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STATE FISCAL YEAR 2011 INDEPENDENCE, DIGNITY, AND CHOICE IN LONG-TERM CARE ANNUAL REPORT

STATE OF NEW JERSEY

Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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1

Introduction

The Independence, Dignity, and Choice in Long-Term Care Act (the Act), Public Law 2006, chapter 23, requires an annual report to the governor and the legislature that documents the reallocation of funds to home- and community-based care.

Mercer Government Human Services Consulting (Mercer) has been engaged by the State of New Jersey (State) Division of Aging Services (DoAS) , previously known as the Division of Aging and Community Services in the Department of Health and Senior Services, to provide long-term services and supports (LTSS) member and expenditure data and projections for DoAS. With the transfer in the state fiscal year 2012 budget of senior supports and services from the Department of Health to DoAS, the Department of Human Services is now charged with presenting this newest report covering state fiscal year (SFY) 2011 from July 1, 2010 through June 30, 2011. The data is derived from the budget rebalancing model that Mercer developed for DoAS to meet the charge set forth under the Act. The model is designed to document the reallocation of funds to home- and community-based services (HCBS) away from nursing home placement. The model utilizes current and past members, service utilization, and expenditure information to forecast potential Medicaid LTSS spending over time.

Key findings in this annual report include the following:

- In SFY 2011, although 39% of LTSS members resided in nursing facilities (Figure V), expenditures for nursing facility members accounted for 67% of total expenditures for LTSS members (Figure XI).
  - In SFY 2008, 44% of LTSS members resided in nursing facilities; this figure fell to 43% in SFY 2009 and to 41% in SFY 2010 before ending SFY 2011 at 39% (Figure V).
  - Similarly, expenditures for nursing facility members accounted for 73% of spending in SFY 2008; this figure fell to 72% in SFY 2009 and to 70% in SFY 2010 before the SFY 2011 figure of 67% (Figure XI).
  - These results demonstrate significant improvement since SFY 2008, as the State has expanded efforts to rebalance the LTSS system.

- In SFY 2011, nursing facility expenditures accounted for 67% of total LTSS expenditures (Figure XI), which is a 6% reduction in spending from SFY 2008 (Figure XI and Table IV).

- Total expenditures have remained essentially unchanged for SFY 2010 ($2.589 billion) and for SFY 2011 ($2.580 billion) (Table IV), while enrollment in nursing facilities has decreased (Figure I) and HCBS, including medical day care (MD), personal care assistant (PCA), and

Global Options for Long-Term Care (GO) Waiver, have increased (Figure II, Figure III, Figure IV, Figure V, and Table II).

- Overall, there was a decrease of slightly more than 2.5% in nursing facility member months (MMs) from SFY 2010 to SFY 2011 (Figure I). GO Waiver member enrollment increased over 8% during the same time period and was the main driving force of the overall HCBS MMs increase of 4.3% (Figure IV and Table II).

- Mercer uses per-member per-month (PMPM) as a standardized measure of costs. PMPM shows the average monthly cost for a member in a given population. With the increasing proportion of members utilizing HCBS, the overall PMPM in the LTSS program is decreasing (Figure XII). Seven counties (Cape May, Hunterdon, Morris, Salem, Somerset, Sussex, and Warren) decreased their percentage of MMs classified as nursing facility by 9% or more between SFY 2008 and SFY 2011. Six counties (Cumberland, Essex, Hudson, Mercer, Passaic, and Union) saw their percentage of MMs classified as nursing facility decrease by 4% or less between SFY 2008 and SFY 2011 (Map II).

- Counties have had varying results in shifting LTSS nursing facility expenditures. Comparing SFY 2008 and SFY 2011 data, the percentage of LTSS expenditures spent on nursing facilities decreased by 5% or more in nine counties (Bergen, Camden, Gloucester, Hunterdon, Middlesex, Morris, Salem, Somerset, and Warren) and decreased by as little as 2% in only two counties (Essex and Sussex) (Map IV).

- The county aging and disability resource centers (ADRCs) have had a positive impact on rebalancing, and the results in Tables VII and VIII show that for those counties with fully functioning ADRCs, the average MMs in a nursing facility and the percentage of spending in nursing facilities has decreased more than those counties where roll-out of the ADRC program had not yet been fully implemented.

- While the key factors identified above directly impact the overall costs, it is clear from all the data shown in this report that the combination of enrollment and PMPM associated with nursing facilities makes it, by far, the biggest driver of LTSS costs. As utilization of HCBS increases and nursing facility decreases, we should see a decrease in the overall PMPM of the LTSS population.

The budget projection model focuses entirely on members that receive fee for service LTSS and the costs of those services. In order to be included in the model's calculations, a member must be a member of a waiver program, receive services in a nursing facility, or incur a MD or PCA service in a given month. The model does not require a member to meet nursing facility level of care; any member receiving a MD or PCA service, including the community well population, is included in the analysis. Once the members are identified as LTSS members, only those same LTSS costs are included; a member's acute care costs are not reflected within the model.

The model used in this annual report projects the future based on historical data and trends based upon data prior to SFY 2011 and, consequently, reflects a fee for service environment. Therefore, while managed LTSS would be expected to impact the utilization of LTSS services in the future, it is a factor that has not been accounted for in the update of the current model. Beginning with the SFY 2012 annual report, however, the model will change to incorporate the transition of LTSS into a managed care environment as a future factor in projections.

In the model, members are classified monthly and their MMs are counted based on an algorithm with a very specific hierarchy. First, if the member is shown as part of a waiver program in the State's eligibility system during a month, he/she is categorized as a waiver member in that month. Next, if the member has a nursing facility service in the month, he/she is categorized as a nursing facility member for the month. Next, if the member has a MD service in the month, he/she is categorized as a MD member. Lastly, if the member has a PCA service in the month, he/she is categorized as a PCA member. The nursing facility, MD, and PCA populations are determined based on claim activity, while the waiver population is determined by eligibility system information. It is possible that the SFY 2011 numbers may change as more claims come in. However, as this data includes claims paid through November 2012, any such change is unlikely to be material.

What follows are brief narratives and various tables and graphs that highlight key data demonstrating the progress in efforts to rebalance the State's LTSS system according to the Act. Additionally, more detailed information about Mercer's actuarial model, classification of members, and the assumptions used in these projections is found in Appendix A.

2

Rebalancing Statistics

Figure I

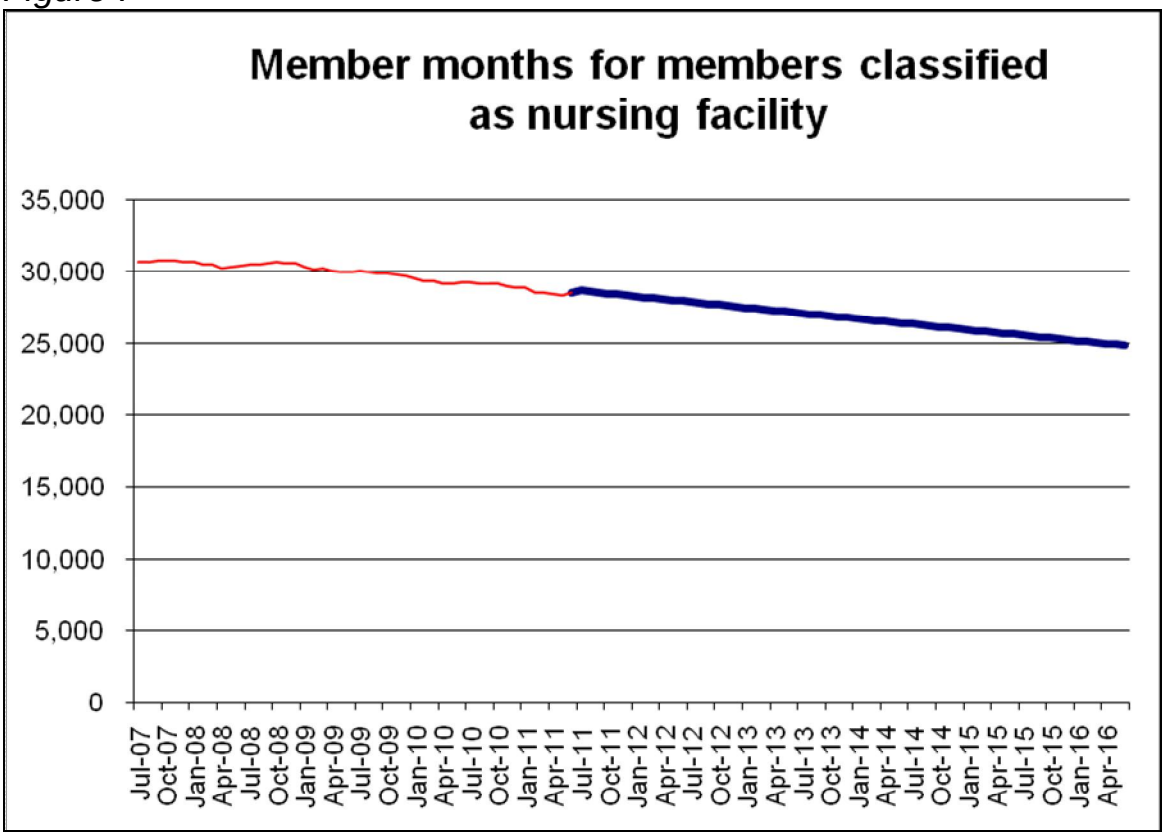
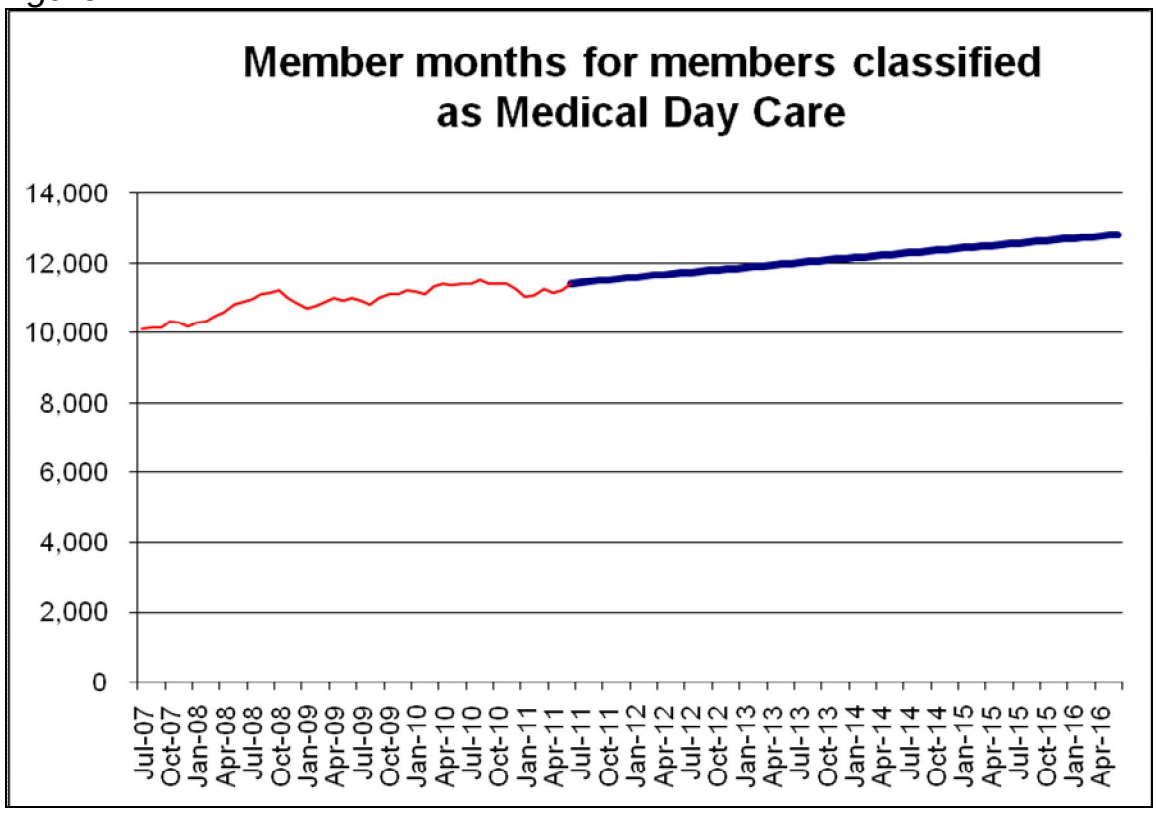


