 84,812	$ 39,681	$ 848,120	$ 396,810	$ 451,310
SFY 2009	10	20	$ 88,529	$ 41,420	$ 1,770,589	$ 828,406	$ 942,183
SFY 2010	10	30	$ 92,410	$ 43,236	$ 2,772,298	$ 1,297,076	$ 1,475,222
SFY 2011	10	40	$ 96,460	$ 45,131	$ 3,858,419	$ 1,805,240	$ 2,053,179
SFY 2012	10	50	$ 100,689	$ 47,109	$ 5,034,428	$ 2,355,460	$ 2,678,969
SFY 2013	10	60	$ 105,102	$ 49,174	$ 6,306,119	$ 2,950,446	$ 3,355,673
SFY 2014	10	70	$ 109,709	$ 51,330	$ 7,679,620	$ 3,593,066	$ 4,086,554
SFY 2015	10	80	$ 114,518	$ 53,579	$ 9,161,412	$ 4,286,353	$ 4,875,059
SFY 2016	10	90	$ 119,537	$ 55,928	$ 10,758,351	$ 5,033,513	$ 5,724,838
SFY 2017	10	100	$ 124,777	$ 58,379	$ 12,477,684	$ 5,837,938	$ 6,639,746

VI. ACKNOWLEDGEMENTS

This report has been founded upon the collection and analysis of extensive stakeholder feedback. Among the many stakeholders who contributed to this report were consumers, family members, guardians, advocates, providers, and state staff, including:

ADA Coalition

ADAPT- WV

Advocacy Legal Aid

Appalachian Center for Independent Living

Bureau for Behavioral Health & Health Facilities

Bureau for Medical Services

Bureau of Senior Services

Center for Excellence in Disabilities at WVU

Department of Health and Human Resources

Legal Aid of WV Behavioral Health Advocacy Project

Legal Aid of WV Long Term Care Ombudsman

Mountain State Center for Independent Living

Mountain State People's Alliance

Northern WV Center for Independent Living

Office of Health Facility Licensure & Certification

Office of the Ombudsman for Behavioral Health

Olmstead Advisory Council

West Virginia AARP

West Virginia ADA Coordinator

West Virginia Advocates

West Virginia Assisted Living Association

West Virginia Behavioral Health Providers' Association

West Virginia Board of Examiners for Registered Professional Nurses

West Virginia Center for Independent Living

West Virginia Council on Home Care Agencies

West Virginia EMS-TSN Advocacy Program

West Virginia Fair Shake Network

West Virginia Mental Health Planning Council

West Virginia Developmental Disabilities Council

West Virginia Health Care Association

West Virginia Health Care Authority

West Virginia Mental Health Consumers' Association

West Virginia Statewide Independent Living Council

In addition to interviews and conference calls with the stakeholders listed in the preceding page, public forums were held throughout the state in April of 2007 to obtain input for this study, with the following turnout observed:

Table 50: Public Forums – Dates & Attendance

Forum Location	# In Attendance	Date
Parkersburg	9	4-17-2007
Clarksburg	37	4-18-2007
Martinsburg	6	4-19-2007
Beckley	18	4-25-2007
Charleston	32	4-26-2007

An email address was also set up (wvrebalancing@pcgus.com) to obtain feedback from all interested parties on needs within the long term care system as well as input on the draft report.

The Office of the Ombudsman's website was utilized to disseminate this report statewide amongst stakeholders. PCG and the Office of the Ombudsman extend our thanks and gratitude to all stakeholders who participated in this important process. Obtaining feedback and perspectives from stakeholders was integral to understanding the issues currently facing the system and determining feasible strategies to resolve these issues.

APPENDICES

APPENDIX A

NURSING FACILITY LEVEL OF CARE CRITERIA IN SELECTED STATES

1. HAWAII

To qualify for an ICF level, beneficiaries must need intermittent skilled nursing, daily skilled nursing assessment and 24-hour supervision provided by RNs or LPNs. They may also require non-skilled nursing services such as administration of medications, eye drops and ointments, general maintenance care of colostomies or ileostomies, and other services and significant assistance with ADLs.

2. INDIANA

Individuals are eligible if they have an unstable medical condition or three or more of 14 substantial medical conditions or ADL impairments. The list includes: supervision and direct assistance on a daily basis to ensure that prescribed medication is taken correctly; 24-hour supervision and/or direct assistance due to confusion; disorientation not related to a mental illness; inability to eat, transfer from bed or chair, change clothes, bathe, manage bladder and/or bowel functions or ambulate or use a wheelchair without direct assistance. The criteria allow a person with three ADLs or 2 ADLs and the need for medication assistance to receive waiver services.

3. KENTUCKY

The low intensity nursing status (equivalent to the former intermediate care patient status standards) is met, if the individual requires intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting. Kentucky assesses functional and medical factors. The following criteria are used:

1. An individual with a stable medical condition requiring intermittent high-intensity nursing care services not provided in a personal care home;

2. An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner.

3. An individual with a stable medical condition manifesting a significant combination of at least two (2) or more of the following care needs shall be determined to meet low-intensity patient status if the professional staff determines that the combination of needs can be met satisfactorily only by provision of intermittent high-intensity nursing care, continuous personal care or supervision in an institutional setting: assistance with wheelchair; physical or environmental management for confusion and mild agitation; must be fed; assistance with

going to bathroom or using bedpan for elimination; old colostomy care; indwelling catheter for dry care; changes in bed position; administration of stabilized dosages of medication; restorative and supportive nursing care to maintain the individual and prevent deterioration of his condition; administration of injections during time licensed personnel is available; services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care; or routine administration of medical gases after a regimen of therapy has been established.

4. An individual shall not be considered to meet patient status criteria if care needs are limited to the following: minimal assistance with ADLs; independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch or cane; a limited diet such as low salt, low residue, reducing or another minor restrictive diet; or medications that can be self-administered or the individual requires minimal supervision.

4. MAINE

Individuals must meet a combination of medical, medical/functional or cognitive/behavior requirements. They must have a need for daily skilled nursing (including occupational, speech or physical therapy) or extensive assistance in three of the following ADLs: bed mobility, transfer, locomotion, eating and toileting; *or* a combination of three needs in the following areas: skilled nursing, cognition, behavior, and at least limited assist in 1 of the following ADLs: bed mobility, transfer, locomotion, eating and toileting. Eligibility may also be met through a nursing need, behavioral assistance, and one ADL or a nursing need, cognition assistance and one ADL or nursing need, cognition and behavioral assistance or a nursing need and two ADLs.

The cognition and/or behavior requirements apply for individuals who do not require professional nursing intervention at least 3 days per week but are eligible if they have a qualifying score on the cognitive screen and/or behavioral screen, in combination with a need for at least "limited assistance" with an ADL, for a total of three service needs. The qualifying scores are cognitive score of 13 points and two ADLs; or cognitive score of 13 points and behavioral score of 14 points and one ADL; or behavioral score of 14 points and two ADLs.

The list of nursing services includes any specified physician-ordered services provided on a frequent rather than daily basis; professional nursing assessment, observation and management for impaired memory, and impaired recall ability, and impaired cognitive ability; professional nursing assessment, observation, and management for problems including wandering, physical abuse, verbal abuse or socially inappropriate behavior; administration of treatments, procedures, or dressing changes that involve prescription medications and require nursing care and monitoring; and professional nursing for physician-ordered radiation therapy, chemotherapy, or dialysis.

Skilled services also include physician-ordered occupational, physical, or speech/language therapy or some combination of the three, which must require the professional skills of a licensed or registered therapist.

5. MARYLAND

NF care is covered when an individual requires health related services provided on a daily basis by or under the supervision of a nurse due to medical, cognitive or physical disability. The need for intermittent, part-time services does not qualify (for example home health nursing), nor does the need for unlicensed care (e.g., personal care) even if care is needed full time.

6. OHIO

For the skilled level of care, individuals must require at least one skilled nursing service at least seven days a week, or a skilled rehabilitation service at least five days a week. For intermediate care, an individual must need hands-on assistance with at least two ADLs; or assistance with one ADL and is unable to perform self-administration of medications and requires assistance with administration; or requires one or more skilled services at less than a skilled care level (seven days per week); or the person requires the supervision of another person 24-hours a day due to dementia.

7. OREGON

Regulations set priorities for services based on the amount of assistance needed with a specified ADL or combination of specified ADLs and cognition. Due to recent budget constraints, the priority thresholds have been changed. Eligibility had been limited to levels 1-11 but was expanded to levels 12 and 13 on July 1, 2004.

(1) Dependent in mobility, eating, toileting, and eating;
(2) Dependent in mobility, eating, and cognition;
(3) Dependent in mobility or cognition or eating;
(4) Dependent in toileting;
(5) Substantial assistance with mobility, assistance with toileting and eating;
(6) Substantial assistance with mobility and assistance with eating;
(7) Substantial assistance with mobility and assistance with toileting;
(8) Assistance with eating and toileting;
(9) Substantial assistance with mobility;
(10) Minimal assistance with mobility and assistance with toileting;
(11) Minimal assistance with mobility and assistance with eating;
(12) Assistance with mobility;
(13) Assistance with eating;
(14) Minimal assistance with mobility;
(15) Dependent in bathing and dressing;
(16) Assistance in bathing or dressing.

8. PENNSYLVANIA

Consumers must have a medical diagnosis, illness, or condition which creates medical needs that require medical care and services which are ordered by or provided under the direction of

a physician; need to be given on a regular basis and provided by or under the supervision of skilled medical professional; or because of a mental or physical disability, the individual requires nursing and related health and medical services in the context of a planned program of health care and management.

9. VIRGINIA

Residents must meet functional and medical criteria. Functional criteria include:

- Dependent in two to four ADLs and semi-dependent or dependent in behavior pattern and orientation, and semi-dependent in joint motion or dependent in medication administration; or
- Dependent in five to seven ADLs and dependent in mobility; or
- Semi-dependent in two to seven ADLs and dependent in mobility and behavior pattern and orientation.

Medical or nursing supervision means:

- A condition that requires observation and assessment; or
- Potential for instability is high or exists; or
- Ongoing nursing services are required.

10. WASHINGTON

Individuals eligible for admission to a NF and COPES waiver services must meet one of four criteria:

- Require care provided by or under the supervision of an RN or LPN on a daily basis;
- Have an unmet need requiring substantial or total assistance with at least two or more of the following ADLs: eating, toileting, ambulation, transfer, positioning, bathing and self-medication;
- Have an unmet need requiring minimal, substantial or total assistance in three or more of the above ADL; or
- Have a cognitive impairment and require supervision due to one or more of the following: disorientation, memory impairment, impaired judgment, or wandering and have an unmet or partially met need with at least one or more of the ADLs.

