



**“Money Follows the Person”
and
Long Term Care System
Rebalancing Study**

Executive Summary

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EXECUTIVE SUMMARY

I. INTRODUCTION

A. LONG TERM CARE IN THE UNITED STATES TODAY

By definition, “long term care” means a variety of services and supports utilized by individuals to meet their health and/or personal care needs over an extended period of time. The overall goal of long term care services is to help individuals maximize their independence and functioning.

The need for long term care services and supports in the US is increasing. In 2007 about 9 million Americans aged 65 and over will need long term care services. Many individuals develop the need for long term care as they age or as a chronic illness or disability requires more support.

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

The July 1999 *Olmstead v. L.C.* Supreme Court decision serves as a catalyst for improving our country’s LTC system. The decision requires states to administer services, supports, programs and activities “in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” In 2001, the President Bush’s New Freedom Initiative created a national effort to remove barriers to community living for all individuals with disabilities and chronic illnesses regardless of age. Two of the approaches most frequently used as vehicles for system change are “Money Follows the Person” and “long term care rebalancing.”

The goal of MFP is to reduce reliance on institutional care and develop community-based long term care services which support individuals’ independence and full participation in the community. MFP has two major components. One component is a financial system that promotes sufficient Medicaid funding of home and community-based services (HCBS). This often involves a redistribution of state funds between the LTC institutional and HCBS programs. The second component is a transition program that identifies individuals in institutional settings, including nursing facilities (NFs) and intermediate care facilities for people with mental retardation and developmental disabilities (ICFs/MR), who wish to remain in or return to their home and community.

Rebalancing of states’ long term care systems has also become an important part of the federal New Freedom Initiative. The federal Centers for Medicare and Medicaid Services (CMS) has defined ‘rebalancing’ as “reaching more equitable balance between the proportion of total Medicaid long term support expenditures used for institutional services (i.e. NFs and ICFs/MR) and those used for community-based supports under its state plan and waiver options”.¹ Under

¹ “Rebalancing Long term Care.” www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp. Accessed 2-16-07.

CMS’ definition, a balanced long term care system offers individuals a reasonable array of options with adequate choices of community and institutional services without a financial and service bias for facility-based services and supports.

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

C. PURPOSE AND METHODOLOGY OF THIS STUDY

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

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

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

West Virginia’s long term care system is integral to supporting the health and well-being of its citizens. As the result of the state’s demographics, most West Virginians will come into contact with the long term care system at some point in their lives, either directly or indirectly. The state reportedly has “the highest rate of disability in the nation at 23% of the general population and 48% of senior citizens report having some type of disability.”²

With 1.8 million people spread over 24,282 square miles of mountainous terrain, West Virginia’s rural Appalachian geography provides a significant challenge to the capabilities of the long term care system.

² MFP Demonstration Project Narrative.

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

A. SERVICE DELIVERY

The analysis begins with an assessment of West Virginia's LTC service infrastructure: the facility-based and community-based services available to West Virginia residents and other factors that influence the LTC system. An effectively operating state LTC system supports two goals of long term care:

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

An effective LTC system must include a variety of flexible services that can be adapted to meet the unique needs of each person across their lifespan. The second important element in a LTC system is the actual adequacy of the array of service options available. The third important element in a LTC system is service coordination.

West Virginia's system of long term services and supports are shaped by a combination of federal and state initiatives.

1. Federal Initiatives

Three federal initiatives influence West Virginia's LTC system infrastructure: the *Olmstead v. L.C.* decision; the New Freedom Initiative; and the Deficit Reduction Act of 2005 (DRA).

- The Olmstead decision requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities."
- The New Freedom Initiative is intended to remove barriers to community living options for people of all ages with disabilities and long term illnesses.³

³ www.cms.hhs.gov Accessed 4-2-07

- The Deficit Reduction Act of 2005 (DRA) was signed into law on February 8, 2006 with the intention to reduce Medicaid spending. It impacts Medicaid eligibility, benefits and cost-sharing, provider payments, and program integrity.

2. State Long Term Care Elements

At the state level, there are a variety of elements that have influenced the current make-up of West Virginia’s long term care delivery system:

- State legislation over the past decade has played a major role in shaping West Virginia’s long term care system.
- Over the years, West Virginia has made strides in moving individuals with disabilities and long term care needs from facility-based settings to community-based settings.

West Virginia has made progress in shifting funding and service provision from facility-based to community-based programs. At the same time there is an opportunity to continue West Virginia’s efforts to decrease institutional, facility-based long term care.

Nursing Facilities (NFs) are an important component of any state’s long term care system infrastructure. They provide accommodations and nursing care 24 hours per day for persons who are elderly, ill or otherwise incapacitated. This holds true in West Virginia where NFs provide medical services and supports to nearly 16,000 new admissions per year.⁴

- On average, WV utilizes more Medicaid and Medicare dollars and less private pay for NF stays than the national average.
- West Virginians are admitted into NFs from homes without home health services being provided at a rate above the national average.
- A higher percentage of “independent” individuals are NF residents in WV than the national average.
- The highest percentage of NF residents in WV is in the age group from 75 to 84, while on average in the U.S., the age group of highest percentage in nursing facilities is 85 to 95.

The statewide capacity of NFs is considered adequate at the present time. At the same time, there is concern about the current distribution of NF beds. There are geographic pockets in West Virginia that could use more NF beds and other areas that appear to have an oversupply. While redistribution of the existing statewide NF capacity may have merit, there are legal issues that come into play. NF beds cannot be reallocated geographically because of state statute and a moratorium that has been placed on NF beds since 1987.

Across the United States, policymakers have used the Certificate of Need (CON) process for over 30 years to help direct health care delivery. In comparison with other states, West Virginia’s CON system is fairly restrictive in regulating health care providers’ ability to enter

⁴ WV Health Care Association, LTC Facts 2006.

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

In West Virginia, the Level of Care criteria that an individual must meet to qualify for nursing facility services are restrictive. West Virginia is more restrictive in its NF eligibility requirements than some neighboring states, such as Ohio. As the result, some individuals who desire NF care and do not meet West Virginia’s LOC requirements seek services across the state border or try to get by with little long term care system does not provide an adequate supply of supports to those with specialty care needs. The challenge is increasing the availability of more community-based services, including assisted living services, for those individuals who are in need of some support in order to continue to live safely in their own homes and who do not qualify for NF care.

In speaking with stakeholders throughout the state, a consistent theme is that West Virginia’s long term care system does not provide an adequate supply of supports to those with specialty care needs. Specifically ventilator care units were mentioned as a needed resource within the state. In fact, West Virginia has fewer special care beds in NFs than any other state in the U.S.⁵ Because several neighboring states to West Virginia have the needed specialty NF units, some West Virginians who require specialty nursing care travel to these neighboring states, away from their home communities, families, and social network, in order to receive needed services. It should be noted that HCBS have the potential for meeting specialty care needs in people’s own homes rather than in an institutional setting. This potentially could be done for less cost than an individual needing to go to a NF.