Figure I is reflective of movement in the population served by nursing facilities. The data suggests a strong effect of rebalancing on the LTSS population. While some clients are being transitioned into the community, others are simply having their eventual admission into a facility delayed. From a system cost perspective, these are both positive outcomes and demonstrate the movement towards a sustainable LTSS system. Overall, there was a decrease of slightly more than 2.5% in the MMs classified into nursing facilities in the model from SFY 2010 to SFY 2011. As will be shown later in the report, this decline demonstrates a reduction in State spending relative to the number of individuals served and cost per individual. The State is now serving more of its vulnerable population at a lower cost per person, and as rebalancing grows, additional costs will decline in total.

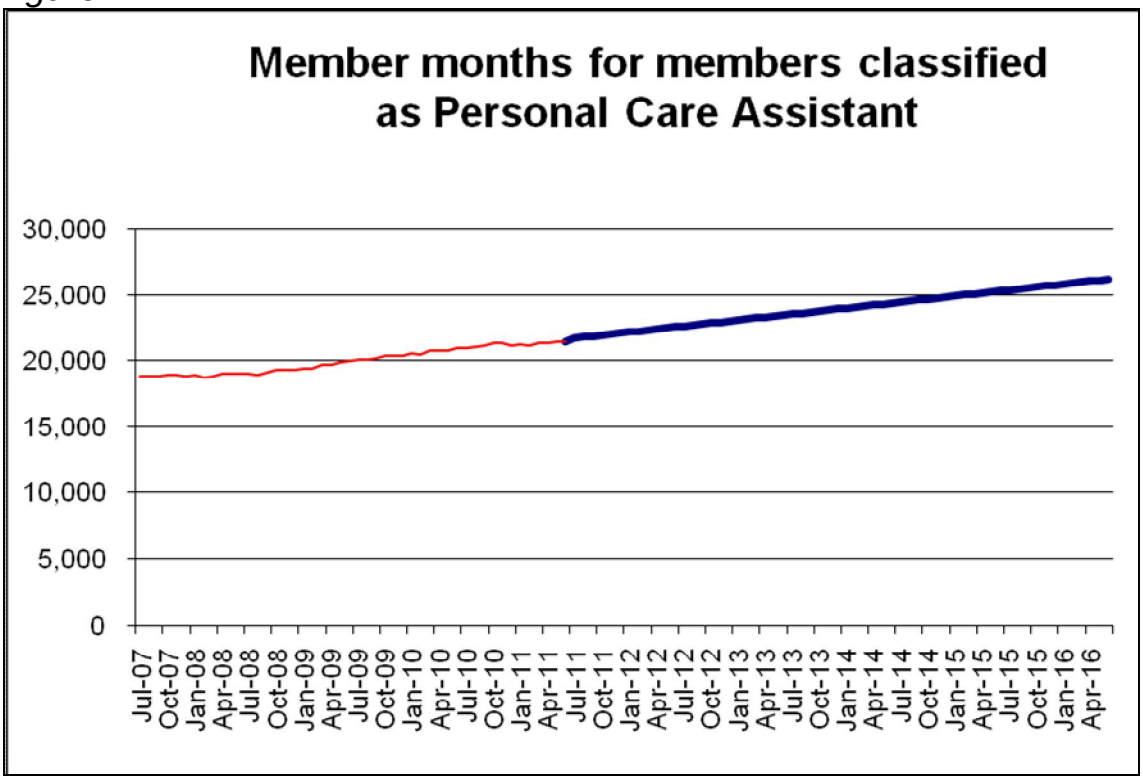
Figure II



Similar to Figure I, Figure II shows the member month data for members classified as MD. The data shows that the number of members receiving MD services is increasing, exhibiting growth of slightly more than 1% from SFY 2010 to SFY 2011. This is further evidence that the State is diverting members from nursing facilities into the more cost-effective LTSS.

In July 2011, MD and PCA moved under managed care from a fee for service (FFS) approach. Since then, the managed care plans have assumed the prior authorization and billing/claims processing functions. As the State moves forward, the basis for the budget projections will change and need to be modified, taking into account the growth of MLTSS. Starting with the SFY2012 annual report, the model will need to incorporate the move to managed care for the MD and PCA programs.

Figure III



Member month data for members classified as PCA is shown in Figure III. The number of members receiving PCA services has grown almost 4% from SFY 2010 to SFY 2011. Growth in PCA service utilization is a positive outcome of rebalancing efforts when compared to the alternative of more costly nursing facility admission.

Figure IV

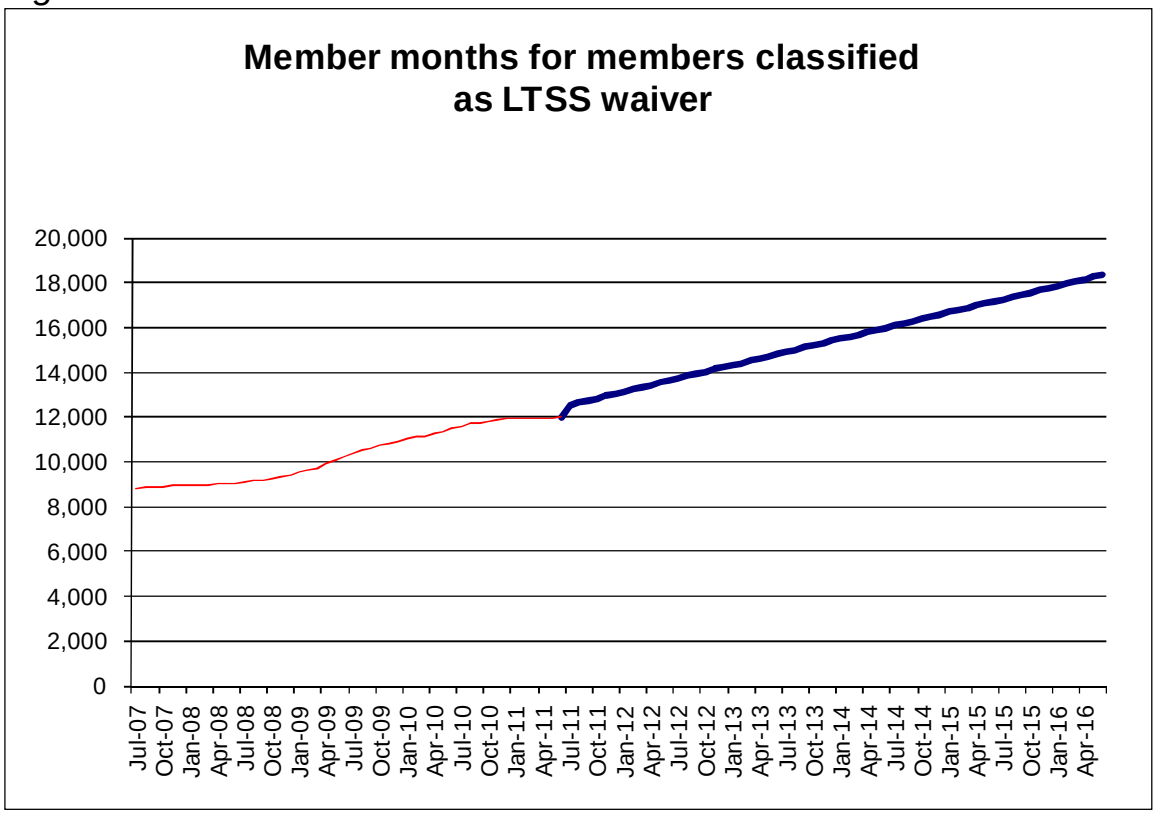


Figure IV shows the MMs classified as waiver based on a member having a waiver eligibility code in the State's eligibility system. For this report, Mercer has grouped four waivers together. This includes the following four programs: Global Options (GO), Community Resources for People with Disabilities (CRPD), Traumatic Brain Injury (TBI) and AIDS Community Care Alternatives Program (ACCAP).

