

**A Year in State Management Practices for
Rebalancing Long-Term Care Systems:**

Update of Activities in 8 States, July 2005 to July, 2006

by

**Rosalie A. Kane
Reinhard Priester
Robert L. Kane
Donna Spencer**

Submitted to the

**Centers for Medicare & Medicaid Services (CMS),
Advocacy and Special Initiatives Division**

CMS Project Officer, Dina Elani

This 3 ½ year project (10/1/2004 to 3/31/2008) is being conducted through a Task Order (#CMS-04-0014) under a CMS Master Contract between CMS and the CNA Corporation (CNAC) (Master Contract #500-00-0035), Arlington, VA, with a subcontract to the University of Minnesota. Rosalie and Robert Kane, University of Minnesota, are Project Director and Co-Director, and Linda Clark-Helms is the CNAC project manager. This Update of Rebalancing Management Approaches in 8 States is one of the deliverables under the contract.

The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states.

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. In October 2004, CMS commissioned that mandated study. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in this 3 ½ 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.” A balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The Rebalancing Study products include State-specific case studies that qualitatively and quantitatively examine each State’s management approaches to rebalance their long-term care systems. The first set of case studies, which reviewed each State’s experiences up to July 2006, along with an Executive Summary for all 8 States, have already been released.¹ This report provides an update on developments in all 8 States during the year since the baseline reports. Follow-up reports covering the period until the summer of 2007 are planned for release in the fall of 2007. The other products are comprised of a series of papers, called *Topics in Rebalancing*. Each Topic Paper highlights an issue of importance in State rebalancing efforts, and each draws on experiences in some or all of the 8 States in the Rebalancing Study to illustrate the issue. Two Topics papers were issued in 2006.²

For these updates, we relied on information from personnel in each State and from various State data management centers and we consulted on-line reports. We concentrated on identifying changes over the year, and in following up on management activities identified in the baseline reports. We also updated quantitative markers on rebalancing by adding another year to the longitudinal record. We thank our State liaisons, who currently are Herb Sanderson, Arkansas; Beth Kidder and Wendy Smith, Florida; Larhae Knatterud, Minnesota; Deborah Armstrong, New Mexico; Dale Laninga, Pennsylvania; Marc Gold, Texas; Patrick Flood, Vermont; and Kathryn Leitch, Washington. We also thank our CMS project officer, Dina Elani, for her continual assistance. The findings and conclusions in the paper are those of the authors and do not necessarily reflect CMS or its staff, or any State officials. As with all products of the Rebalancing Research Project, we welcome any comments or reactions.

Rosalie A. Kane, Project Director

¹ The Executive Summary and the 8 abbreviated case studies are available on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage, as well as on <http://www.hcba.org> and the Study director’s website at <http://www.hsr.umn.edu/LTCResourceCenter/>. Longer State reports can be found at <http://www.hsr.umn.edu/LTCResourceCenter/>.

² See Topic Paper # 1, *State Strategies to Build and Sustain Consumer Advocacy* by Reinhard Priester, Amy Hewitt, and Rosalie Kane, September 2006; and *State Long-Term Care Systems: Organizing for Rebalancing* by Rosalie Kane, Robert Kane, Martin Kitchener, Reinhard Priester, and Charlene Harrington, December 2006. These papers can be found at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage and <http://www.hsr.umn.edu/LTCResourceCenter/>.

Table of Contents

Executive Summary	iv
Introduction	1
Background	1
Method and Focus	1
Changes in Context	3
Hurricanes	3
Medicaid Reform	3
Political Directions	4
State Leadership for LTSS	4
State Organizational Structures	4
Service System	5
Developmental Activity	5
<i>Real Choice System Change Grants</i>	5
<i>Cash and Counseling</i>	5
Developments in Specific States, August 2005 to August 2006	6
Arkansas	6
Florida	8
Minnesota	10
Pennsylvania	13
Texas	15
Vermont	16
Washington	17
Update on Quantitative Markers of Rebalancing	18
Conclusions and Next Steps	27
Appendix Table A-1. Litigation Update for 2005-2006	28

List of Tables and Figures

Table 1. Approaches to Rebalancing Utilized in 8 States as of July 2005	2
Table 2. Real Choice System Change New Grants in 2005	6
Table 3: Cash and Counseling Programs in the 8 States	7

Table A-1. Litigation Update for 2005-2006	28
Figure 1: Numbers of LTC Participants in Waivers and Institutions, 2000 and 2005.....	19
Figure 2: Changes in the Numbers of Participants Served 2000 to 2005.....	20
Figure 3: LTC Expenditures in 2000 and 2005	21
Figure 4: Change in LTC Expenditures from 2000 to 2005	22
Figure 5: Change in Nursing Home Case Mix and LTC Utilization from 2000 to 2005	23
Figure 6: Cost per Participant Served, 2005	24
Figure 7: Ratios of Costs per Participant, 2005	25
Figure 8: Ratio of Expenditures, 2005	26

A Year in State Management Practices for Rebalancing Long-Term Care Systems: Update of Activities in 8 States, July 2005 to July, 2006

Executive Summary

The 8 States participating in the Rebalancing Study all made steady progress with the initiatives and activities described in the base-line case studies. As a group, they experienced considerable stability in executive leadership related to long-term support services (LTSS) and their legislatures were supportive of appropriations to expand home and community services. Where retirements or resignations affected State leadership personnel, the new appointments to the positions were seasoned individuals with leadership experience in state government and LTSS. None of the States shows a change in goals or direction over the past year.

