Independence, Dignity and Choice in Long-Term Care Act Annual Report

January 1, 2008

Jon S. Corzine
Governor

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

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I. ACKNOWLEDGEMENTS

The report was made possible by the work and commitment of the following members of the Medicaid Long-Term Care Funding Advisory Council:

- Sherl Brand, President, The Home Care Association of New Jersey, and co-chair of the Medicaid Long-Term Care Funding Advisory Council
- Theresa Edelstein, MPH, LNHA, Vice President of Continuing Care Services, New Jersey Hospital Association, and co-chair of the Medicaid Long-Term Care Funding Advisory Council
- Thomas D. Begley, Jr., Begley & Bookbinder, PC, representing AARP
- Martin Cramer, Elder Rights Alliance of New Jersey
- Jim Donnelly, Chief Executive Officer, Senior Care Centers of America, representing Adult Day Health Services Association
- Susan Lennon[1], Executive Director, Warren County Division of Senior Services, representing New Jersey Association of Area Agencies on Aging
- Gary Gilmore, Executive Director, Wiley Mission, representing New Jersey Association of Homes and Services for the Aging
- Paul Langevin, President, Health Care Association of New Jersey
- Charles Newman, Director, Union County Office for the Disabled, representing New Jersey Association of County Disability Services
- Milly Silva, President, SEIU Local 1199NJ
- Lorraine Scheibener, Director, Warren County Division of Temporary Assistance and Social Services, representing County Welfare Directors Association of New Jersey
- Marsha Rosenthal, M.P.A., Ph.D., Rutgers Center for State Health Policy

In addition, the following State staff participated in the work of the Medicaid Long-Term Care Funding Council as ex-officio designees of the Commissioners of the Departments of Health and Senior Services and Human Services and the State Treasurer:

[1] Susan Lennon's appointment as the representative for the New Jersey Areas Agency on Aging is pending confirmation.

- Christopher Bailey, Budget Manager, Office of Management and Budget, Department of the Treasury

- Elena Josephick, Bureau Chief, Office of Policy Development, Division of Medical Assistance and Health Services, Department of Human Services

- Patricia Polansky, Assistant Commissioner, Division of Aging and Community Services, Department of Health and Senior Services

II. EXECUTIVE SUMMARY

On June 21, 2006, Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act (Act) to create a process to reallocate Medicaid long-term care expenditures and develop a more appropriate funding balance between nursing home care and home and community-based care services (HCBS). The State is now charged in rebalancing its Medicaid long-term care system to include more community care and greater consumer choice, and ensure that "money follows the person," allowing maximum flexibility between nursing homes and home and community-based settings.

The report summarized here is in accordance with Public Law 2006, chapter 23: *"The Commissioner of the Department of Health and Senior Services (DHSS), in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this Act, shall no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved."*

This report includes a description of the highlights and opportunities identified for the period beginning June 21, 2006 from the passage into law of the Act until the due date of this first annual report on January 1, 2008. There has been measurable progress vis-à-vis rebalancing since the Act's passage.

The Aging and Disability Resource Connection (ADRC) initiative has become the primary catalyst for rebalancing long-term care in New Jersey. Global Options for Long-Term Care (GO) with a focus on community residents and consumer direction was implemented in the ADRC pilot counties of Atlantic and Warren. Consumers are informed about appropriate long-term care options: Based on their eligibility criteria, they are counseled on appropriate home and community-based services (HCBS). The achievements and outcomes of the ADRC are significant to date. Between January 1, 2006 and October 31, 2007 the pilot counties responded to more than 66,000 contacts from older adults.

Under the new Medicaid Eligibility Fast Track Determination (Fast Track) process, consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria can receive HCBS for up to 90 days while they complete the full Medicaid application and eligibility determination process. To date, 625 names have been processed through the DHSS' Low Income Subsidy database: of these, 45 individuals were able to benefit immediately from the Fast

Track process, 82 individuals had a Community Medicaid card and were referred for further clinical eligibility screening to see if they qualified and 498 were counseled about other funded HCBS such as Jersey Assistance for Community Caregiving (JACC), a state funded program, and Older Americans Act programs.

The Nursing Home Transition component of GO has increased available funding, expanded HCBS options, and provided more flexibility for nursing home residents to control and direct their services. Since implementing GO in State Fiscal Year 2006, nearly 1,000 nursing home residents have been transitioned to alternative long-term care options in New Jersey. Of those discharged, 813 individuals were enrolled in GO and currently, 720 cases are still active. The remaining 83 individuals are no longer in GO for a variety of reasons, ranging from death to out-of-state moves.

The Act (C.30:4D-17.26) specifically requires the Commissioners of the Departments of Health and Senior Services and Human Services, together with the State Treasurer, to create a new budgetary process for expanding home and community-based services within the existing budget allocation by diverting persons from nursing homes to allow maximum flexibility between nursing homes and home care options. A new budget process is under development in the DHSS to support the rebalancing of the State's long-term care budget. The three Medicaid waiver programs for home and community-based services are being consolidated and a web-based client tracking system is being implemented.

Mercer Government Human Services Consulting (Mercer) is now engaged to support the State's long-term care initiatives—to assist in the State's efforts to advance rebalancing and establish funding parity between nursing homes and home and community-based services. In addition, Mercer is working with the DHSS and DHS to develop quality assurance and performance standards, the interface with Information Technology (IT) and data management support, and the integration of other programs in the Department of Human Services (DHS).

Under the first phase, Mercer will create a budget projection model that allows for accurate and timely financial projections to avoid large, unanticipated surpluses or deficits. A forecasting model will be developed that captures New Jersey's current budget situation and then projects the State general and total fund expenditures for current and upcoming budget years. The Excel-based budget projection model will both satisfy short-term projections for current and upcoming budget years, and provide long-term forecasts that account for macroeconomic changes in the New Jersey system. State staff will be trained to use the budget projection model, and technical assistance will be provided as necessary.

Mercer will also work with the State to develop a process by which individual service plans are created to drive individual budgets: a "money follows the person" or "cash and counseling" approach. A reasonable and equitable

provider reimbursement schedule for HCBS also needs to be developed since the ultimate success of rebalancing and achieving parity will likely be largely dependent upon how services are reimbursed.

Since November 2006, the Medicaid Long-Term Care Funding Advisory Council (see acknowledgements on page one for membership) has been meeting quarterly to provide input on this multi-year process to rebalance the allocation of funds for the expansion of HCBS. The Council's recommendations have emerged from their on-going review of progress as reported from the State to the Council— its management practices, initiatives and investments towards HCBS.

Specific to this report, the Council's recommendations focused on these issues:

- **Definition of Funding Parity**—The Council's consensus is to create a projection model unique to New Jersey that allows maximum flexibility between nursing home placements and HCBS services and gives individuals control over accessing care. One Council member felt it was critical that there be a goal of achieving equality of funding between nursing home placements and HCBS. The Act says that "funding parity between nursing home care and home and community-based care means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting."
- **Importance of Sustainability**—The federally funded ADRC initiative provides the underpinning of long-term care reform in the Act. It was begun with a federal grant award of $798,041 and is now being funded with a supplemental federal grant of $400,000. The Council wants to ensure the State's commitment in securing the necessary funding to sustain its long-term care reform efforts begun through federal dollars, including the ADRC's statewide expansion. The ADRC rollout in all 21 counties is essential to the success of rebalancing.
- **Workforce Upward Mobility and Retention**—There needs to be a strengthened collaboration between the DHSS, DHS, the Department of Labor, provider associations, and labor organizations for the benefit of the workforce, health care providers and the State. A Workforce workgroup was created through the Council that has developed recommendations on workforce issues to recruit and train a stable workforce. This workgroup is continuing to meet and formulate next steps.

