

**Rebalancing Long-Term Care Systems in Arkansas:
Case Study as of December 2007**

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3-year Rebalancing Study. For the study, CMS defined 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.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 3 iterations of State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance its long-term care systems, six crosscutting topic papers on issues in rebalancing, and a series of 5 Chartbooks presenting quantitative analyses of Medicaid expenditures for consumers in HCBS versus nursing homes, as well as Medicare expenditures for individuals dually eligible for Medicaid and Medicare. A list of these products with web links for completed documents is provided in the Appendix.

For the final case studies—in this instance for the State of Arkansas, we concentrated on the perspective of State officials on accomplishments in rebalancing their long-term support systems for all clientele, and the future directions for the State. We also updated particular strategies that we had highlighted in the 2005 case study and the 2006 Updates. The report is based on comprehensive review of web and print materials, a site visit conducted by Rosalie and Robert Kane on November 1 and 2, 2006, supplemented by telephone interviews before and after the site visit as needed.

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Executive Summary

Arkansas has moved steadily ahead in the evolution of a system of LTSS that is characterized by infusion of consumer direction in as many programs as possible, and an effort to create community choices for Arkansans. The state has made maximum use of federal grants (from CMS and other sources) and foundation grants, which it has used effectively to work toward its own umbrella goals of developing a wide array of choices for Arkansan seniors and persons with disabilities about where and how they live. The grants have also been used to further system goals such as improving access, making information available to consumers, developing a data driven quality management system, and developing housing and group residential options. Continuity of leadership in the Division of Aging and Adult Services and the Medicaid agency helped with this mission. Arkansas leaders have made a practice of being very informed about developments around the country, and identifying programs that seem worthy of adaptation to the State.

Arkansas is still challenged to close its remaining state-run regional MR/DD facilities, and bucks a strong lobby group of state employees and parents in that effort. It is also challenged to distribute its Medicaid resources for seniors between nursing homes (which have high vacancy rates) and HCBS. By quantitative indicators of the way expenditures are balanced between HCBS and institutions, Arkansas ranks average among states for aging and disability and towards the bottom for developmental disability. Nevertheless, Arkansas has managed to change the system of long-term support services towards more community care despite the success of the nursing home industry in hanging on to resources and despite rather low rates of payment in HCBS. Moreover, the state seems poised to develop important refinements in its system in the next decade, which will result in an ability to use data better to manage its system.

This case study highlights the following:

- the further solidification of the Independent Choices program (formerly the Arkansas Cash and Counseling Demonstration), which will now be converted to a State Plan j waiver for personal assistant services;
- the infusion of consumer directed programs through other waivers and the new AOA-funded Diversion Program;
- the piloting of ARHome, a program to cash out nursing home care;
- the development of the SOURCE program, a primary care based case management program, which will be piloted in four counties;
- the implementation of a legislatively mandated Options Counseling program;
- planning toward the Money Follows the Person demonstration;

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- a variety of housing initiatives, including a collaborative program with the University of Arkansas and multiple state agencies to develop accessible, affordable housing that adheres to universal design principles.

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Introduction and Background

General Background

Arkansas has a population slightly under 3 million people with a greater than average population over age 65 (13.9% in 2006), a lower than average per capita income, and a high proportion of the population below the poverty level (15.5% compared to 12.7% nationally in 2006). Much of the long-term care activity in Arkansas is administered or led by the Division of Aging and Adult Services (DAAS), which also serves as the State Unit on Aging for the Older Americans Act, within an umbrella agency, the Department of Human Services. Also involved are other units in the Department of Human services, including: the Division of Developmental Disabilities Services, which collaborates with DAAS on some joint initiatives but is responsible for administering institutional and community services for persons with MR/DD; the Division of County Operations, which is responsible for all program eligibility; and the Division of Medical Services (Medicaid).

Arkansas has a track record of impressive success in acquiring federal and other grants to help develop components of its long-term care system, and an ability to innovate and adapt successful programs around the country. Between 2001 and 2006, for example, Arkansas had been awarded about \$8.6 million dollars in Real Choice System Change Grants (RCSCG) from CMS; in absolute dollars Arkansas received the 3rd most funding and ranked first in RCSCG grants per population. One of the original three states to implement the Cash and Counseling demonstration, Arkansas' hallmark has been to emphasize consumer-directed programs and cash allowances. Arkansas serves substantial numbers of participants in home and community based

services through Medicaid waivers and the State Medicaid Plan. This progress is not yet reflected in reduced expenditures in the nursing home sector, however, in part because of relatively high payment rates for nursing homes with low occupancy.

Among the challenges identified by state leaders at the beginning of this century were to create a single entry system for consumers to gain information about and access to long-term services, and to speed the eligibility and service initiation process.