Among the contextual factors affecting the states were the need to respond to the hurricanes of 2005 (especially making an impact in Arkansas, Florida and Texas because of evacuees in those States or receipt of evacuees from other States or both). Overall health reform continued to be an issue for State governors. Florida and Vermont both implemented Medicaid reform, taking advantage of the possibility of block grants to the State to manage a fixed Medicaid budget. Florida's program is being initiated on a demonstration basis but Vermont is undertaking a state-wide initiative. Several States have implemented or continued high-level initiatives to address problems of health care access and the uninsured. Governor Gregoire of Washington initiated a task force to study broad health care issues and to propose ways to improve coverage. These issues have also been a continuing priority in New Mexico and Pennsylvania.

State-specific management approaches include:

- Arkansas worked on creating quicker and more equitable access to LTC, using its System Transformation Grant to establish a virtual single-entry system and to integrate MR/DD and behavioral health into that access system. Arkansas also continued to expand consumer direction and cash options, and to develop its replication of Georgia's SOURCE program to implement primary care case-management for people with chronic disease.
- Florida expanded its community care and its employment programs for persons with MR/DD, using savings achieved by prior utilization review and supplemental legislative appropriations to cut down the waiting lists. Related to older people, the State received Federal approval for a combined 1915 (b) and (c) waiver to implement an integrated managed care initiative, Florida Senior Care, as a pilot project in 2 areas of the state.. The program's implementation is still pending legislative approval. The Diversion Program, a managed care option under 1915(c) waivers, also expanded and had been subjected to intensive evaluation. Finally, Florida introduced controversial plans to reorganize the Area Agencies on Aging (AAAs) as Aging Resource Centers (an expansion of the Centers modeled under its Aging and Disability Resource Center grant); final decisions about the roles of AAAs and the Senior Care Options program are still pending.

- Minnesota continued its broad-scale planning for the aging of the baby-boomers, emphasizing the importance of increasing private funding for LTSS, and receiving CMS approval for a State Plan amendment for a Public-Private Partnership program for long-term care insurance. Efforts to create a universal assessment for four of the States HCBS waivers continue, and the State initiated a county-by-county review of quality in its lead agencies for LTC. By November of 2006, all the State's managed care organizations (MCOs) were constituted as Special Needs Plans (SNPs) under Minnesota Senior Health Options (MSHO), which was reorganized into MSHO SNPs for the Medicare component of the integrated capitation. Seniors in the Elderly Waiver and Medicaid program chose or were passively enrolled into MSHO and arrangements were made on a county by county basis for the interaction between the MSHO SNPs and the counties. Consumer-directed community support programs also expanded and the State continued to downsize its nursing-home sector.
- New Mexico continued to support consumer directed care options in its State Personal Care Option program and *Mi Via*, a consumer directed 1115 waiver plan which began enrolling consumers in 2006. The New Mexico legislature enacted Money Follows the Person legislation, and the state is exploring expanding its managed long-term care initiatives. The Behavioral Health Collaborative, a cross-agency managed care initiative begun in July 2005 received high satisfaction ratings from consumers in a large-scale study completed in July 2006.
- Pennsylvania created a Long-Term Living Council to continue rebalancing initiatives begun by the Governor's Commission for Health Care Reform. Early priorities included nursing home transition efforts and a program of quality assurance and monitoring of the case management system.
- Texas established into state law its Money Follows the Person (MFP) program, initiated under Riders to the Appropriation process. It also conducted a pilot program to move MFP to ICF-MRs, and strengthened its transition counseling capacity State-wide. Texas planned to expand its Star+Plus integrated care waiver from Houston to 3 other multi-county areas in the State, conditioned on Federal approval.
- Vermont implemented its 1115 waiver Choices for Care program for seniors and persons with physical disabilities, achieving a smooth start-up. The State established an initial milestone of at least 40% of program enrollees residing in home or community settings in all regions, and was close to achieving it.
- Washington continued its initiatives for independent provider and consumer-directed care and its concerted effort to assist individuals with mental illness, including establishing a congregate housing setting for that group. The State also undertook a long-range Governor-commissioned planning initiative for LTC.