As of May, 2007, there were 66 privately-operated Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR) that provide care for individuals with developmental disabilities in West Virginia. These facilities are licensed for a total of 515 beds. As of August 1, 1989, there has been a moratorium on the construction or development of new ICF/MR facilities in West Virginia.⁶ The moratorium was intended to assure that any new resources available to the Bureau for Behavioral Health and Health Facilities (BHHF) are used to develop small, individualized residences and home-based programs for individuals.⁷

On average in West Virginia, there are eight individuals living in an ICF/MR facility. Eight individuals per ICF/MR facility does not reflect a home-like setting where individuals may exercise personal choice. It is also unclear how much choice individuals have about who they

⁵ CMS OSCAR Form 671: F15 – F22, Current Surveys, June 2007, American Health Care Association – Health Services Research and Evaluation.

⁶ Ibid.

⁷ ICF/MR Moratorium, Civil Action No. Misc-81-585.

live with (selection of house/roommates) and the compatibility of interests versus matching people based on staffing patterns and needs.

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

There are five state-operated LTC facilities geographically dispersed throughout West Virginia. Because of the limited home and community-based options available in the state, many West Virginians who have long term care needs and no private insurance or financial resources, turn to the state’s five LTC facilities for care.

The state psychiatric acute care hospitals – Sharpe Hospital and Bateman Hospital – have become long term care facilities for some. Some individuals are admitted to the state acute psychiatric hospitals because their inability to access community-based services results in crisis situations. Some individuals cannot access waiver services because of the waiting list (in the case of the MR/DD Waiver) or high level of care requirements, which individuals may not meet at the time they apply for waiver services. These admissions do contribute to the overcrowding at Bateman and Sharpe, resulting in a diminished quality and ability to provide effective treatment for hospital residents.

This growing, expensive problem within West Virginia’s long term care and behavioral health systems would be eased by available and affordable HCBS services. Individuals and the state as a whole would benefit from increased opportunities and supports to transition from the state psychiatric hospitals to their homes and/or community-based settings of their choice.

3. Home and Community-Based Services (HCBS)

West Virginia has made strides in providing an increased amount and variety of home and community-based services (HCBS) options for individuals needing long term care supports and services. A range of HCBS services and supports are provided in West Virginia in a variety of settings. Examples of HCBS long-term care services include: Aged and Disabled Waiver Program (AD); Mental Retardation/Developmental Disabilities (MR/DD) Waiver Program; Home Health services; Hospice services; Medical Day Care; and Personal Care services. At the same time, the state’s community-based service infrastructure could be improved in the areas of scope, duration, funding and availability.

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

- Create greater consistency across the state in the availability of services;
- Expand the variety of HCBS options;

- Emphasize HCBS rather than institutional settings, when appropriate; and
- Expand waiver services to more West Virginians and provide more appropriate services and supports.

Improving the existing network of HCBS in West Virginia would allow individuals to transition from institutional-based services back home or to a community-based support system more quickly and with greater success. Availability of services in the community would also decrease the number of individuals needing care in an institution.

Assisted living residences provide housing, personal services, and sometimes medical care. A small assisted living residence has a bed capacity of four to sixteen. A large assisted living residence has a bed capacity of seventeen or more. They can range in design from a luxury apartment building to a modest group setting. Assisted living residences are typically for those individuals who are too frail to live alone and do not need the 24-hour care provided in nursing facilities.

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

The availability of assisted living resources in West Virginia is far behind other states. WV ranks in the bottom fifth of the country in total number of assisted living facilities (45th of 50) and beds (42th of 50). This ranking implies a straightforward conclusion: West Virginia needs to dramatically improve its statewide availability of assisted living residences. This service setting should be available to all West Virginians, not just those individuals who can afford the option through private health insurance or by paying for it out-of-pocket.

The state licensing rule governing medical adult day care centers defines this setting as “an ambulatory health care facility which provides an organized day program of therapeutic, social, and health maintenance and restorative services and whose general goal is to provide an alternative to twenty-four hour long term institutional care to elderly or disabled adults who are in need of such services by virtue of physical and mental impairment.”⁸

There currently are no Medical Adult Day Care providers licensed in the state. However, there are 14 social model day care centers operating in the state, commonly operated by the county senior centers, that are not required to be licensed by the Office of Health Facilities Licensure and Certification (OHFLAC).

With only fourteen social model adult day care centers and no medical adult day care centers, there are not enough services to meet the need. West Virginia ranks second to last among states in the availability of medical and social adult day care resources and facilities in the US. The

⁸ Title 62, Series 2 of Department of Health Licensure Rules: Medical Adult Day Care Centers.

expansion of this particular type of HCBS in West Virginia – especially in the geographic regions that are presently underserved by social model adult day care centers – would greatly assist aging West Virginians and state residents with disabilities to stay out of nursing facilities by having their needs met in a setting closer to their own homes and communities.

As defined by the federal government, waivers allow states flexibility in operating their Medicaid programs, as authorized by the Social Security Act. West Virginia has two CMS 1915(c) HCBS waivers, one for individuals with mental retardation/developmental disabilities and another for individuals who qualify as aging or disabled that are important elements in West Virginia’s long term care system. A third waiver for assisted living is not operational.

The waiver programs are administered by DHHR. These waivers do make available an important variety of community-based services to individuals who qualify. While there are limits on eligibility and availability of services, many West Virginia residents benefit from these programs. At the same time, the waivers’ limitations do mean that some individuals do not have access to these services which can jeopardize their ability to continue to live in the community. The MR/DD Waiver has a waiting list.

The Bureau of Behavioral Health and Health Facilities’ Division of Developmental Disabilities manages the MR/DD Waiver Program for BMS. The MR/DD Waiver Program currently serves almost 4,000 West Virginians across the state and provides the following types of services to enrollees: Residential Habilitation; Day Habilitation; Adult Companion; Respite; Pre-Vocational Services; Supported Employment; Environmental Accessibility Adaptations; Transportation; Service Coordination; Interdisciplinary Team Participation (to develop the Individual Program Plan (IPP)); Therapeutic Consultative Services (such as skills and behavioral consultation); Nursing; and Extended Professional Services (such as services from a psychologist, dietician, physical therapist, occupational therapist, or speech therapist).

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

The MR/DD waiver does have a waiting list. The number of individuals on the waiting list has risen steadily from 76 in January of 2005 to 482 in June of 2008. Of the individuals currently on the waiting list, over 79% have been on the waiting list for more than 90 days.

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

- The program imposes unnecessary or unwanted services on program enrollees.
- Individuals who qualify for the MR/DD Waiver require 24-hour supports and receive a comprehensive package of services, while individuals who are not eligible for this comprehensive waiver receive significantly less or no services. Non-waiver services for individuals with MR/DD are limited and fragmented in their availability.