Summary of Early Rebalancing Case Studies

Management strategies in Arkansas that have been tracked in the initial 2005 case studies included: the expansion of consumer-directed and cash options, following the successful participation in the National Cash and Counseling Demonstration; related to that, the development of Next Choice, a program to “cash out” nursing homes; the Together We Can initiative to improve community services for people with MR/DD; strategies for consumer empowerment, especially the creation of an Aging and Disability Leadership Academy; development of a policy that permitted delegation of nursing tasks; and development of a primary care case management program, called SOURCE (Service Options Using Resources in a Community Environment), modeled after a program in Georgia. The following year, we also highlighted the enactment of legislation to create mandatory Options Counseling for all long-term care participants in the State. Short and long baseline case studies on rebalancing in Arkansas were released in 2005, and an update of activities in Arkansas between July 2006 and July 2007 was released in April 2007.¹

¹ Links to the short case study *Rebalancing Long-Term Care Systems in Arkansas: Experience up to July 31st, 2005* and to the update report, *A Year in State Management Practice for Rebalancing Long-Term Care Systems: Update of Activities in 8 States*, July 2005 to July 2006 are on the CMS New Freedom website, last visited on April 8, 2008 at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage. A long baseline case study on Arkansas is on the website of the Long-Term Care Resource Center at University of Minnesota, at http://www.hpm.umn.edu/ltrsourcecenter/on_going_research/Rebalancing_state_ltc_systems_case_studies.htm.

State Initiatives

Update on Previously Identified Initiatives

Consumer-directed programs (Cash and Counseling sequel). Arkansas' Cash and Counseling Demonstration entailed cashing out the Personal Care Option program under the Medicaid State Plan for elderly and disabled participants and participants with intellectual or developmental disabilities who meet the criteria that a physician has certified there need for hands-on assistance. (Participants in the HCBS Elderly Waiver may also self-direct companion services, if companion services are part of their plan.) After the demonstration period, the program continued to flourish under the name, Independent Choices, though it was not until early 2007 that state officials considered the program fully staffed with state-employed counselors and in a stable situation with a single contracted fiscal intermediary agency. During Fiscal Year 2006, an unduplicated count of 1543 consumers participated in Independent Choices. Thereafter, enrollment was at the pace of 50 to 100 persons a month. In July 2007, there were 17,000 participants in the program.²

At the time of the site visit to Arkansas, planning was underway to convert the Independent Choices program from a section 1115 Medicaid waiver to a Medicaid State Plan service under 1915(j) of the Social Security Act (as permitted under Section 6087 of the Deficit Reduction Act of 2005). This change was thought to bring greater permanency to the program and improve its administrative functioning. With that change, it would then be possible to enroll participants in MR/DD HCBS waivers, who thus far have been precluded from participating because of budget neutrality considerations, and several thousand new participants are expected to enroll as a result. Other goals for the program in the next several years are to incorporate the MDS-HC as the

² See Aging & Adult Services Division (2007). Arkansas State Plan on Aging, 2008-2010. Submitted to Governor Mike Beebe July 2007. On web, visited May 24, 2008, at <http://www.arkansas.gov/dhs/aging/arstateplanonaging08.pdf>.

assessment form for the program and to shorten the period from application to start of the cash allocations to 45 days. To facilitate access in the Independent Choices program, Arkansas used a CMS Direct Work Force Grant to establish a registry for people seeking employment as direct care workers, or consumers wanting to hire direct care workers (see www.dswregistry.ar.gov).

Alternatives for Persons with Physical Disabilities, a Medicaid waiver for persons with physical disabilities age 18 to 64, is available as a consumer directed attendant program or as an agency program; participants are eligible for up to 8 hours of services per day, seven days a week. In 2007 this waiver served 2, 072 people, and most of them used the consumer-directed modality; it was recently amended to: 1) add spousal impoverishment; 2) remove upper age limit allowing consumers to remain in the waiver after they turn 65; 3) add waiver case management/counseling support; and 4) add an “agency option” for those who do not want to direct their own care.

In 2007, Arkansas was awarded a Nursing Home Diversion Grant from the Administration on Aging. This program, implemented initially in two counties, will utilize consumer-directed services. This program is modeled after Independent Choices, but the target group is non-Medicaid consumers who have care needs and want to remain in the community.

ARHome, Cashing Out Nursing Homes. Arkansas has worked for several years on a program to cash out nursing homes, originally called Next Choice. At the time of the baseline study, the state was working under a grant from the U.S. Office of the Assistant Secretary for Planning and Evaluation to study the feasibility of the program and analyze nursing home MDS data to determine a formula for the cash-out amounts. The program, now called ARHome, will be developed under a new 1915 a & c waiver program. It will be piloted in all 12 counties in the Southwest Arkansas Area Agency on Aging Region before being implemented state-wide.