Quantitative markers suggest continued progress in all 8 states towards rebalancing goals, but with variation within and across states, particularly as to the patterns of change for seniors in

contrast to persons with disabilities. Highlights from the comparisons between 2000 and 2005 include:

- Despite the substantial growth in HCBS participants in most of the states, little change is found in the acuity of nursing-home residents from 2000 to 2005.
- The number of participants in nursing homes in 2005 exceeded those in elderly and disabled waivers in all States except Washington, but the number of participants in MR/DD waivers consistently outpaced the participants in institutions.
- Arkansas and Florida show a slight decrease in aging and disability waiver participants, Texas and Washington show slight increases, and the others show substantial increases.³ The number of participants in nursing home declined in 5 States (Arkansas, Minnesota, New Mexico, Washington, and Vermont).
- Taken as a cross-sectional for 2005 as a whole, nursing home expenditures are highest, followed by expenditures on MR/DD waivers. In Texas and Washington, elderly and disabled waiver expenditures exceed expenditures on MR/DD waivers. Over the 5 year period, the growth of expenditures on waivers exceeded that on institutions, with the exception of Florida, where expenditures on elderly and disabled waivers grew less than expenditures on nursing homes. Expenditures on ICF/MRs decreased in Minnesota, Texas and Vermont.

³ Officials from Florida inform us that they believe the results should be the reverse, and show a slight decrease in NH participants and increase in aging waiver participants. We reran our data and found the results unchanged, but will continue to try to understand the discrepancy. According to Wendy Smith, Florida Agency for Health Care Administration the discrepancy may be because “one of the complications of looking at waiver enrollment in Florida through the use of paid claims data is that it is often difficult to identify individuals who are enrolled in HCBS waivers, since there is no “waiver identifier” on our FMMIS eligibility screens for the majority of our waivers (email communication, February 28, 2007).”

A Year in State Management Practices for Rebalancing Long -Term Care Systems: Update of Activities in 8 States, July 2005 to July, 2006

Introduction

In 2005, the Rebalancing Research Project issued comprehensive reports on State management approaches to rebalance State long-term supportive services (LTSS) towards greater community care in Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. Those reports covered a period roughly starting in the 1980s through August 2005. This report provides a brief update for the period ending in August 2006. It is intended as an interim product that sets a stage for detailed follow-up case studies that will be prepared in 2007.

Background

The original case studies traced the evolution of State long-term policy and programs with an emphasis on the Medicaid program.⁴

All 8 States were in the process of changing the balance towards more community care utilization and expenditures, but varied in their accomplishments both before and after the *Olmstead* decision of 1999. As of July 2005, three States (MN, NM, and VT) had eliminated State regional centers for people with mental retardation and developmental disabilities (MR/DD) and large intermediate care facilities for mental retardation (ICF-MRs); in the MR/DD area, the challenges for those States was to conserve the accomplishments of the past while increasing efficiency and, if possible, diverting other populations from institutions. Three States (TX, VT, and WA) had consolidated State organizational structures for LTSS, and others had introduced different ways to communicate and collaborate more effectively across agencies (NM, MN, and PA). Table 1 summarizes major findings from the baseline reports.

Method and Focus

We updated qualitative information through review of Web materials, and made telephone contacts with key informants in the States as needed, buttressed by in-person contacts at various national meetings. No site visits were performed for this update. We gathered an additional year of data from each State on expenditures and utilization of institutions, adding the year 2005 to our longitudinal profiling and to our MDS data on the acuity of nursing home residents. The focus is on change in context, organization, or services, and on developments in the management approaches we were tracking. Although the period for the Update ends in the summer of 2006, we sometimes provided information about later developments in footnotes.

⁴ Each long State report was organized as follows: Section I, context for rebalancing (demography, economics, and political context; the vision for LTSS; leadership in legislative and executive branches; State and local organization for LTSS; relevant litigation history; supply and characteristics of services in the State; and programmatic building blocks for LTC in terms of HCBS waivers, Medicaid State-plan services, and State-funded programs for persons with disability of all ages); Section II, systems assessment (access to LTSS, array of services in the system, consumer direction, quality initiatives, systematic efforts to downsize nursing homes and other institutional care, linkages to housing; linkages to acute care services, and linkages to mental health services), Section III, selected management approaches; and Section IV, quantitative markers of rebalancing in participant utilization and expenditures.