- **Medicaid Application Process** – The reasons for prolonged Medicaid eligibility determinations by the counties need to be analyzed so that the State, providers and applicants can incorporate and utilize better, more efficient approaches in the application process, including the use of other State databases to fulfill Medicaid eligibility requirements. In addition, the outcomes of the Fast Track Eligibility Determination process need to be studied from a quantitative and qualitative perspective.

III. BACKGROUND

A. History of Independence, Dignity and Choice in Long-Term Care Act

New Jersey is witnessing a fundamental change in its long-term care policy for older adults and persons with disabilities across all income levels. It is a transformation that is directed at giving more people more control over their care and providing more support for community living. The plan for New Jersey is a "Money Follows the Person" long-term care system: a person-centered approach of providing service delivery that promotes dignity, choice and independence in the most integrated community setting.

It is also Governor Jon S. Corzine's vision for New Jersey, which was reaffirmed when the Governor signed the Independence, Dignity and Choice in Long-Term Care Act (the Act) into law on June 21, 2006. As a result of this historic bill signing, the State's long-term care funding structure is being redesigned to provide more options for older adults through budgetary rebalancing under Public Law 2006, chapter 23.

New Jersey's efforts to reform its long-term care system have been recognized nationally by the federal government, namely the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS). New Jersey has been awarded all major federal grants to support the modernization and rebalancing of its long-term care system:

- **Nursing Home Diversion Modernization Grant** ─ In 2007, the Department of Health and Senior Services (DHSS) was awarded an 18-month grant for the maximum award amount of $500,000 to develop a nursing home diversion program for individuals who are not Medicaid eligible. It targets individuals who are at risk of nursing home placement and who are spending down to Medicaid eligibility. The program is using a flexible, consumer-directed model of care. This Cash and Counseling approach will give consumers greater control over their care and more effectively use their personal income and resources to avoid spend down to Medicaid.
- **Real Choice Systems Change Grants for Community Living** ─ The DHSS, in partnership with the Department of Human Services (DHS), is the recipient of a five-year Systems Transformation Grant (STG) of $2.3 million from CMS. It serves as a catalyst for continued infrastructure, process and delivery of long-term support services changes for older adults and persons with disabilities across all income levels. New Jersey's three impact goals under the STG focus on: (1) creating a "one-stop" service delivery system to make it easier for consumers to access necessary services—the ADRC; (2) developing an Information Technology (IT) strategy that facilitates consumer choice and control

throughout enrollment, planning, service delivery and quality assurance/quality improvement (QA/QI); and (3) changing the funding methodology to a more flexible State budgeting process that better manages long-term care funds to promote home and community-based services (HCBS) so that "Money Follows the Person." This grant also focuses on the development of a more effective payment methodology for HCBS providers. The grant was awarded in 2006.

- **Aging and Disability Resource Center (ADRC) Initiative: Building Upon Success** – The DHSS, in partnership with the DHS, has a two-year ADRC grant of $400,000 from AoA, known in New Jersey as the Aging and Disability Resource Connection (ADRC). Awarded in 2006, the funding allows New Jersey to expand the ADRC model from its testing in Atlantic and Warren Counties to Mercer, Camden, Hunterdon, Morris and Bergen Counties. Greater access to long-term care support options is at the center of the ADRC—to make it easier for seniors and people with disabilities to learn about and access long-term care service options. The original three-year grant awarded in 2003 was for $798,041.
- **Empowering Older People to Take More Control of their Health through Evidence Based Prevention Programs** – The DHSS is the recipient of a three-year federal grant of up to $600,000 from AoA. New Jersey was among 16 states selected in 2006 to implement low-cost, community-based disease and disability prevention programs that have proven to reduce the risk of disease and disability among older adult participants. These programs were developed by Stanford University through funding by the Agency for Healthcare Research and Quality. New Jersey's initiative builds upon the Department's existing wellness activities for older adults, specifically the HealthEASE physical activity model and health education efforts.
- **Alzheimer's Disease Demonstration Grant** – In 2007, the DHSS was one of three states awarded the *Translating Evidence-Based Alzheimer's Diseases and Related Dementia Direct Services Research into Practice* grant from AoA. With $187,500 in funding, the grant's model will replicate the National Institute on Aging-sponsored Philadelphia Resources Enhance Alzheimer's Caregiver Health (REACH) Initiative, a nationally renowned research project in the field. The initiative targets persons with Alzheimer's disease or related disorders and their caregivers. In 2005 and 2006, the DHSS received $150,000 in federal funding from AoA for another Alzheimer's Disease Demonstration grant—*Environmental Interventions for Dementia Care*.

The roadmap to Medicaid long-term care reform in New Jersey began well before the February 2006 passage of the Deficit Reduction Act (DRA). However, the DRA gave New Jersey additional tools to help rebalance its long-term care system with the federal awarding of the Real Choice Systems Change Grant for Community Living. Other DRA opportunities for change also resulted, from the

Money Follows the Person (MFP) Rebalancing Demonstration initiative to the Nursing Home Diversion Modernization Grant.

Under the MFP demonstration, in 2007 New Jersey was awarded a grant from CMS that could total up to $30.3 million over five years. A partnership of the DHS and the DHSS, New Jersey's plan will assist people who are elderly and/or physically or developmentally disabled to live and receive services in local communities rather than in institutions. CMS will award New Jersey an enhanced federal medical assistance percentage for each qualified transition: 75 percent federal match versus the usual 50 percent. Like under the regular Medicaid program, New Jersey will still need to spend State funds to draw down grant dollars, which is in the form of enhanced federal funding participation.

New Jersey qualified to receive these federal grants because of its strong leadership commitment and progress in enhancing and expanding long-term care support services. Over the past several years through Real Choice Systems Change grants, New Jersey has developed and implemented strategies to change the service delivery system for its residents based upon CMS' four key building blocks of access, services, financing and quality improvement.

Any long-term care reform in New Jersey needs to take into account that as the State Unit on Aging, the Division of Aging and Community Services (DACS) is responsible for carrying out the unique mission of the Older Americans Act. The Act was created in 1965 to help older people remain healthy and independent in their own homes and communities for as long as possible, before Medicaid may even be an option.

And the 2006 reauthorization of the Older Americans Act played an important role in redirecting New Jersey's comprehensive system of long-term care to help elderly residents maintain their dignity in their homes and communities. The new grant awarded to New Jersey, called the Nursing Home Diversion Modernization Grant, strengthens the State's capacity to provide more choices for high-risk individuals before they enter a nursing home and need to spend down to Medicaid – and conserve Medicaid dollars that would ultimately be paid for by the State and federal government.

In 2003, New Jersey was selected by AoA/CMS as one of the original 12 states to pioneer an ADRC grant to improve access to information, services and streamline the Medicaid eligibility process. (The ADRC is now in 43 states.) New Jersey's ADRC initiative was the first joint venture between DHSS and DHS to create a "no wrong door" coordinated single entry system for persons of all ages, physical disabilities and long-term illnesses regardless of income. Its six impact goals focus on the development and implementation of a state model with a system-wide focus. The State introduced the concept beginning with Atlantic and Warren Counties as pilots. An algorithm, as a client pathway, was developed as an operating framework for the service delivery system.

The ADRC grant is enabling the State to redesign the State's aging and disability service delivery systems by:

- Creating a system that is visible, trusted and easy to access for information and assistance (I&A) on the broad array of home and community-based services (HCBS);
- Addressing the changing needs of older adults, persons 18 years and older with physical disabilities and their caregivers, including those from culturally-diverse populations and all income levels across the lifespan;
- Supporting individuals to make informed quality of life and quality of care choices; and
- Streamlining the clinical and financial eligibility process for long-term care Medicaid services.