ARHome creates a Prepaid Health Plan, which will receive a prospective payment for each consumer enrolled in the plan. Nursing homes in Arkansas average \$48,000; based on an assessment using MDS-HC, six capitated rates have been established ranging from \$43.23 to \$133.23 a day for the services. The consumers may elect to direct their own services (cash and counseling model), purchase services from an agency or a combination of the two. Services include adult day health care, adult family (foster) home, assisted living II, chore; companion, community transition, environmental accessibility adaptations/modifications, home-delivered Meals, individual-directed goods and services, personal emergency response system, personal attendant; respite, specialized medical equipment and supplies, and skilled medical service This program will interact with Arkansas' Money Follows the Person (MFP) Demonstration; those individuals leaving nursing home in the time frame that qualifies them for the MFP, will be able to receive long-term support services through ARHome.

SOURCE. Developed as one of the objectives under Arkansas' System Transformation Grant, SOURCE is a voluntary primary care case management (PCCM) program that combines primary care, social case management, and home and community-based services to coordinate care for dually eligible persons and other adult Medicaid participants with chronic conditions. The program is scheduled to start in late 2008 in four pilot counties, two in the Southwest Area Agency on Aging Region and two in the Northwest region. Based on the experience, a determination will be made about the feasibility of moving the program statewide.

Options Counseling. The legislation establishing Options Counseling provides information on long-term care options to individual (or their representatives) who: (a) seeks an Options Counseling consultation; (b) seeks admission to a long term care facility, regardless of payment source; or (c) resides in a long-term care facility and applies for Medicaid reimbursement. Each

long-term care Options Counseling consultation shall include information about: (1) factors to consider when arranging for care, including methods for maximizing independence and self-reliance; (2) available options; (3) costs and potential payment sources. This program is scheduled to be implemented in June 2008; 16 additional FTEs were added to DAAS to begin the statewide program.

Nursing homes are required to notify DAAS of all persons admitted to nursing homes within 24 hours. The State also has a data use agreement with CMS to use MDS data through 2015 to target individuals likely to leave nursing homes to permit triage for Options counseling and Money Follows the Person (see below). In 2007, Arkansas contracted with Robert Kane at University of Minnesota to develop a predictive model for nursing home discharge.

Other initiatives highlighted in earlier reports. The *Aging and Disability Leadership Academy* was a time limited program developed under Arkansas' 2004 Real Choice Grant. Funds were not available for its continuation after the grant ended. Key informants believed that the Academy helped develop capability and motivation for consumer involvement in program development. The Governor's Integrated Services Task Force, the main body of stakeholders guiding community services development, remains a viable organization and the various programs in operation or under development in Arkansas have a strong consumer stakeholder presence.

The activities to develop *Nurse Delegation* in Arkansas were successfully completed, and it is now possible for nurses to delegate to unlicensed assistive personnel.

Together We Can (TWC) is a multi-agency, multi-departmental program (involving the Divisions of Children and Family Services, Developmental Disabilities Services, County Operations, Mental Health, Medical Services, Youth Services, and Office of Administrative

Services in the Department of Human Services), the Department of Education, and the Department of Health), which is available to children with MR/DD and multiple needs who have not been successfully served in the past. TWC services are meant to deal with “intense emotional, interpersonal, or behavioral challenges, a lack of success in traditional services, the need for services from multiple agencies, and the desire to remain the community.” The program is now is available in 26 counties.

New Initiatives

Money Follows the Person. In 2007 Arkansas was awarded a grant to participate in the Money Follows the Person (MFP) demonstration; the goal is to assist the transitions of 305 participants over a 4-year operational period. Several new services are proposed to facilitate these transitions. Some of these additions are meant to provide a more intensive amount of health-related services in the community because of the anticipated higher needs of those leaving nursing homes, and some which are meant to serve rural areas. These include: a 24-Hour Help Line staffed by highly trained registered nurses with extensive clinical backgrounds and using a state-of-the-art health information system to identify emergencies, guide patients to appropriate care, and provide self-help instructions; ; telemedicine services in-home monitoring technology, therapeutic interventions, including medical interventions; individually tailored 24-hour supportive living services provided in person’s own homes or in a protected environment on a short term basis, and 24-hour attendant care on a short-term basis. The development of the 24-hour supportive living services, especially for seniors, will be a new endeavor. Other added services address the costs of the transition itself, including ; intensive transition coordination, which is an enhanced case management; and a bundle of community transition services (defined as items, goods, or services that can be provided 60 days before to 60 days after, including assistive

devices, security deposits, rental and utility deposits, and essential furniture, appliances, and household items).

Other current activities. The State has new grants in place since the last case study appeared, and also is presently emphasizing particular activities under the System Transformation Grant, which continues until 2010. One such transformation activity is the creation of a single point of access and one-stop shopping for services, a long held goal for Arkansas. Towards that end, a prototype for The Choices in Living Resource Center is now under development. This will utilize the webtools developed as ARGetCare that were discussed in an earlier topic paper, and will consolidate Options Counseling. Staff has now been hired for the Choices in Living Resource Center. As part of the Systems Transformation grant, Arkansas is moving ahead with efforts to utilize a single assessment tool based on the MDS-HC, and to develop the information platforms based on this to develop useful and timely data to manage the system.