Table 1. Approaches to Rebalancing Utilized in 8 States as of July 2005

State	Management Approaches and Plans
AR	<ul style="list-style-type: none"> ▶ Conscious use of development grants from CMS and others. ▶ Consumer direction, cash & counseling program (Independent Choices). ▶ Planning for Next Choice, a program to cash out nursing homes. ▶ Web-based program to provide basis for consumers & families to make decisions ▶ Innovative State-sponsored Leadership Institute for Aging & Disability. ▶ SOURCE program for primary care case management under development. <p><i>Management approaches tracked:</i> Next Choice, SOURCE, efforts to develop single-entry programs.</p>
FL	<ul style="list-style-type: none"> ▶ Senior Care, a legislatively mandated managed LTC pilot in 2 areas of the State (8 counties) ▶ Consumer-directed services waivers, and expanded HCBS for MR/DD ▶ Multiple state-wide training initiatives for nursing home & HCBS personnel. <p><i>Developments tracked:</i> Senior Care demonstration; changing roles for Aging Network; studies of relative efficacy of various HCBS waiver programs.</p>
MN	<ul style="list-style-type: none"> ▶ Managed Care for LTSS for participants in Elderly Waiver implemented October 2005. ▶ Further efforts to downsize nursing homes, plus State-wide quality initiative for NHs. ▶ Consolidation of assessment, individual budgeting & care planning principles in 4 HCBS waivers. ▶ Consumer-Directed Community Supports emphasis ▶ Decision tools for Long-Term Care consultants. <p><i>Developments tracked:</i> all above directions.</p>
NM	<ul style="list-style-type: none"> ▶ Expansion of personal care (and consumer-directed care) under the Medicaid State Plan ▶ Mi Via, a consumer directed waiver for all populations ▶ Evolution of role of Department of Aging and Long-Term Care services ▶ Interdepartmental collaboration on managed behavioral health initiative. ▶ Discussions of managed care for long-term care. <p><i>Developments tracked:</i> Mi Via, Personal Care Options, managed care planning.</p>
PA	<ul style="list-style-type: none"> ▶ Governor's Office for Health Reform Initiatives on LTC ▶ Fast track demonstration for eligibility and service initiation in 10 counties. ▶ Some downsizing of Nursing Home sector, especially public sector. <p><i>Developments tracked:</i> LTC planning through Governor's initiatives; expansion of fast-track; issues in quality and coverage of Assisted Living; efforts to improve monitoring abilities; cash & counseling project.</p>
TX	<ul style="list-style-type: none"> ▶ Massive State government reorganization and integration across functions and target populations. ▶ Money Follows the Person (MFP) initiatives combined with vigorous relocation assistance ▶ Project Independence Advisory Group with vigorous consumer involvement in tracking rebalancing goals ▶ 222 and TIERS System to facilitate local entry to services. ▶ Potential Star+ Managed Care expansion. ▶ Consolidated HCBS demo in San Antonio. <p><i>Developments tracked:</i> Evolution of MFP & pilot in MR/DD area; further articulation of system.</p>
VT	<ul style="list-style-type: none"> ▶ Community Choices 1115 waiver to break link between NH eligibility and HCBS ▶ Reorganization of both State LTC and local entry systems. ▶ Comprehensive Integrated Care Project (acute & LTC) <p><i>Developments tracked:</i> Community Choices implementation which began October 2005.</p>
WA	<ul style="list-style-type: none"> ▶ Home Care Quality Authority overseeing and facilitating large growth of unionized Independent Provider sectors ▶ Reorganization & Integration of State government for LTC ▶ CARES system: an integrated, modularized, computerized assessment, care management, & quality assurance system. ▶ Quality programs across the continuum, including Community Based Residential Care Systems. <p><i>Developments tracked:</i> Quality authority and IP evolution; development of residential settings for persons with serious mental illness; added modules in CARES system; cash & counseling project.</p>

Source: Kane, RA, Kane, RL, Priester, J, & Mollica, RM (2005). Management Approaches to Rebalancing Long-Term Care Systems: Experience in 8 States up to July 2005, Executive Summary. Minneapolis: University of Minnesota School of Public Health http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage

Changes in Context

Hurricanes

To varying degrees, three of the States (AR, FL, and TX) experienced hurricane evacuations or were involved in receiving evacuees, or both. All three States received additional waiver funds to assist with LTSS related to the hurricanes. In particular, in Florida and Texas many resources, including financial and personnel, were devoted to responding to the past hurricanes and making emergency preparations for future ones.

Medicaid Reform

Two States, Florida and Vermont, accepted the opportunity to receive a block grant for their entire Medicaid Programs; in this program States accept a capped amount of money for their total Medicaid programs and in exchange have flexibility to manage those programs.

In the Florida Medicaid Modernization program, which is being implemented as a pilot program, the State contracts with managed care plans to provide all services to beneficiaries (initially excluding long-term care services). The pilot upends Medicaid's bedrock principle of beneficiaries' open-ended entitlement to a broad range of medical services by capping the coverage provided and giving MCOs the flexibility (at least for adult beneficiaries) to determine the amount, duration, and scope of benefits enrollees receive. Individually risk-adjusted premiums will be set for beneficiaries within the overall limit of Medicaid spending. Legislation authorizing AHCA to seek a demonstration waiver was passed in 2005, CMS approved the waiver in October 2005, and enrollment began on July 1, 2006. The pilot will be conducted in Broward and Duval counties, county seats for Fort Lauderdale and Jacksonville, respectively and affecting about 10% of the states 2.2 million Medicaid beneficiaries. At the time of initiation, Broward County had 7 MCOs, whereas Jacksonville had just one. After initial implementation in the 2 counties, the demonstration may be expanded to 3 other counties adjacent to Duval County. The demonstration extends until 2011.⁵

Vermont's statewide initiative, called Global Commitment to Health, was initiated under an 1115 waiver in October 2005 for a 5-year period. Building on its prior experience, the Vermont program utilizes a public entity as the managed care organization (MCO); that is, the Office of Vermont Health Access (OVHA) (i.e. the Medicaid program) functions as the MCO that holds the funds and administers the program. The State hopes that this change will result in eliminating uninsured populations and improving overall health outcomes, and it anticipates savings for reinvestment in the health of Vermonters. OVHA directly administers the health insurance program, including various pharmacy and SCHIP programs, and allocates funds to the Department of Aging and Disability Services to administer nursing homes programs, community LTSS programs, and Developmental Services, and to the Department of Health to administer mental health programs, substance abuse programs, and wellness and preventive initiatives.⁶

⁵ The Winter Park Health Foundation issued Briefing Papers on Florida's Medicaid Modernization plans and their implications, which can be viewed at <http://www.wphf.org/pubs/briefs.html>, last visited on February 2, 2007.