An algorithm for the ADRC model was created to identify a new client pathway and decision-making process for determining clinical and financial eligibility and accessing information. The algorithm consists of these six steps: (1) building organizational capacity; (2) initiating contact with consumers; (3) identifying consumers' needs; (4) counseling consumers on LTC options; (5) coordinating consumer directed care plans, and (6) integrating a continuous quality management framework into the ADRC model.

Now under the additional two-year grant that began in October 2006 from the AoA, the ADRC has expanded to five more counties (Mercer, Camden, Hunterdon, Morris and Bergen) from its testing as a pilot in Atlantic and Warren counties.

In 2004, DACS received a CMS-funded technical assistance award from the National PACE Association to establish PACE (Programs of All-inclusive Care for the Elderly). PACE is CMS' only approved managed care model providing a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate. New Jersey's first PACE site expects to open in 2008 at St. Francis Hospital in Mercer County. The hospital was awarded a Robert Wood Johnson Foundation grant for administrative start-up costs. It will be yet another option for some of the State's frailest elders to avoid or delay nursing home placement.

Between 2004-2005, two former governors, with the support of AARP, signed executive orders directing the DHSS to develop and implement a global budgeting process and fast track eligibility process for Medicaid long-term support services. For the first time in State Fiscal Year 2006, $30 million in state and federal funds were allocated to rebalance the budget and move from an institutional bias to a greater emphasis on HCBS.

The Act calls for the reallocation of Medicaid long-term care expenditures and the creation of a more equitable balance between public funding for nursing homes and HCBS. The program, known as Global Options for Long-Term Care (GO for LTC), is continuing the restructuring of New Jersey's long-term care system from a fragmented service delivery system currently provided to New Jersey seniors and persons 18 years and older with physical disabilities to a single entry system for both populations.

The Act also directed the DHSS to implement a system of statewide long-term care service coordination and management; to identify HCBS long-term care models that are efficient and cost-effective alternatives to nursing home care; develop and implement a consumer assessment instrument that is designed to expedite the process to authorize the provision of home and community-based services through fast-track eligibility prior to formal financial eligibility determination; develop a quality assurance system; seek to make information available to the general public, and create a Medicaid Long-Term Care Funding Advisory Council.

B. Overview of Rebalancing Efforts in Model States

The most recent report on rebalancing Medicaid long-term care expenditures across the United States was produced in April 2007 at the direction of the U.S. Congress, which in 2003 directed the Centers for Medicare & Medicaid Services (CMS) to study the rebalancing efforts in up to eight states, from their management techniques and programmatic features to their investments in long-term care supportive services.[2] This CMS-commissioned report (the Rebalancing Study) includes eight states that are at various stages in their long-term care reform efforts: Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. Both quantitative and qualitative approaches are used in the Rebalancing Study.[3]

For the purposes of the Rebalancing Study, CMS defines rebalancing as "reaching a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its state plan and waiver options." Additionally, a balanced long-term care system "offers individuals a reasonable array of balanced options, particularly adequate choices

[2] US Department of Health and Human Services. Centers for Medicare & Medicaid Services. Rebalancing Project Update Report—April 2, 2007. By Rosalie A. Kane, Reinhard Priester, Robert L. Kane and Donna Spencer. <http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp>.

[3] US Department of Health and Human Services. Centers for Medicare & Medicaid Services. Management Approaches to Rebalancing Long-Term Care Systems: Experience in Eight States up to July 31, 2005: Executive Summary. By Rosalie A. Kane, Reinhard Priester, Robert L. Kane and Robert Mollica. <http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp>.

of community and institutional options." CMS also did not provide specific target goals as a means to refer to a system as appropriately balanced.[4]

The latest national data available from Thomson Healthcare (formerly Medstat) shows data on Medicaid long-term care expenditures[5] for the United States in Federal Fiscal Year (FFY) 2006, which ran from October 2005 through September 2006. The CMS 64 data includes nursing home services and ICF/MR services under institutional services. Community-Based Services include HCBS waiver services, Personal Care, Home Health, HCBS authorized under Section 1115 waivers and HCBS authorized under Section 1929. This data is provided in Appendix C.

Of the eight states aforementioned in the CMS-commissioned study, New Jersey has achieved a distribution of Medicaid long-term care expenditures between institutional versus community-based services in FFY2006 that places it in the middle of the states studied. Florida, Arkansas, Pennsylvania and Vermont – come after New Jersey in their rankings among the 50 states for this distribution. In FFY2006 for New Jersey, 66 percent was spent on institutional long-term care and 34 percent on community-based services.[6]

The other four states – New Mexico, Minnesota, Washington and Texas – rank above New Jersey in FFY2006:

- New Mexico: 37 percent institutional to 66.8 percent community-based services
- Minnesota: 39.2 percent institutional to 60.8 percent community-based services
- Washington: 39.4 percent institutional to 60.6 percent community-based services
- Texas: 56.5 percent institutional to 43.5 percent community-based services

While quantitative markers of rebalancing were important in the Rebalancing Study, there were other important measures considered, including the state's context for rebalancing, a system assessment of each state, management approaches and baseline case studies. It was neither an evaluation

[4] US Department of Health and Human Services. Centers for Medicare & Medicaid Services. Management Approaches to Rebalancing Long-Term Care Systems: Experience in Eight States up to July 31, 2005: Executive Summary.

[5] Burwell, Brian, and Kate Sredl and Steve Eiken. Medicaid Long-Term Care Expenditures, FY 2005 and Medicaid Long-Term Care Expenditures, FY2006,Thomson Healthcare <http://www.hcbs.org/search>

[6] Burwell, Brian, and Kate Sredl and Steve Eiken. Medicaid Long-Term Care Expenditures, FY 2006.

of any state's rebalancing efforts nor was it based on any normative views of what is adequate in terms of rebalancing.[7]

As New Jersey moves forward with achieving parity, it is important to take into account the experiences of other state examples of achieving funding parity between nursing home care and home and community-based care. In March 2004, AARP New Jersey released a report—"Rebalancing Long-Term Care in New Jersey: Money Follows the Person" in support of its long-term care reform agenda for the State, which ultimately helped shape the language in the Independence, Dignity and Choice in Long-Term Care Act. In its report, AARP's key components for achieving rebalancing were showcased as access, financing, services and quality, drawing upon the CMS definition of the concept of Money Follows the Person.

C. Highlights of Commissioner's Report on Budget and Management Plan for Effectuating the Independence, Dignity and Choice in Long-Term Care Act

Federal funding opportunities through the Deficit Reduction Act of 2005 and grant awards from the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS) are advancing New Jersey's efforts to reform its long-term care system. With the budgetary support and commitment from Governor Corzine, the partnership of the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) responsible for developing strategies to carry out the Independence, Dignity and Choice in Long-Term Care Act's (Act) requirements and the input and guidance from the Medicaid Long-Term Care Funding Advisory Council (Council), the State is making progress toward fulfillment of the Act's mandates.

The Council was created within the DHSS and has been meeting quarterly since November 2006. There are 12 public members and three designees from the Commissioners of Health and Senior Services and Human Services, and the State Treasurer. These are the Council's recommendations to Governor Corzine and the Legislature as written into the October 2007 report:

- Expand the Aging and Disability Resources Connection (ADRC) model, clinical assessment, fast-track eligibility process, and client-tracking system piloted in Atlantic and Warren Counties, statewide based on the evaluation and analysis of the pilot.
- Establish a task force including representatives from the DHSS Division of Aging and Community Services (DACS) and the DHS,

[7] US Department of Health and Human Services. Centers for Medicare & Medicaid Services. Management Approaches to Rebalancing Long-Term Care Systems: Experience in Eight States up to July 31, 2005: Executive Summary.