Among other initiatives underway, the Bridging the Gap project being developed as part of the information base in ARGetCare is directed at the interface between Alzheimer's disease and MR/DD. The AOA Diversion Grant, mentioned above, will develop self-directed services for seniors needing LTSS who don't yet qualify for Medicaid. In 2007, Arkansas was awarded one of the CMS grants to profile the long-term care system, and the state expects the work under that grant to further its general goals around data adequacy. A rural PACE program, under development for several years, will soon open in the Jonesboro area. Finally, Arkansas is planning a new waiver program for persons with brain injuries.

Goals, Objectives, and Accomplishments

The mission of the Division of Aging and Adult Services is to promote the health, safety, and independence of older Arkansans and adults with physical disabilities. On its website, the Division of Disability Services (DDS) has a more elaborate mission statement with multiple, somewhat conflicting goals, followed by a statement that to achieve its mission, the DDS is committed to the principles and practices of normalization; least restrictive alternatives; affirmation of individuals' constitutional rights; provision of quality services; the interdisciplinary service delivery model; and the positive management of challenging behaviors.

For the work under the System Transformation Grant, the vision statement is that older Arkansans and people with disabilities have choices in how and where they receive long-term care. The mission is "to improve the quality of life of all older Arkansans and people with disabilities by fostering independence, promoting better health, maximizing and simplifying access to services and programs, and utilizing data and other information to drive decisions and actions." The

building blocks for the system transformation activity to be conducted in the five-year period are shown in Figure 1. The Figure is titled "Rebalancing" because each circle lists building blocks

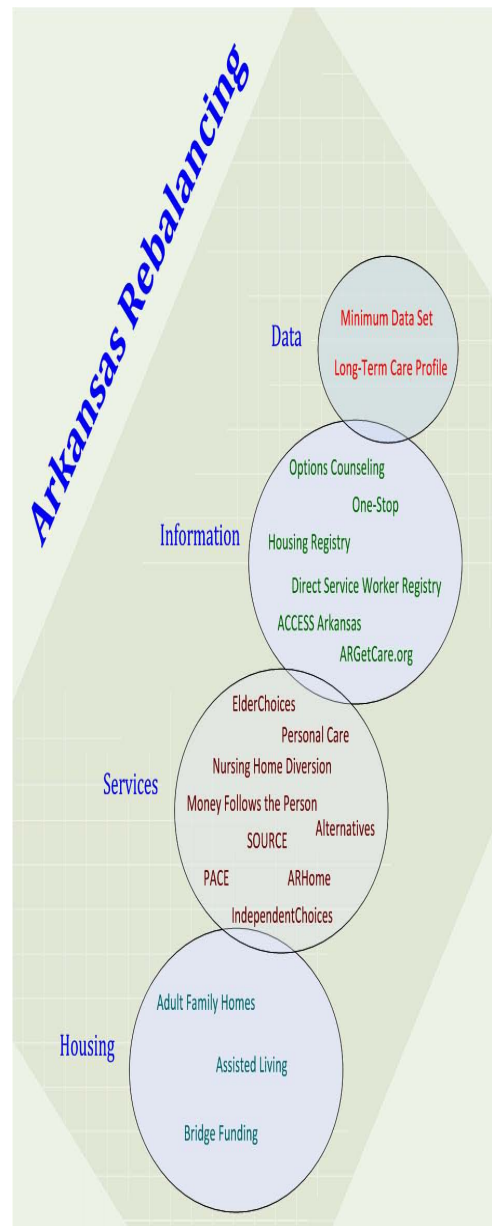


Figure 1. Elements of System Transformation in Arkansas.

Source. Provided by Herb Sanderson, Director, Division of Aging and Adult Services, November, 2007.

in a rebalanced system. Considerable progress has been made to establishing the various elements, at the rest of the Case Study shows.

It seems indisputable that choice is becoming available for seniors and people with disabilities in Arkansas, and certainly nursing home occupancy rates are among the lowest in the nation. But by the conventional quantitative measures comparing expenditures in the HCBS and institutional sector, Arkansas fares less well. In 2006, the state spent 70.3% of its Medicaid LTSS dollars on institutions, ranked 38th in the proportion of expenditures in community care. For seniors and persons with disabilities, 74% of Medicaid LTSS expenditures were in institutions, which was a bit more than the national average of 71.4%. For persons with MR/DD, 58.7% of resources were expended in institutions compared to 39.3% nationally, and Arkansas ranked 45th among the 50 states and the District of Columbia on this metric.³

Access

Providing information about options and facilitating rapid processing of applications for services have been long-standing goals of the DAAS, and several grant programs have assisted towards those goals. On the information side, Arkansas has developed extremely user-friendly print and web materials about programs and resources. ARGetCare with its self assessment tool is an exemplary resource in that regard (<http://www.argetcure.org/>).⁴ Recent products include

It's Your Choice: Hiring and Managing Your Own Care

(<http://www.arkansas.gov/dhs/aging/itsyourchoice.pdf>), and the Arkansas Nursing Home Consumer

³ From Tables developed by Thompson-Medstat, available on the web, last visited May 25, 2008, at http://www.hcbs.org/moreInfo.php/source/150/doc/2016/Medicaid_Long_Term_Care_Expenditures_FY_2006.