⁶ A slide presentation, State of Vermont Global Commitment to Health, Program Summary, October 2005, prepared by Susan Besio, Director of Planning for Vermont Agency for Health Services clearly lays out the parameters of the program and the expectations held for it at its outset. At <http://www.google.com/search?sourceid=navclient&aq=t&ie=UTF-8&rls=SUNA.SUNA:2006-48.SUNA:en&q=Vermont+Global+Commitment>, last visited February 1, 2007.

Political Directions

Although no major elections occurred in the period under consideration, six of the States held gubernatorial elections in November 2006 (AR, FL, MN, PA, TX, and VT), meaning that some energy in 2005 was directed towards the politics of national elections. In Arkansas and Florida, the incumbent governor did not run for re-election and a change in governor was certain. Access to health care and the problem of uninsured persons continued to be a priority political issue in several States, notably New Mexico, Pennsylvania, and Washington. In the State of Washington, Governor Gregoire created a 14-member Washington State Blue Ribbon Commission on Health Care Costs and Access, comprised of legislators and executive branch administrators and co-chaired by the Governor and Senator Pat Tribaudeau, and charged the Commission with reforming the state's overall health care system. The vision adopted by the Commission foresees a health care system in Washington by 2012 "which provides every Washingtonian the ability to obtain needed health care at an affordable price." The Commission began meeting in June 2006 and will issue its final report and recommendations in December 2006.

State Leadership for LTSS

The year was largely marked by continuity in administrative leadership. Where resignations occurred at high levels, typically the successors had been intensively involved in State leadership related to LTSS. In Minnesota, several Division heads changed within Continuing Care when Jim Varpness, the director of the Aging and Adult Services Division, moved to the Chicago HHS Regional Office and the director of the Division of Disability Services, Shirley York, retired; both were succeeded by individuals with experience in the respective Divisions. In Pennsylvania, Governor Rendell appointed the Long Term Living Council, an Inter-Departmental entity and named Michael Nardone of the Department of Public Welfare, to head the Council Staff. In Texas, Jim Horne resigned as Commissioner of the Department of Aging and Disability Services (DADS), and was succeeded by Adelaide Horne, formerly his Deputy. Marc Gold, long-time expert in LTSS, was named Manager for the Promoting Independence Initiative, reporting directly to Commissioner Horne. In Washington, Penny Black, Director of Home and Community Services in the Aging and Disability Services Administration (ADSA) retired; Bill Moss, formerly the Policy Chief of Home and Community Services in ADSA was appointed to the position.

State Organizational Structures

Few major changes were noted in state organizational structure for LTSS, though States continued to refine the organizational changes set in motion some years before, for example, in Texas and New Mexico. As an exception, Arkansas had made a major consolidation at the end of the previous reporting period by incorporating the previously free-standing Department of Health into the Department of Human Services, creating the State's largest agency, the Arkansas Department of Health and Human Services (HHS) in July 2005 with a budget of over \$4 billion. John Selig, formerly the Director of the Division of Mental Health Services within the Department of Human Services, and before that the manager of the Health Department's home health and personal care programs, was appointed to head HHS, and the department of health became a unit within the expanded umbrella agency. These changes have no practical effect on the level of visibility and authority of the Aging and Adult Services and Developmental Disability Divisions that have major responsibilities for LTSS.

Litigation

Legal activities related to LTSS and rebalancing largely entailed continuation of matters initiated many years before rather than new legal challenges. Appendix A summarizes this litigation activity. Most of the legal action was directed at establishing firmer authority for and rights to community care. One exception was activity undertaken in Florida by family-member plaintiffs that directed slowing down the closure of regional centers for Developmental Services Institutions.

Service System

Relatively few new waiver programs or State Medicaid Plan programs for LTSS were initiated in the year but several states expanded current programs. Most notably, Vermont's 1115 Waiver for the Community Choices program and New Mexico's MiVia HCBS waiver for consumer-directed care began enrollments; both are discussed below. In accordance with a legislative mandate, Texas expanded Money Follows the Person activity to persons with MR/DD under a pilot authority. Texas is working on expanding its Star+Plus managed care program to 3 other areas in the State, but receipt of federal waivers were delayed.

Developmental Activity

Real Choice System Change Grants. The 8 States all historically used federal and foundation grant funds to further the development of their HCBS systems, including CMS Real Choice System Change (RCSC) Grants. Table 2 shows new RCSC grants awarded in the 2005. Notably Arkansas and New Mexico both received large 3-year grants under the Systems Transformation Initiative, underwriting strategic planning for LTSS in those States. Texas, Vermont, and Washington received grants to create Aging and Disability Resource Centers (ADRC); the other 5 States in the project had already received ADRC grants.