APPENDIX B

ANALYSIS OF REBALANCING EFFORTS IN OTHER STATES

In any effort that seeks to change the delivery of health services and supports within a state, it is useful to compare service delivery in that state with the current status of service delivery of other states. This serves to isolate specific areas in need of improvement as well as particular areas of strength. As such, the assessment detailed below highlights major differences between WV's long term care system and the long term care systems of other states. Additionally, we include LTC rebalancing initiatives and models that have been successfully implemented in other states. These could serve as a template or at least a baseline guide for change in West Virginia.

One of the most significant data comparisons reveals that WV is far below the national average when it comes to the percentage of State General Funds allocated for Medicaid expenditures. While on average, states put 17.9% of State General Funds towards Medicaid, West Virginia allocates only 8.6%, ranking the state 45th out of 50 states (see Table B-1 below). It is important to point out this discrepancy in funding, as it has a direct, considerable impact on the annual amount of dollars set aside for long term care services and supports for West Virginians.

Table B-1: Distribution of State General Fund Expenditures (in millions), FY 2005

	Rank	Elementary & Secondary Ed	Higher Ed	Public Assistance	Medicaid	Corrections	Trans-portation	Other
U.S. Avg	---	35.8%	11.7%	2.3%	17.9%	7.2%	0.4%	24.7%
WV	45	46.9%	12.4%	0.8%	8.6%	4.4%	0.2%	26.7%

Source: Kaiser State Health Facts, 2005.

A. LONG TERM CARE IN WEST VIRGINIA AND TEN OTHER STATES

HOME AND COMMUNITY-BASED SERVICES

There are three primary ways that states can provide HCBS to its residents: 1) personal care services; 2) home health services; and 3) CMS 1915(c) waiver programs. In comparing the utilization and amount of expenditures for these three types of HCBS between West Virginia and ten other states, it appears that WV is currently behind other states.

Personal Care Services

Table B-2 illustrates a comparison between West Virginia's personal care expenditures and those of several other states. Because personal care is an optional state plan service, many of the states in this ten-state comparison do not offer personal care and therefore do not have a ranking in Table B-2. However, of those states ranked in the comparison study, the table shows that WV is spending more on personal care Medicaid services than MD and OR, two states with higher Medicaid enrollment, but less than ME, a state with a similar number of Medicaid enrollees.

Table B-2: Medicaid Personal Care Services Expenditures, 2003

National Rank	State	Medicaid Enrollment	Total Yearly Expenditures
4	New Jersey	974,500	$280,035,241
6	Washington	1,160,600	$215,675,176
17	Maine	378,200	$27,291,222
19	West Virginia	366,400	$26,850,264
21	Maryland	752,000	$20,739,902
26	Oregon	625,600	$3,099,567
N/A	Indiana	945,000	N/A
N/A	Kentucky	809,900	N/A
N/A	Ohio	1,938,800	N/A
N/A	Pennsylvania	1,786,300	N/A
N/A	Virginia	736,500	N/A

Source: Kaiser State Health Facts, 2003.

Home Health Services

When comparing states' annual Medicaid home health service expenditures, WV ranks 45th in total amount of yearly expenditures and almost last in a 10-state comparison.

Table B-3: Medicaid Home Health Services Expenditures, 2003

National Rank	State	Medicaid Enrollment	Total Yearly Expenditures
6	Pennsylvania	1,786,300	$134,775,999
8	Ohio	1,938,800	$114,662,541
14	Kentucky	809,900	$58,123,840
15	Indiana	945,000	$52,176,197
17	New Jersey	974,500	$36,607,938
32	Maine	378,200	$5,567,061
34	Virginia	736,500	$4,434,208
37	Washington	1,160,600	$3,843,462
44	Maryland	752,000	$2,633,317
45	West Virginia	366,400	$2,593,635
48	Oregon	625,600	$1,006,080

Source: Kaiser State Health Facts, 2003.

Maine, a state with a similar number of Medicaid enrollees, spends, on average, more than twice that of WV on Medicaid home health services. This data provides evidence that the amount of Medicaid dollars that WV allocates toward home health services should be considered for further study and improvement. Home health services are an important Medicaid support that individuals rely on to stay in their own homes and communities rather than be placed in facility-based settings.

1915(c) Medicaid Waiver Programs

Table B-4 below reveals that WV ranks last in the nation in the number of approved and utilized HCBS Medicaid waivers. This is another area that the state should take a closer look at, as these waiver programs are crucial in assisting many individuals with disabilities and the elderly to obtain necessary, desired, and appropriate services and supports that allow them to remain in their own homes and communities rather than in facilities.

Table B-4: Total HCBS Waivers

Rank	State	Total No. HCBS Waivers
1	Pennsylvania	10
6	Indiana	7
6	New Jersey	7
10	Ohio	6
10	Virginia	6
19	Maryland	5
19	Oregon	5
31	Maine	4
31	Kentucky	4
43	Washington	3
50	West Virginia	2

Source: Kaiser State Health Facts, 2005.

Table B-5 shows a comparison of existing Medicaid HCBS waivers in 10 states, including West Virginia, and Table B-6 shows a comparison of waiver expenditures for the comparison states. In reviewing the two tables, it appears that while Kentucky and Maine are serving a similar of individuals on their MR/DD Waivers, West Virginia is spending less to serve the total amount of individuals using its MR/DD Waiver.

Table B-5: Medicaid 1915(c) HCBS Waiver Participants, by Type of Waiver, 2003

STATE	MR/ DD	Aged	Aged & Disabled	Physically Disabled	Children	HIV/ AIDS	TBI/ SCI	Total
IN	7,374	N/A	3,688	N/A	134	N/A	170	11,366
KY	2,097	N/A	15,629	61	N/A	N/A	91	17,878
ME	2,388	1,059	416	333	N/A	N/A	N/A	4,196
MD	7,689	2,755	N/A	389	844	N/A	N/A	11,677
NJ	4,888	N/A	8,614	297	219	628	241	14,887
OH	12,068	N/A	25,411	6,492	N/A	N/A	N/A	43,971

STATE	MR/ DD	Aged	Aged & Disabled	Physically Disabled	Children	HIV/ AIDS	TBI/ SCI	Total
OR	7,891	N/A	31,834	N/A	95	N/A	N/A	39,820
PA	24,560	12,826	N/A	2,542	61	92	N/A	40,081
VA	5,737	162	9,950	337	N/A	283	N/A	16,469
WA	8,685	N/A	30,167	N/A	N/A	N/A	N/A	38,852
WV	2,962	N/A	5,632	N/A	N/A	N/A	N/A	8,594

Source: Kaiser State Health Facts, 2003.

Table B-6: Medicaid 1915(c) HCBS Waiver Participants, by Type of Waiver, 2003

STATE	MR/ DD	Aged	Aged & Disabled	Physically Disabled	Children	HIV/ AIDS	TBI/ SCI	Total
IN	$287,095	N/A	$28,044	N/A	$1,623	N/A	$3,210	$319,972
KY	$110,921	N/A	$70,920	$5,500	N/A	N/A	$3,841	$191,182
ME	$176,044	$10,983	$6,194	$8,723	N/A	N/A	N/A	$201,944
MD	$288,460	$36,872	N/A	$6,774	$17,333	N/A	N/A	$349,439
NJ	$286,629	N/A	$72,694	$16,926	$333	$4,040	$14,674	$395,296
OH	$431,415	N/A	$187,137	$157,087	N/A	N/A	N/A	$775,640
OR	$307,797	N/A	$258,409	N/A	$93	N/A	N/A	$566,300
PA	$975,982	$119,459	N/A	$43,926	$7,126	$71	N/A	$1,146,564
VA	$221,509	$45	$98,630	$20,265	N/A	$689	N/A	$341, 138
WA	$247,811	N/A	$286,721	N/A	N/A	N/A	N/A	$534,531
WV	$125,421	N/A	$60,566	N/A	N/A	N/A	N/A	$185,987

Source: Kaiser State Health Facts, 2003.

In looking more closely at the two main populations served by Medicaid HCBS waivers—elders and adults with physical disabilities and individuals with MR/DD—Figures IV-1 and IV-2 (below) show that in 2005, WV spent much more on HCBS for individuals with developmental disabilities (77.5%) than for elders and adults with physical disabilities (23.3%). West Virginia compares favorably to neighboring states in overall HCBS spending, but lower than national leaders.

Figure IV-1: Elders and Adults with Physical Disabilities

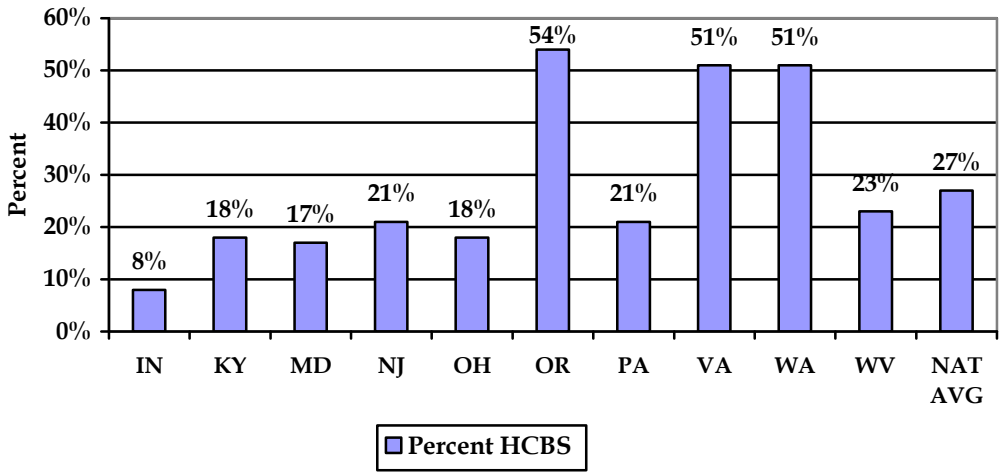
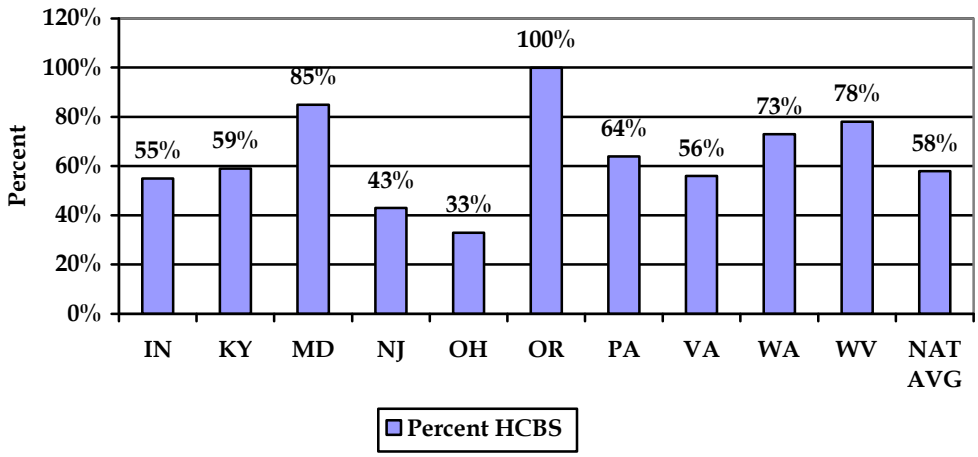


Figure IV-2: MR/DD



2. NURSING FACILITIES

In addition to our 10-state comparison on HCBS long term care services and supports is a comparison of states' nursing facilities. Table B-7 shows that West Virginia's number of nursing facilities and beds is comparable to other states.