⁴ Topic Paper Number 4 in this series highlighted the ARGetCare website. See Kane, RA, Priester, R, & Kane, RL (2007). State Long Term Support Systems to Promote Informed Consumer Decisions: Information Provision, Decisions Tools, and Options Counseling. On web at http://www.hpm.umn.edu/ltreresourcecenter/on_going_research/Rebalancing_state_ltc_systems_topic_papers.htm.

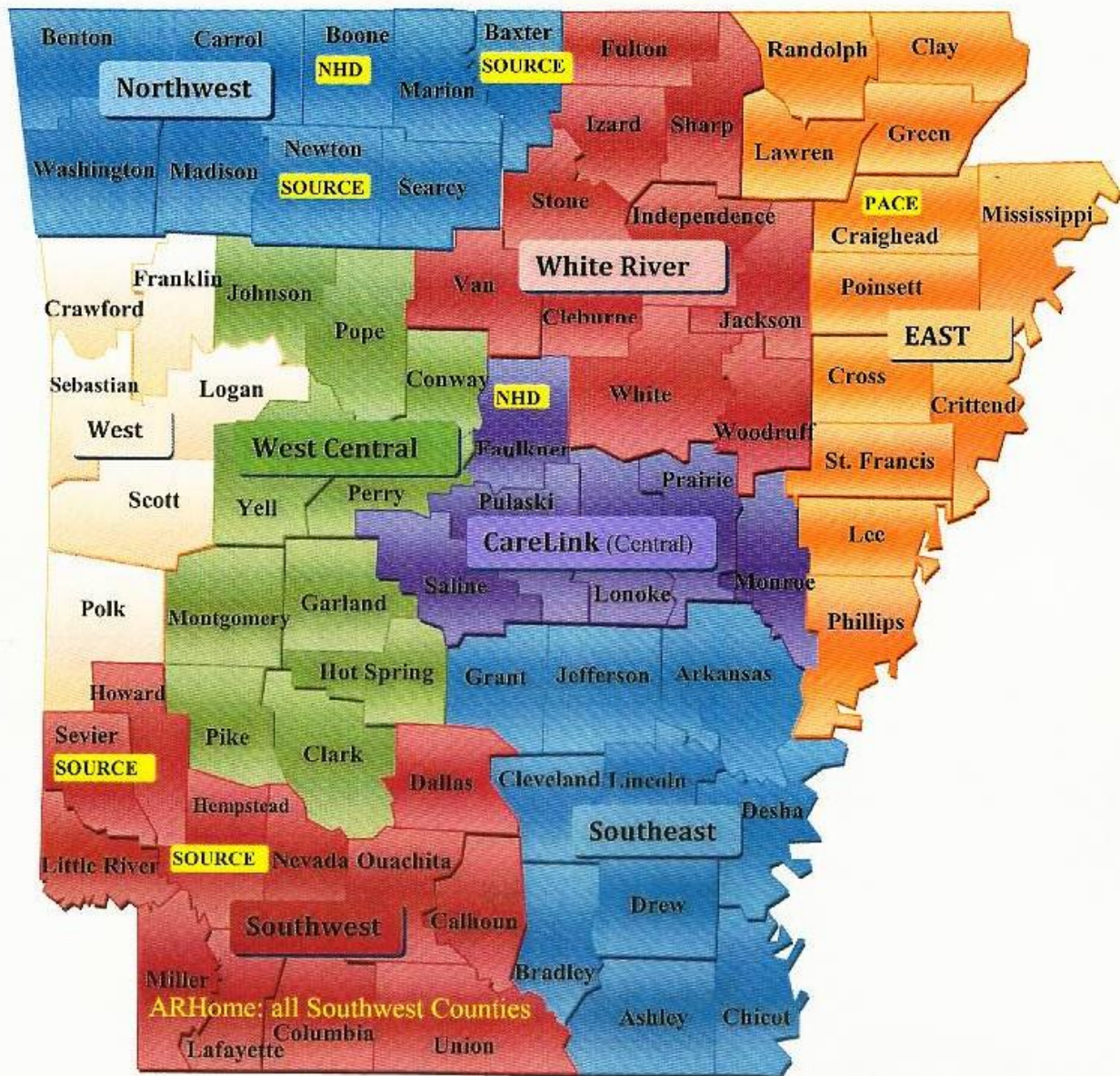
Guide (<http://www.arkansas.gov/dhs/aging/dco645.pdf>). Both are clear, prepared at an easy reading level, yet meaty in terms of the information conveyed.