Cash and Counseling. By 2005, all but one of the 8 States (Texas) had received developmental grants to develop Cash and Counseling programs. See Table 3 for a summary of each State's activities under Cash and Counseling. In the view of the National Cash and Counseling program, Minnesota and New Mexico "created ambitious plans using innovative practices to expand significantly beyond the basic Cash & Counseling model." They were each awarded additional \$100,000 grants to effectuate those plans and have implanted training programs and other supportive elements. Because the Washington New Freedom and Vermont Flexible Choices are being superimposed into States that already have implemented programs with substantial consumer direction and independent provider models of care, including paid family caregivers, the programs are exploring the added benefits of moving to a cash allowance option in already flexible programs.

The Arkansas 1115 grant for IndependentChoices was due to expire in October 2006. Accordingly, the State entered into negotiations with CMS and the Office of Management and Budget to renew the 1115 authority and add some additional services beyond personal care that could be cashed out. During 2006, the State needed to replace the large state-wide counseling contractor, and took that opportunity to recruit additional State personnel and bring the counseling function "in-house." During this slow process, growth in IndependentChoices was artificially low and a waiting list of about 500 developed. The intent was to serve those on the

waiting list and conduct social marketing for the program once the waiver was renewed and the state-employed counselors were in place.

Table 2. Real Choice System Change New Grants in 2005

State	Type of grant/ Amount	Purpose
AR	System Transformation \$2,856,575	Achieve the following outcomes or products: <ul style="list-style-type: none"> Streamlined application process for HCBS Individuals wanting HCBS receive them through a triage process Measurable quality improvements Easier participant access via IT Improved outcomes and reduced use of institutional care via case management for dual eligibles
NM	System Transformation \$2,736,384	<ul style="list-style-type: none"> Improved access to long-term support services: development of one-stop system Comprehensive quality management system Transformation of information technology to support systems change
TX	Aging & Disability Resource Center \$332,400 Family to Family \$165,000	<ul style="list-style-type: none"> Establish up to three ADRC pilot sites ADRC pilots will streamline and improve all access processes Target populations <ul style="list-style-type: none"> Year I – Persons age 60+ Years II & III – Persons age 60+ and persons with disability <p>Texas Parent to Parent, a non-profit, will</p> <ul style="list-style-type: none"> Help children with disabilities remain in home or community setting Assist with long-term plans and supports when children leave home
VT	Aging & Disability Resource Center \$332,400	<ul style="list-style-type: none"> Improve statewide I&R/A system for older adults Assess options for expanding I/R&A to younger adults Target populations <ul style="list-style-type: none"> Year I – Persons 60+ Year II – Persons 60+, adults with physical disabilities and TBI Year III – Persons 60+, adults with physical disabilities, TBI and DD
WA	Aging & Disability Resource Center \$332,400	<ul style="list-style-type: none"> Expand state’s I&R/A system Target populations <ul style="list-style-type: none"> Year I – Persons 60+, adults with functional disabilities Years II & III – Persons 60+, adults with functional disabilities, people with DD

Developments in Specific States, August 2005 to August 2006

Arkansas

The year under consideration in Arkansas was one of intensive planning. In September 2005, the State of Arkansas was awarded a \$2,850, 000 Systems Transformation Grant; the related goals of the grant were: 1) to streamline the application process for HCBS waiver services, reducing the time from eligibility determination to actually receiving services from an average of 45 days to an average of 5 days; 2) introducing a triage process in applications for HCBS services; 3) improving quality and developing an information capacity to demonstrate those improvements; 4) improving participant access through integrated information technology; and 5) improving health outcomes and reducing institutional use through a primary care case management system for dually eligible individuals with chronic illnesses.

Table 3: Cash and Counseling Programs in the 8 States

State	Program	Comments
AR	IndependentChoices: 3,597 participants to date	Program began under demonstration for persons age 18 and over who choose a cash allowance instead of Agency-managed Person Care Option Services. The program continues under the 1115 waiver. Lead agency: Aging and Adult Services Division.
FL	Cash & Counseling Waiver: 1095 participants to date	Program began under demonstration. It identified clientele in separate waivers (Aging and Disabled, Developmental Disability, and TBI), who were moved to the 1115 Cash & Counseling 1115 waiver. The program continues under the 1115 waiver. Lead agency: Department of Elder Affairs.
MN	Consumer Directed Community Supports: Goal 743 by 9/2007	State-wide program to create a cash allowance capacity for consumer directed community supports for participants in all 5 HCBS waivers. The CDCS operates under existing 1915 © authority as an option within each waiver with the Minnesota Department of Human Services as the lead agency.
NM	MiVia: Enrollment target, 400 by 10/2007	Targets enrollees in existing HCBS waivers for elderly, disabled, developmental disability, HIV/AIDS, and medically fragile, using a new 1915 © waiver for the consumer-direct services program. In March 2006 New Mexico issues a request for proposals for a contractor to oversee the counseling function. In 2005 the Legislature appropriates \$2 million to allow persons with brain injury to participate in MiVia. The Aging and Long-Term Service Department is lead agency with agreements with the Department of Health and the Department of Social Services.
PA	PA Cash & Counseling Program: Enrollment target, 400 by 10/2007	21 counties 13 AAA planning and service areas are piloting cash and counseling. The cash allowances will be an option under two 1915(c) waiver programs: the Pennsylvania Department of Aging (PDA) waiver and the Attendant Care waiver. The Governor's Office of Health Care reform is the lead agency.
VT	Flexible Choices: Enrollment target: 150 by 10/2007	Will serve seniors and persons with disabilities as an option under Vermont's broad 1115 Choices for Care Waiver. The Department of Aging, Disabilities, and Independent Living (DAIL) is lead agency.
WA	New Freedom: Enrollment target: 100 by 9/2007	Targeted for aged persons and persons with physical disabilities in King County, which includes Seattle. The authority will be the existing 1915(c) waivers, under which New Freedom is an option. Aging and Disability Services in the Department of Health and Social Services is the lead agency