Division of Medical Assistance and Health Services (DMAHS) to prepare and evaluate a State budget and cost impact analysis for the potential expansion of the home and community-based Medicaid waiver programs to include the Medically Needy population. Also determine if legislative action would be necessary to implement such an expansion. The Medically Needy Program provides Medicaid benefits for persons whose income exceeds the Medicaid Program's eligibility requirements but is reduced by documented medical expenses.

- Strengthen collaboration between DHSS, DHS and the Department of Labor and Workforce Development to maximize and coordinate the resources of the Workforce Investment Boards and other programs/funding for the benefit of the workforce, health care providers and the State.
- Create mechanisms for upward mobility to help attract and retain direct care workers in the long-term care field.
- Redesign the nursing home rate setting methodology so that Medicaid rates are stable, predictable and adequate.
- Develop and implement a flexible budgeting methodology that provides the State with the authority to allocate and coordinate Medicaid long-term care dollars to support consumer choice across departments, programs, and populations.
- Review the adequacy of reimbursement for Medicaid funded home care services with DHS, including rates for skilled visit services, private duty nursing, and home health aide services to ensure that rates are adequate to cover the costs associated with direct care delivery, inclusive of ongoing nursing supervision.
- Transfer the home health aide certification program and process from the Board of Nursing in the Division of Consumer Affairs at the Department of Law and Public Safety to the DHSS.
- Include individuals with mental illness in New Jersey's long-term care reform efforts as written into the Act. The U.S. Supreme Court ruling in *Olmstead v. L.C.* upholds that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act.

IV. PROGRESS UNDER THE INDEPENDENCE, DIGNITY AND CHOICE IN LONG-TERM CARE ACT FOR REBALANCING NURSING HOME AND HOME AND COMMUNITY-BASED SERVICES

A. Rebalancing Progress since June 2006

Again, the latest national data available from Thomson Healthcare (formerly Medstat) shows data on Medicaid long-term care expenditures[8] for the United States in Federal Fiscal Year (FFY) 2006, which ran from October 2005 through September 2006. The CMS 64 data includes nursing home services and ICF/MR services under institutional services. Community-Based Services include HCBS waiver services, Personal Care, Home Health, HCBS authorized under Section 1115 waivers and HCBS authorized under Section 1929.

In this report, New Jersey's ranking among the 50 states in terms of its distribution of Medicaid long-term care expenditures between institutional versus community-based services has improved from FFY 2005 to FFY2006—from 39th to 32nd place. In FFY2006 for New Jersey, a total of $3,677,078,087 was spent on Medicaid long-term care expenditures with 66 percent ($2,421,727,657) spent on institutional long-term care and 34 percent ($1,255,350,430) on community-based services. In FFY 2005 for New Jersey, a total of $3,394,840,186 was spent on long-term care expenditures: 73 percent ($2,483,896,701) on institutional long-term care services and 27 percent ($910,943,485) on community-based services. This data is provided in Appendix C.

On June 21, 2006, Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act (Act) into law. It is the Aging and Disability Resource Connection (ADRC) model – with its partnerships, products and processes – that provides the framework underpinning the Act. The creation of the ADRC model has included the testing of a clinical assessment tool and a Medicaid Fast Track Eligibility process, the purchase of a web-based client tracking system, and the design of a new business process to transition individuals from nursing homes to home care options.

The ADRC initiative has become the primary catalyst for rebalancing long-term care in New Jersey. Because of its emphasis on consumer direction, Global Options for Long-Term Care (GO) – with a focus on community residents – was implemented in the ADRC pilot counties of Atlantic and Warren to offer flexible service dollars, allowing consumers to purchase services to meet their

[8] Burwell, Brian, and Kate Sredl and Steve Eiken. Medicaid Long-Term Care Expenditures, FY 2005 and Medicaid Long-Term Care Expenditures, FY2006,Thomson Healthcare <http://www.hcbs.org/search>

care needs. Consumers are informed about appropriate long-term care options. Based on their eligibility criteria, they are counseled on appropriate HCBS. Giving the ADRC flexibility to coordinate multiple funding streams, such as Medicaid, Older Americans Act and State-funded programs, results in more cost-effective use and better stewardship of limited resources. The new delivery and coordination of funding streams still provides the State with the necessary cost controls and assures budget neutrality for HCBS.

1. Aging and Disability Resource Connection (ADRC)

The achievements and outcomes of the ADRC pilot initiatives in Atlantic and Warren Counties are significant. They have laid the foundation for the rebalancing of New Jersey's public long-term care budget from its emphasis on institutional settings to an increased focus on home and community-based services (HCBS). From January 1, 2006 to October 31, 2007 the pilot counties have responded to more than 66,000 contacts from older adults (44.5 percent), family members (12.2 percent), caregivers (9.3 percent), younger persons with disabilities (4.5 percent), and others (29.5 percent). The top seven reasons consumers called the ADRC were (in order of highest to lowest) for general information, in-home services, financial benefits, insurance/Medicare, home-delivered meals, Adult Protective Services (crisis intervention), and health/medical care.

An algorithm for the ADRC model was also created to identify a new client pathway and decision-making process for determining clinical and financial eligibility and accessing information. To target those individuals who are seeking in-home services or may be at risk for nursing home placement, a computerized screening tool was created. The tool consists of 20 questions focusing on the person's ability to perform Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL). Since 2006, the pilot counties screened 2,206 consumers, of which 61.5 percent appeared to have functional limitations that could benefit from HCBS. Of those who appeared to need HCBS, the ADRC assessors conducted full comprehensive assessments on 988 consumers, with the outcome showing that 67.1 percent of those assessed had two or more ADL deficits.

2. Fast Track Eligibility Determination (Fast Track)

Fast Track is the process through which consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria receive home and community-based services (HCBS) for up to 90 days while they complete the full Medicaid application and eligibility determination process. Because federal financial participation is not available for services delivered to

applicants who are not eligible for Medicaid, the State of New Jersey will pay for services should the applicant be determined ineligible.

The Screen for Community Services triggers the Fast Track Eligibility process. Names of individuals who meet this requirement are forwarded to the DHSS, Division of Senior Benefits and Utilization Management (SBUM) to check income and resources against the Medicare Part D Low Income Subsidy (LIS) database. Within two business days, SBUM forwards the financial information to the ADRC for review and approval or denial of Medicaid benefits under the Fast Track process. To date, 625 names have been processed through the DHSS' Low Income Subsidy database: of these names, 45 individuals were able to benefit immediately from the Fast Track process, 82 individuals had Medicaid cards and were referred for further clinical eligibility screening to see if they qualified and 498 were counseled about other funded HCBS such as Jersey Assistance for Community Caregiving (JACC), a state funded program, and Older Americans Act programs.

At the direction of Governor Corzine, the Fast Track process will be operational statewide by December 31, 2007.

3. Global Options for Long-Term Care—Statewide Nursing Home Transitions

The Nursing Home Transition component of Global Options for Long-Term Care (GO) has increased funding, expanded HCBS options and provided more flexibility for residents to control and direct their services. Since implementing GO in State Fiscal Year (SFY) 2006, nearly 1,000 nursing home residents have been transitioned to alternative long-term care options in New Jersey. Of those discharged, 813 individuals were enrolled in GO and currently, 720 cases are still active. The remaining 83 individuals are no longer in GO for a variety of reasons, ranging from death to out-of-state moves.

In SFY 2007, the State spent a total of $5,696,145: $3,448,604 for Medicaid waiver services and $2,247,541 for State Plan services for 509 GO participants. The average monthly cost for waiver services was $1,541.

Based upon claims data, the top five services used by GO participants are enhanced community care case management, initial assessment and care planning, homemaker (personal care) – weekday, personal emergency response system (PERS), and homemaker (personal care) – weekend. Based upon expenditures, the top five services (highest to lowest) are assisted living/adult family care, homemaker-week day, home-based supportive (provided by an agency), homemaker-weekend, and case management.