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- A potential conflict of interest that exists between the needs of the waiver enrollees and the providers. Often the provider agencies complete the initial assessment, coordinate services, and provide waiver services.⁹ This could create a potential conflict where it might be in the providers’ best interest for the individual to receive a wider array of services than wanted or needed.
- Some consumers served by the MR/DD Waiver are receiving unwanted services or more services than desired and others are not receiving the level of care called for in their Individual Personal Program, or IPPs.

The AD Waiver Program provides services to enable an individual to remain at or return home rather than receiving NF care. The AD Waiver provides the following HCBS services to individuals 18 years of age and older who are medically and financially eligible: Case Management; Homemaker Services; Medical Adult Day Care (however there are no service providers in West Virginia); Transportation; and Registered Nurse (RN) Assessment and Review.¹⁰

To be medically eligible for the AD Waiver, individuals must meet the same Level of Care criteria as is required for nursing facility placement. In comparison to other states and waiver programs, West Virginia uses a relatively high level of care threshold. As the result, access to the AD Waiver from an eligibility perspective is an issue. It is not surprising that people who are aging or have changing health needs find themselves in need of community supports and end up not qualifying for services.

For the first time since 1999, in 2007 the AD Waiver waiting list was reduced to zero as the result of additional funding from the Legislature. Additionally, the ability for individuals to self-direct their waiver services was added to the program. This allows participants to access an individualized budget based on their level of care and use the funds to purchase all waiver services, except for Medical Adult Day Care. There is also a savings option built into the Personal Options program designed to give individuals more flexibility.

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

On behalf of BMS, Bureau of Senior Services (BoSS) administers the Personal Care Program for Medicaid-eligible individuals. It provides hands-on, in-home services to individuals through a number of agencies that have obtained a CON to provide this service. Services may include activities related to personal hygiene, dressing, feeding, nutrition, environmental support

⁹ Lewin Group’s Assessment of WV MR/DD Waiver Program (March 30, 2005).

¹⁰ WV AD Waiver Manual.

functions, and health-related tasks.¹¹ As of August 1, 2007, BoSS reported that over 4,000 people have utilized the Personal Care Option that assists individuals to stay in their homes and communities.

Home health agencies in West Virginia can provide Medicaid-eligible individuals with the following services in their homes: skilled nurse visits, physical therapy, occupational therapy, speech-language pathology, home health aide, and medical social worker. At the same time, a number of needed services, such as homemaker services and respite care, are not available at this time.

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

West Virginia has been progressive in embracing self-directed options for people. Implemented in 2001, the self-directed case management option within the AD Waiver allows participants to coordinate their own services rather than working through a case management agency.¹² In 2007, the Personal Options program was added to the AD Waiver, allows participants to direct their own supports, and has no limit on participation.

West Virginia has taken the initiative to implement other progressive options for individuals with long term care needs to direct the type of services and supports received. These self-directed options include the Long Term Attendant Care Program and the Ron Yost Personal Assistance Services (RYPAS) Program.

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

- The West Virginia Transition Initiative, a pilot program serving 22 of the 55 West Virginia counties, will assist West Virginians with disabilities and seniors who reside in NFs to live and be supported in their communities. The Initiative will not replace current formal and informal transition/diversion processes, but will develop a statewide program to support future rebalancing and "MFP" strategies in the state.
- Since November, 2007, BoSS has been using a Nursing Home Diversion Grant from the U.S. Administration on Aging to establish the "Fair Plus" pilot project. BoSS is partnering with the Upper Potomac AAA and its new, state-funded Aging & Disability Resource Center (ADRC) to provide self-directed funds in the Family Alzheimer's In-Home Respite (FAIR) Program.

¹¹ www.state.wv.us/seniorservices/wvboss_article2.cfm?atl=9B8412E9-BDE4-DB4F-142F1CC01F15730A&fs=1. Accessed 5-18-07.

¹² West Virginia Choice Cash and Counseling Grant.

4. Nurse Practice Act

State regulations that govern the practice of registered professional nurses often affect the extent to which consumer autonomy is permitted by the state boards of nursing, which are charged with the responsibility to protect the public’s safety. Consistent with most states, West Virginia’s Board of Nursing (BON) policies permit registered nurses (RNs) to delegate tasks to competent individuals. In the broadest sense, the practice of registered nursing includes “the supervision and teaching of other persons with respect to such principles of nursing.”¹³ RNs are to implement the plan of care by delegating and supervising nursing care activities.¹⁴

The BON stipulates that RNs shall only delegate nursing tasks to a person that is prepared or qualified by training, experience or licensure to perform them.¹⁵ It appears there is latitude for the nurse to delegate to UAP who have not obtained training and certification, as long as they have sufficient experience to assure the nurse that they are able to perform the specified task(s). RNs must supervise those to whom they delegate, but there appears to be discretion for the nurse to determine how often that occurs.¹⁶

At the same time, West Virginia appears to be increasing its emphasis on accountability for delegation in ways that could discourage nurses from delegating in home and community-based settings. An RN retains accountability for nursing care when delegating nursing interventions.¹⁷ The BON’s guidance document for scope of practice and delegation of decisions was changed between 1996 and 2005.¹⁸ The definition of delegation was changed from one emphasizing each individual’s accountability to the National Council of State Boards of Nursing definition, which emphasizes the nurse’s accountability. The new definition is a version of “strict liability,” in which the nurse retains accountability for the outcome of the delegation, even if s/he follows all the correct delegation procedures and the UAP does not follow the directions.

Like most states, West Virginia exempts family members. There is no specific exemption for consumer-directed care in the Nurse Practice Act (NPA). An exemption that permits care by a “domestic servant” can be used to support consumer-directed care if the consumer hires an attendant to provide personal care that includes health maintenance tasks. However, this exemption was not found in the West Virginia’s NPA and could be explored further.

¹³ WV NPA (RN: Ch 30, Art 7; LPN: Ch 30, Art 7A), www.legis.state.wv.us.

¹⁴ WV Code of State Rules for RN (Title 19), www.wvsos.com/csr/rules.asp.

¹⁵ WV Code of State Rules for LPN (Title 10, Series 3): www.lpnboard.state.wv.us/

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Criteria for Determining Scope of Practice for Licensed Nurses and Guidelines for Determining Acts that may be Delegated or Assigned by Licensed Nurses (known as “The Purple Book” or PB).

B. ACCESS

In interviews with consumers, family members, providers and state staff, the point was made that there is room for improvement related to access to the LTC system in West Virginia.

Access issues can be summarized into the following four areas:

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

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

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

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

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

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

for Independent Living. These Centers have collectively eight offices distributed across the state.

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

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

The ADRCs are playing an increasing role in providing enrollment information and support to WV seniors who are 60+ years of age and adults (18 years or older) with physical disabilities. This is being accomplished through both their web sites and through direct contact. In addition, the inROADS website (wvinroads.org) assists individuals and their family members. A self-screening process on the site evaluates the user for possible eligibility and tells the user which benefits the members of the household may be eligible to receive. It then lets the user apply online for multiple DHHR benefits by completing one online application.

Other issues related to determining eligibility for and enrolling in state LTC services include the following.