Source: The Cash and Counseling Website contains state-specific information about developments in the expansion of cash allowance programs at <http://www.cashandcounseling.org/about>, last visited on February 1, 2007. Texas did not do a Cash and Counseling replication.

Many of the elements in Arkansas' system transformation plans were under consideration prior to the grant award, but the grant created a strong catalyst to proceed. The vehicles for achieving the Systems Transformation goals included: development of a one-stop service system for access to all HCBS services (whether under public or private auspices); building a comprehensive, automated quality management system based on the CMS quality framework and using Medicaid data to generate routine and special reports; moving from paper-based assessments and plans of care to web-based technology; and developing a state-wide primary care case management system based on the SOURCE program developed in the State of Georgia. To streamline processes in Arkansas, the goal was to combine 3 of the HCBS waivers into a single waiver program; the developmental disability waiver would remain outside this planned consolidation. The plan was to combine Elder/Choice, Alternatives for Adults with Physical Disabilities, and the Living Choices/Assisted Living Waivers into a "super waiver."

Arkansas is creating a virtual one stop or single entry system, where consumers can enter the system and complete the transaction without getting bounced around. It will be a call center where consumers talk to experts in the programs; call center staff would have the authority to authorize immediate services under a presumptive eligibility model being developed. The call center will include MR/D and Behavioral Health.

Although the Leadership Institute for Aging & Disability was discontinued after the funding ended, the State has proceeded with strategic planning involving stakeholders. For example, in January of 2006, the System Transformation Steering Committee held a 2-day meeting to discuss goals under the grant, and publicized long lists of issues raised by consumer and provider stakeholders. During the last year, the State of Arkansas has worked to “brand” its HCBS programs for greater public visibility, all under the umbrella of the word “Choice.” The Governor’s Integrated Services Taskforce (GIST), which was established to develop an Olmstead Plan, remains viable and now has adopted a 3-committee structure for aging and physical disabilities, MR/DD, and mental illnesses.

In 2003 partly with funding from the US Secretary of HHS, Office of the Assistant Secretary Assistant for Planning and Evaluation, Arkansas began a planning process to determine whether it could provide cash allowances to participants who left nursing homes, and in 2005 studies were undertaken to develop a system to determine the amount of the cash allowances. Called Next Choice, this initiative has been folded into Arkansas’ plans for Money Follows the Person.⁷ As of the summer of 2006, Arkansas was planning to create a 1915(a)(c) waiver: the “a” part gives the State the authority to create a Prepaid Ambulatory Health Plan (PAHP) which can receive a prospective per member per month fee and operate very much like a cash and counseling waiver. Plans for ARSource are still underway and also incorporated into the overall plan. Arkansas is still intent on developing a capacity for adult foster care, and an expanded assisted living capacity. Finally, the website, AR-GET-Care, that was highlighted in the earlier report, has been somewhat expanded and includes more information on MR/DD and behavioral health as a precursor to the one-stop virtual center being planned.

Florida

In Florida, the expansion of HCBS services for people with MR/DD continued into the year following the baseline study. Considerable inroads were made into the waiting lists for waived services and many new participants were added to the waivers. According to the Agency for Persons with Disabilities (APD) some of the expansion was made possible by savings created by Prior Service Authorizations Plans for select services such as residential habilitation and high cost plans. During this period the APD continued to emphasize training and employment initiatives and partnerships with businesses to create such opportunities.

In the aging area, much of the energy on long-term care in Florida was directed at implementing Florida Senior Care (FSC), a demonstration project proposed for two geographic regions of the state pursuant to a mandate by the 2005 Florida Legislature to create an

⁷ In January 2007, after the period covered in this Report, CMS announced that Arkansas is one of 17 States to have been awarded Money Follows the Person Demonstration grants, which will provide the State with a greatly enhanced federal match for the first year of service after individuals are transitioned from institutions.

“integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 60 and older.” In turn, considerable reflection has taken place during this year on the roles of the aging network in relation to long-term supports and services if those agencies no longer perform the bulk of long-term care management.