In regards to State Plan services, the top five services GO participants used were prescription drugs, transportation, durable medical equipment, outpatient services, and physician services. Based upon expenditures, the top five services were nursing home (GO pays for nursing home readmissions), transportation, outpatient services, prescription drugs, and hospital.

B. Project Plan to Implement a Process That Rebalances Overall Allocation of Funding Within Existing Levels of Appropriations

In this section, the mandate in Public Law 2006, chapter 23 below is used to outline the project plan that has been developed to drive forward the reallocation of Medicaid long-term care expenditures and the creation of a more appropriate balance between public funding for nursing homes and home and community-based services (HCBS):

> ***C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.***
> *4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.*

1. Budgetary Processes to Support Rebalancing

While the Independence, Dignity and Choice in Long-Term Care Act (Act) calls for rebalancing the allocation of funding for the expansion of long-term care services within the existing level of appropriations, it is the Systems Transformation Grant that is helping to drive this charge. The goals established under the STG advance the Act's mandates. It is also the grant's goal to change the funding methodology to a more flexible State budgeting process that better manages long-term funds to promote home and community-based services (HCBS) and develop a more effective payment methodology for HCBS providers.

In addition, there is a workgroup of long-term care industry professionals, community advocates and consumers who are professionally and personally dedicated to the development of a methodology that will rebalance New Jersey's long-term care budget. The Medicaid Long-Term Care Funding Advisory Council Co-Chairs Sherl Brand (President of The Home Care Association of New Jersey) and Theresa Edelstein (Vice President of Continuing Care Services of the New Jersey Hospital Association) participate in this workgroup.

According to the Act, the State must create a process for expanding HCBS within the existing budget allocation by diverting persons from nursing homes to allow maximum flexibility between nursing homes and home care options. The State Treasurer has oversight in this budget process.

As a result, the Department of Health and Senior Services (DHSS) has engaged Mercer Government Human Services Consulting (Mercer) to assist in the State's efforts to advance rebalancing and establish funding parity between nursing homes and HCBS. Technical assistance is also included for the development of quality assurance and performance standards for HCBS, interfacing with IT and data management support, and integrating other programs in the Department of Human Services (DHS).

By leveraging the STG funds with State funds, the DHSS and DHS will hire a national consultant to assist the departments in the development of a flexible budget projection model and a more effective reimbursement methodology for home and community-based services. Mercer has a contract with the Division of Medical Assistance and Health Services (DMAHS) at the DHS that is being amended to include this scope of work.

Phase One: Development of a Budget Projection Model

Under the first phase, Mercer will create a budget projection model that allows for accurate and timely financial projections to avoid unusually large, unanticipated surpluses or deficits. A forecasting model will be developed that captures New Jersey's current budget situation and then projects the State general and total fund expenditures for current and upcoming budget years. The Excel-based budget projection model will both satisfy short-term projections for current and upcoming budget years, and provide long-term forecasts that account for macro changes in the New Jersey system. State staff will be trained on use of the budget projection model and technical assistance will be provided as necessary.

Here is an overview of the components that need to be accounted for in the budget model:

- Population categories within the consolidation of the 1915 (c) Medicaid waivers;
- Funding parity;

- Service categories as defined in the waivers;
- Data periods that will be utilized for the budget projections;
- Claims expenditure and utilization information from UNISYS;
- Source of enrollment information;
- Process for incorporating historical and prospective legislation and fee schedule changes which impact the projection period;
- State versus federal funding;
- Geographical areas;
- Movement from nursing homes to HCBS, and
- Changes in cost and utlilization as individualized budgeting moves forward.

Other activities in the proposed scope for the development of the budget projection model are:

- Interviewing of staff responsible for the movement of individuals from nursing homes to HCBS to develop an approach for how this process will be factored into the budget projection model;
- Drafting of the modeling methodology and reporting format to include in the development of an Excel-based model;
- Testing of the budget projection model using historical data;
- Analysis of the actual data versus the projected data as the experience emerges, and
- Development of a procedure manual to accompany the budget projection model.

Phase Two: Creation of an Individualized Budget Process

The State is currently operating a participant employed provider option that allows clients to hire for services other than traditional agency services with the intent to expand this program -- and tie it to the global budget.

Under the second phase, Mercer will work with the State to develop a process by which individual service plans are created to drive individual budgets: a “money follows the person” or “cash and counseling” approach.

The following is the necessary work to carry out the second phase:

- Evaluate the current planning process and resources for individual service allocations and recommend a plan based on best practices and national trends;
- Review and develop recommendations for possible approaches to managing individualized budgets;
- Develop a mapping of the current fee schedule to a level of care needs tools, allowing for a budget neutrality component and identifying any concerns;

- Work with staff to link the clinical level of care needs to a budgeting process that assists case managers in service planning, and
- Update the budget projection model to allow for more precise assumptions related to individualized budgets.

Phase Three: Develop and Implement More Effective Payment Methodologies for HCBS

The ultimate success of rebalancing and achieving parity will likely be dependent upon the development and maintenance of a reasonable and equitable provider reimbursement schedule. To develop a new HCBS rate system, the following activities are proposed:

- Review of the current HCBS rate methodology and rate system;
- Obtaining of stakeholder input on concerns with the current HCBS rate methodology and rate system and consider rates being paid for similar rates in other state programs;
- Development of a concept paper and recommendations for rate methodology and rate system, considering stakeholder input, other state experiences, CMS approved approaches and budgetary issues;
- Development of a cost survey for providers to collect relevant cost data, considering allowed versus non-allowed costs and limits on costs and services;
- Obtaining of cost survey and utilization and cost data;
- Development of the proposed rates, and
- Determination of the budget impact of proposed versus existing rates.

2. Consolidation of Medicaid Waivers

The Department of Health and Senior Services (DHSS), Division of Aging and Community Services (DACS), is working in collaboration with the Department of Human Services (DHS), Division of Medical and Health Services (DMAHS), to consolidate the 1915(c) Medicaid waivers operated in DACS effective July 1, 2008. The Centers for Medicare & Medicaid Services (CMS) has given authorization to New Jersey to proceed with its plan. A Medicaid waiver is a tool used by states to obtain federal Medicaid matching funds from CMS to provide long-term care to people in settings other than nursing homes.

Currently the DHSS offers Medicaid waiver services that compete against one another. Enormous differences currently exist among their service packages, which lead to many inconsistencies for consumers and their caregivers:

- The Community Care Program for the Elderly and Disabled (CCPED) offers four State Plan services and four Medicaid waiver services – the others offer all State Plan services and up to 11 additional Medicaid

waiver services. CCPED was renewed October 1, 2006 and will be effective for five years.

- Assisted Living (AL) offers Medicaid waiver services in residential settings while the Enhanced Community Options (ECO) waiver offers services in the home. The AL and ECO waivers will expire December 31, 2008.

CMS has told the State that a new waiver will not be necessary in order to combine New Jersey's 1915(c) Medicaid waivers, and has encouraged the DHSS to proceed to amend the CCPED waiver to reflect a consolidation with the other two waivers (Assisted Living and Enhanced Community Options). Individuals receiving services under the current Medicaid waivers will be transferred into the consolidated waiver under a seamless transition.

The DHSS is ready to submit the Waiver Amendment Request to CMS as soon as DHS is notified that the abbreviated Interim Procedural Guidance (IPG) reports have been approved by CMS. The IPG for both AL and ECO provide substantial evidence that the State is fulfilling its obligation to meet the federal quality assurances.

The Office of Management and Budget, Department of the Treasury, is working with the DHSS to consolidate the multiple Medicaid waiver budgets into a single Global Budget line item.