Gradually Arkansas has become well-staffed with state-employee positions to provide information about programs. The Options Counseling efforts go into effect in June 2008 and are meant to be a resource to all potential LTSS participants in the state. It has yet to be seen whether nursing homes will cooperate with making options counseling available as the law requires for new residents regardless of payment source and residents transitioning to Medicaid funding. As a compromise to get the law enacted, nursing home residents or their agents have the right to decline Options Counseling. The Office of Long-Term Care plans fines for failure to make options counseling available and to execute the informed consent properly, although it is not yet clear how that office will be able to show noncompliance.

Arkansas has not yet developed a speedier process for financial and functional eligibility for long-term care, and it still requires physician orders for personal care under Medicaid. One of the goals of the Systems Transformation grant is to speed the eligibility and service initiation process and the uniform assessment is meant to be a vehicle. The programs of the Division of Disability Services are still quite separate from those of the DAAS, but the collaborative projects on which they are working, including Money Follows the Person and System Transformation helps to bring the agencies closer.

Arkansas is largely a rural state, with an urban central area around Little Rock, and considerable growth in the Northwest area. All but one of the 9 Area Agencies on Aging act as in-home service providers, which is one of the reasons why the eligibility assessment function is performed by state employees. As new programs are being phased in, they tend to be piloted first in a few areas. Figure 2 maps the plans for implementing four new initiatives. The

ARHome program will be tested in the Southwest Arkansas AAA area, the one region where the AAA does not provide home care and the area where the Aging and Disability Resource Center was piloted. Five of the AAA regions are not taking part in any of the piloting being planned though all will participate in Money Follows the Person and Options Counseling, which are being implemented statewide.



Notes:
NHD: AoA Nursing Home Diversion Grant.
ARHome: Piloted in Southwest AR then expanded statewide.
PACE: Main clinic in Jonesboro with satellite operations in surrounding area.
Money Follows the Person (MFP): Statewide

Figure 2. Arkansas Area Agency on Aging Regions and Location of Pilot Programs

Service Array

In terms of in-home services, the HCBS waivers in Arkansas contain a wide array of services. Furthermore, the emphasis on consumer-direction that permeates the system allows provides additional flexibility. In recent years, modifications to the waivers have added a few additional services, including companion services in the Elder Waiver (which may be consumer directed). As mentioned above, new services are being added to the waivers to support the goals of the Money Follows the Person Demonstration. These include services that pertain directly to transition activities and expenses (e.g. rent deposits, furnishings and appliances, transition counseling) but also some more professionally oriented and technical services that might be needed when people with serious illnesses and vulnerabilities return to the community, including heightened therapeutic services and a 24-hour RN hotline. Similarly the ARHome program envisages a heightened service capacity.

The array of community group residential settings for older people is not as well developed in Arkansas. Development of adult family homes is a longstanding goal that is hoped to be accelerated as part of System Transformation and Money Follows the Person Activities. Arkansas is also encouraging the development of Assisted Living (AL). In the earlier case study, we reported on the states strategy of developing assisted living as a regulatory category, beginning with 2001 legislation and establishing its regulations. At present, Arkansas recognized two levels of AL; only Level II which serves people who would be eligible for nursing homes, may participate in the Assisted Living Choices Waiver. As of this writing, Level II Assisted Living settings have expanded to 14 AL I and 27 AL II settings; 20 of the latter participate in Medicaid. All told, there are 1308 AL II beds in the state distributed in 10 counties, and 947 are available under the Medicaid waiver.

State Organization

The Division of Aging and Adult Services in the Department of Human Services (DHS) is the lead agency for many of the initiatives in long-term care. The Medicaid program is a separate division in DHS, which collaborates closely with DAAS, a collaboration that is assisted by the long tenure of the leaders in the agencies. The Division of Disability Services (DSS) manages the MR/DD services. DSS is part of GIST, the Governor's Task force for implementing the Olmstead decision, and various other initiatives, including Money Follows the Person involve both DDS and DAAS, but the MR/DD programs are functionally managed by a different group than the other long-term support programs. Another possibility for fragmentation is that all the eligibility services are located in yet another unit, the Division of County Services. The licensure and quality assurance for nursing homes, ICF-MRs, and assisted living are in the Department of Health.

When we visited Arkansas in 2005, the Department of Human Services was preparing for a merger with the Department of Health, which the then Governor Huckabee supported as a way of bringing health and mental health and human services together and achieving efficiencies. By our 2007 visit the Department of Health and Human Services had been "de-merged" by the current Governor Beebe. The merger and the subsequent change to the two departments seemed to have little effect on the evolution of long-term care programs in Arkansas.

Quality Initiatives

In 2004 Arkansas received a 3-year CMS Real Choice System Change grant to develop a quality assurance system modeled on the grant for CMS Quality Framework. Essential to the plan was developing an integrated data set to monitor activities and a system for incorporating direct feedback from participants into the quality activities. Another goal was to shorten the time

between identifying a problem and remediation. The original grant also contained an activity to develop a peer-counseling and mentoring program for participants in HCBS waivers. These activities are also inherent in the System Transformation Grant (which emphasizes a usable data system to manage the programs and a way of getting feedback from program participants) and are built into the operational plan for the Money Follows the Person Demonstration, which requires a quality management. A quality unit has been created in DAAS and additional staff provided for it.