These four waivers will be consolidated in the move to managed long-term services and supports (MLTSS) in the State's new Section 1115 Demonstration Comprehensive Medicaid Waiver (CMW). GO is the dominant program among these four distinct waiver programs, accounting for approximately 93% of the MMs in this category in SFY 2011.

There has also been a strong effort on the part of the State to provide waiver services to a greater number of participants. While all HCBS services (e.g., PCA, MD) have seen growth (as exhibited in the previous pages and Table I), the waiver programs have shown continued and substantial growth since their inception. From SFY 2010 to SFY 2011, the waiver membership grew by over 8%. As the data in Table II indicates, there was a lower, but still significant, growth of 4.3% when all HCBS related MMs were combined.

The GO budget has thus far supported the increase in waiver members, and the model is currently constructed to take recent enrollment changes into account without regard for factors, such as enrollment caps. It should be noted that while growth in the GO waiver population has been significant, other waivers operated by the Division of Disability Services (DDS) have not seen similar growth due to slot caps and limited participation. As the State moves forward to the new CMW, the basis for these projections may undergo significant change.

Table I

GO Waiver Recipients by County, 2008–2011[1]

County	2008	2009	2010	2011	Change in Recipients — 2008 to 2011	Percentage Change — 2008 to 2011
Atlantic	648	656	769	593	-55	-8%
Bergen	690	686	797	874	184	27%
Burlington	536	531	688	733	197	37%
Camden	973	940	1,112	1,155	182	19%
Cape May	297	300	357	362	65	22%
Cumberland	444	423	442	386	-58	-13%
Essex	567	551	604	605	38	7%
Gloucester	485	473	600	606	121	25%
Hudson	823	846	1,094	1,261	438	53%
Hunterdon	89	85	116	125	36	40%
Mercer	468	432	498	455	-13	-3%
Middlesex	685	701	816	834	149	22%
Monmouth	1,141	1,106	1,255	1,286	145	13%
Morris	401	414	555	520	119	30%
Ocean	1,077	1,033	1,273	1,274	197	18%
Passaic	585	564	691	712	127	22%
Salem	133	125	170	174	41	31%
Somerset	334	348	419	385	51	15%
Sussex	104	117	150	142	38	37%
Union	620	636	766	801	181	29%
Warren	224	290	401	356	132	59%
Total	11,257	11,324	13,573	15,650	4,326	38%

[1] Consists of GO Waiver clients, including those who are in a nursing facility and listed as part of the GO waiver, as well as those clients who are double counted because they moved between counties. When a monthly eligibility snapshot is taken, there are approximately 12,000 individuals on the GO Waiver.

Table I shows the count of people by county served through the GO Waiver in each calendar year since 2008. It is clear that the GO Waiver is expanding throughout the State. By providing less-costly HCBS to its members, the GO Waiver helps to keep the cost of the State's overall LTSS program down. The growth in this program is one of the major drivers of the State's recent success in rebalancing the LTSS program.

Figure V

Percentage of LTSS Member Classification by SFY

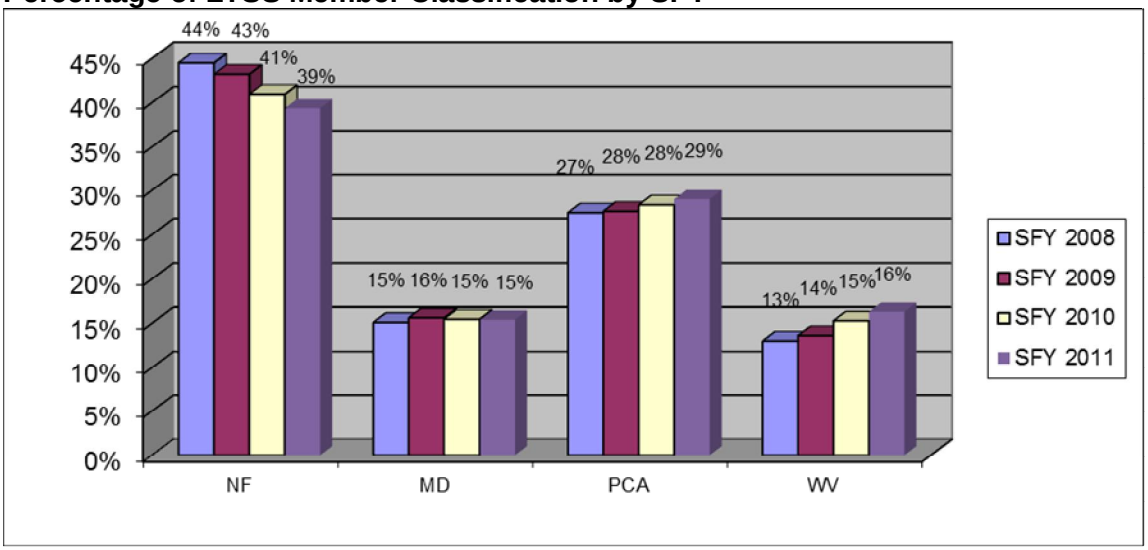


Table II

LTSS Classification by SFY

Service	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Nursing facility	366,949	363,991	354,923	345,855
Medical day care	124,420	131,343	133,774	135,358
Personal care assistant	226,534	232,739	245,553	254,848
Waiver services	107,266	114,561	132,143	143,164
Total	825,169	842,634	866,393	879,225

In SFY 2008, 44% of MMs for clients receiving LTSS services were classified as nursing facility based on the model's algorithm, while 13% were classified as LTSS waiver. Through SFY 2009 and SFY 2010, however, the percentage of members classified as nursing facility decreased by two percentage points, from 43% to 41%, while the percentage of members classified as waiver increased one percentage point, from 14% to 15%. This trend continued into SFY 2011, as the percentage of members classified as nursing facility decreased an additional two percentage points to 39%, resulting in an overall five-percentage point decrease over the SFY 2008

baseline. During SFY 2011, the percentage of members classified as waiver increased to 16%, increasing the total population utilizing HCBS waiver programs to three percentage points over the SFY 2008 baseline.

This trend indicates directional movement on behalf of clients being educated about and opting for HCBS settings to address their LTSS needs.

Table III

Percentage of LTSS Members Classified as Nursing Facility by County and SFY

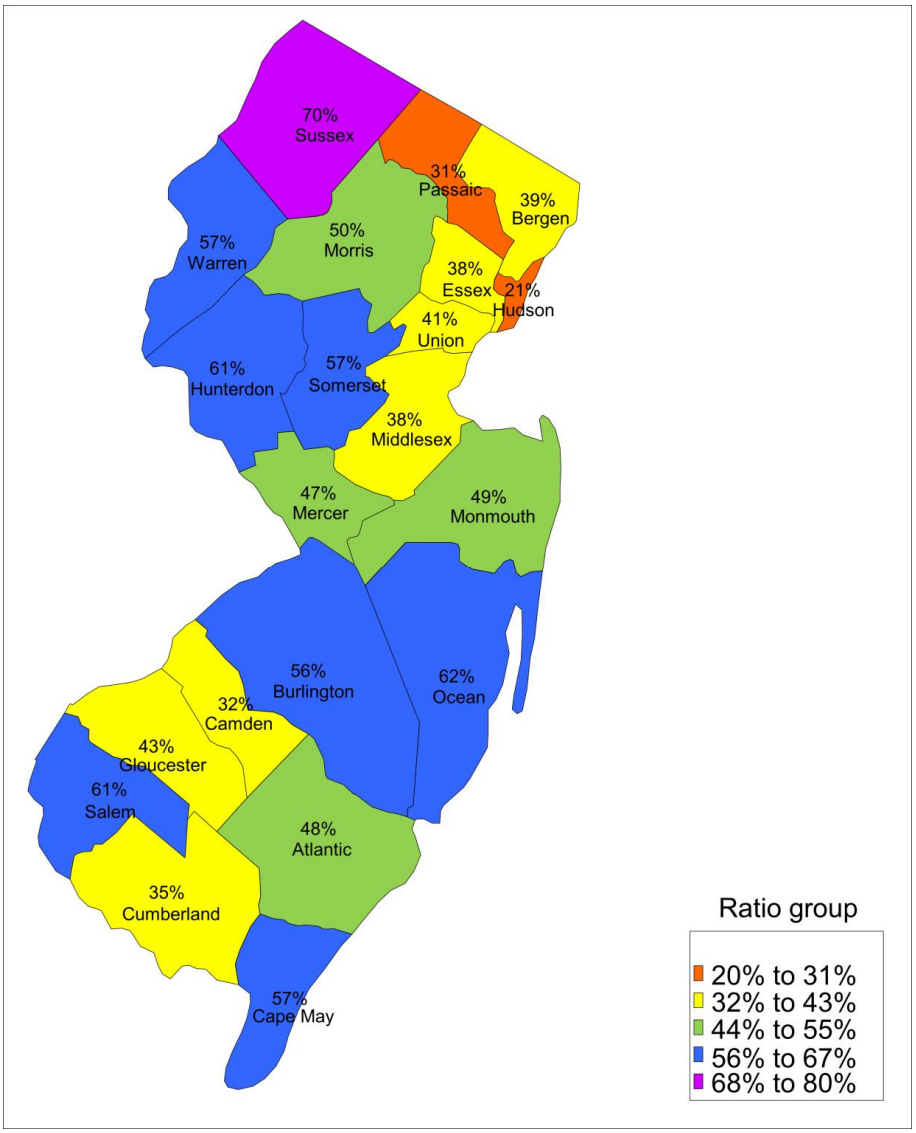
County	2008	2009	2010	2011	Percentage Change – 2008 to 2011
Atlantic	54%	52%	48%	48%	-6%
Bergen	45%	43%	41%	39%	-6%
Burlington	64%	62%	59%	56%	-8%
Camden	39%	37%	34%	32%	-7%
Cape May	66%	65%	59%	57%	-9%
Cumberland	38%	38%	36%	35%	-3%
Essex	39%	38%	38%	38%	-1%
Gloucester	49%	50%	47%	43%	-6%
Hudson	23%	23%	22%	21%	-2%
Hunterdon	75%	72%	67%	61%	-14%
Mercer	51%	49%	48%	47%	-4%
Middlesex	45%	44%	41%	38%	-7%
Monmouth	55%	54%	51%	49%	-6%
Morris	59%	56%	53%	50%	-9%
Ocean	70%	69%	65%	62%	-8%
Passaic	35%	33%	32%	31%	-4%
Salem	71%	70%	66%	61%	-10%
Somerset	67%	63%	60%	57%	-10%
Sussex	79%	77%	72%	70%	-9%
Union	45%	44%	42%	41%	-4%
Warren	70%	64%	60%	57%	-13%
Total	45%	44%	42%	40%	-5%

Table III shows the percentage of the LTSS members that have been classified as nursing facility through the budget projection model algorithm. Since the first categorization in the algorithm is into the waiver category, the rise of members receiving waiver services has a direct impact on the number of members classified into the nursing facility group. It is clear that since

2008, New Jersey has made significant gains in the number of members receiving waiver services, which is indicative of the State's success in its efforts to place greater public emphasis on community-based LTSS options, consistent with the Act.