Table B-7: Total Number of Beds and Certified Nursing Facilities, 2005

State	No. Facilities	No. Beds	Medicaid Enrollees	Beds / Medicaid Enrollees
New Jersey	341	47,966	974,500	20.3
Pennsylvania	702	86,224	1,786,300	20.7
Indiana	468	43,666	945,000	21.6
Ohio	864	80,977	1,938,800	23.9
Virginia	248	27,708	736,500	26.6
Maryland	228	27,953	752,000	26.9
Kentucky	295	25,969	809,900	31.2
West Virginia	120	9,577	366,400	38.3
Washington	243	22,189	1,160,600	52.3
Maine	106	6,978	378,200	54.2
Oregon	124	11,454	625,600	54.6

Source: Kaiser State Health Facts, 2005.

Table B-8 shows that WV ranks last in the nation in the number of special care beds in nursing facilities. Special care beds are defined as beds available in dedicated special care units in the following categories: Alzheimer's, AIDS, Hospice, Rehabilitation, Ventilator, and Dialysis. This is another important issue for WV to study. The addition of special care beds to the state's NFs could assist many individuals to obtain needed specialized services they currently get in other states. These types of special care services should also be available to people living within their home community.

Table B-8: Total Number of Special Care Beds in Certified Nursing Facilities, 2005

Rank	State	No. Special Care Beds
3	Pennsylvania	7,768
5	Ohio	6,930
9	Indiana	4,777
18	Virginia	1,899
19	Washington	1,882
21	New Jersey	1,741
26	Maryland	1,449
31	Kentucky	743
32	Oregon	695
39	Maine	513
50	West Virginia	46

Source: Kaiser State Health Facts, 2005.

Putting the 10 comparison states side by side when evaluating the average number of deficiencies in NFs (Table B-9), it is revealed that WV is one of the highest in deficiencies among the ten states. The Kaiser Family Foundation has defined a 'deficiency' as a problem that can result in a negative impact on the health and safety of residents. West Virginia's number of deficiencies per NF—8.7—is also considerably higher than the national average of 7.1. As such, this is another area that should be considered more closely in order to identify improvements.

Table B-9: Average Number of Deficiencies per Certified NF, 2005

Rank	State	Avg. # Deficiencies
13	Maine	9.3
19	West Virginia	8.7
22	Maryland	8.4
29	Indiana	7.0
32	Washington	6.7
34	Virginia	5.7
38	Ohio	5.4
38	Oregon	5.4
41	Pennsylvania	5.2
42	Kentucky	4.9
44	New Jersey	4.7

Source: Kaiser State Health Facts, 2005.

B. REBALANCING METHODS USED IN OTHER STATES

Policymakers often talk about rebalancing their long term care system, as if at one point it met some standard that defines "balanced". To achieve progress toward a balanced system, state officials first need to define what "balance" means and to establish indicators that allow them to track their progress.

Achieving balance is difficult because of the inherent institutional bias that is built into Federal Medicaid policy. Institutional bias is attributable to several factors:

- NF care, the most costly service, is an entitlement. Any Medicaid beneficiary who meets the state's level of care criteria for admission must be served if a Medicaid provider is willing to admit them.
- HCBS are provided under waivers that allow states to limit expenditures.

Enrollment is capped and waiting lists are established when the state reaches its approved capacity or appropriation.

Waivers must be budget neutral. Medicaid expenditures under the waiver may not exceed what would have been spent in the absence of the waiver.

The array of waiver services is determined by the state and may be broad or narrow.

Delays in determining Medicaid financial and functional eligibility may mean that services cannot be initiated in a timely manner and, in the absence of services, applicants may need to enter a NF. Medicaid LTC systems may be biased for several reasons:

Most HCBS must be covered through a waiver that may have a waiting list.

- Medically needy spend-down requirements are easily met in an institution but are more difficult to meet in the community.
- Absence of coverage for a full array of in-home, community and residential settings may limit an individual's options.
- Lack of access and awareness of community options may limit choice.

Though not clearly defined, balance is most often discussed in relation to:

- The percentage of Medicaid funds spent on HCBS compared to institutional care;
- The number of beneficiaries served in community settings versus institutional settings; and
- NF supply and occupancy rates.

Setting goals based on the percentage of Medicaid LTC funds spent on community versus institutional services may be misleading, since NF spending can be affected by rate increases and provider tax strategies that mask shifts in utilization. Measuring the percentage of beneficiaries served in institutional and community settings, the number of Medicaid bed days, and HCBS waiver service days may be better measures of progress toward a balanced system.

State leaders contend that balance is achieved by developing a comprehensive system rather than implementing individual strategies. While each of the following strategies plays its own important role, officials in states with the most balanced system suggest that the whole is more important than the sum of its parts.

1. PHILOSOPHY OF CARE

Developing public policy involves multiple decision makers and stakeholders including the executive branch agencies, the legislature, providers, consumers, families, and advocacy organizations. Developing a philosophy establishes a baseline to discuss policy options and strategies. Reaching consensus requires balancing the different perspectives and interests of each group of stakeholders. Once stakeholders agree, new proposals can be evaluated based on whether they are consistent with the purpose and philosophy of the system. Several states have described a philosophy for LTC programs that guides policy, budget and program decisions.

Oregon's philosophy is stated in statute as follows:

> …in keeping with the traditional concept of the inherent dignity of the individual in our democratic society, the older citizens of this state are entitled to enjoy their later years in health, honor, dignity, and disabled citizens are entitled to live lives of maximum freedom and independence. (§410.010)

The statute directs:

- That policies coordinate the effective and efficient provision of community services to older and disabled citizens so that services will be readily available to the greatest number over the widest geographic area;
- That information on these services be available in each locality;
- That older citizens and disabled citizens retain the right of free choice in planning and managing their lives; and
- Increases the number of options in life styles available by strengthening the natural support systems of family, friends and neighbors to further self-care and independent living. (§410.020).

State law in Washington (Revised Code of Washington §74.39.005) describes its vision of a comprehensive LTC system and directs the state agency to:

- Establish a balanced range of health, social, and supportive services that deliver long term care services to chronically, functionally disabled persons of all ages;
- Ensure that functional ability shall be the determining factor in defining long term care service needs and that these needs will be determined by a uniform system for comprehensively assessing functional disability;
- Ensure that services are provided in the most independent living situation consistent with individual needs;
- Ensure that long term care service options shall be developed and made available that enable functionally disabled persons to continue to live in their homes or other community residential facilities while in the care of their families or other volunteer support persons;
- Ensure that long term care services are coordinated in a way that minimizes administrative cost, eliminates unnecessarily complex organization, minimizes program and service duplication, and maximizes the use of financial resources in directly meeting the needs of persons with functional limitations;
- Encourage the development of a statewide long term care case management system that effectively coordinates the plan of care and services provided to eligible clients;
- Ensure that individuals and organizations affected by or interested in long term care programs have an opportunity to participate in identification of needs and priorities, policy development, planning and development, implementation, and monitoring of state supported long term care programs;

- Support educational institutions in Washington state to assist in the procurement of federal support for expanded research and training in long term care; and
- Facilitate the development of a coordinated system of long term care education that is clearly articulated between all levels of higher education and reflective of both in-home care needs and institutional care needs of functionally disabled persons.

Section 74.39A.005 states that "the public interest would best be served by a broad array of long term care services that support persons who need such services at home or in the community whenever practicable and that promote individual autonomy, dignity, and choice."

Each state must consider program options and budget decisions in the context of their own state. Legislators in Oregon and Washington considered funding and policy changes in light of the philosophy contained in statute. Revenue shortfalls pose challenges for states as they make policy and program decisions about spending for institutional and HCBS. Many states are able to respond to budget constraints by moving resources from institutional to community services. Washington was able to avoid reductions in its community-based programs because its commitment is to reduce the NF caseload and expand HCBS waiver spending.

2. ORGANIZATION STRUCTURE

Oregon and Washington consolidated all LTC functions, including determining Medicaid financial eligibility, licensing NFs and residential settings, rate setting, contracting and policy setting into a single agency. Vermont consolidated all the functions except Medicaid financial eligibility, and Massachusetts and New Mexico implemented partial consolidations.

Charles Reed, a former Assistant Secretary with the State of Washington, indicated that while he collaborated with his peers prior to the reorganization, they often had different priorities and made decisions that did not support the goals and philosophy of the LTC system. Reed contends that it is much easier to implement the state's philosophy and policy when you have the authority to make decisions rather than negotiating with the director of another agency whose priorities are different from yours. For example, most state agencies responsible for licensing and oversight of NFs are concerned about compliance with regulations and the survey process. The LTC agency is concerned about helping people in NFs move to the community if they are able to do so. When these functions are consolidated, you can do both more easily.

Pennsylvania created an Intra-Governmental Council on Long Term Care by Executive Order in 1998 and codified by Act 185. Its purpose is to study the long term care system from a funding, operational and consumer perspective and to make recommendations to the governor on ways to streamline administration of the system, and develop a full spectrum of options for consumers and their families. The Council is chaired by the Secretary of Aging and includes 3 members of the Cabinet, 4 legislators, providers and consumers. The Council's mandate includes:

- Providing a public forum for discussion on long term care issues;

- Analyzing and assessing the current system, examining options and suggesting recommendations for action;
- Developing a framework for a system of LTC services at the state and local level;
- Seeking short and long range options for financing long term care;
- Expanding efforts to educate consumers about long term care issues and alternatives;
- Examining and making recommendations on the organizational structure of services at the state and local level; and,
- Making recommendations on regulations and licensure of personal care homes.

The Council provided a mechanism for discussing LTC issues, identifying barriers and recommending policy changes and was the catalyst for the Governor's Office of Health Care Reform (GOHCR), created in 2003. GOHCR set a goal to develop a long term living system that is efficient and effective, focused on the well being of consumers and their family members and operating within the economic wellbeing of the state. GOHCR found that policies tend to be organized around departments rather than the delivery of services and therefore developed several key questions to guide the development of long term living services and financing:

- Do we know how much money we spend, should spend and can spend on LTC?
- What fact based data do we have to monitor program outcomes of providers?
- What has been, should be and could be the priority spending patterns on state supported access?
- What should the statutory and regulatory changes be to achieve accessible, affordable care?
- Do we know which socio-economic trends are having and will have the greatest impact on the demographics and the severity of need for state paid health and long term care services over the next five years?