- Regulations allow that eligibility for NF and ICF/MR placement can be presumed with the person admitted and then application made. As the result, eligibility for these services can happen much faster than eligibility for waiver services. This situation does influence and create a bias toward institutional placement.
- Individuals who do not know how to apply for Medicaid services often show up at a provider site and apply for Medicaid with the provider’s assistance. This creates a potential conflict of interest for providers, who assist individuals in completing their assessment forms to determine eligibility for services. There is the potential that the individual will be influenced to use the services offered by the provider. This situation also limits the range of information about comparative services that consumers receive.¹⁹

Specific populations in West Virginia were identified as being either un-served or under-served. These groups include:

- Individuals who are ventilator dependent;

¹⁹ Saucier, Paul and Dr. Elise Bolda. “Progress and Potential in West Virginia’s LTC System.” Edmund S. Muskie School of Public Service, University of Southern Maine, February 2001.

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

Those West Virginians listed above need a wider array of services and supports so that they can continue to live their lives richly and fully within the borders of the state and preferably within their home communities.

Institutional bias appears to exist in the WV long-term care system as evidenced by the following.

- A representative from the Center for Excellence in Disabilities at WVU stated that “over 2,000 people in institutional care have expressed an interest to move to the community.”
- BoSS noted that for years West Virginia residents have seen NFs as the only option for seniors as they age. As a result, there has been little interest and investment in assisted living residences and other community-based options including day care, respite and home health services.
- When comparing requests for NF care and AD Waiver services, both the number and percentage of NF approvals are significantly larger.
- More than 50% of the requests for MR/DD Waiver services were declined, while all requests for ICF/MR placement were approved.
- In West Virginia, there is a presumption of eligibility for NF and ICF/MR services that allows for much faster placement in these settings than establishing eligibility for and gaining access to waiver services. As the result, institutional placements rather than securing community-based services are more likely to occur when the need requires the securing of services within a short timeframe.
- The CON process has a significant impact on the availability of services and is a factor in the inadequate supply of qualified providers to meet the needs of the LTC population requesting community-based options.

C. FINANCING

Financing is a crucial component of any LTC system. As West Virginia investigates the rebalancing of the LTC system and implementing a MFP approach to long term care, financing will be an important issue to address. Funding for the LTC system must be available so providers receive adequate payment for services in the individual’s setting of choice.

On a national level the following trends exist.

- From 1990 to 2006, unduplicated annual aged beneficiaries increased from 3.2 million in 1990 to 6.1 million in 2006: an increase of nearly 91 percent. Unduplicated annual blind and disabled enrollment rose 162 percent in this time period, from 3.7 million in 1990 to 9.7 million in 2006.
- Since 1990, CMS has been increasing its spending on the senior population by 8.21% each year and by 12.08% for persons with disabilities.
- National trends in MR/DD spending and participation also show significant increases in the number of individuals served and the cost per person.

West Virginia's Medicaid spending on the LTC population has tended to mirror national trends. In general, more funding is spent on institutional care (including NFs and ICFs/MR) than on community-based services. Also, Medicaid spending for HCBS for individuals with developmental disabilities exceeds HCBS spending for older people. This leaves the delivery system much more institutionally focused for people age 65 and older.²⁰

- Expenditures on NF services in West Virginia have grown from \$204 million in 1995 to \$385.1 million in 2006, an average increase of about 5.95% a year.
- AD Waiver expenses have been growing at a rate of 5.09% from \$35.4 million in 1995 to \$59 million in 2006.
- In 2006, the cost per case on the AD Waiver was \$13,012 and the cost per case in NFs was \$34,569, which does not include the residents' share of the cost.
- ICF/MR expenditures have grown approximately 2.46% a year from \$50.3 million in 1995 to \$64.3 million in 2006. MR/DD Waiver expenses have grown approximately 18.05% a year from \$29.9 million in 1995 to \$182.1 million in 2006.
- The cost per case for ICF/MR services has increased from \$78,582 in 1995 to \$117,620 in 2006, while the number of persons served has declined from 640 persons in 1995 to 547 persons in 2006.
- The cost per case for MR/DD waiver services has increased from \$29,652 in 1995 to \$48,687, while the number of persons receiving waiver services has increased from 1,007 persons in 1995 to 3,741 persons in 2006.
- The dramatic increase in MR/DD Waiver slots can be partially explained by the court decisions that have periodically reshaped West Virginia programs.

In general, the quality of a state's long term care system can be largely attributed to the success of three critical components: workforce, housing and transportation. These three areas within West Virginia's LTC system are fragmented and lacking coordination, leading to a level of overall quality in the system that needs improvement.

²⁰ Weiner, J. (2006). It's not your Grandfather's Long-Term Care Anymore. *Public Policy & Aging Report* 16, 28-35.

LTC system's difficulty with hiring and retaining qualified and reliable staff in sufficient numbers is far-reaching and includes nurses and physicians, direct service workers, administrators, case managers, and data processing staff. Low pay, inadequate training, and lack of on-the-job support were cited as reasons for the state's LTC workforce shortages. The Center for Excellence in Disabilities at WVU noted that workforce development issues are particularly problematic in the northern and eastern panhandles of the state because of the employment pull from bordering states.

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

Affordable, accessible, and safe housing is simply not readily available to people with a variety of disabilities and very limited fiscal resources. As the result, West Virginia may want to support a statewide initiative to develop more affordable, accessible housing stock. It is unlikely that there is one single or easily achievable approach for remediation of the housing problem. A combination of efforts will produce a workable solution for the state. Potential opportunities include the following.

- Better management of the federal Housing and Urban Development (HUD) Section 8 housing vouchers;
- Increasing accessibility through the construction of houses using Universal Design would also increase accessibility;
- The HOME Program is a federally-funded housing program offered by the WV Housing Development Fund for low and very low-income individuals and families; and
- The United States Department of Agriculture (USDA) offers many programs that assist with the construction, rehabilitation, or relocation of a dwelling and related facilities for low - or moderate-income rural individuals.

Transportation plays a critical role in the delivery of quality long term care services and supports. When an individual cannot physically access service providers, his or her support plan cannot be appropriately implemented. West Virginia, like most states, is challenged in meeting the needs.

- There simply are not enough transportation resources to meet the needs.
- State's regulations for transportation are restrictive in some programs and only provide for rides to medical appointments, which limit individuals' abilities to attend social, recreational and spiritual events. This, in turn, restricts overall quality of life. At the same time, this restriction does not apply to people receiving services through the MR/DD Waiver.

D. QUALITY

Quality assurance is an important component in any state LTC system. West Virginia has made many strides to enhance the quality of services delivered to LTC consumers and their families. At the same time, there remain several challenges apparent within the system that hamper the provision of high-quality services and supports.

Quality assurance initiatives include the following.