Housing

The Department of Human Services under the leadership of DAAS has been concerned about availability of affordable and suitable housing for seniors and people with disabilities. Working in collaboration with the Arkansas Development Finance Authority and Public Housing Authorities (PHAs), in connection with the startup of Money Follows the Person, the State Director of Public Housing for the Arkansas HUD office sent a request to all Arkansas housing authorities to establish local preferences for people leaving nursing homes, and to use public housing units and set aside Housing Choice vouchers and Mainstream Vouchers for participants in the MFP project. Also underway is the development of an inventory of available units and other housing resources (such as the Choice vouchers), as specified by local PHAs and other related organizations, will be developed for use by the transitional coordinators and/or case managers.

Since 2003, the Tenant Based Bridge Rental Assistance (TBRA) fund, developed with HOME funds from the Arkansas Development Finance Authority (ADFA), has provided rental assistance for up to two years for an individual wishing to divert or transition from an institution. The funds are currently contracted to community service providers, who in turn assist individuals

with the completion of the application and assist the participants in working with the local Public Housing Authority to make application for a Section Eight voucher.

Other housing initiatives, developed through Arkansas' RSCS grant for LTC Supports with Housing, relate to developing more specialized housing for seniors and adults with disabilities. Adult family homes (called Adult Foster Homes in some states) are underdeveloped for this population. There is also an interest in developing affordable assisted living facilities for individuals with low incomes. Arkansas was one of the original states working with the National Cooperative Development Bank (now NCB Impact) to develop affordable assisted living, largely using low-income tax credits. The result was an affordable AL setting in Bentonville, AR.

Some long-range efforts are underway to employ universal design and develop housing where tenants can remain if they incur disabilities by encouraging accessible, low-cost housing for all citizens. Korydon Smith, a professor at the University of Arkansas School of Architecture leads what is known as the Arkansas Universal Design Project, a pioneering attempt to develop and implement inclusive design housing standards that move beyond ad hoc, retrofit solutions for people with disabilities.⁵ A fruitful collaboration has occurred among: the University of Arkansas for Medical Sciences, Partners for Inclusive Communities; the Arkansas Department of Workforce Education, Rehabilitation Division; and the Arkansas Department of Human Services, which has resulted in the adoption of usability standards by the Arkansas Development Finance Authority (ADFA).⁶ Professor Smith has also developed the Studio for Adaptive + Inclusive Design (Studio AID) to further this work.

⁵ These activities were initiated under a CMS Real Choice System Change Grant on combining LTC Supports with Housing.

⁶ Two extremely useful publications have resulted from this effort. Smith, C (ed) (2007) Usability: Arkansas Standards in Housing (guidance manual for designing & constructing inclusive functional dwellings) and Smith, C (ed) (2007). Disability, Housing, and Arkansas, A Primer. Both are available from the Arkansas Rehabilitation Services, Department of Workforce Education.

Interestingly, Arkansas provides creative examples of building affordable, accessible housing using historical preservation tax credits as a major financing vehicle and preserving old historical buildings into housing. The Arc of Arkansas has provided leadership in this area. Since 1999, the Arc has completed 8 large housing development projects in the Little Rock area and other parts of the state, including four projects in old high schools, two in old hospitals, and one in a hotel. Presently they are working with two large freestanding auditoriums attached to old high schools. All together they have leveraged more than \$30 million in tax credits, and have developed a track record of excellence in historic preservation. The resultant projects are typically a mix of low-income and market rate apartments.⁷ In 2006, the Arc was named Arkansas' non-profit business of the year in recognition of this activity and in 2007 it was one of 31 organizations receiving a National Preservation Honor Award from the National Association of Historic Preservation.⁸ Key informants told us that the Arc became involved in this work serendipitously, beginning with a concern for the lack of affordable rental properties in the State and becoming involved in a number of collaborative housing projects. One informant put it that the Arc became "an accidental preservationist." Although this is an example of a strategy from the private sector rather than state government, state officials are enthusiastic supporters of this work, and the strategy seems to one that could be employed in other states.

⁷ The Arc of Arkansas website describes many of these projects and illustrates them with photographs. Last visited May 27, 2008 at <http://www.arcarts.org/>.

⁸ In presenting the award, the atypical nature of the Arc as one of the awardees was acknowledged: "you won't see historic preservation in the Arc's mission statement, but its there in every aspect of this great organization's work, said Roger Moe, president of the National Trust for Historic Preservation. . . . the Arc is revitalizing historic buildings and preserving the physical reminders of our past that are essential in instilling a sense of civic pride and community spirit." For more detail, see newspaper article on the web, last visited May 27, 2008 at http://press.nationaltrust.org/index.php?option=com_content&task=view&id=172&Itemid=69.