GOHCR coordinated policy across agencies and programs and developed new initiatives that were supported through federal grants to reform the state's LTC system.

In New Mexico, the legislature enacted in 1998 the Long Term Care Services Act, which created an Interagency Committee on Long Term Care Services. The Committee was charged with designing and implementing a coordinated service delivery system. Members of the Committee included the State Agency on Aging, the Human Services Department, the Department of Health, Children, Youth and Families, Labor Department, Governor's Committee on Disability, the DD Planning Council, and the Department of Insurance. In 2002, membership was expanded to low income consumers with a disability, various disability organizations, the State Mortgage Finance Agency, the Department of Transportation and the Department of Finance and Administration. The Committee was not implemented until a new administration supported the realignment of agency responsibilities and cross agency planning and collaboration.

3. FINANCING STRATEGIES FOR REBALANCING

Despite the high growth in spending for HCBS, Grabowski (2006 Medical Care Research Review) found few recent evaluations of HCBS waivers in a review of the literature, one by the U.S. General Accounting Office (GAO 1994) and second by *Alecxih, et.al.* that supported their cost savings. The GAO report found that average expenditures for NF residents exceeded average expenditures for HCBS waiver participants in Oregon, Washington and Wisconsin. The report also reported that NF beds decreased slightly in each state between 1982 and 1993 while beds increased 20% nationally during the same period. *Alecxih* reviewed programs in Colorado, Oregon and Washington in 1996 to determine whether the growth in Medicaid waiver spending was associated with overall Medicaid savings. The study created a model that found expanding waiver spending accounted for $33.8 million less in spending in CO in 1994 than would have occurred in the absence of the program, with savings of $49 million in OR in 1994 and $57.1 million in WA.

States need the financial tools to implement a balancing plan and create a level playing field. As noted earlier, NF care is an entitlement under the Medicaid state plan while the preferred HCBS waiver services can be capped and sometimes have waiting lists. Creating a level playing field means removing barriers for individuals to choose community options.

Washington

In the State of Washington, budgets for LTC services are based on caseload forecasts prepared by an independent Caseload Forecasting Council. The Council projects and adjusts the expected caseloads for NF and HCBS programs for elders and adults with physical disabilities based on historic trends and changes in policy. Caseloads are projected for each month of the biennium. The home care caseload was expected to grow 3.0% from June 2005 to June 2006 and 2.9% from June 2006 to June 2007. The Medicaid NF caseload will decline 2.9% each year and the Medicaid personal care state plan caseload will rise 4.2% and 4.4% respectively.

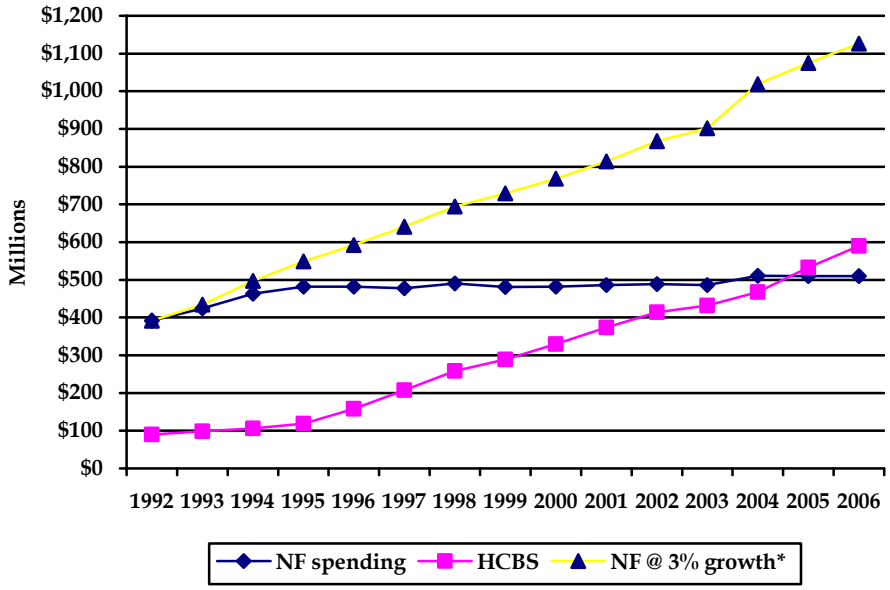
Table B-11: Caseload and Spending Trends for Elders & Adults with Physical Disabilities

Fiscal Year	Community Services		Nursing Facilities		Projected Nursing Facilities	
	Avg # consumers	Spending (Millions)	Avg # consumers	Spending (Millions)	Avg # consumers	Spending (Millions)
1995	19,772	$118.9	16,642	$481.6	18,962	$548.7
1996	20,887	$158.5	15,904	$482.1	19,531	$592.0
1997	23,116	$206.8	14,992	$477.7	20,117	$640.9
1998	25,675	$257.6	14,643	$490.4	20,721	$693.9
1999	27,576	$289.5	14,080	$480.9	21,343	$728.9

Fiscal Year	Community Services		Nursing Facilities		Projected Nursing Facilities	
	Avg # consumers	Spending (Millions)	Avg # consumers	Spending (Millions)	Avg # consumers	Spending (Millions)
2000	29,319	$329.9	13,782	$481.8	21,983	$768.5
2001	30,913	$374.2	13,529	$486.3	22,642	$813.9
2002	32,213	$414.4	13,152	$487.5	23,331	$864.4
2003	33,729	$432.4	12,943	$485.8	24,021	$901.6
2004	34,636	$467.8	12,447	$512.6	24,742	$1,018.9
2005	35,516	$533.2	12,084	$509.8	25,484	$1,075.2
2006	37,008	$589.7	11,900	$510.5	26,249	$1,126.1

In the mid-1990s, the WA legislature directed the Aging and Disability Services Administration to reduce the NF census by 750 individuals. Because funds for NF and HCBS are appropriated in a single line item, the state agency can allocate and spend funds flexibly. Over a 10 year time period, this flexibility allowed WA to reduce its Medicaid NF census from 17,000 to 11,900. The savings allowed the HCBS caseload to grow from 19,680 to 37,008 people, with 75% of beneficiaries receiving services in the community in FY 2006. This is important, as the average cost of serving one person in a community setting is one-third the cost of a NF. State officials estimate that if HCBS had not expanded, the Medicaid NF census would have risen 3% a year. Spending for NF care alone would have exceeded $1.1 billion a year in SFY 2006, which is greater than the combined cost of NF and community spending.

Figure IV-3: Projected Expenditures without HCBS expansion in Washington



Vermont

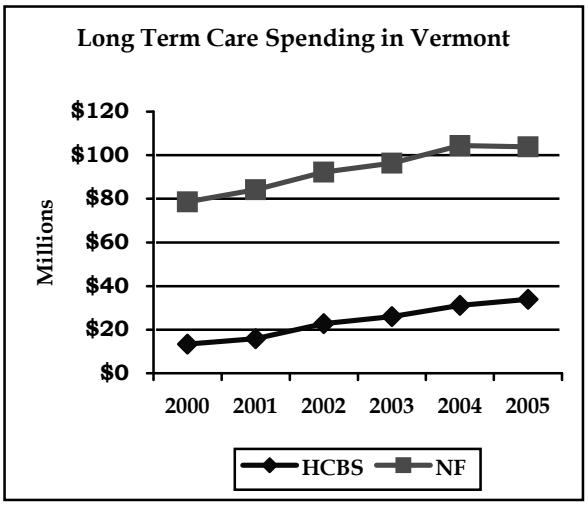
Vermont offers another example. Since 1995, Vermont's Medicaid spending for HCBS rose from 12% of Medicaid spending to 32% in 2005. The legislature passed Act 160 in 1996 which allowed unspent NF funds at the end of each fiscal year to be placed into a trust fund for use in subsequent years for HCBS or for mechanisms that reduce the number of NF beds. The law gave priority to NF residents who wanted to relocate to a community setting, anyone on a waiting list who was at the highest risk of admission to a NF, others at high risk and people with the greatest social and economic need.

The goal of the Vermont Department of Disabilities, Aging and Independent Living (DAIL) Services was that for every 100 people in a county who needed LTC, 40 of those people would receive HCBS and 60 would be in NFs. DAIL is considering moving that goal to a 50-50 ratio. The number of Medicaid NF beneficiaries declined by 12%, 466 people, between 1994 and 2004 and the number of HCBS participants rose 238% or 838 participants. State officials indicated that the shift reduced NF spending by 33% from what would have been spent if the number of waiver participants had not expanded.

In 2005, Vermont implemented "Choices for Care" through a §1115 Demonstration Waiver, a unique demonstration program that equalizes access to institutional, residential, community and in-home services for elders and individuals with disabilities who meet the "highest need" criteria. DAIL developed the demonstration as a broad based financing and delivery system

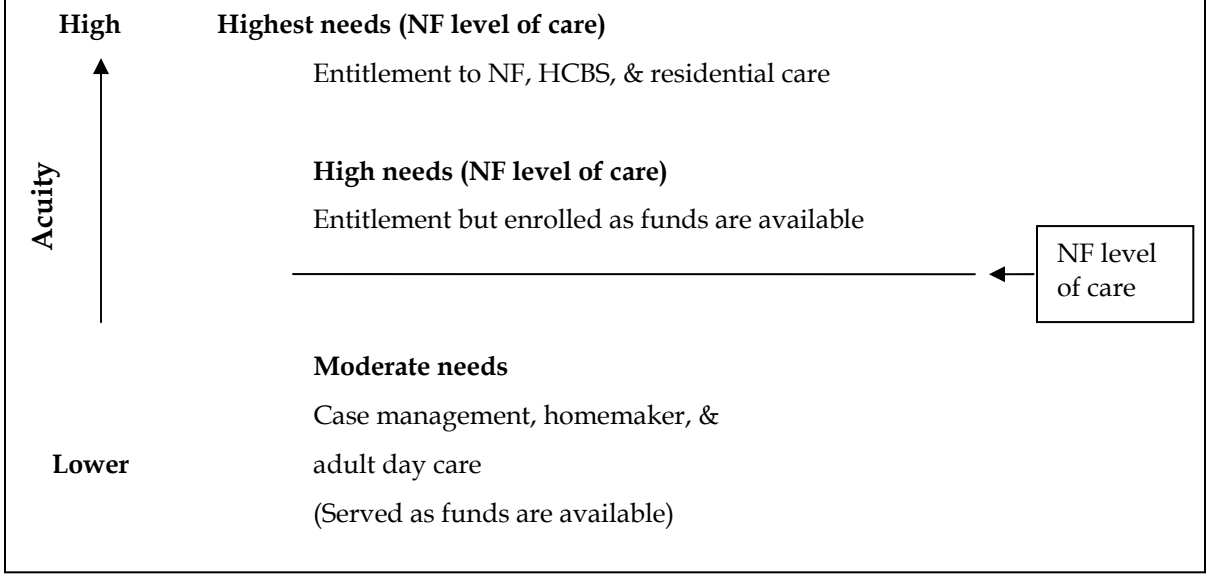
reform due in part to limited state revenues that threatened to undermine Act 160, which expanded HCBS services in the mid 1990s.