- WVMI is serving as a Local Area Network of Excellence (LANE) for the Home Health Quality Improvement National Campaign 2007, a collaborative quality improvement effort among the home health community and healthcare leaders, to improve the quality of care in the home health setting.
- WV’s MR/DD Waiver Program is currently establishing the “Quality System Plan,” a standardized and comprehensive set of procedures for assessing the quality of MR/DD Waiver care and services.”
- The AD Waiver is also using the CMS Quality Framework. The AD Waiver established the QAI Advisory Council in 2003 made up of stakeholders including five members/family members or legal guardians and ten people who have a direct interest in the AD Waiver program such as providers, Ombudsman, and community members.
- “A Vision Shared” was a collaboration of business and economics organizations and groups that issued a report in 2007. The report included recommendations to change the health and human services system in West Virginia and enhance the quality of life for all citizens in the state.
- The Office of the Ombudsman for Behavioral Health assists with concerns and grievances from West Virginians utilizing the state’s long term care system and provides a well-documented and advertised grievance process to resolve issues.
- BoSS successfully completed the first year of a 3-year Alzheimer’s Disease demonstration grant and continues to operate the WV Call Center for the Medicare Prescription Drug Program (Medicare Part D).

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

- Transition to Inclusive Communities (TIC) Grant, which ended in 2004, demonstrated promising practices in NF transition and diversion, as it assisted over 84 individuals to transition from NFs to the community and assisted over 180 individuals to remain in community settings of their choice.
- Community-Integrated Personal Assistance Services and Supports (C-PASS) developed the model for Personal Options, researched PAS workforce issues and created a directory of personal assistance services and supports.

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- West Virginia Real Choice System Change Grant created an information and referral system and online web-based resource directory which is affiliated with the WV 2-1-1 collaborative for families, professionals and communities.
- Aging and Disability Resource Center grant coupled with a state appropriation established four ADRCs to provide information and access to LTC support services;
- Quality Assurance and Improvement Project accomplishments include the establishment of a Quality Improvement Team that oversees the implementation of the QAI Project and coordinates the quality management initiatives of both the AD & MR/DD Waivers;
- People’s Advocacy Information and Resource Services (PAIRS) Project has developed and implemented training on self-directed supports, trained 20 peer-to-peer coordinators, and established a WV Family Links Network of advocates;
- The Cash & Counseling Grant from the Robert Wood Johnson Foundation was awarded to the BoSS in 2004 to provide funding and technical assistance to finalize the design and develop the infrastructure (financial management, supports brokerage, and quality management) for Personal Options, the self-directed model within the A/D Waiver Program.²¹
- The Transition Initiative, which was initiated in March 2008, is funded and managed by the Olmstead Office in collaboration with the BMS and BoSS. The purpose of the Initiative is to assist West Virginia citizens with disabilities and seniors who reside in nursing facilities to live and be supported in their communities.
- Nursing Home Diversion Modernization Grant was awarded to West Virginia by the AoA in November 2007. The grant will allow the state to go forward with its “Fair Plus” pilot project in which BoSS) will partner with the Upper Potomac AAA and its new, state-funded ADRC to provide self-directed funds in the Family Alzheimer’s In-Home Respite (FAIR) Program.

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

III. RECOMMENDATIONS

This study’s recommendations have been organized according to the following four components of a rebalanced long-term care system:

- Service Sufficiency and Provider Capacity

²¹ MFP Demonstration Project Narrative

- Equal Access to Institutional and Community Services
- Financing of Programs and Services That Follows People Into the Community; and
- Quality Assurance and Improvement.

In reviewing these recommendations, please note the following:

- The scope of this study did not allow for an in-depth examination of all the issues, including financial considerations, involved in making significant adjustments to the existing long term care system. Further analysis of recommendations should be considered prior to implementation to ensure that unintended consequences do not occur.
- Every recommendation that follows is sound on its own merits and has been successfully implemented in one or more states.
- It is assumed that the cost of implementing recommendations that expand the availability of home and community based long-term care services will be paid for by reinvesting the savings gained through the implementation of other recommendations.

SERVICE SUFFICIENCY AND PROVIDER CAPACITY

1. Create an action plan for increasing the availability of home health, adult medical day care, and assisted living services in West Virginia through a review of the existing CON program and Medicaid payment rates.
2. Expand the AD Waiver to provide a wider variety of services to more individuals and continue to support the self-directed option under the waiver.
3. Replace ICFs/MR with waiver services and apply for two new Medicaid waivers to incorporate into the West Virginia long term care system: a Traumatic Brain Injury waiver and an MR/DD Supports waiver.
4. Boost the existing ACT program and expand telemedicine services.
5. Continue and expand options for self-direction and individualized budgeting into statewide LTC programs and services.
6. Improve access to community-based services for underserved and un-served populations.

EQUAL ACCESS TO INSTITUTIONAL AND COMMUNITY SERVICES

7. Expand the Transition Navigator Program.
8. Continue to develop a Single Point of Entry system through the ADRCs with other community services for improved information accessibility and a streamlined eligibility and assessment process.
9. Change the current assessment process for long term care consumers to: a) ensure providers are not completing individuals' assessments (remove the apparent conflict of interest); b)

ensure that options / benefits counseling is occurring at the time of potential facility admission; and c) utilize a presumptive eligibility process or fast track initiative for home and community based services.

10. Modify the Nurse Practice Act.
11. Modify current policies and practices that reinforce institutional bias.
12. Review the medical records of and discuss HCBS options with current LTC facility residents to identify those more appropriately served in/ready for transitioning to the community.

FINANCING OF PROGRAMS AND SERVICES THAT FOLLOWS PEOPLE INTO THE COMMUNITY

13. Expand the amount of funding resources set aside for assisted living services so that Medicaid and Medicare recipients can access assisted living more equitably.
14. Expand the variety of services and the number of recipients utilizing Personal Care Services by allocating more state-only dollars toward these services.
15. Continue to apply for Federal Grants to increase funding for LTC services and supports.

QUALITY ASSURANCE AND IMPROVEMENT

16. Promote affordable and accessible housing.
17. Work with the Department of Transportation to provide more affordable and accessible transportation that allows individuals to access recreational, social, medical and spiritual events.
18. Tackle the state's critical workforce shortage by increasing direct care workers' salaries and implementing new methods for recruitment, retention, training and credentialing.
19. Continue to increase consumer and family involvement in the development of policy and the development or redesign of quality improvement/quality assurance activities and processes.

IV. FISCAL PROJECTIONS AND IMPACTS

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

The process of developing models to illustrate the estimated savings from the implementation of MFP consisted of 3 parts:

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

The first step in this process is to establish a baseline of what institutional and waiver expenditures in West Virginia would be like in the absence of enhanced diversion and transition efforts.