Map I

SFY 2011 New Jersey Percentage of Member Classification in Nursing Facility

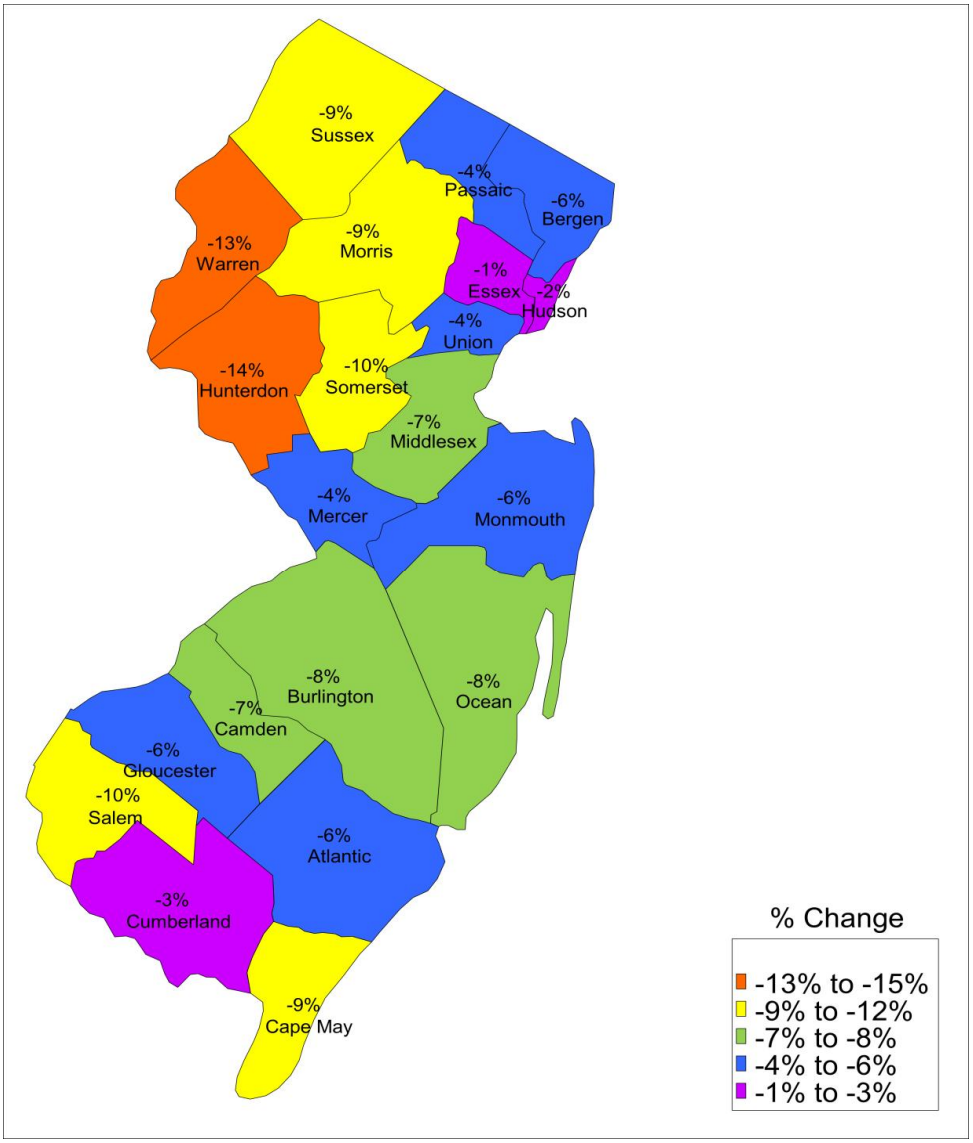


Map I shows the percentage of members classified as nursing facility residents in the model in SFY 2011, by county. There is a wide range of percentages represented at the county level,

from a low of 21% in Hudson County to a high of 70% in Sussex County. These percentages are driven by a wide range of factors, such as the adequacy of the HCBS network in offering LTSS and the number of nursing home beds in the county.

Map II

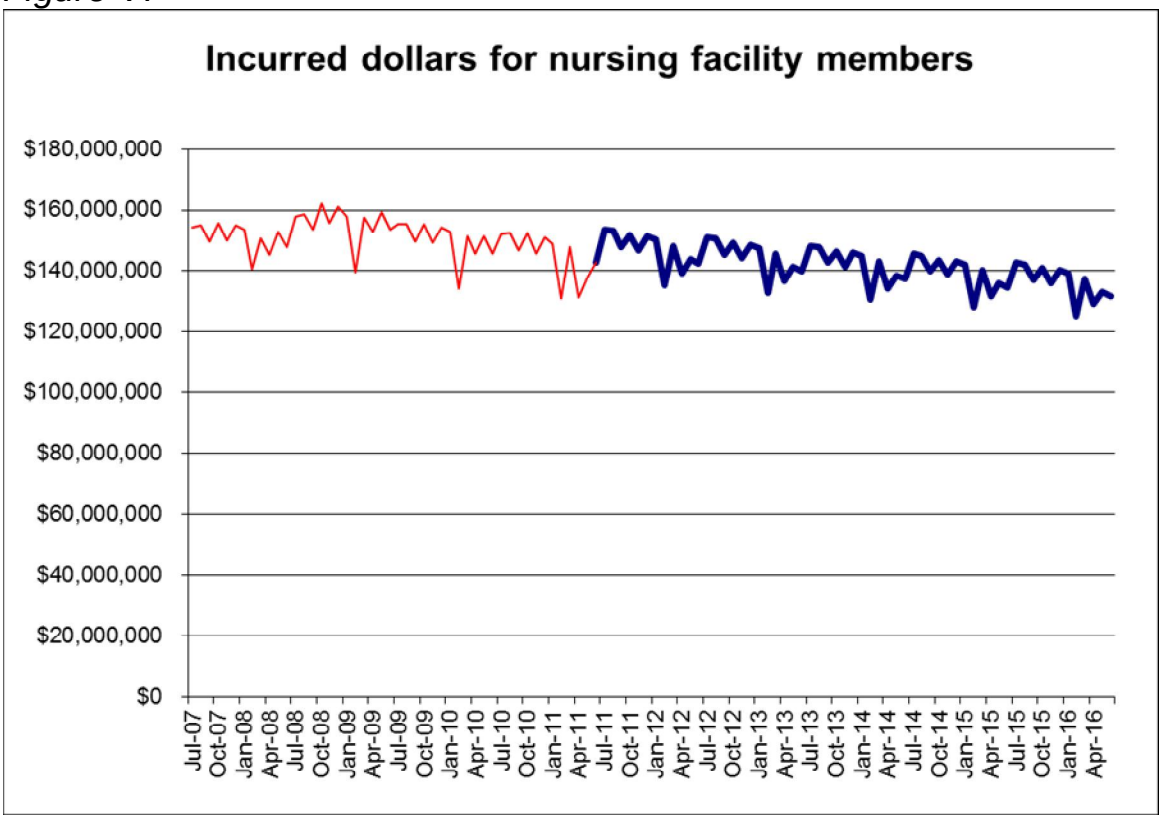
Change in New Jersey Percentage of Member Classification in Nursing Facility, SFY 2008–SFY 2011



Map II shows the change in percentage of nursing facility-classified members between SFY 2008 and SFY 2011. It is readily apparent that movement has been significant. In fact,

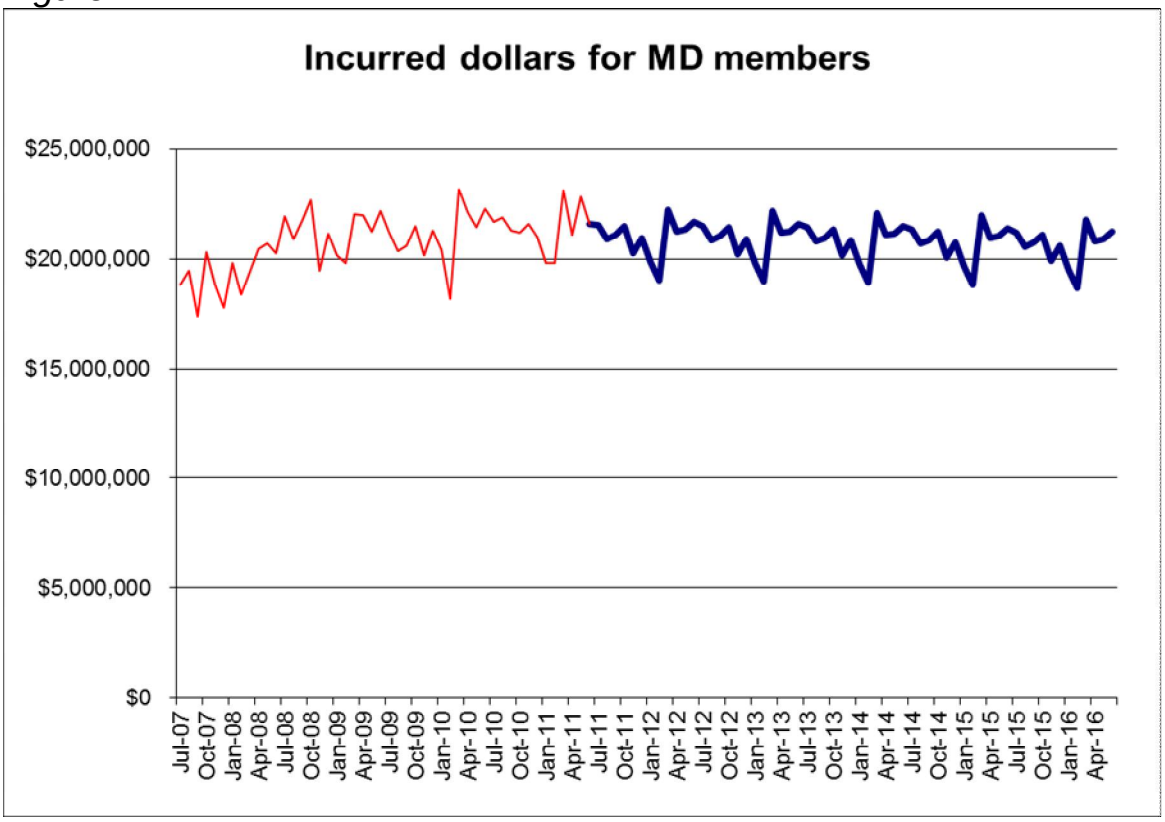
more counties have shown a decrease greater than 6% than have shown a decrease of 6% or less. In addition, every county has shown some decrease in the percentage of MMs classified into nursing facility. There is strong evidence across the entire State that rebalancing is impacting the mix and setting of services utilized by the LTSS population.