The State believes that offering choice through a global budget that gives equal access to HCBS and NF services would allow more beneficiaries to select HCBS. The Choices for Care Demonstration creates a global budget for in-home, community, residential and NF services.



The Demonstration created 3 clinical eligibility tiers: Highest Needs, High Needs and Moderate Needs. The Demonstration addresses institutional bias through an entitlement to HCBS for individuals who meet the clinical criteria for individuals in the Highest and High Needs categories. Although individuals in the High Needs group are clinically eligible for LTC, the Demonstration allows the state to create a waiting list for that group and they are served as funds become available. The Moderate Needs group, who are not clinically at the NF level of care, are served as funds are available. Individuals who received NF or waiver services prior to the Demonstration were automatically enrolled.

Figure 1 – Choices for Care Functional Groups



Twelve DAIL RNs complete the "Choices for Care Clinical Assessment," a seven page tool, to determine clinical eligibility using information received from the referral source or the applicant. The RNs are co-located with the financial eligibility staff to expedite and coordinate the clinical and financial eligibility processes. Hospital discharge planners are no longer able to place Medicaid beneficiaries into a NF without an assessment by the DAIL registered nurse except in emergencies or unless the NF is willing to take the risk. The DAIL RNs receive referrals, visit the applicant, complete the assessment and screen and determine the priority (highest need, high need or moderate need). Participants who select HCBS are referred to either the AAA or the HHA for case management based on their choice. Once eligible, the case management agency completes the longer Independent Living Assessment tool and develops a care plan which is reviewed and approved by DAIL.

In September 2006, DAIL served 2,131 in NFs (7% decline), and 1,343 received HCBS waiver services (12% increase). About 94% of the participants were in the highest needs group, with 65 on a waiting list. The demonstration also served 509 individuals in the moderate needs group. As of March 2007, there was no waiting list for the high need group. Vermont has experienced rapid growth in spending for HCBS: 154% between 2000 and 2005, while NF spending grew 32%.

Table B-12: Number of People By Category of Service

	September 2005	September 2006	March 2007	% Change
NF	2,286	2,131	2086	-8%
HCBS	1,207	1,343	1468	21%
Moderate needs	NA	509	506	NA
Waiting list	207	65	0	100%

Building on investment in home care services under Act 160 in 1996, spending on community services rose from 12 % in 1996 to 32% in 2005 (Wasserman, Shaping the Future of Long Term Care and Independent Living, 2006). As a result, the Medicaid NF census declined from 3,600 in 1996 to 3,150 in December 2005. The number of Medicaid certified NF beds dropped about half a percent from 3,560 in December 2001 to 3,401 in June 2006. By March 2007, that number had dropped to 3,329. Nationally, Medicaid certified NF beds grew 2.5% during same period. NF occupancy rates in Vermont were comparable, 90.8% in December 2001 and 90.1% in June 2006. The national occupancy rates were 85.9% in 2001 and 85.4% in 2006. As NFs are closed or downsized, occupancy levels increased to a more stable 93% by January 2007.

Wisconsin and Michigan

Several years ago, Wisconsin created a budget strategy to shift funds from the NF appropriation to HCBS. At the end of the fiscal year, the difference between the budgeted Medicaid bed days and actual Medicaid bed days was multiplied by the average Medicaid payment. The savings were available to be shifted to the HCBS waiver program in the following year.

Michigan also allows surplus funds appropriated for NF care to be used for HCBS. The appropriations bill states:

> If there is a net decrease in the number of Medicaid NF days of care during the most recent quarter in comparison with the previous quarter and the net cost savings attributable to moving individuals from a NF to the HCBS waiver program, the department shall transfer the net cost savings to the home- and community-based services waiver.[151]

In its report to the legislature, the Michigan Department of Community Health stated:

> The Mental Illness (MI) choice waiver program transitioned three hundred thirty seven individuals into the MI Choice Waiver program during Fiscal Year 2006. These transitions were reported in the MI Choice Waiting List Report. This represents a savings of approximately $4.43 million in FY 2006. The ability of Michigan senior citizens to age in the setting of their choice offers a measure of dignity and respect that goes far beyond the fiscal savings. These cost savings are reflected in the increased service costs associated with our current NF transition procedures.

4. SINGLE OR COMPREHENSIVE ENTRY POINTS

Earlier in the report, we reported that individuals seeking services, family members and advocates frequently express frustration in trying to obtain information about LTC services that are available to them. Without a visible entity that offers seamless entry to the system, consumers often have to contact multiple agencies and organizations, complete several application forms, and apply for programs that have different financial and functional eligibility criteria.

Comprehensive entry points (CEPs) have been established in many states to reduce fragmentation, provide information about LTC options and streamline access to services.[152] In their broadest forms, these organizations perform a range of activities that may include providing information, referral and assistance; screening; NF pre-admission screening and

[151] www.michigan.gov/documents/mdch/1689_2__11_01_06_190350_7.pdf
[152] Mollica, Robert and Jennifer Gillespie. "State Single Entry Point Systems: State Survey Results." Rutgers/NASHP Community Living Exchange, August 2003. www.nashp.org/Files/SEPReport 11.7.03.pdf

options counseling; assessment; care planning; service authorization; monitoring; and reassessment using one or more funding sources. CEPs may also provide protective services and may utilize Internet websites to provide information or screening tools that help individuals and family members understand their needs and the resources available to them. It is important to note that organizations that only provide information, referral and assistance are not considered CEPs.

A CEP may serve all consumers, including private pay, and offer options or benefits counseling and NF relocation/transition assistance, yet CEPs do not typically provide services that they authorize.

Consumers and family members typically need LTC services during a crisis. Delays accessing services needed to stay at home, or return home after a hospital admission, can lead to preventable NF admissions. Short term NF stays can become long term stays if social workers do not actively implement a discharge plan or case managers from community agencies do not work with the individual to assess their needs and arrange for community services.

Twenty-four states operate CEPs that serve older adults and manage access to Medicaid-funded HCBS and many manage Medicaid state plan services, Older Americans Act services, and programs funded by state general revenues. [153] States either combine CEP functions in a single agency or split them among agencies. In most cases, a particular agency or organization is the CEP, although some of the functions are contracted out to other organizations. For example, the local AAA may serve as the CEP and contract with local community-based nonprofit organizations to perform specific tasks, but the AAA is the responsible party. In other cases, functions are split between agencies. For example, in Washington, the state agency performs the assessment, eligibility determination, service authorization and ongoing case management for individuals in NFs, adult family homes and assisted living. The AAAs implement the consumer's care plan and provide ongoing case management for individuals living in the community. Other states may separate the information and screening functions from the authorization and case management activities. CEPs in a particular state may facilitate access to one or more, but not necessarily all, funding sources or programs.

5. OPTIONS COUNSELING

Many states conduct assessments to ensure that individuals seeking admission to a NF meet the state's level of care criteria. Over time, this pre-admission screening process has been expanded to include a presentation of the options that are available in the community. This is known as Options Counseling or Benefits Counseling and it is available in many states to inform

[153] Mollica, Robert and Jennifer Gillespie. "State Single Entry Point Systems: State Survey Results." Rutgers/NASHP Community Living Exchange, August 2003. www.nashp.org/Files/SEPReport 11.7.03.pdf

individuals and family members who apply for admission to a NF about the community services that are available to help them remain at home. Options Counseling is often mandatory for Medicaid beneficiaries seeking admission to a NF. It may be advisory for individuals who are not eligible for Medicaid but are likely to spend-down within 6 months of admission. Options Counseling may also be optional or mandatory for all individuals seeking admission to a NF. In some situations, the case manager informs the individuals who are not Medicaid beneficiaries about community alternatives. If the person does not meet the Medicaid level of care criteria, they are informed that Medicaid will not be able to pay for their care if they choose to enter a NF and later apply for Medicaid. Options Counseling allows individuals to make an informed decision about entering a NF and has been successfully implemented in the following ways:

Legislation adopted in Arkansas in 2007 created an Options Counseling program within the Department of Health and Human Services. It offers individuals:

- Information about LTC options and costs;
- An assessment of functional capabilities;
- A professional review, assessment and determination of appropriate LTC options;
- Information about sources of payment for the options;
- Factors to consider among available programs, services and benefits; and
- Opportunities for maximizing independence.

The program, set to begin in January 2008, will be available to all individuals admitted to a NF regardless of payment source, individuals admitted to a NF who apply for Medicaid, and any individual who requests a consultation. The counseling may be offered prior to or after someone is admitted to a NF (NFs in AR are required to notify the Department of admissions within 3 days).

Indiana provides counseling for all Medicaid beneficiaries applying for waiver services or admission to a NF and to all consumers seeking admission to a NF.

Since 1993, Maine has required preadmission screening of all applicants for admission to a NF, including private pay applicants, and for HCBS. Maine's rules are as follows:

- If the assessment finds the level of NF care clinically appropriate, the department shall determine whether the applicant also could live appropriately and cost effectively at home or in some other community-based setting if home-based or community-based services were available to the applicant. If the department determines that a home or other community-based setting is clinically appropriate and cost-effective, the department shall advise the applicant that a home or other community-based setting is appropriate; provide a proposed care plan and inform the applicant regarding the degree to which the services in the care plan are available at home or in some other community-based setting and explain the relative cost to the applicant of choosing community-based care rather than NF care; and offer a care plan and case management

services to the applicant on a sliding scale basis if the applicant chooses a home-based or community-based alternative to NF care.

Minnesota provides Long Term Care Consultation (LTCC), an evolution of a prior pre-admission screening program, to assist consumers in choosing the services that best meet their needs.[154] State law requires screening prior to admission to Medicaid-certified NF or boarding home and in addition, all individuals may request a Consultation. ADRCs developed a web-based decision tool that allows the consumer to enter information and receive information about the options that might be available in their community.

Ohio added LTC consultation for non-Medicaid beneficiaries in 2005 – defined by statute as "including, but not limited to, such services as the provision of information about long term care options and costs, the assessment of an individual's functional capabilities, and the conduct of all or part of the reviews, assessments, and determinations specified."[155] The information provided covers the availability of any LTC options open to the individual; sources and methods of both public and private payment for LTC services; factors to consider when choosing among the available programs, services, and benefits; and opportunities and methods for maximizing independence and self-reliance, including support services provided by the individual's family, friends, and community. Consultations are required for all NF applicants and current residents who apply for Medicaid. NFs that contract with Medicaid are not allowed to admit or retain any individual as a resident unless the facility has received evidence that a LTC consultation has been completed (unless the individual meets criteria exempting them from the requirement).