- As a starting point, BMS provided twelve years of CMS 372 data covering the period of 1995 through 2006. This data set is a main component of establishing a baseline.
- AD Waiver: The average percentage increase in total AD Waiver spending over the ten year period between 1995 and 2006 is 3.77%. The per person AD Waiver cost is projected by assuming that the rate of increase in AD Waiver spending from 1995 through 2006 will continue thru 2017. The average rate of increase on a per person basis during over the next ten years is projected to be 2.67%.
- Medicaid NF: Per person NF costs increased at a rate of 5.87% from 1995 through 2006 while the number of persons served gradually increased about .09% per year. The assumption is that this trend will continue into the future.
- MR/DD Waiver: Expenditures over the past ten years have been growing at a rate of 18.5% per year. It does not seem reasonable to assume that past trends will continue for another ten years. Annual MR/DD Waiver cost per person increases averaged 4.85%, from a cost per case of \$29,652 in 1995 to \$48,687 in 2006. Going forward, the assumption is a 2.5% average increase in MR/DD Waiver enrollment and a 4.85% increase in cost per case.
- ICF/MR: From 1995 to 2006, the cost per person in ICFs/MR increased at an average, annual rate of 3.85%. The projection of total spending assumes a flat case load and a 3.85% trend in the cost per case.

Having projected future spending, the next step in the analysis is to consider the effect of transition programs upon future spending. When thinking about transition, it is also important to recognize that there will be some "start-up" expenses. The Transition Initiative will provide up to \$2,500 per participant for reasonable and necessary transitional start-up costs. This includes one-time costs for: 1) security deposit for housing; 2) set-up fees for utilities; 3) moving expenses; 4) essential home furnishings; and/or 5) home accessibility adaptations.

Having established baseline expenditure projections, the next step in the analysis is to identify the parameters of a "low model" and calculate its fiscal impact. Transition models have five key

parameters in the estimation of fiscal impact: how many persons can be transitioned; where do persons go when they leave the institution; what additional state Medicaid costs do persons incur because they now receive Medicaid waiver services; what is the impact of provider taxes; and, what are the administrative and other transition costs.

Low Model

Number of Individuals to Transition:

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

Where do persons go when they leave the institution?

- For those leaving nursing facilities, PCG conservatively assumes that 90% of them will receive services on the AD Waiver and ten percent will be able to function in the community without receiving state services. It is also reasonable to assume that about ten percent will return to the NF after one year.

Additional State Medicaid Cost Incurred

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

Impact on Provider Taxes

- The provider tax is not considered a factor in making the projections of future spending and cost per case increases since the tax was in existence prior to 1995.

Administrative and Other Transition Costs

- It is assumed that the administrative and start-up costs in West Virginia for the low model will be \$300,000 in SFY 2008 with inflationary adjustments for subsequent years. It is also assumed that transition costs are built into the AD and MR/DD Waivers therefore qualifying for federal matching funds.

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

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

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

The fiscal analysis makes one additional assumption that addresses the question: how long into the future should we project the savings for an individual? The analysis assumes that 75 persons will be helped and 10% will return to the NF after one year.

On the basis of the assumptions stated above, the Low Model results in a net savings to West Virginia of over \$57,000,000 over a ten year period.

High Model

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

PCG's high model presupposes working with double the number of people in the low model and assumes that the state has encouraged and adopted policy changes that provide more residential options, other waiver expansions and expanded state plan services. These policy assumptions create the need for a different analysis to look at costs and savings of a more "aggressive" model.

Home Health Agency

- In West Virginia, approximately \$1,500 has been spent per member per year on home health services since FY 2002. This figure was used to forecast rebalancing costs related to HHA services.

Adult Day Care

- PCG estimates that the annual cost for adult day care per person per year would be \$18,250 or \$50 per person per day. This estimate of \$50 per day easily falls in the per diem range of \$17.50 to \$192.38 seen in other states.

Assisted Living

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

Traumatic Brain Injury Services

- The cost of traumatic brain injury services in other states was reviewed. States were selected based on the proximity to West Virginia in population size and whether they were one of the five states discussed in the court documents. The average cost in 2006 programs was \$20,256.

Telemedicine

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

Personal Care Services

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

MR/DD Waiver

- Based on the programmatic recommendations presented earlier in this study, PCG calculated the annual cost for an individual in two distinct levels of MR/DD Waiver programs. The first of these levels, which closely mirrors the mix of services covered by the MR/DD Waiver as it exists now, is called the MR/DD Waiver- Comprehensive. The annual cost for this level of waiver care of \$48,687 is based on the FY 2006 cost for the current MR/DD Waiver as illustrated by the CMS-372 data.
- The second level of MR/DD Waiver care, called MR/DD Waiver- Supports, mirrors the MR/DD Waiver- Comprehensive with the major difference being that the "supports" level of waiver care does not include a residential habilitation component. Based on the same FY 2006 CMS-372 data used to calculate the MR/DD Waiver- Comprehensive less the residential component, the annual cost for an individual on the MR/DD Waiver- Supports is estimated to be \$34,420.

AD Waiver

- Based on the study recommendation that the AD Waiver be restructured and the CMS-372 data from FY 2006, the annual cost for the AD Waiver (Other) is estimated to be \$12,634.

With the annual cost for an individual in each service defined, it is necessary to determine a blended annual rate for services based on the institutional setting from which an individual is being transitioned. In order to calculate these blended rates, PCG made assumptions as to the number of people transitioned from each institutional setting and what services these individuals would receive in the community. As illustrated in the table below, it was assumed that there would be 100 people transitioned from a NF setting, 100 people from an ICF/MR setting, and 80 from State LTC settings. Within each of these settings, the table below shows the

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primary setting or service that an individual would receive as well as any secondary services that would be received.

Number of Residents Transitioned by Program

Transition Service Type	Per Year	NF (100 Residents)	ICF/MR (100 Residents)	State LTC (80 Residents)
Assisted Living	\$ 30,000	55		45
A&D Waiver (Other)	\$ 12,634	30		25
TBI	\$ 20,256	5		10
Home with No Services **	\$ -	10		
Personal Care	\$ 6,000	30	20	30
Adult Day Care	\$ 18,250	25		25
Home Health	\$ 1,500	20		20
Telemedicine *	\$ 1,000	10		10
MR/DD Comprehensive	\$ 48,687		70	
MR/DD Supports	\$ 34,420		30	
Total Bed Counts		11,153	547	400+

To calculate the blended rate for individuals transitioning from each of the institutional settings, the annual cost of each service was multiplied by the number of transitioned individuals receiving that service in the community. For example, with 40 individuals being transitioned from a NF to an Assisted Living setting at a rate of \$30,000 a year per individual, the total cost would be \$1.2 million. When the total cost for each service for an institutional setting was calculated, the total cost for transitioning individuals from the institutional setting to the community was calculated. The blended rate was then calculated by dividing the total cost by the number of individuals transitioned. The following table illustrates these costs.