Figure VI



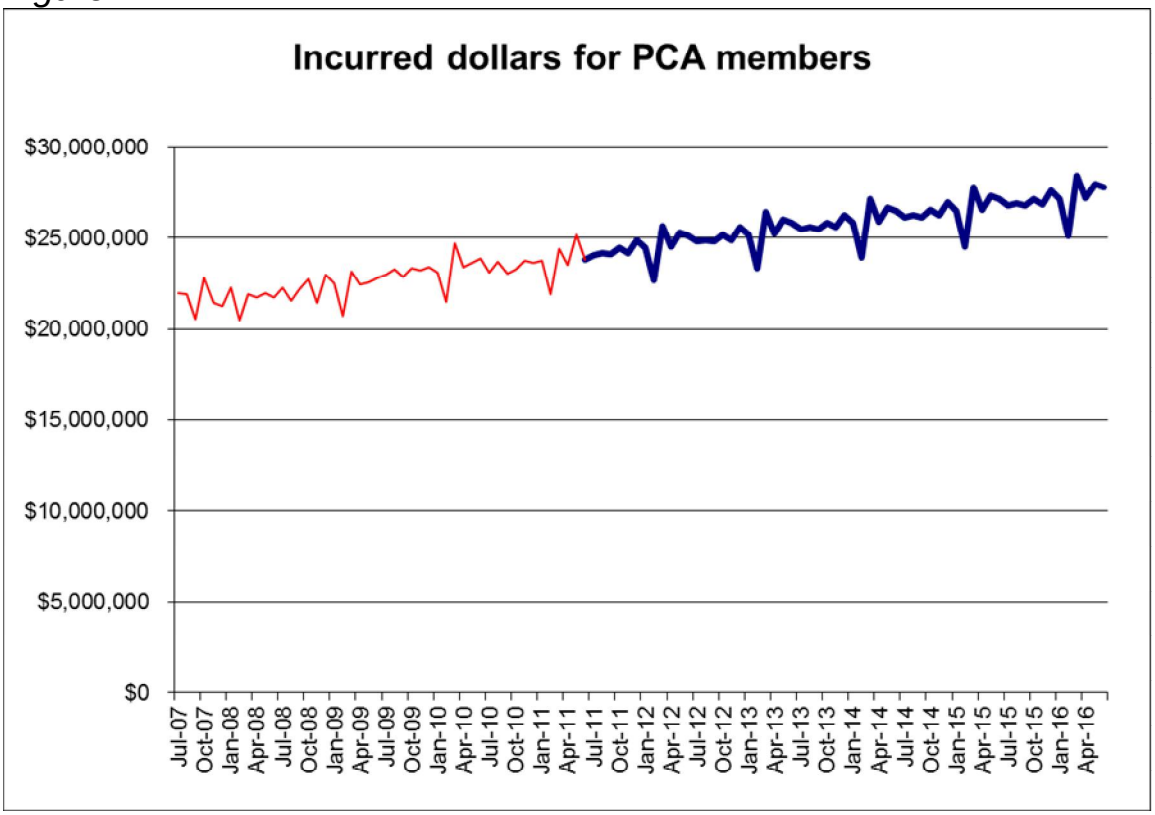
In SFY 2011, approximately $2.58 billion was spent on Medicaid LTSS members, with $1.74 billion of that figure spent on members classified as residing in a nursing facility. Spending for this set of graphs is defined by member classification; that is, incurred dollars for nursing facility members (and similarly for the members receiving HCBS services in the next several pages) is spending on all services (nursing facility or otherwise) for members that the model has classified as nursing facility. While the total LTSS spend in SFY 2011 was very similar to that of SFY 2010, there was a decrease in spending on these members of about $60 million (approximately 3.3%). This decrease is projected to continue into the future and exhibits a decreasing reliance on nursing facilities to care for this population. Note that these projections are driven by a combination of projected enrollment, PMPMs for the different service categories, and mix of services utilized. Additionally, this model excludes data from intermediate care facilities for the intellectually disabled.

Figure VII



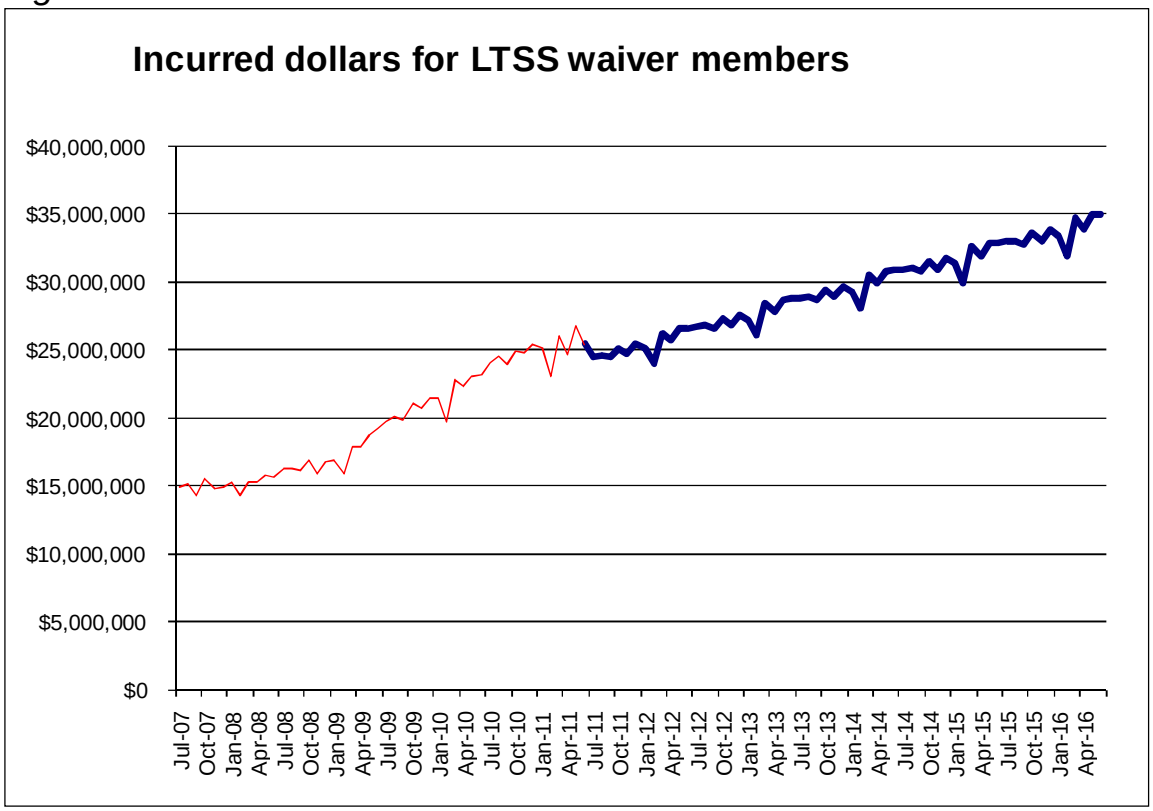
Spending on members for MD services has shown growth over the past several years. The State spent around $257 million on these members in SFY 2011, representing an increase of over $4 million from SFY 2010, or almost 2%.

Figure VIII



Spending on services for PCA members continues to grow as well. The State spent over $280 million on these members in SFY 2011, which was an increase of about 1.4% over SFY 2010.

Figure IX



Of the $2.58 billion LTSS budget in SFY 2011, there was almost $300 million spent on members receiving LTSS through the State's various waiver programs. This is an increase of almost 17% from the approximately $255 million spent on these members in SFY 2010 as a result of the Act. As expected during the rebalancing process, spending on waiver services continues to increase rapidly and is projected to continue this upward trend in the coming years. The bulk of the spending for these waiver members is for waiver services, made up of both DoAS GO waiver services and DDS waiver services. The majority of spending, almost 80%, is for DoAS GO waiver services.