3. Implementation of Client-Tracking System

In November 2006, the Department of Health and Senior Services (DHSS) submitted a waiver of advertising to purchase a complex web-based client tracking data system from Synergy Software Technologies, Inc. It is the integrated application – the Social Assistance Management Systems (SAMS) application – that advances the Aging and Disability Resource Connection's (ADRC) objectives as described in the Independence, Dignity and Choice in Long-Term Care Act (Act). The integrated application includes intake, case management, service planning, service provision, service invoicing, and the federal reports mandated for the State of New Jersey under the Older Americans Act (OAA).

The State Office of Information and Technology (OIT) required the DHSS to conduct a six-month pilot in seven counties to validate the application's capacities to support its data requirements across State and county offices, their grantees, and provider agencies in administering OAA programs, the ADRC, Medicaid Waiver Services, and other State funded programs.

The Act has accelerated the statewide implementation of Information Technology (IT) solutions included in the original waiver of advertising approval.

It requires a web-based client-tracking system to support clinical eligibility determination, fast-track financial approvals, service coordination, and the deployment of quality assurance beginning March 2008. The law also requires that the State Treasurer review and analyze client service utilization and costs to determine the transfer of long-term care funding to home and community-based services (HCBS).

To successfully demonstrate the capacity of SAMS, the Division of Aging and Community Services (DACS) established five objectives: (1) compile data for federal/state reports; (2) screen and target consumers at risk of nursing home placement; (3) capture and analyze clinical and financial eligibility data; (4) facilitate service planning and coordination; (5) collect data to meet federal quality assurance requirements, and (6) collect data elements for rebalancing long-term care funding streams.

Based upon the six-month pilot, the following objectives were achieved:

a. **Compilation of data for federal/state reports**: To serve as the single database to collect, analyze, and transfer federally required data elements to the Administration on Aging (AOA), the pilot agencies entered information to produce the following reports: Participant and Expenditure Tracking Reporting, Provider Contract Reporting, and the Unduplicated Participant County Reports. The combination of these modules enabled DACS to successfully deliver the mandated federal report for the AoA.

b. **Capacity to screen and target consumers at risk of nursing home placements**: To perform the intake, community screening and financial fast-track approval processes that accurately direct consumers to the most appropriate programs, staff at the pilot sites successfully entered client data into the consumer details module. This module satisfied the federal requirements to target consumers most in need and to track unduplicated county participants. To achieve the additional mandates identified in Public Law 2006, chapter 23, and support the ADRC IT requirements, Synergy will expand intake and screening data elements by incorporating New Jersey's screen for community services into its Beacon Information and Referral module. This additional component is critical to support the Medicaid Eligibility Fast Track Determination (Fast Track) process.

c. **Capture and analysis of clinical eligibility data**: To support the clinical assessment process and determination of nursing facility level of care (NF-LOC) needs and services, the ADRC has successfully piloted a computerized comprehensive clinical assessment tool, which incorporates the internationally validated InterRAI clinical assessment. This tool, known as MI-Choice, will become the clinical assessment tool for the Pre-Admission Screening (PAS).

Through a professional services contract, the University of Michigan, the national repository for state-level MDS-HC (InterRAI) data, provided to DACS (1) an analysis of New Jersey's State Fiscal Year 2007 PAS assessments and recommended a clinical nursing facility level of care (NF-LOC) algorithm to support the State's 8:85 regulations and Adult Day Health Care Services 8:86 regulations; (2) a reformulation of the current MI-Choice Screening algorithm for the ADRC; and (3) refinement of the NF-LOC and telephone screen based on clinical input and data analysis. This analysis provides the State with two algorithms: one for determining New Jersey's NF-LOC and a second for level of service needs.

The algorithms will be programmed into the PAS database administered by DACS. This database has the capacity to support the ADRC and PAS business processes, including the Fast Track process. Public Law 2006, chapter 23, also mandates the clinical assessment tool.

d. **Facilitation of service planning and coordination**: To create a universal database that supports a statewide, county-based care management network, DACS explored the potential capacities of SAMS 2000 software to provide the tools that New Jersey's care managers need to oversee and manage their client caseloads. Upon review, several of the SAMS care management features will need to be customized to support the State's business processes and quality assurance standards established by the Centers for Medicare & Medicaid Services (CMS). A truly coordinated statewide system will enable professionals to provide and monitor care management services through the collection of routine demographic data; to conduct an assessment of care needs; to plan and authorize services and providers; to monitor care; and to verify service delivery. SAMS will permit DACS, for the first time, to monitor care management practices in an aggregate capacity.

e. **Collection of data to meet CMS Quality Assurance requirements**: The SAMS product was examined to understand its capacity to meet the federal requirements put forth through the CMS Quality Assurance Framework for HCBS reporting requirements and CMS' Medicaid Waiver Assurances. Additional modifications will be required to capture data for quality oversight such as provider qualifications, clinical needs assessment, service planning and coordination, and monitoring participant health and welfare.

f. **Collection of data elements for rebalancing long-term care funding streams**: To test the application's capacity to capture and track multiple funding stream allocations, expenditures, and utilization of services, the pilot sites successfully entered client data into the Participant and Expenditure Tracking Reporting and Provider Contract Reporting modules. This will enable the State to track and trend expenditures by

individuals, services, and funding streams and ultimately provide the Department of the Treasury with data to analyze and determine the transfer of funds between nursing home and HCBS budgets.

V. APPENDICES

Appendix A

P.L. 2006 CHAPTER 23
AN ACT concerning long-term care for Medicaid recipients and supplementing Title 30 of the Revised Statutes.
BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*
C.30:4D-17.23 Short title.
1. This act shall be known and may be cited as the "Independence, Dignity and Choice in Long-Term Care Act."
C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.
2. The Legislature finds and declares that:
a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;
b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;
c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;
d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;
e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in *Olmstead* v. *L.C.* and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;

f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health and Senior Services, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global long-term care budgeting process designed to provide the Department of Health and Senior Services with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;
g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;
h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and
i. The enactment of this bill will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.
3. As used in this act:
"Commissioner" means the Commissioner of Health and Senior Services.
"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.
"Home and community-based care" means Medicaid home and community-based long-term care options available in this State, including, but not limited to, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community-based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and community-based services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner, in consultation with the Commissioner of Human Services, shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) the provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the

Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and

(b) the use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and

(2) commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. no later than October 1, 2007, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and

b. no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community-based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:

a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home

beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community-based long-term care options available to Medicaid recipients; and annual percentage changes in both long-term care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;
b. Commence the following no later than January 1, 2008:
(1) implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;
(2) identify home and community-based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;
(3) develop and implement with the Commissioner of Human Services a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and
(4) develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and
c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.
7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Health and Senior Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health and Senior Services, Human Services and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.
b. The advisory council shall:
(1) monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and

(2) develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.
c. The advisory council shall comprise 15 members as follows:
(1) the commissioner, the Commissioner of Human Services and the State Treasurer, or their designees, as ex officio members; and
(2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.
d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.
e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

C.30:4D-17.30 Waiver of federal requirements.
8. The Commissioner of Human Services, with the approval of the Commissioner of Health and Senior Services, shall apply to the federal Centers for Medicare and Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

C.30:4D-17.31 Tracking of expenditures.
9. The commissioner, in consultation with the Commissioner of Human Services, shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.
10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal

year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.