Oregon screens all Medicaid beneficiaries seeking NF care and private pay applicants who are likely to convert to Medicaid within 3 months of admission to a NF or HCBS services, as well as private pay consumers who will become Medicaid eligible within 90 days of admission.

Washington screens private pay applicants who are likely to spend-down within 180 days of admission.

Illinois requires NF Screening for all individuals age 60 and over, regardless of the payment source, prior to placement in a facility. Screenings are completed by the Department on Aging through contracts with Care Coordination Units and are conducted by hospital discharge planners/social workers who have been trained. Individuals receive information about all appropriate options and have the right to refuse any or all services. Post screening occurs if an individual is admitted to a NF without benefit of pre-screening; after NF placement in an emergency situation but within 15 calendar days from the date of the request for post screening;

---

[154] Kane, Rosalie and Robert Kane, et al. "Rebalancing Long Term Care Systems in Minnesota." CMS. www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp. Also: Auerbach, Roger and Susan Reinhard. "Minnesota's LTC Consultation Services." www.hcbs.org/openFile.php/fid/3965/did/1426

[155] Ohio Revised Code Section 173.42.

or for NF admissions from a hospital emergency room, outpatient services, or an out-of-state hospital.

6. NF RELOCATION PLANNING

This strategy involves helping NF residents who are interested in moving back to the community. Two states are good examples of this type of program: Washington and New Jersey.

The State of Washington, Aging and Disability Services Administration case managers are assigned to work with NF residents in 2-3 facilities with a caseload ratio of 1:400 for maintenance case management and 1:100 for active relocation. Case managers had been assigned to hospitals to work with discharge planners, but the state found that people being discharged from hospitals frequently needed short term rehabilitation services before they could return home. So the state shifted staff from hospitals to NFs to work with residents as their potential to move home improved. Case managers, who may be social workers or RNs, contact residents within 7 days of admission to the NF to inform them of their right to decide where they will live, discuss their preferences, likely care needs and the supports that are available in the community, and other service options. A full comprehensive assessment is completed when the consumer indicates that s/he is interested in working with the social worker to relocate and the nurse/social worker develops a transition plan with the consumer.

The Community Choice Counselors in New Jersey are state employees who are cross-trained to complete NF pre-admission screening, options counseling and transition support. They work with Independent Living Centers to transition people under age 60 who desire peer support. In 2003, there were 73 clinical staff (12 social workers and 61 RNs) funded with a federal match of 50% for social workers and 75% for RNs. Community Choice Counselors are organized into 3 regions, with assignments to specific hospitals and NFs in those regions. They follow a specific caseload of "Track II" individuals who have been screened and determined to need short-term NF care but have the potential to return to the community. Transition costs were initially funded from state general revenues until New Jersey received approval from CMS to add transition services under their HCBS waiver. About 40% of people transferred from NFs do not need Medicaid waiver services, but some Medicaid beneficiaries do use state plan services. In FY 2004, the Community Choice Counselors transferred 498 people and in prior years have transitioned as many as 1,000 people a year.

7. MAINTAINING A HOME

One important barrier a NF resident faces in relocating to the community is a lack of funds to maintain an existing home or to re-establish a residence. States have several options in this scenario.

First, states can exempt income that would normally be paid to the NF to allow residents to maintain or establish a home in the community. Beneficiaries who qualify for Medicaid under

the Special Income Level or Medically Needy program have income that is paid to the NF. Post-eligibility treatment of income rules (CFR435.832) permit states to exempt income so it can be used to maintain a home or to pay for costs related to moving to a residential or community setting. Exempting income raises the Medicaid payment to the NF during this transition period, with exemption allowed for up to 6 months. The exempt income can be used to cover rent, mortgage, property taxes, insurance, and utilities.

Other states use transition service coverage under their HCBS waiver(s). CMS allows HCBS waivers to cover the reasonable costs of community transition services, such as security deposits that are required to obtain a lease on an apartment or home; essential furnishings and moving expenses required to occupy and use a community domicile; set-up fees or deposits for utility or services access (e.g. telephone, electricity, heating); health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy. Essential furnishings include a bed, table, chairs, window blinds, eating utensils and food preparation items. Televisions, cable TV access or VCRs may not be included when they are for purely diversion or recreational purposes, but may be justified by the State when they serve other functions, such as the prevention of isolation.

8. PRESUMPTIVE ELIGIBILITY

Providing access to appropriate LTC services as quickly as possible is an important goal of state healthcare delivery systems. The array of community, residential and institutional service options, fragmented delivery systems and the confusing, often time consuming, Medicaid eligibility process makes it difficult for individuals and family members to navigate the system.

States have an incentive to expedite applications from individuals seeking LTC services, although the incentive may be less apparent to the staff and managers responsible for these determinations: eligibility delays influence the service choices that may be available to the applicant. Financial eligibility is often determined by an agency that is not under the direct control of the State Medicaid Agency (SMA), which makes setting priorities and managing work flow more difficult for the Medicaid agency. The Medicaid staff may be more concerned that errors will be made that force the agency to forego federal reimbursements for HCBS.

A report to CMS from the Medstat Group, Inc. on presumptive eligibility reported that almost half of all NF residents are admitted from hospitals and another 11 percent are admitted from other NFs, with less than 30% coming from private or semi-private residences.[156] Delays in determining Medicaid eligibility may affect the decision about where services may be available. NFs are more willing to admit individuals while their Medicaid application is pending than community care providers, who face a higher risk of not being paid for services delivered.

---

[156] David Stevenson, Joanne McDonald and Brian Burwell. "Presumptive Eligibility for Individuals with Long Term Care Needs: An Analysis of a Potential Medicaid State Option." Prepared for CMS, CMSO, DEHPG by the Medstat Group, Inc. August 23, 2002.

Residents who are found ineligible, or their families, can be charged for services delivered and expected to pay. NFs are able to measure the resident's income and resources and judge whether they will become a Medicaid beneficiary or remain private pay. Community service agencies have less experience with Medicaid eligibility criteria and less assurance that individuals who are found ineligible will be able to pay for services. Uncertainty about Medicaid eligibility and a source of payment means that community agencies are less willing to accept a referral while the Medicaid application is processed. Therefore, individuals who are not able to pay privately for in-home or residential services are more likely to enter a NF.

There are 2 primary ways to expedite eligibility:

- With presumptive eligibility, the eligibility workers or case managers, nurses or social workers are responsible for the functional assessment and level of care decisions. Using pre-determined criteria, they decide whether the individual is likely to be financially eligible for services and may initiate services before the official determination is made by the eligibility staff.
- Fast track initiatives accelerate the process and address the factors that are most likely to cause delays by fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing HCBS, helps the individual or family member complete the application and attach sufficient documentation of income, bank accounts, and other assets to allow the financial eligibility worker to make a decision. Fast track processes reduce the time it takes to complete a financial application using the normal channels.

The Washington Aging and Disability Services Administration (ADSA) developed a presumptive eligibility process for LTC programs for adults with disabilities and elders.[157] The financial eligibility workers, social workers or nurses who conduct assessments and authorize LTC services are located within ADSA. The policy allows social workers or nurses to authorize delivery of essential services before the full eligibility process is completed. This approach is used when the case manager has sufficient financial information (including a statement or declarations by the individual) that lead staff to the reasonable conclusion that the applicant will be financially eligible for Medicaid. The case manager consults with the financial worker, completes an assessment and service plan and authorizes services for 90 days. The individual must submit a formal application for Medicaid within 10 days of the service start date. Individuals sign a fast track agreement that specifies that services are time-limited and the applicant must complete an application with 10 days and will be liable for the cost of delivered services if they are found ineligible. Eligibility workers are able to "presume" eligibility and approve Medicaid coverage in a day, if it means that a beneficiary can receive services in a residential or community setting instead of a NF. Since FFP is not available for services

[157] Robert Mollica. Expediting Medicaid Financial Eligibility. Rutgers/NASHP Community Living Exchange. August 2004. Available at: www.nashp.org/Files/SEPReport11.7.03.pdf

delivered if the applicant is not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the risk is limited compared to the savings realized by serving a person in the community. Washington officials have determined that clients presumed eligible save Medicaid an average of $1,964 per person per month when community services are authorized for people who would have entered an institution if services were delayed.

Nebraska allows presumptive eligibility for potential waiver clients when the client has signed and submitted a Medicaid application to the Medicaid eligibility staff. To avoid confusion with the federally-approved presumptive eligibility option, Nebraska named its program "Waiver While Waiting." Financial eligibility is the responsibility of a state agency that is separate from the division responsible for waiver services. However, staff in both divisions have joint access to the data system that is used for Medicaid eligibility and for waiver services authorization, provider enrollment and billing/payment. Service coordinators receive some training on the Medicaid financial eligibility criteria but do not advise applicants. Service coordinators work closely with the financial eligibility worker to determine when a person may be presumed eligible. After the assessment has been completed and the level of care determined, clients are given a choice of entering a NF or receiving waiver services. The service coordinator contacts the Medicaid eligibility staff to determine if the applicant is likely to be Medicaid eligible. To receive services under presumed eligibility, the applicant must agree to complete the application, submit all necessary financial records and meet any cost sharing obligations. Applicants sign a consent form and a notation is made on the consent form indicating that the applicant is presumed eligible until a final Medicaid eligibility decision has been made. When the consent form is approved by the financial eligibility worker, service coordinators may authorize ongoing waiver services and medical transportation services for clients while the application is being processed. Home modifications and assistive technology services may not be presumptively authorized. The service coordinator maintains regular contact with the Medicaid eligibility staff until a final decision is made. If the client is found ineligible, the services coordinator sends a written notification to the client in writing that services are terminated and offers assistance and referrals to other programs or resources. In the few instances in which applicants were later found to be ineligible, Social Services Block Funds were used to pay for the services delivered.

9. EXPEDITING ACCESS

As previously mentioned in this section, in Pennsylvania, the Intra-Governmental Long Term Care Council conducted a system-wide review of access to LTC services and as a result, developed the Community Choices program to address twenty-two processes, information and systemic barriers to HCBS. Many barriers related to the delays in establishing Medicaid functional and financial eligibility. As such, Community Choices offered the following efficiencies:

- A reduction in the Medicaid financial application from 12 to 4 pages;

- Self-declaration of income and assets for applicants under the 300% special income level;;
- Presumptive financial eligibility to facilitate access within 24 hours when necessary;
- Exemption for $6,000 in assets;
- Exemption for burial plots;
- 24/7 access to assessments and eligibility determination;
- Reduction in the functional assessment form from 30 to 5 pages; and
    - Expedited appeal process for denials.