Figure X

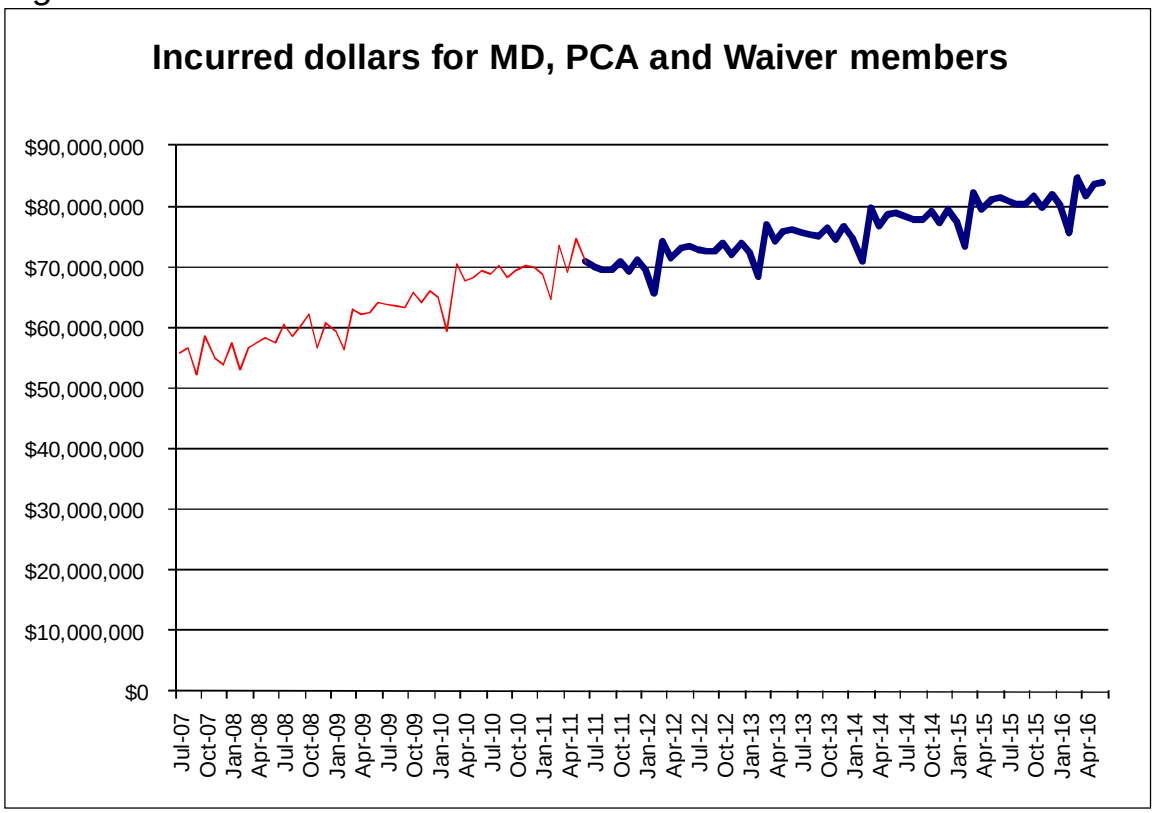


Figure X is a combination of Figure VII, Figure VIII, and Figure IX. As the overarching concern with rebalancing is the overall shift between nursing facilities and HCBS, it is useful to examine the overall spending trends for HCBS members. It is clear that, despite shifts and varying changes among the three distinct HCBS groups (Waiver, MD, and PCA), the overall picture over the past several years, and projected into the future, is one of continued growth.

Figure XI

Percentage of LTSS Spending by Member Classification and SFY

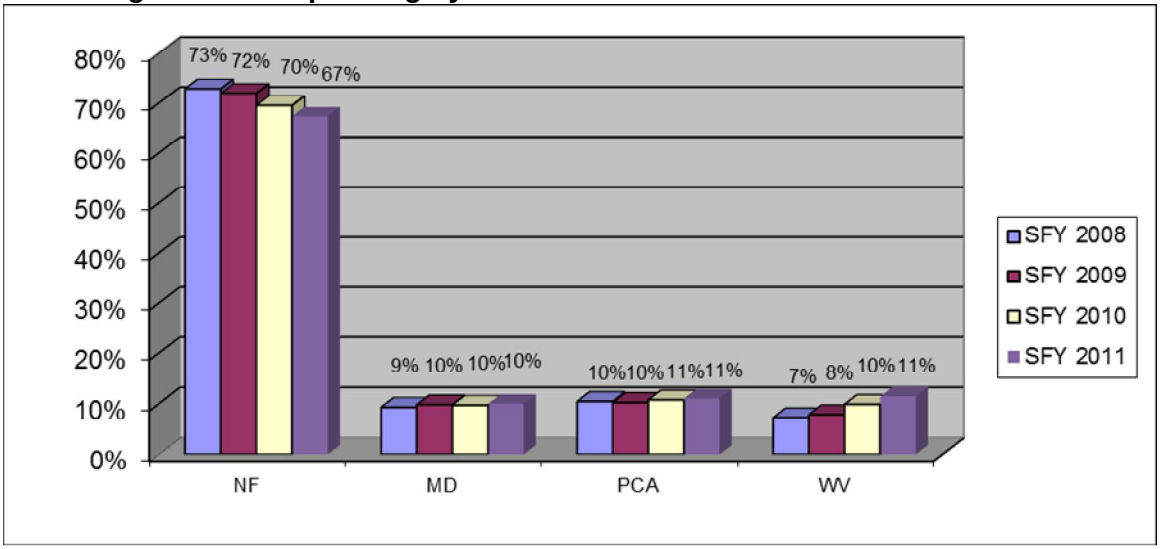


Table IV

LTSS Spending by Member Classification and SFY (in millions)

Service	SFY 2008	SFY 2009*	SFY 2010*	SFY 2011*
Nursing facility	$1,810	$1,870	$1,801	$1,740
Medical day dare	$ 231	$ 255	$ 253	$ 259
Personal care assistant	$ 260	$ 267	$ 279	$ 286
Waiver services	$ 181	$ 204	$ 256	$ 296
Total	$2,483	$2,597	$2,589	$2,580

**Note that there was no rebasing of the nursing facility rates in SFY 2009, SFY 2010, or SFY 2011. Pieces may not sum to Total due to rounding.*

One way to measure the effectiveness of the State's rebalancing efforts to date is to evaluate the percentage of total spend among the different LTSS services. If rebalancing efforts are working, then the percentage of nursing facility spending should decrease over time, with a corresponding increase in HCBS spending (including waiver, PCA, and MD). Data from SFY 2008 was used as the baseline, while data from SFY 2009, SFY 2010, and SFY 2011 was used to measure change.

In SFY 2008, expenditures for nursing facility members represented 73% of Medicaid LTSS spending, while waiver expenditures, including DoAS GO and DDS, represented only 7% of spending. In SFY 2009 and SFY 2010, nursing facility expenditures decreased to 72%, and then to 70%, of Medicaid LTSS spending, while waiver expenditures increased to 8%, and then to 10%, of spending, indicating a slight statewide shift. This shift continued into SFY 2011, as we

see nursing facility expenditures fall to 67% while waiver expenditures continued to grow to 11% of Medicaid LTSS spending.

One item that may have influenced the slower (or negative) growth of spending for nursing facilities is that there was no rebasing of nursing facility rates starting in SFY 2009. Additionally, in SFY 2010, inflation was not applied to the nursing facility rates. While these factors directly impact the overall costs, overall utilization of nursing facilities also fell, and data analysis indicates that utilization is the main driver of the decrease in spending. A new budget neutral rate setting system was implemented in SFY 2011.