Future of Nursing Homes

The vast majority of nursing homes in Arkansas are proprietary and ably represented by the Arkansas Health Care Association, which has many links to leaders in the Arkansas legislature. The reimbursement formulas for property costs are favorable to the industry; 70% occupancy is considered full for those calculations. The State has not enunciated any particular numerical goal for the number of nursing homes needed in the future, but rather emphasizes choice and is proceeding with the development of HCBS options. Using 2005 data, AARP showed the occupancy rate in Arkansas as 71%, ranking it 48th lowest occupancy of the 50 states and District of Columbia.⁹ Kaiser Foundation's Health Facts updates the figures for 2006, citing an occupancy rate of 73% in Arkansas nursing homes, compared to an 85% national average, but ranking was not available.¹⁰

Officials in the Office of Long Term Care (OLTC) in the Arkansas Department of Health are interested in encouraging resident-centered, individualized forms of nursing-home care in improved environments and in advancing the general goals of the culture change movement in nursing homes. The Director of the OLTC visited the Green House® projects in Tupelo, MS, and was positively impressed by the small-house model of nursing homes demonstrated there. Consequently, the OLTC undertook a comprehensive revision of all its state nursing home regulations to remove the prescriptive quality, especially where the rules that might interfere with culture change, and to develop rules for new construction that would encourage household kinds of physical settings (for example, eliminating references to nursing stations). The state also developed a new section of regulations applicable specifically to trademarked Green Houses

⁹ AARP rankings of occupancy levels for 2005 are found on web, last visited May 27, 2008, at http://assets.aarp.org/rgcenter/health/d18763_2006_atr_rankings.pdf.

¹⁰ For Facts on Nursing Homes in Arkansas in 2006, see Kaiser Foundation website, last visited May 27, 2008, at <http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=97&rgn=5>.

or to similar small-house nursing homes approved by the OLTC. The rationale for a separate section for Green Houses when the overall regulations were revised to promote culture change was to accommodate the “universal worker” model of nursing assistant that is inherent in Green House. Having promulgated nursing staff standards a few years before, partly in response to consumer stakeholders, OLTC was reluctant to permit that degree of permissiveness to all nursing homes. When nurse’s aides have much broadened roles that encompass cooking, meal service, personal laundry, and light housekeeping as well as some activity aide and rehabilitation aide functions, OLTC was concerned about how compliance with the nursing-to-resident ratios would be assured and preferred to deal with that issue in the narrower context of the exemplary facilities approved for Green Houses.

The Arkansas legislature developed a trust fund for the civil monetary penalty payments, which by statute was to be spent only in activities to protect residents subject to poor quality care or emergencies endangering their health, such as to assist them with relocation or to allow for the state to temporarily manage poor quality nursing homes. In 2006, that statute was revised to permit money from the fund to be used to encourage positive culture change and related facility construction to develop Eden Alternative nursing homes and Green Houses. At present, the Fund has about six million dollars that it has designated to award to three facilities who decide to develop a Green House. As of the spring of 2007, the revised regulations, including the Green House parts, are available in draft and are being reviewed by stakeholder groups, including the Arkansas Health Care Association. Once the regulations are in force, OLTC plans to issue an RFP for the Green House awards.

Integration of Acute and Long-Term Care

Arkansas has been working toward the development of a rural PACE site, which is expected to open in Jonesboro in 2008.

Apart from that, the other major development to integrate medical management and long-term care is the replication of the Georgia SOURCE program, which is a primary care case management model that worked well in rural Georgia. The development of SOURCE was a major thrust of the System Transformation grant. It will initially be piloted in four rural counties in two parts of the state.

Conclusions

Arkansas has moved steadily ahead in the evolution of a system of LTSS that is characterized by infusion of consumer direction in as many programs as possible, and an effort to create community choices for Arkansans. The state has made maximum use of federal grants (from CMS and other sources) and foundation grants, which it has used effectively to work toward its own umbrella goals of generating choices, creating a system with easy access, making information available to consumers, developing a data driven quality management system, and developing housing and group residential options. Continuity of leadership in the DAAS has helped with this mission. Arkansas leaders have made a practice of being very informed about developments around the country, and identifying programs that seem worthy of adaptation to the State.

Arkansas is still challenged to close its remaining state-run regional MR/DD facilities, and bucks a strong lobby group of state employees and parents in that effort. It is also challenged to distribute its Medicaid resources for seniors between nursing homes (which have high vacancy

rates) and HCBS. By quantitative indicators of the way expenditures are balanced between HCBS and institutions, Arkansas ranks average among states for aging and disability and towards the bottom for developmental disability. Nevertheless, Arkansas has managed to change the system of long-term support services towards more community care despite the success of the nursing home industry in hanging on to resources and despite rather low rates of payment in HCBS. Moreover, the state seems poised to develop important refinements in its system in the next decade, which will result in an ability to use data better to manage its system.