During the first year of operation, the Community Choice pilot sites received 8,810 applications, with 89% of applicants aged 60 years and older. Twelve percent of all applications were processed within 72 hours and 5 percent within 24 hours. About 30% of the referrals were made by family members, 19% were from hospitals, and 11% were from AAA network agencies, NFs, and other service providers. 74% of applicants were found eligible while about 10% were either financially or functionally ineligible, and another 10% were pending at the end of each reporting period. The data indicated that 27% of applicants were diverted from NF placement, relocated from a NF or were referred by a NF and the remaining 67% accessed services more quickly. State agencies are currently adapting existing information to determine the impact on NF admissions and Medicaid bed days within Pennsylvania's Community Choice demonstration counties.

10. ARRAY OF SERVICES

When states offer a full array of in-home, community and residential service options, individuals have the most choice and the best opportunities to avoid admission to a NF.

Services in assisted living or similar residential settings are covered in 43 states through HCBS waivers, Medicaid state plan personal care services, and state general revenues. In 2004, approximately 121,000 Medicaid beneficiaries received supportive services in assisted living or other licensed residential settings.[158] The comparison of the Medicaid waiver level of care criteria and the regulations setting admission and retention criteria in assisted living settings is one of the important issues in covering services in licensed facilities.

West Virginia combined separate licensing categories for personal care homes and residential board & care homes into one assisted living category in 2003, with final rules for assisted living residences promulgated in February 2004. An Assisted Living Residence (ALR) in WV is "any living facility or place of accommodation in the State, however named, available for four (4) or more residents, that is advertised, offered, maintained or operated by the ownership or management, for the express or implied purpose of providing personal assistance, supervision,

[158] Mollica, Robert and Heather Johnson Lamarche. "State Assisted living and Residential Care Policy: 2004." http://aspe.hhs.gov/daltcp/reports/04alcom.htm

or both, to any residents who are dependent upon the services of others by reason of physical or mental impairment, and who may also require nursing care at a level that is not greater than limited and intermittent nursing care. A small assisted living residence has a bed capacity of four (4) to sixteen (16). A large ALR has a bed capacity of seventeen (17) or more."

ALRs may not[159]:

- Admit individuals requiring ongoing or extensive nursing care and shall not admit or retain individuals requiring a level of service that the residence is not licensed to provide or does not provide. A resident whose condition declines after admission, and is receiving services coordinated by a licensed hospice or certified HHA, may receive these services in the residence if the residence has a backup power generator for services using equipment that requires auxiliary electrical power in the event of a power failure.
- If a resident exhibits symptoms of a mental or developmental disorder that seems to pose a risk to self or others, and the resident is not receiving behavioral health services, the residence must advise the resident or his or her legal representative of the behavioral health service options within the community.
- Individuals who become bedfast subsequent to admission may remain in the home for 90 days during a temporary illness or when recovery from surgery if the resident's care does not require nursing care in excess of limited and intermittent nursing care.

West Virginia needs explore whether its current assisted living regulations and statutes offer the array of services that are actually needed and desired by the residents of the state.

11. WAIVER LEVEL OF CARE

There are two philosophies about setting level of care thresholds for waivers: setting higher levels limits eligibility for admission to a NF and also for participation in an HCBS waiver, while setting a lower threshold expands the number of individuals who would qualify for admission to an institution as well as for waiver services. Proponents of a lower threshold contend that it helps prevent admission to a NF by allowing people who are at risk to receive waiver services, since, when given a choice, individuals often will choose to remain in the community with waiver services over entering a NF.

[159] Ibid.

APPENDIX C

LIST OF ACRONYMS

Acronym	Definition
AAA	Area Agencies on Aging
ABI	Acquired Brain Injury
ACT	Assertive Community Treatment
ADA	Americans with Disabilities Act
ADC	Adult Day Care
ADL	ADLs
ADP	Average Daily Population
ADRC	Aging and Disability Resource Centers
ADSA	Aging and Disability Services Administration (Washington State)
ADW	AD Waiver (WV)
ALR	Assisted Living Residences
AoA	Administration on Aging
APS	Adult Protective Services
BHHF	Bureau for Behavioral Health and Health Facilities
BMS	Bureau for Medical Services
BON	Board of Nursing
BoSS	Bureau of Senior Services
CAMC	Charleston Area Medical Center
CEP	Comprehensive Entry Point
CFR	Code of Federal Regulations
CIL	Center for Independent Living
CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CONREP	Forensic Conditional Release Program

Acronym	Definition
CoP	Conditions of Participation
C-PASS	Community Integrated Personal Assistant Services and Supports
CPS	Child Protective Services
CR	Conditional Release
CRIPA	Civil Rights of Institutionalized Persons Act
CSR	Code of State Regulations
CY	Calendar Year
DAIL	Disabilities, Aging and Independent Living
DD	Developmental Disability
DHHR	Department of Health and Human Resources (WV)
DHHS	Department of Health and Human Services
DOJ	Department of Justice (US)
DRA	Deficit Reduction Act
DRS	Division of Rehabilitation Services (WV)
EHR	Electronic Health Record
FFP	Federal Financial Participation
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FTE	Full Time Equivalent
FY	Fiscal Year
GAO	General Accounting Office (US)
GOHCR	Governor's Office of Health Care Reform (Pennsylvania)
HCBS	Home and Community-based Services
HHA	Home Health Agency
HUD	Housing and Urban Development
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation

Acronym	Definition
inROADS	Information Network for Resident Online Access and Delivery of Services
IPP	Individual Program Plan
LANE	Local Area Network of Excellence
LIFE	Legislative Initiative for the Elderly
LOC	Level of Care
LOCHHRA	Legislative Oversight Commission on Health and Human Resources Accountability
LPN	Licensed Practical Nurse
LTC	Long Term Care
LTCC	Long Term Care Consultation (Minnesota)
MDS	Minimum Data Set
MDTV	Telemedicine
MFP	MFP
MH	Mental Health
MI	Mental Illness
MI/MR	Mental Illness/Mental Retardation
MR	Mental Retardation
MR/DD	Mental Retardation/Developmental Disability
MSW	Master of Social Work
NAIC	National Association of Insurance Commissioners
NF	Nursing Facilities
NNA	Net Negotiated Amount
NOS	Not Otherwise Specified
NPA	Nurse Practice Act
NWVCIL	Northern WV Center for Independent Living
OHFLAC	Office of Health Facilities Licensure and Certification
OQPI	Office of Quality and Program Integrity (BMS)

Acronym	Definition
OSCAR	On-Line Survey and Certification and Reporting
OT	Occupational Therapy
PAAS	Physician Assured Access System
PACE	Program for All-Inclusive Care for the Elderly
PAIRS	People's Advocacy Information and Resource Services
PAS 2000	Pre-Admission Screening
PB	Purple Book (WV Board of Nursing)
PCCM	Primary Care Case Management
PCG	Public Consulting Group
PCP	Person-Centered Planning
PCP	Primary Care Physician
PCS	Personal Care Services
PT	Physical Therapy
QA	Quality Assurance
QAI	Quality Assurance and Improvement
QI	Quality Improvement
RHS	Rural Housing Services
RN	Registered Nurse
RRDC	Regional Resource Development Centers
RYPAS	Ron Yost Personal Assistant Services
SAMHSA	Substance Abuse and Mental Health Services Administration
SAV	Standard Appraisal Value
SFY	State Fiscal Year
SMA	State Medicaid Agency
SNV	Skilled Nurse Visit
SSA	Social Security Administration
SSI	Social Security Income

Acronym	Definition
ST	Speech Therapy
SVP	Sexually Violent Predator
TANF	Temporary Assistance to Needy Families
TBI	Traumatic Brain Injury
TIC	Transition to Inclusive Communities
UAP	Unlicensed Assistive Personnel
USDA	United States Department of Agriculture
VA	Veterans Administration
WV	West Virginia
WVDDC	WV Developmental Disabilities Council
WVMHCA	WV Mental Health Consumers' Association
WVMI	WV Medical Institute
WVSILC	WV Statewide Independent Living Council
WVTCC	WV Transportation Coordinating Council
WVU	West Virginia University

APPENDIX D

SUMMARY OF STATE ELIGIBILITY & ENROLLMENT PROCEDURES FOR LONG TERM CARE SERVICES

The following summarizes the West Virginia eligibility and enrollment procedures for the MR/DD Waiver Program, the ICF/MR Program, the AD Waiver, Nursing Facility Services and Personal Care Services. The source of the information is the BMS Manual accessed on-line on 06/05/08.

MR/DD Waiver Program Enrollment Process:

1. A member may obtain an application packet from local Behavioral Health Centers, local/county DHHR offices or the State MR/DD Waiver Office.
2. Once the applicant completes the application (DD-14), s/he will submit the DD-14 to the selected MR/DD Waiver provider agency or the State MR/DD Waiver Office.
3. Upon receipt of the DD-14, the selected Waiver provider agency will sign and date the DD-14.
4. The Waiver provider agency will forward a copy of the DD-14 to the State MR/DD Waiver Office.
5. Once the State MR/DD Waiver Office receives the application, it will be processed and determination of medical eligibility should occur within 90 days.
6. Then the selected MR/DD Waiver has 45 days to submit the application packet to the State Waiver Office which consists of: annual medical evaluation (DD-2A); comprehensive psychological evaluation (DD-3); social history (DD-4); IEP (if applicable); Birth to Three Assessments (if applicable); and any other documentation or information deemed necessary.
7. The State MR/DD Waiver Office will make a final eligibility determination within 45 days of receipt of the application packet.
8. If deemed eligible, the individual will be placed on the waiting list until a slot becomes available.
9. If an applicant is denied medical eligibility, a Notice of Decision is sent to the applicant/applicant's and an appeal may be filed within 90 days.

ICF/MR Program Enrollment Process:

1. Medical eligibility is determined by submitting an application packet to the Bureau for Medical Services, Office of Behavioral and Alternative Health Care for member consideration.

2. The application packet consists of the Identification and Demographic Information Face Sheet (DD-1), the Medical Evaluation (DD-2A), the Psychological Evaluation (DD-3), the Social History (DD-4) and the Individual Program Plan (IPP or DD-5).
3. The application packet must be current and received by the BMS within ninety (90) days of admission to the ICF/MR or authorization of payment.
4. When the current information is received in its entirety an eligibility determination will be made as quickly as possible (maximum 45 days) and the decision communicated to the recipient and provider.
5. Presumptive eligibility is available to those seeking ICF/MR services. Individuals can have their eligibility determined after their admittance to an ICF/MR. To establish eligibility, a complete packet as described above must be submitted to BMS within thirty (30) days after placement. The provider will assume the financial risk of providing services during the period that eligibility is being considered.

MR/DD Waiver Medical Eligibility Criteria

The MR/DD State Waiver Office determines the medical eligibility for an applicant in the MR/DD Waiver Program. In order to be eligible to receive MR/DD Waiver Program Services, an applicant must meet the following medical eligibility criteria:

1. Have a diagnosis of mental retardation and/or a related condition,
2. Require the level of care and services provided in an ICF/MR (Intermediate Care Facility for the Mentally Retarded) as evidenced by required evaluations and corroborated by narrative descriptions of functioning and reported history. An ICF/MR provides services in an institutional setting for persons with mental retardation or related condition. An ICF/MR facility provides monitoring, supervision, training, and supports.