Figure XII

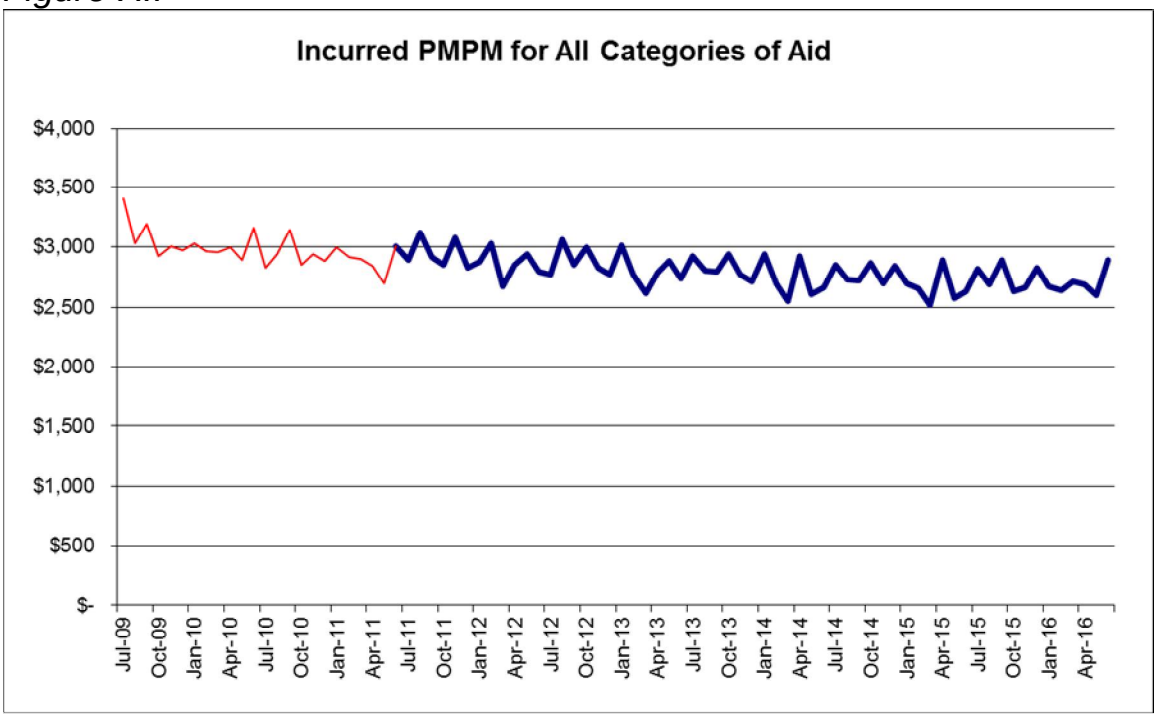


Table V

SFY 2011 PMPMs by LTSS Service and SFY

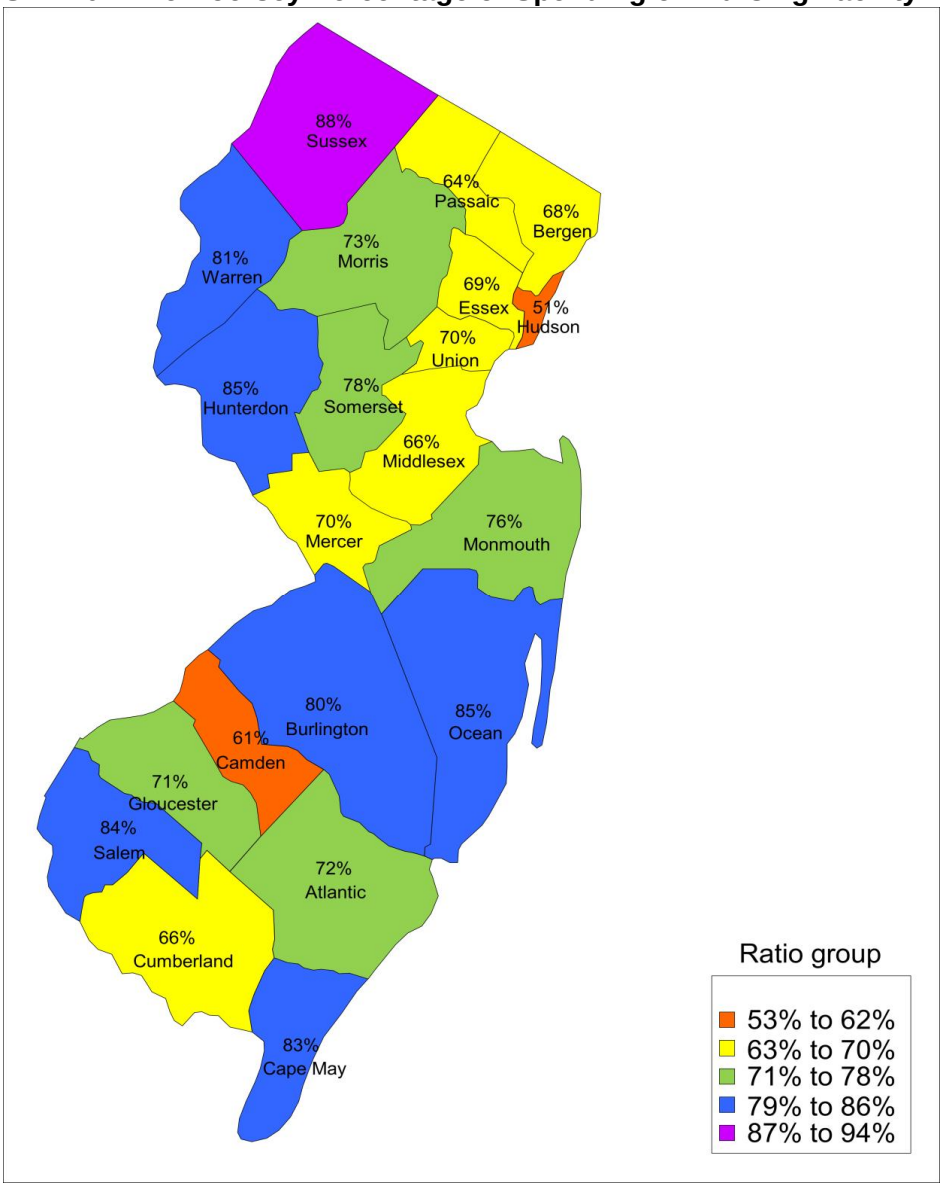
Service	Service-specific PMPM	Total PMPM
Nursing facility	$5,192	$2,044
Medical day care	$1,486	$ 229
Personal care assistant	$1,382	$ 401
Waiver services	$1,471	$ 238
Total	$2,913	$2,913

As an illustrative example, in Table V, the service-specific PMPM is calculated as the incurred nursing facility cost divided by MMs in the hierarchical nursing facility category of aid (COA) in SFY 2011. For example, the total PMPM on the nursing facility line is calculated as the incurred nursing facility cost divided by all LTSS MMs in SFY 2011. The other service-specific PMPMs are calculated in a similar manner, as the specific service's cost divided by the members classified into that category. The figures show that the three non-nursing facility services are much less costly than nursing facility services on a PMPM basis. While nursing facilities cost over $5,000 PMPM, the costs for the three distinct HCBS groups are closer to $1,500 PMPM.

Additionally, the table also indicates the influence of the membership, as it shows how the total PMPM cost is made up of the different service pieces. It is clear that the combination of enrollment and PMPM cost associated with nursing facilities makes it, by far, the most significant driver of LTSS costs. As utilization of HCBS increases, we should see a decrease in the overall PMPM of the LTSS population. Indeed, this decrease can be seen in the data, as shown in Figure XII.

Map III

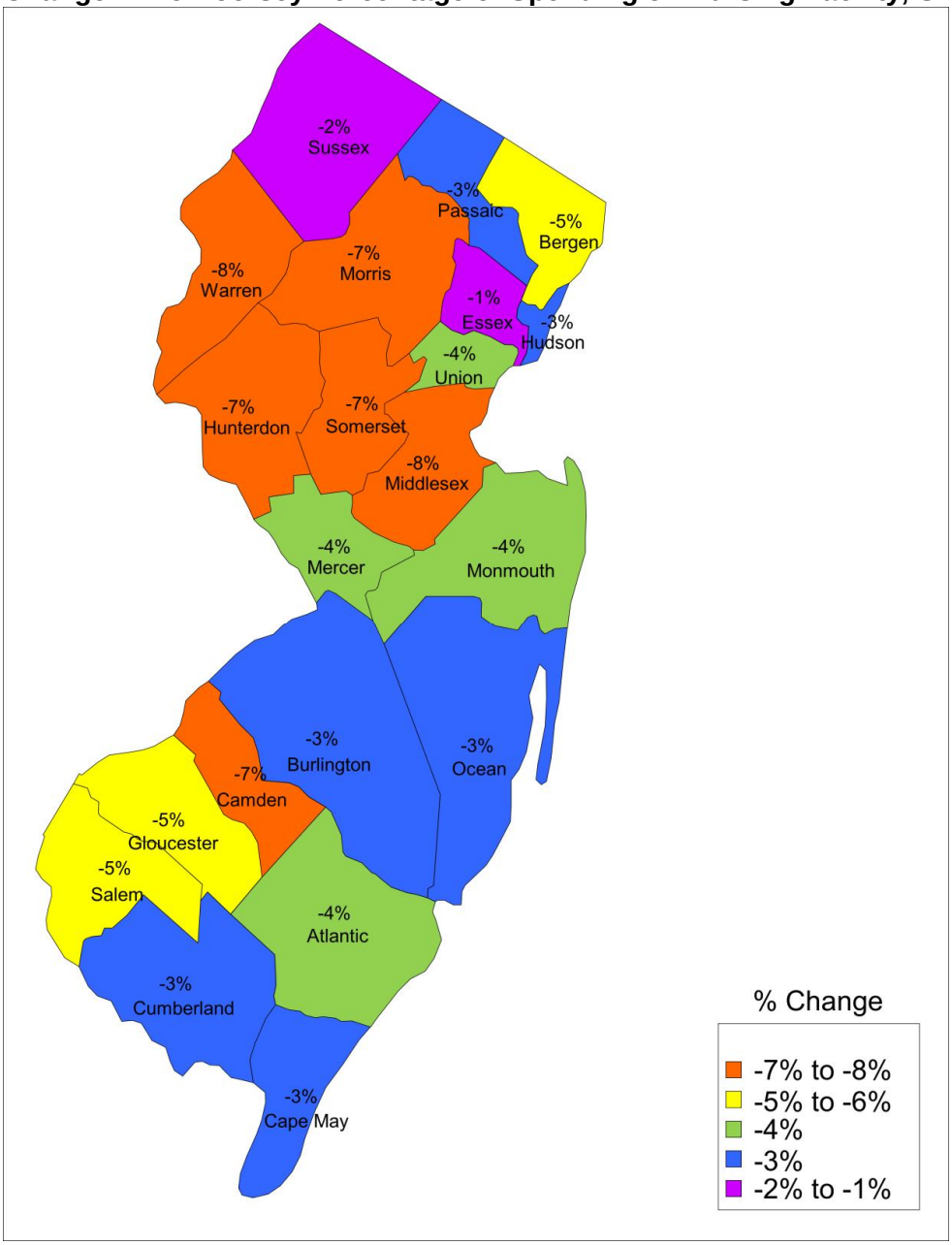
SFY 2011 New Jersey Percentage of Spending on Nursing Facility



The percentage of LTSS spending in nursing facilities in SFY 2011 is shown in Map III. This exhibit shows that the percentage of LTSS spending in nursing facilities varied greatly in SFY 2011 by county, from a low of 51% to a high of 88%. Similar to the earlier data regarding member classification, these percentages are driven by a wide range of factors, including nursing facility rates and the number of nursing home beds in the specific county.

Map IV

Change in New Jersey Percentage of Spending on Nursing Facility, SFY 2008–SFY 2011



Map IV displays the change in percentage of LTSS spending on nursing facilities from SFY 2008 to SFY 2011. It is very clear in this graphic that there has been significant rebalancing progress made in the majority of counties in the State. In fact, every county has seen a reduction in

nursing facility percentage, and only two counties showed a decrease as low as 2% (Essex and Sussex). The majority of counties are in the 3% – 6% range for a decrease, meaning the improvement has been both significant and displayed quickly.

It is important to note the relationship between the changes in spending and enrollment. From the data, it is easy to conclude that the percentage of members classified into nursing facilities is changing faster than the percentage of spending on nursing facilities. This is the result of several factors, including changes in nursing facility rates between SFY 2008 and SFY 2011.

Aging and Disability Resource Center County Impact

The State of New Jersey was among 12 states in the nation to receive the original ADRC grant in 2003. The goal of the ADRCs has been to effect LTSS rebalancing through an integrated approach that strengthens communications between acute and HCBS settings, focuses on early identification and response to health care risks, and ensures continuity of care across providers and settings. As shown below, ADRC activities have positively impacted the reduction in nursing facility costs in those counties where ADRCs are functioning in SFY 2011.

Table VI

Member Months in Nursing Facility by County by SFY

County Type	SFY 2008	SFY 2009	SFY 2010	SFY 2011	2008 to 2011 Change
ADRC counties	50%	48%	45%	43%	-7%
Non-ADRC Counties	44%	43%	41%	39%	-5%

In the counties with functioning ADRCs prior to 2011 (Atlantic, Bergen, Gloucester, Hunterdon, and Warren), those counties experienced a greater decline in MMs in nursing facility when compared to the average of non-ADRC counties.

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Conclusion

The State of New Jersey has had a budgetary model for tracking its LTSS system expenditures and projecting future expenditures since the charge set forth in 2006 under the Act. The model is designed to track the increase in the home- and community-based care by diverting persons from nursing home placement. By allowing greater freedom of choice between nursing homes and HCBS, the State is advancing a LTSS system that is less costly, that better serves the needs of its vulnerable populations, and supports consumer choice.