11. This act shall take effect immediately. Approved June 21, 2006.

Appendix B

Abbreviations and Acronyms

Activities of Daily Living	ADLs
Administration on Aging	AoA
Adult Family Care	AFC
Aid to Families with Dependent Children	AFDC
Aging and Disability Resource Connection	ADRC
Assisted Living	AL
Caregiver Assistance Program	CAP
Centers for Medicare & Medicaid Services	CMS
Certified Nurse Aide	CNA
Community Care Program for the Elderly and Disabled	CCPED
Deficit Reduction Act of 2005	DRA
Department of Health and Senior Services	DHSS
Department of Labor and Workforce Development	LWD
Department of Human Services	DHS
Division of Aging and Community Services	DACS
Division of Disability Services	DDS
Division of Developmental Disabilities	DDD
Enhanced Community Options	ECO
Division of Medical Assistance and Health Services	DMAHS
Federal Financial Participation	FFP
Federal Fiscal Year	FFY
Federal Medical Assistance Percentage	FMAP
Global Options for Long-Term Care	GO for LTC
Home and community-based services	HCBS
Home Health Aide	HHA
Information & Assistance	I&A
Independence, Dignity and Choice in Long-Term Care Act	Act
Information Technology	IT
Instrumental Activities of Daily Living	IADLs
Inter-Disciplinary Team	IDT
Jersey Assistance for Community Caregiving	JACC
Long-Term Care	LTC
Living Independently for Elders	LIFE
Low Income Subsidy	LIS
Medicaid Eligibility Fast Track Determination	Fast Track
Medicaid Long-Term Care Funding Advisory Council	Council
Medicaid Management Information System	MMIS
Medically Needy Income Level	MNIL
Mercer Government Human Services Consulting	Mercer
Money Follows the Person	MFP

New Freedom Initiatives	NFI
Nursing Facility Level of Care	NF-LOC
Office of Community Choice Options	OCCO
Office of Information Technology	OIT
Office of Management and Budget	OMB
Programs of All Inclusive Care for the Elderly	PACE
Quality Review Committee	QRC
Quality Management Panel	QMP
Social Assistance Management Systems	SAMS
Senior Benefits Utilization & Management	SBUM
State Fiscal Year	SFY
Systems Transformation Grant	STG

Appendix C

Medicaid 1915(c) Home and Community-Based Services Waiver Expenditures

Figure 1: Distribution of Medicaid Long-Term Care Expenditures, Institutional vs. Community-Based Services, FY2005

Distribution of Medicaid Long Term Expenditures Institutional vs. Community-Based Services, FY 2005					
STATE	Institutional LTC Services		Community-Based Services		TOTAL LTC Expenditures
	Expenditures	% of Total Medicaid LTC Dollars	Expenditures	% of Total Medicaid LTC Dollars	
Oregon	$255,636,038	29.9%	$600,549,989	70.1%	**$856,186,027**
New Mexico	$219,625,404	32.8%	$450,981,337	67.2%	**$670,606,741**
Alaska	$119,071,602	37.0%	$202,452,251	63.0%	**$321,523,853**
Vermont	$104,706,607	40.2%	$155,953,459	59.8%	**$260,660,066**
Minnesota	$1,030,551,911	40.9%	$1,490,266,154	59.1%	**$2,520,818,065**
Washington	$709,632,730	42.5%	$962,010,877	57.5%	**$1,671,643,607**
Wyoming	$81,483,237	45.9%	$95,870,119	54.1%	**$177,353,356**
California[1]	$3,689,787,337	47.4%	$4,091,291,411	52.6%	**$7,781,078,748**
Kansas	$410,499,678	50.2%	$407,190,529	49.8%	**$817,690,207**
Maine	$259,899,930	51.1%	$248,859,307	48.9%	**$508,759,237**
Colorado	$499,704,437	55.6%	$398,926,885	44.4%	**$898,631,322**
Montana	$150,878,249	56.6%	$115,787,986	43.4%	**$266,666,235**
Rhode Island	$301,561,336	57.0%	$227,405,738	43.0%	**$528,967,074**
Texas	$2,520,883,567	57.2%	$1,886,590,517	42.8%	**$4,407,474,084**
New York	$9,656,047,019	57.5%	$7,124,118,871	42.5%	**$16,780,165,890**
Idaho	$184,532,052	57.6%	$136,040,368	42.4%	**$320,572,420**
North Carolina	$1,585,917,088	58.2%	$1,137,797,244	41.8%	**$2,723,714,332**
Wisconsin	$1,131,221,184	58.5%	$803,963,766	41.5%	**$1,935,184,950**
West Virginia	$446,561,234	59.1%	$308,648,840	40.9%	**$755,210,074**
Utah	$199,949,030	60.5%	$130,737,461	39.5%	**$330,686,491**
Oklahoma	$572,471,968	61.4%	$360,604,674	38.6%	**$933,076,642**
Massachusetts	$1,904,767,653	62.3%	$1,153,900,297	37.7%	**$3,058,667,950**
South Dakota	$148,769,396	62.6%	$88,994,100	37.4%	**$237,763,496**
Nevada	$178,571,919	62.8%	$105,762,081	37.2%	**$284,334,000**
Hawaii	$206,853,980	63.1%	$121,012,262	36.9%	**$327,866,242**
Connecticut	$1,270,108,075	63.3%	$737,002,996	36.7%	**$2,007,111,071**
Missouri	$1,061,577,145	63.5%	$610,291,786	36.5%	**$1,671,868,931**
Maryland	$957,793,883	63.6%	$547,656,963	36.4%	**$1,505,450,846**
Virginia	$914,756,439	64.6%	$500,198,366	35.4%	**$1,414,954,805**
New Hampshire	$350,497,379	66.0%	$180,245,777	34.0%	**$530,743,156**
Iowa	$671,274,635	66.4%	$339,863,445	33.6%	**$1,011,138,080**
Nebraska	$412,159,736	66.5%	$207,680,038	33.5%	**$619,839,774**
Arizona[2]	$24,034,178	68.0%	$11,311,033	32.0%	**$35,345,211**
South Carolina	$668,055,316	69.0%	$300,093,728	31.0%	**$968,149,044**
Delaware	$180,677,623	69.9%	$77,622,769	30.1%	**$258,300,392**
Michigan	$1,625,852,412	70.3%	$687,639,144	29.7%	**$2,313,491,556**
Arkansas	$632,660,254	70.8%	$260,605,028	29.2%	**$893,265,282**

Figure 1: continued…

Distribution of Medicaid Long Term Expenditures Institutional vs. Community-Based Services, FY 2005					
STATE	Institutional LTC Services		Community-Based Services		TOTAL LTC Expenditures
	Expenditures	% of Total Medicaid LTC Dollars	Expenditures	% of Total Medicaid LTC Dollars	
Illinois	$2,135,220,646	71.2%	$862,495,223	28.8%	**$2,997,715,869**
New Jersey	$2,295,242,670	71.6%	$909,947,172	28.4%	**$3,205,189,842**
Kentucky	$829,036,389	72.0%	$322,143,881	28.0%	**$1,151,180,270**
Florida	$2,529,776,700	72.9%	$939,227,170	27.1%	**$3,469,003,870**
Alabama	$865,154,457	74.0%	$304,733,517	26.0%	**$1,169,887,974**
Louisiana	$1,077,395,672	74.7%	$364,347,937	25.3%	**$1,441,743,609**
Tennessee	$1,196,912,041	75.4%	$390,044,735	24.6%	**$1,586,956,776**
Indiana	$1,578,904,250	76.1%	$496,957,902	23.9%	**$2,075,862,152**
Pennsylvania	$4,914,610,303	76.5%	$1,513,587,716	23.5%	**$6,428,198,019**
North Dakota	$226,019,214	77.0%	$67,363,502	23.0%	**$293,382,716**
Ohio	$3,735,734,612	77.2%	$1,101,026,660	22.8%	**$4,836,761,272**
Georgia	$1,540,968,459	77.3%	$451,904,192	22.7%	**$1,992,872,651**
Washington DC	$255,543,319	83.9%	$49,188,501	16.1%	**$304,731,820**
Mississippi	$821,447,351	87.3%	$119,720,304	12.7%	**$941,167,655**
United States	**$59,340,997,744**	**62.8%**	**$35,158,616,008**	**37.2%**	**$94,499,613,752**
Institutional services include nursing homes services and ICF-MR services. Community-based services include HCBS waiver services, personal care services, home health services, and Texas' Community Assistance Services program.					