Cost of Transition by Program

Transition Service Type	Per Year	NF (100 Residents)	ICF/MR (100 Residents)	State LTC (80 Residents)
Assisted Living	\$ 30,000	\$ 1,650,000	\$ -	\$ 1,350,000
A&D Waiver (Other)	\$ 12,634	\$ 379,020	\$ -	\$ 315,850
TBI	\$ 20,256	\$ 101,280	\$ -	\$ 202,560
Home with No Services **	\$ -	\$ -	\$ -	\$ -
Personal Care	\$ 6,000	\$ 180,000	\$ 120,000	\$ 180,000
Adult Day Care	\$ 18,250	\$ 456,250	\$ -	\$ 456,250
Home Health	\$ 1,500	\$ 30,000	\$ -	\$ 30,000
Telemedicine *	\$ 1,000	\$ 10,000	\$ -	\$ 10,000
MR/DD Comprehensive	\$ 48,687	\$ -	\$ 3,408,090	\$ -
MR/DD Supports	\$ 34,420	\$ -	\$ 1,032,600	\$ -
Total Cost		\$ 2,806,550	\$ 4,560,690	\$ 2,544,660
Per Person/Per Year Transition Cost		\$ 28,065.50	\$ 45,606.90	\$ 31,808.25

NF Transition

The analysis of NF costs uses the same methodology as used with the low model. Applying the same cost assumptions identified in the analysis of the low model results in the following savings.

Savings before Costs from a High Model of Transition Activities 2008-2017

The High Model Savings before Costs	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person NF Cost	NF Savings before Costs	Provider Tax Adj.	NF Savings after Adj.
SFY 2008	150	75	\$ 38,745	\$ 2,905,863	\$ 159,822	\$ 2,746,041
SFY 2009	150	210	\$ 41,018	\$ 8,613,838	\$ 473,761	\$ 8,140,077
SFY 2010	150	345	\$ 43,425	\$ 14,981,663	\$ 823,991	\$ 14,157,671
SFY 2011	150	413	\$ 45,973	\$ 18,963,932	\$ 1,043,016	\$ 17,920,916
SFY 2012	150	413	\$ 48,671	\$ 20,076,681	\$ 1,104,217	\$ 18,972,464
SFY 2013	150	413	\$ 51,527	\$ 21,254,723	\$ 1,169,010	\$ 20,085,713
SFY 2014	150	413	\$ 54,550	\$ 22,501,889	\$ 1,237,604	\$ 21,264,285
SFY 2015	150	413	\$ 57,751	\$ 23,822,234	\$ 1,310,223	\$ 22,512,012
SFY 2016	150	413	\$ 61,140	\$ 25,220,054	\$ 1,387,103	\$ 23,832,951
SFY 2017	150	413	\$ 64,727	\$ 26,699,894	\$ 1,468,494	\$ 25,231,400

The next table takes PCG's analysis of where persons might go if they left the NF and assumes that the state develops a reasonable array of services for them. The major difference is shown in the average cost of the alternatives. Based on the analysis of alternatives illustrated above, PCG estimates the average SFY 2007 cost of a blended array of home and community-based alternatives might be approximately \$28,066 for individuals transitioning from a NF to the community. This is greater on average than the cost of the existing AD Waiver and reflects the higher costs of residential care, especially assisted living which has a cost of approximately \$30,000 per year. The following table shows the costs, assuming that ten percent of the persons transitioned out of nursing facilities will not incur state waiver costs. For example, in 2008, the equivalent of 75, 12-month persons will be transitioned out of NFs, but only 68 of them will receive waiver services.



Costs from a High Model of Transition Activities, 2008-2017

The High Model	# of Persons Receiving AD Waiver Services	Per Person AD Waiver Cost	AD Waiver Costs	Added Acute Care Costs	Administrative Costs	Total Costs
SFY 2008	68	\$ 26,897	\$ 1,815,525	\$ 101,250	\$ 300,000	\$ 2,216,775
SFY 2009	189	\$ 27,615	\$ 5,219,198	\$ 283,500	\$ 1,000,000	\$ 6,502,698
SFY 2010	311	\$ 28,352	\$ 8,803,334	\$ 465,750	\$ 1,025,000	\$ 10,294,084
SFY 2011	371	\$ 29,109	\$ 10,806,762	\$ 556,875	\$ 1,050,625	\$ 12,414,262
SFY 2012	371	\$ 29,886	\$ 11,095,303	\$ 556,875	\$ 1,076,891	\$ 12,729,068
SFY 2013	371	\$ 30,684	\$ 11,391,547	\$ 556,875	\$ 1,103,813	\$ 13,052,235
SFY 2014	371	\$ 31,504	\$ 11,695,701	\$ 556,875	\$ 1,131,408	\$ 13,383,985
SFY 2015	371	\$ 32,345	\$ 12,007,977	\$ 556,875	\$ 1,159,693	\$ 13,724,545
SFY 2016	371	\$ 33,208	\$ 12,328,590	\$ 556,875	\$ 1,188,686	\$ 14,074,150
SFY 2017	371	\$ 34,095	\$ 12,657,763	\$ 556,875	\$ 1,218,403	\$ 14,433,041

The following table summarizes the savings and costs from using a high model of transition. Based on this analysis, the High Model projects a savings of over \$62,000,000 over a ten year period as the result of moving people from NFs back to the community.

A comparison of the low and high model shows that the high model does not produce twice the savings of the low model even though the number of persons transitioned is double and the same per person NF costs are used. The reason is the cost per person is higher with a blended array of home and community services. The table below shows that considerable savings are available with an aggressive model of transition despite the higher per person cost of a blended array of home and community services.

Net Savings from High Model of Transition-NF

The High Model Savings - Nursing Facility	Number of Persons Transitioned	Number of 12 - mth. Persons Counted for this Year	Per Person Nursing Facility Cost	Per Person Transition Cost	Total Nursing Facility Cost	Total Transition Cost	Net Savings
SFY 2008	150	Varies	\$ 36,614	\$ 33,432	\$ 2,746,041	\$ 2,216,775	\$ 529,266
SFY 2009	150	Varies	\$ 38,672	\$ 31,409	\$ 8,140,077	\$ 6,502,698	\$ 1,637,379
SFY 2010	150	Varies	\$ 41,037	\$ 31,009	\$ 14,157,671	\$ 10,294,084	\$ 3,863,587
SFY 2011	150	Varies	\$ 43,392	\$ 31,665	\$ 17,920,916	\$ 12,414,262	\$ 5,506,654
SFY 2012	150	Varies	\$ 45,938	\$ 32,468	\$ 18,972,464	\$ 12,729,068	\$ 6,243,396
SFY 2013	150	Varies	\$ 48,634	\$ 33,294	\$ 20,085,713	\$ 13,052,235	\$ 7,033,478
SFY 2014	150	Varies	\$ 51,487	\$ 34,141	\$ 21,264,285	\$ 13,383,985	\$ 7,880,300
SFY 2015	150	Varies	\$ 54,509	\$ 35,010	\$ 22,512,012	\$ 13,724,545	\$ 8,787,467
SFY 2016	150	Varies	\$ 57,707	\$ 35,903	\$ 23,832,951	\$ 14,074,150	\$ 9,758,801
SFY 2017	150	Varies	\$ 61,093	\$ 36,819	\$ 25,231,400	\$ 14,433,041	\$10,798,359

“Money Follows the Person” and Rebalancing Study
ICF/MR Transition – High Model

The number of residents in ICFs/MR has been stable since 1998 and the projections of ICFs/MR caseloads assume no increase in their population. PCG has used a caseload count of 515 ICF/MR residents to project per resident spending for each of the next 10 fiscal years. PCG also assumed that 10 residents per year could be transitioned into the community for each of the next 10 years. Based on these assumptions, the net savings associated with transition from ICF/MR level care to community-based care is projected to exceed a total of \$50,000,000 over the ten year period reaching over \$10 million per year by SFY 2017.