To be eligible, the member:

1. Must have a diagnosis of mental retardation, with concurrent substantial deficits (substantial limitations associated with the presence of mental retardation), and/or
2. Must have a related developmental condition which constitutes a severe and chronic disability with concurrent substantial deficits. Examples of related conditions which may, if severe and chronic in nature, make an individual eligible for the MR/DD Waiver Program include but are not limited to, the following: (a) any condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires services similar to those required for persons with mental retardation; (b) Autism; (c) Traumatic brain injury; (d) Cerebral Palsy; (e) Spina Bifida; (f) Tuberous Sclerosis

Additionally, the member who has a diagnosis of mental retardation and/or related conditions and associated concurrent adaptive deficits must have the following:

1. Manifested prior to the age of 22
2. Likely to continue indefinitely
3. Must have the presence of a least three (3) substantial deficits out of five of the major life areas

Functionality

Substantially limited functioning in three (3) or more of the following major life areas; ("substantially limited" is defined on standardized measures of adaptive behavior scores as three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or equal to or below the seventy fifth (75) percentile when derived from MR normative populations. The presence of substantial deficits must be supported not only by the relevant test scores, but also the narrative descriptions contained in the documentation submitted for review, i.e., psychological, the IEP, Occupational Therapy evaluation, etc.). Applicable categories regarding general functioning include**:** Self-care; Receptive or expressive language (communication); Learning (functional academics); Mobility; Self-direction; Capacity for independent living (home living, social skills, employment, health and safety, community and leisure activities).

Active Treatment

Requires and would benefit from continuous active treatment.

Medical Eligibility Criteria: Level of Care

To qualify for ICF/MR level of care, evaluations of the applicant must demonstrate: (a) a need for intensive instruction, services, assistance, and supervision in order to learn new skills, maintain current level of skills, and increase independence in activities of daily living; (b) a need for the same level of care and services that is provided in an ICF/MR institutional setting.

Conditions Ineligible

1. Substantial deficits associated with a diagnosis other than mental retardation or a related diagnosis do not meet eligibility criteria.
2. Additionally, any individual needing only personal care services does not meet the eligibility criteria.

3. Individuals diagnosed with mental illness whose evaluations submitted for medical eligibility determination indicate no previous history of co-occuring mental retardation or developmental disability prior to age 22. The member's clinical evaluators must provide clinical verification through the appropriate eligibility documentation that their mental illness is not the primary cause of the substantial deficits and the mental retardation or developmental disability occurred prior to the age of twenty-two (22).

ICF/MR Medical Eligibility Criteria:

BMS through its contracted agent determines the medical eligibility for an applicant in the ICF/MR Program. In order to be eligible to ICF/MR Services, an applicant must have both a diagnosis of mental retardation or a related condition and also manifest concurrent substantial adaptive deficits.

1. Persons with **related conditions** means individuals who have a severe, chronic disability which is attributable to:
   a. cerebral palsy or epilepsy; or
   b. any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; and the severe chronic disability
      (1) The mental retardation or related condition is manifested (both diagnosis and substantial deficits) before a person reaches twenty two (22) years of age and
      (2) the mental retardation or related condition is likely to continue indefinitely

2. The applicant must have substantial limits in three (3) or more of the following major life areas: self care; receptive and/or expressive language (communication); learning (functional academics); mobility; self direction; capacity for independent living (home living, social skills, employment, health and safety, community use, leisure).
   a. Substantial adaptive deficits is defined as scores on standardized measures of adaptive behavior three (3) standard deviations below the mean or less than one (1) percentile when derived from non MR normative populations or in the average range or below the seventy fifth (75th) percentile when derived from MR normative populations.

b. The presence of substantial deficits must be supported by the additional documentation submitted for review (e.g. IEP, OT evaluations, narrative descriptions, etc.).

3. The applicant must have a need for an ICF/MR level of care that: is certified by a physician (DD-2A) and, is recommended by the evaluating psychologist (DD-3) and, is identified by a licensed social worker (DD-4).

The applicant requires and would benefit from active treatment. Evaluations of the applicant must demonstrate a need for intensive instruction, services, assistance, and supervision in order to learn new skills and increase independence in activities of daily living.

AD Waiver Enrollment Process:

1. An applicant shall initially apply for the AD Waiver by having his/her treating physician submit a Medical Necessity Evaluation Request form by fax or mail.
2. The physician's signature is only valid for sixty (60) days.
3. Once the referral is received, the QIO will send a letter of verification of its receipt to the applicant/applicant's representative and the referring physician.
4. An RN from the QIO will attempt to contact the applicant/applicant's representative to schedule a home visit, allowing at least two weeks notification before the evaluation. The RN will make up to three attempts to contact the applicant. Certain diagnoses of the applicant will require the presence of the guardian, contact person, or legal representative to assist during the interview.
5. When the home visit occurs, the QIO RN, through observation and/or interview process, completes the PAS. The RN will record observations and findings regarding the applicant's level of function in the home.
6. If the applicant is determined medically eligible, a notice of approved medical eligibility is sent to the applicant, the referring physician, and applicant's representative.
7. When an allocation becomes available in the AD Waiver Program, a second notice of approved medical eligibility is sent.
8. Then the QIO sends a Freedom of Choice Case Management Selection Form to the applicant, advising of the applicant's need to choose a case management agency, Personal Options, or the self-directed case management option.

9. A copy of the applicant's PAS is sent to the case management agency to begin service provision.
10. If an applicant is denied medical eligibility, a Notice of Decision is sent to the applicant/applicant's and an appeal may be filed within 90 days.

AD Waiver Eligibility Criteria:

An individual must have five (5) deficits o the Pre-Admission Screening (PAS) to qualify medically for the AD Waiver Program. These deficits are derived from a combination of the following assessment elements of the PAS:

1. Decubitus - Stage 3 or 4
2. In the event of an emergency, the individual is medically unable or physically unable to vacate a building.
3. Eating - Level 2 or higher (physical assistance to get nourishment, not preparation)
4. Bathing – Level 2 or higher (physical assistance or more)
5. Dressing – Level 2 or higher (physical assistance or more)
6. Grooming – Level 2 or higher (physical assistance or more)
7. Continence, bowel – Level 3 or higher; must be incontinent
8. Continence, bladder – Level 3 or higher; must be incontinent
9. Orientation – Level 3 or higher (totally disoriented, comatose)
10. Transfer – Level 3 or higher (one-person to two-person assistance in the home)
11. Walking – Level 3 or higher (one-person assistance in the home)
12. Wheeling – Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in home. Do not count outside of home.
13. Individual has skilled needs in one or more of these areas: suctioning; tracheostomy; ventilator; parenteral fluids; sterile dressings; or irrigations.
14. Individual is not capable of administering own medications.

Nursing Facility Enrollment Process:

An application for NF benefits may be requested by the resident, the family/representative, the physician, or the health care facility. The steps involved in approval for payment of NF services are:

1. The application for NF services is made to the local DHHR office. The determination of financial eligibility for Medicaid is the responsibility of the local DHHR office; and
2. Medical eligibility determination is the responsibility of the BMS based on a physician's assessment of the medical and physical needs of the individual. This assessment must have a physician signature dated not more than sixty (6) days prior to the start of services.

To qualify for the NF Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The BMS has designated a tool known as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical need of the individual.

Once the PAS is certified/signed and dated by the physician, it is forwarded to the BMS or its designee for medical necessity review.

Nursing Facility Eligibility Criteria:

An individual must have five (5) deficits o the Pre-Admission Screening (PAS) to qualify medically for Nursing Facility care. These deficits are derived from a combination of the following assessment elements of the PAS:

1. Decubitus - Stage 3 or 4
2. In the event of an emergency, the individual is medically unable or physically unable to vacate a building.
3. Eating - Level 2 or higher (physical assistance to get nourishment, not preparation)
4. Bathing – Level 2 or higher (physical assistance or more)
5. Dressing – Level 2 or higher (physical assistance or more)
6. Grooming – Level 2 or higher (physical assistance or more)
7. Continence, bowel – Level 3 or higher; must be incontinent
8. Continence, bladder – Level 3 or higher; must be incontinent
9. Orientation – Level 3 or higher (totally disoriented, comatose)
10. Transfer – Level 3 or higher (one-person to two-person assistance in the home)
11. Walking – Level 3 or higher (one-person assistance in the home)

12. Wheeling – Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in home. Do not count outside of home.
13. Individual has skilled needs in one or more of these areas: suctioning; tracheostomy; ventilator; parenteral fluids; sterile dressings; or irrigations.
14. Individual is not capable of administering own medications.

Personal Care Enrollment Process:

Personal Care Services (PCS) must be (a) prescribed by a physician on a Personal Care Medical Eligibility Assessment (PCMEA); (b) necessary tot eh long term maintenance of the individual's health and safety; (c) provided pursuant to a plan of care developed and monitored by an RN; (d) rendered by an individual who has met the basic training requirements of the program.

The physician completes the PCMEA. The assessment must be signed and dated by the physician, and becomes the physician's order and certification for PCS for the individual. Upon request for PCS, an RN must review the PCMEA information to determine that the medical and physical care needs of the applicant meet the medical needs criteria of BMS for reimbursement by Medicaid. An RN must sign and date the PCMEA as directed o the form. This signature means that the RN verifies by direct observation and assessment that the applicant has met the medical level of care set forth by BMS.

Personal Care Eligibility Criteria:

An individual with three (3) or more deficits at the appropriate level in the following functional areas qualifies for PCS.

The following are the minimum ratings considered as deficits in activities of daily living for PCS:

1. Eating Level II or higher (physical assistance or more)
2. Bathing Level II or higher (physical assistance)
3. Grooming Level II or higher (physical assistance)
4. Dressing Level II or higher (physical assistance)
5. Continence Level II/III (occasional incontinence or incontinent)
6. Orientation Level III or higher (totally disoriented;comatose)
7. Transferring Level III or higher (1or 2 person assist)
8. Walking Level III or higher (1 or 2 person assist)
9. Wheeling Level III or higher (situational/total assistance)

An individual may also qualify for personal care level service if he/she has two (2) functional deficits identified as listed above, (items refer to PCMEA) and any one or more of the following conditions indicated on the PCMEA:

1. Pressure-sores rated at Stage 3 or 4
2. The individual is incapable of vacating a building
3. Professional/Technical Care: The individual has professional or technical care needs which are provided by the individual himself or by a family member for one or more of the following services: suctioning; tracheostomy; ventilator; parenteral fluids; sterile dressings; or irrigations.
4. Medication Administration (item #28) indicates that the individual is not capable of administering his/her own medications. Injections are a skilled need and are not considered in this area.