In this latest annual report, the trend continues from SFY 2008 to SFY 2011 to show a statewide shift in long-term care services and expenditures. In SFY 2008, expenditures for nursing facility members represented 73% of Medicaid LTSS spending, while waiver expenditures represented only 7% of spending. In SFY 2011, the State has seen additional progress with rebalancing, with nursing facility expenditures falling to 67%, while waiver expenditures continued to grow to 11% of Medicaid LTSS spending.

The SFY 2011 results show that the State continues to make significant progress in meeting the goals of the Act. Success in redirecting long-term care away from institutional care toward more home and community based options can be attributed to a number of State activities, such as the implementation of HCBS options, additional ADRC interventions that seek to avoid unnecessary hospital readmissions or nursing home placement and the introduction of PACE (Program of All-Inclusive Care for the Elderly) in 2009. PACE is designed to serve individuals 55 and older who require nursing facility level of care but who can continue to reside safely in their communities. PACE organizations receive capitated Medicare and Medicaid payments. They are full risk bearing organizations (i.e., insurers) for the total cost of care and all incentives are aligned to promote cost effectiveness and optimal outcomes.

The October 2012 approval of the Section 1115(a) Demonstration CMW and the associated roll-out of MLTSS will be critical to the State's ongoing efforts to rebalance LTSS spending. In July 2011, MD and PCA moved away from a FFS system into a managed care model.

The model used in this report projects the future based on historical data and trends based upon data prior to SFY 2011 and, consequently, reflects a FFS environment. Therefore, while managed LTSS would be expected to impact the utilization of LTSS services in the future, it is a factor that has not been accounted for in the update of the current model. Beginning with the SFY 2012 annual report, however, the model will change to incorporate the transition of LTSS into a managed care environment as a future factor in projections.

Since the last annual report, and as of May 2012, the remaining 16 counties became fully operational under the ADRC model. The maturation of the ADRC model and the roll-out of the MLTSS program should result in an even greater increase in HCBS spending as a percent of LTSS funding.

The State, through its reform efforts, has made strides in obtaining its goal of rebalancing the LTSS system. Opportunities for rebalancing will be greatly enhanced with the rollout of MLTSS under the CMW. The State will be making a significant investment in MLTSS in the coming years, and this investment will further support and accelerate the State's rebalancing efforts.

APPENDIX A

Mercer's Actuarial Model

Completion of Claims — The Estimation of Each Month's Incurred Claims from Those Paid to Date

In our analyses of claims, Mercer looked at the service date, rather than the paid date of the claim. Reasons for this include the following:

- Policy changes go into effect on a service date basis. These include changes in who is considered a covered recipient, changes in the services that are eligible for payment, and changes to reimbursement rates for providers.

- The timing of payments can be affected by disruptions in the flow of claims from providers to the State's fiscal agent, administrative delays at the fiscal agent, and timing delays in implementation of policy changes.

The incurred date of a covered service is the date when all conditions have been satisfied that will ultimately result in the service being paid. These include the person receiving the service being eligible to receive that service on the date the service was rendered, and the provider being approved to render the service. For the vast majority of services, the date the service was rendered is the incurred date. For nursing facility services, each day in the facility is considered its own service date, with all services for the month typically batched for claim processing. This is different from an acute hospital stay, for which an entire stay of one or more days is assigned an incurred date of the admission date.

While administrative requirements result in very few claims being paid in the month of service, the majority of claims are paid by the month after the service was rendered. Additional months of payments result in more of the incurred claims for the month being paid, so that after a year, almost no payments or adjustments to payments remain outstanding. Mercer's model uses the actuarial technique known as the development method to estimate each month's incurred claims from the claims paid-to-date and the pattern of claim payments in the data. In the model are the results for using the claim payment lag pattern from the most recent six, nine, and twelve months, as well as results from using the entire data set. Since claim payments are made weekly, lag patterns usually have 26, 39, and 52 weeks of claim payments, respectively. In addition, Mercer also looks at a method that uses the completion pattern of the most recent 12 months, but excludes the highest and lowest completion ratios at each lag duration (months since incurral) from the calculation of the average completion ratio for that duration. This "10 of 12" method is used to remove the effect of possible payment pattern outliers. Such outliers can include mass adjustments for payment rate changes that are applied to claims that have already been processed. The method using the full data set is the one used in the current model.

The estimation of incurred claims by month incurred from claims paid-to-date is the same actuarial process by which health insurers estimate their incurred claims so that they can determine the amount of funds they need to accrue for claims incurred but unpaid, but with one important difference — margins. Typically, an insurer will make a best estimate of its incurred but unpaid claim liability and then add an explicit margin to the amount it accrues. This margin is for fiscal conservatism; it increases the likelihood that the amount of claims that will ultimately be paid will not be greater than the amount accrued. For the DOAS GO rebalancing model, Mercer's estimate of incurred claims is a best estimate (taken from among the various lag pattern methods previously described) without an explicit margin that would tend to overstate incurred claims, and thereby confound the model's measurement of the degree of rebalancing.

Observed Trends and Projections to Future Periods

Because the claim submission and payment pattern result in so few claims being paid in the same month in which they are incurred, estimates of claims incurred in the most recent month of paid data are estimated based on past levels of incurred claims, with adjustments to recognize changes in the covered population and changes in utilization rates and reimbursement rates over time. The model provides several measures of annual observed trend for utilization and PMPM by category of service (COS) — the one-month period compared to the same month a year ago, as well as three-month, nine-month, and 12-month periods compared to the same period a year ago. The shorter periods react quicker to a change in trend, but they are more subject to random and seasonal statistical fluctuation. The longer periods are less subject to random and seasonal statistical fluctuation, but they react more slowly to a change in trend. The user of the model reviews the results of all of the trend measures and makes a judgment as to which to use in the estimation of the most recent month of incurred claims.

Projection of future costs per eligible person starts with seasonally-adjusted incurred claims PMPM. The user of the model has the capability to select the beginning and the end points of the data to be used in the linear regression used in the projection. This allows the user to avoid a base period that includes a bend point where something changed in the data so that prior cost patterns would not be expected to serve as a good basis for projection.

Re-introduction of Seasonality to Projected Future Costs

Because the base data used to project future costs has been adjusted to remove seasonal influences, the initial projected costs are devoid of seasonality. While such results would be reasonable in the aggregate for an annual period, they would not reflect the clearly seasonal pattern of claim incurral that is evident in the incurred claim data. Accordingly, the final projected result includes a re-introduction of the seasonal effect on incurred claims. For example, nursing facility claims clearly show the seasonal pattern of the number of days in each month, with February at 28 or 29 days being noticeably lower than the other months for which the 30-day or 31-day length is also apparent.

Assumptions Utilized in the Current Version of the Model

Projections of future costs are modeled by separate projections of the number of persons eligible for various types of services and projections of the monthly costs of those services. The projected total future cost is the product of the projected number of persons eligible, month by month, for the various services and the monthly cost of those services. Both the number of persons eligible and the monthly cost of services are projected to change over time, as described below.

Eligibility Trends

In the budget model, eligibility is tracked by MMs (a month of coverage for an eligible member), by a COA defined by a hierarchy. Each eligible member is assigned to exactly one eligibility COA in the hierarchy. First on the hierarchy are the four waiver programs – GO, CRPD, TBI, and ACCAP. Persons can be covered under no more than one waiver for a given month, so there is no need within the hierarchy to distinguish between the various waivers. A member's inclusion in a waiver COA is based on information received from the State's eligibility database. Second in the hierarchy are the persons who used at least one nursing facility service during the month (but who were not enrolled in a waiver program). Third in the hierarchy are the persons who used at least one MD service during the month (but were not enrolled in a waiver program and did not use a nursing facility service during the month). Fourth in the hierarchy are the persons who used at least one PCA service during the month (but were not enrolled in a waiver program and did not use a nursing facility service or a MD during the month). Mercer's actuarial model considers only those persons who meet the definitions in the hierarchy. Persons who, in a given month, are not enrolled in one of the listed waivers or do not use a nursing facility service, MD service, or a PCA service are not considered in the model.

The trend rates shown below are the annual rates of increase (or decrease) used in the model to project the size of the eligibility groups to future periods. Each of the COAs is projected separately. These trend rates are based on observed recent changes in eligibility by the hierarchical categories of aid.

Category of Aid (in hierarchy order*)	Approximate Annual Trend
1. Waivers:	
GO Waiver	8% to 11%
CRPD Waiver	0% to 1%
TBI Waiver	0% to 1%
ACCAP Waiver	-86% to -16%
2. Nursing facility	-3% to -2%
3. Medical day care	2% to 3%
4. Personal care assistant	4%

**Based on the model hierarchy*

PMPM Trends

The cost PMPM is the cost of the COS divided by the enrollment in the eligibility COA. For example, the nursing facility cost PMPM is the cost of all nursing facility services for the period, divided by the MMs from the nursing facility hierarchical COA in the same period. This may include a small amount of nursing facility claims for members classified in other hierarchical categories of aid.

The trend rates shown below are the annual rates of increase (or decrease) used in the model to project the PMPM cost by COS. These trend rates are based on observed recent changes in PMPM cost by COS.

Category of Service	Approximate Annual Trend
DoAS Waiver (GO)	5% to 10%
DDS Waiver (CRPD, TBI, and ACCAP combined)	2% to 9%
Nursing facility	-3% to -1%
Medical day care	-3% to 1%
Personal care assistant	-1% to 4%

Other Considerations

While the State is preparing to implement MLTSS, the model used in this report projects the future based on historical data and trends based upon data prior to SFY 2011 and, consequently, reflects a FFS environment. Therefore, while managed LTSS would be expected to impact the utilization of LTSS services in the future, it is a factor that has not been accounted for in this update of the model.

Lastly, the 2011 budget model update quantifies the LTSS population and its service participation differently than other state analyses. For example, the population identification algorithms utilized in the budget model differs from that used in the MLTSS Data Book, and waiver populations are aggregated differently in this analysis versus the MLTSS Data Book.

All estimates are based upon the information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

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derived from the data. Similar situations are likely to account for irregularities in tables reporting other services. In such cases, the summaries and subtotals may be a more useful representation of the experience, in a particular, age/sex group and/or aid category.

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