Net Savings from High Model of Transition- ICF/MR

The High Model Savings - ICF/MRs	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person ICF/MR Cost	Per Person MR/DD and Other Cost	Total ICF/MR Transition Cost	Total MR/DD and Other Transition Cost	Net Savings
SFY 2008	10	10	\$ 124,106	\$ 44,235	\$ 1,241,059	\$ 442,350	\$ 798,709
SFY 2009	10	20	\$ 127,482	\$ 45,438	\$ 2,549,631	\$ 908,764	\$ 1,640,868
SFY 2010	10	30	\$ 130,949	\$ 46,674	\$ 3,928,472	\$ 1,400,223	\$ 2,528,249
SFY 2011	10	40	\$ 134,511	\$ 47,944	\$ 5,380,435	\$ 1,917,746	\$ 3,462,690
SFY 2012	10	50	\$ 138,170	\$ 49,248	\$ 6,908,479	\$ 2,462,386	\$ 4,446,093
SFY 2013	10	60	\$ 141,928	\$ 50,587	\$ 8,515,668	\$ 3,035,235	\$ 5,480,433
SFY 2014	10	70	\$ 145,788	\$ 51,963	\$ 10,205,176	\$ 3,637,426	\$ 6,567,750
SFY 2015	10	80	\$ 149,754	\$ 53,377	\$ 11,980,294	\$ 4,270,130	\$ 7,710,164
SFY 2016	10	90	\$ 153,827	\$ 54,828	\$ 13,844,427	\$ 4,934,562	\$ 8,909,865
SFY 2017	10	100	\$ 158,011	\$ 56,320	\$ 15,801,106	\$ 5,631,980	\$ 10,169,126

State Facility LTC – High Model

PCG also calculated the potential savings through a transition of residents from the state-operated long term care facilities to the community. PCG utilized the average per diem cost for all 5 state facilities (Hopemont, Lakin, Manchin, Pinecrest, and Welch’s Unit) in SFY 2004 as the basis for the “per person/per year” state facility amount. An inflation rate of 4.4% was applied to both the state facility and the transition side. The “per person /per year” transition cost was garnered from the table above. PCG also assumed that 10 residents per year could be transitioned into the community for each of the next 10 years. Based on these assumptions, the net savings associated with transition from State Facility LTC level of care to community-based care could reach over \$6.6 million annually by SFY 2017 and is projected to be over \$32,000,000 between FY2008 and FY2017.

"Money Follows the Person" and Rebalancing Study
**Net Savings from High Model of Transition
 State Facility - Long Term Care**

The High Model Savings - State Facility LTC	Number of Persons Transitioned	Number of 12-mth. Persons Counted for this Year	Per Person State Facility LTC Cost	Per Person Transition Cost	Total State Facility LTC Cost	Total Transition Cost	Net Savings
SFY 2008	10	10	\$ 84,812	\$ 39,681	\$ 848,120	\$ 396,810	\$ 451,310
SFY 2009	10	20	\$ 88,529	\$ 41,420	\$ 1,770,589	\$ 828,406	\$ 942,183
SFY 2010	10	30	\$ 92,410	\$ 43,236	\$ 2,772,298	\$ 1,297,076	\$ 1,475,222
SFY 2011	10	40	\$ 96,460	\$ 45,131	\$ 3,858,419	\$ 1,805,240	\$ 2,053,179
SFY 2012	10	50	\$ 100,689	\$ 47,109	\$ 5,034,428	\$ 2,355,460	\$ 2,678,969
SFY 2013	10	60	\$ 105,102	\$ 49,174	\$ 6,306,119	\$ 2,950,446	\$ 3,355,673
SFY 2014	10	70	\$ 109,709	\$ 51,330	\$ 7,679,620	\$ 3,593,066	\$ 4,086,554
SFY 2015	10	80	\$ 114,518	\$ 53,579	\$ 9,161,412	\$ 4,286,353	\$ 4,875,059
SFY 2016	10	90	\$ 119,537	\$ 55,928	\$ 10,758,351	\$ 5,033,513	\$ 5,724,838
SFY 2017	10	100	\$ 124,777	\$ 58,379	\$ 12,477,684	\$ 5,837,938	\$ 6,639,746

VI. ACKNOWLEDGEMENTS

This report has been founded upon the collection and analysis of extensive stakeholder feedback. Among the many stakeholders who contributed to this report were consumers, family members, guardians, advocates, providers, and state staff, including:

ADA Coalition

ADAPT- WV

Advocacy Legal Aid

Appalachian Center for Independent Living

Bureau for Behavioral Health & Health Facilities

Bureau for Medical Services

Bureau of Senior Services

Center for Excellence in Disabilities at WVU

Department of Health and Human Resources

Legal Aid of WV Behavioral Health Advocacy Project

Legal Aid of WV Long Term Care Ombudsman

Mountain State Center for Independent Living

Mountain State People’s Alliance

Northern WV Center for Independent Living

Office of Health Facility Licensure & Certification

Office of the Ombudsman for Behavioral Health

Olmstead Advisory Council

West Virginia AARP

West Virginia ADA Coordinator

West Virginia Advocates

West Virginia Assisted Living Association

West Virginia Behavioral Health Providers’ Association

West Virginia Board of Examiners for Registered Professional Nurses

West Virginia Center for Independent Living

West Virginia Council on Home Care Agencies

West Virginia EMS-TSN Advocacy Program
West Virginia Fair Shake Network
West Virginia Mental Health Planning Council
West Virginia Developmental Disabilities Council
West Virginia Health Care Association
West Virginia Health Care Authority
West Virginia Mental Health Consumers’ Association
West Virginia Statewide Independent Living Council

In addition to interviews and conference calls with the stakeholders listed in the preceding page, public forums were held throughout the state in April of 2007 to obtain input for this study, with the following turnout observed:

An email address was also set up (wvrebaling@pcgus.com) to obtain feedback from all interested parties on needs within the long term care system as well as input on the draft report.

The Office of the Ombudsman’s website was utilized to disseminate this report statewide amongst stakeholders. PCG and the Office of the Ombudsman extend our thanks and gratitude to all stakeholders who participated in this important process. Obtaining feedback and perspectives from stakeholders was integral to understanding the issues currently facing the system and determining feasible strategies to resolve these issues.

The full length-version of this report can be obtained by contacting the Olmstead Office at (304) 558-3287 or (866) 761-4628. Alternative formats are available upon request.