[1] California's reported expenditures will likely increase as the state submits more prior period adjustments. For community services, FY2001 through FY2004 expenditures were $750 million - $1 billion greater than the amount originally presented. For ICF/MR, adjustments increased expenditures by about $100 million each year after data were originally presented.

[2] Arizona data does not include spending for most long-term care, which is provided through a managed care program.

Source: Burwell, Brian, and Kate Sredl and Steve Eiken. Medicaid Long-Term Care Expenditures, FY 2005,Thomson Healthcare <http://www.hcbs.org/search>

Figure 2: Distribution of Medicaid Long-Term Care Expenditures, Institutional vs. Community-Based Services, FY2006

Distribution of Medicaid Long Term Care Expenditures Institutional vs. Community-Based Services, FY 2006					
STATE	Institutional LTC Services		Community-Based Services		TOTAL LTC Expenditures
	Expenditures	% of Medicaid LTC	Expenditures	% of Medicaid LTC	
Oregon	$280,378,517	28.4%	$708,022,843	71.6%	$988,401,360
New Mexico	$217,970,385	33.2%	$438,067,094	66.8%	$656,037,479
Alaska	$123,440,557	37.0%	$210,116,945	63.0%	$333,557,502
Minnesota	$1,024,222,765	39.2%	$1,589,156,198	60.8%	$2,613,378,963
Washington	$684,006,381	39.4%	$1,051,391,382	60.6%	$1,735,397,763
Wyoming	$81,964,964	44.6%	$101,676,171	55.4%	$183,641,135
Kansas	$386,415,209	46.3%	$448,518,625	53.7%	$834,933,834
Maine	$319,313,565	47.5%	$352,781,972	52.5%	$672,095,537
California[1]	$4,467,529,364	47.9%	$4,860,566,526	52.1%	$9,328,095,890
Colorado	$507,630,173	50.7%	$493,751,896	49.3%	$1,001,382,069
Wisconsin	$1,045,914,632	54.0%	$891,833,641	46.0%	$1,937,748,273
Rhode Island	$305,938,445	55.7%	$243,065,706	44.3%	$549,004,151
New York[2]	$9,844,263,393	55.7%	$7,815,697,101	44.3%	$17,659,960,494
North Carolina	$1,550,146,373	56.2%	$1,209,746,716	43.8%	$2,759,893,089
Montana	$159,497,082	56.3%	$123,890,418	43.7%	$283,387,500
Texas	$2,651,178,647	56.5%	$2,037,938,718	43.5%	$4,689,117,365
Idaho	$193,385,104	56.6%	$148,091,707	43.4%	$341,476,811
Nevada	$176,510,624	57.2%	$131,861,427	42.8%	$308,372,051
Oklahoma	$580,015,224	58.6%	$409,262,039	41.4%	$989,277,263
Utah	$205,385,432	59.2%	$141,356,848	40.8%	$346,742,280
Maryland	$1,001,047,161	59.6%	$679,742,491	40.4%	$1,680,789,652
Massachusetts	$1,838,269,252	59.9%	$1,230,967,333	40.1%	$3,069,236,585
New Hampshire	$293,830,049	60.2%	$193,916,442	39.8%	$487,746,491
West Virginia	$457,633,679	60.4%	$300,626,044	39.6%	$758,259,723
Arizona	$25,653,812	60.6%	$16,662,312	39.4%	$42,316,124
Missouri	$1,000,397,769	60.8%	$643,879,265	39.2%	$1,644,277,034
South Dakota	$154,400,991	62.2%	$93,763,095	37.8%	$248,164,086
Hawaii	$203,196,374	62.8%	$120,520,614	37.2%	$323,716,988
Iowa	$705,118,933	63.4%	$407,310,535	36.6%	$1,112,429,468
Virginia	$947,222,914	64.0%	$533,426,798	36.0%	$1,480,649,712
Nebraska	$407,164,742	64.3%	$226,353,185	35.7%	$633,517,927
New Jersey	$2,421,727,657	65.9%	$1,255,350,430	34.1%	$3,677,078,087
Delaware	$182,713,629	66.1%	$93,661,212	33.9%	$276,374,841
Connecticut	$1,513,930,384	66.7%	$754,413,182	33.3%	$2,268,343,566
South Carolina	$624,351,552	66.8%	$310,733,296	33.2%	$935,084,848
Michigan	$1,455,761,929	68.1%	$680,744,646	31.9%	$2,136,506,575
Florida	$2,710,386,569	70.2%	$1,149,205,024	29.8%	$3,859,591,593
Arkansas	$656,545,362	70.3%	$277,893,710	29.7%	$934,439,072
Kentucky	$862,805,183	70.8%	$356,549,265	29.2%	$1,219,354,448
Ohio	$3,397,524,180	71.1%	$1,378,186,583	28.9%	$4,775,710,763
Illinois	$2,216,698,674	71.6%	$880,714,106	28.4%	$3,097,412,780
Pennsylvania	$4,417,262,041	72.3%	$1,693,224,368	27.7%	$6,110,486,409
Alabama	$864,952,924	72.4%	$330,349,133	27.6%	$1,195,302,057
Vermont	$92,329,680	72.8%	$34,432,312	27.2%	$126,761,992
Louisiana	$1,062,849,610	72.9%	$394,916,369	27.1%	$1,457,765,979
Georgia	$1,398,167,498	73.7%	$498,470,140	26.3%	$1,896,637,638

Figure 2: continued…

Distribution of Medicaid Long Term Care Expenditures Institutional vs. Community-Based Services, FY 2006					
STATE	Institutional LTC Services		Community-Based Services		TOTAL LTC Expenditures
	Expenditures	% of Medicaid LTC	Expenditures	% of Medicaid LTC	
Tennessee	$1,205,069,168	74.8%	$405,492,206	25.2%	**$1,610,561,374**
Washington DC	$252,515,107	75.5%	$81,888,905	24.5%	**$334,404,012**
North Dakota	$230,494,295	75.8%	$73,478,647	24.2%	**$303,972,942**
Indiana	$1,869,620,701	78.8%	$504,156,360	21.2%	**$2,373,777,061**
Mississippi	$901,663,226	87.9%	$124,337,854	12.1%	**$1,026,001,080**
United States	**$60,176,411,881**	**60.6%**	**$39,132,159,835**	**39.4%**	**$99,308,571,716**

Institutional services include nursing homes services and ICF/MR services. Community-based services include HCBS waiver services, personal care, home health, HCBS authorized under Section 1115 waivers, and HCBS authorized under Section 1929.

Institutional data for several states include expenditures for Medicaid Upper Payment Limit programs.

Data do not include most expenditures for managed care programs that provide long-term care.

Please see the accompanying memo for additional information regarding these data.

[1] California's reported expenditures will likely increase as the state submits prior period adjustments. For FY2002 through FY2005, adjustments increased community services expenditures by $750 million - $1 billion and ICF/MR spending by $100 - $135 million.

[2] New York's reported expenditures will likely increase as the state submits prior period adjustments. For FY2002 through FY2005, adjustments increased community services spending by $60 - $120 million and ICF/MR spending by $140 - $270 million.

Source: Burwell, Brian, and Kate Sredl and Steve Eiken. Medicaid Long-Term Care Expenditures, FY 2006,Thomson Healthcare< http://www.hcbs.org/search >