FSC was envisaged as similar to a handful of programs (including Texas STAR Plus and Minnesota’s Senior Health Options) that use managed care organizations (MCOs) to provide integrated acute and long-term care services for Medicaid enrollees. In Florida’s planned program, the MCOs are required to assign care coordinators to enrollees to ensure coordination of all services delivered to each enrollee. In addition to responsibility for all acute and LTSS under Medicaid, the MCOs working under FSC were also to provide the services offered under Community Care for the Elderly (CCE), a long-standing state-funded program and other smaller programs. Beneficiary participation will be mandatory in the Panhandle area (Pensacola) and voluntary in the Central Florida area (Orlando). Florida submitted the initial 1915 (c) waiver application on January 25, 2006, and a revised application on June 21, 2006. Following approval from CMS, the Florida Legislature must approve FSC before enrollment begins.⁸ Considerable opposition to the program has emerged from the Florida Aging Network and from AARP Florida, seemingly centered around concern about possible erosion of the public and nonprofit system of HCBS if Senior Care moved forward. In January 2006, a bill was introduced that would have substantially reduced the functions of Area Agencies on Aging and the county based Lead Agencies for the waivers, and after objections, the legislation was withdrawn.

Meanwhile, Florida is studying its current efforts in providing LTSS through managed care. The Nursing Home Diversion program, one of 5 waiver programs serving frail elders in Florida, was expected to expand from 25 counties to an additional 24 counties. The NH Diversion program, administered by the DOEA, differs from the other HCBS waivers in that it covers both medical and LTC services under Medicaid and that the services are provided by MCOs, which receive a capitated rate for all covered service. In FY 2005-06 the program served nearly 7,400 persons age 65 and older, or about 28% of persons served by Florida’s 5 HCBS waivers for elders, at a total cost of \$130 million, for an average per client cost of \$17,658. Ongoing attention has been given to reconciling discrepancies between two studies of the Diversion program and also looking forward to more recent comparisons of the Diversion program and the major HCBS waiver programs operating through the aging network.⁹ ¹⁰

The Department of Elder Affairs contracts with 11, largely multi-county, area agencies on aging (AAAs) to plan, fund, and coordinate programs for older adults in their service areas under

⁸ CMS approved the waiver on September 13, 2006.

⁹ A study based on a cohort of 2000 enrollees performed by University of South Florida suggested that Diversion providers received too generous a capitation rate, and it was scaled back in 2004. See Mitchell, II, G, Salmon, J R, Polivka, L, & Soberon-Ferrer, H (2006). The relative benefits and costs of home-and-community-based services in Florida. *The Gerontologist*, 46 (4), 483-494.

¹⁰ OPPAGA. The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry. Report No. 06-45. May 2006 <http://www.oppaga.state.fl.us/reports/pdf/0645rpt.pdf> The study stated that frail elders participating in the program were more likely to delay entry into a nursing home than, had shorter lengths of stays, and were more likely to return to their homes

the Older Americans Act; the AAAs also administer several of the Medicaid waiver and State-funded programs in conjunctions with lead agencies in each county. In 2004, the legislature directed DOEA to help the AAAs transition from the above-described roles to becoming Aging Resource Centers (ARCs) that will take on additional responsibilities while maintaining their identity as the local AAS. The new Aging Resource Centers were to perform 7 primary functions: increase access to services; provide more centralized and uniform information and referral; increase screening of elders for services; improve triaging and prioritizing of elders for services; streamline eligibility determination; provide better fiscal control and management of programs; and increase quality assurance. Florida's 3 existing pilot Aging and Disability Resource Centers (ADRCs), funded under a RCSC grant have been making progress toward including the 7 new functions envisaged for the ARCs. However, in November 2005, the DOEA proposed repealing the Aging Resource Center initiative and halted all activities for establishing such centers. Among the reasons cited by DOEA is the concern that the Aging Resource Initiative could conflict with the proposed Medicaid managed care reform establishing Florida Senior Care.¹¹

Minnesota

Minnesota has continued to work on its universal assessment (UA) and data collection tools for persons with disabilities served through 4 of its 5 HCBS Medicaid waivers, comprising all the waivers that serve participants under age 65. The UA effort has a steering committee consisting of state, county, consumer, and provider representatives that meets on a quarterly basis; the work itself is being conducted by Steve Lutzky of HCBS Strategies, Inc. Following the input of stakeholders, concerted efforts have been made to create a culturally sensitive tool and one that responds to issues affecting children and persons with mental illness.¹²

The baseline case study on Minnesota reported that, beginning in October 2005, all Minnesota seniors receiving LTSS under Medicaid or Medicaid waivers would receive those services through managed care organizations. The Minnesota Senior Health Options (MSHO) program was initiated in 1997 as a demonstration of a capitated integrated program for dually eligible seniors and a voluntary alternative to mandatory enrollment in a Medicaid Managed Care program for Seniors. By 2005, MSHO expanded state-wide. MSHO plans transitioned to Medicare Advantage Special Needs Plans (SNPs) by November 2006, and all 9 MCOs in the State now have MSHO SNP status. All Minnesota Medicaid plans were eligible for passive enrollment of Medicaid participants into their MSHO SNPs, which provide Medicare Part A, B, and C services and all Medicaid services, including long-term care under State contracts with each MSHO SNP. MSHO now has about 35,000 enrollees. Minnesota's Elderly Waiver (EW), operating under an 1115 (b) (c) waiver) are included in the capitation negotiated with MSHO plans and services are provided on a fee-for-service basis. Administration and enrollment is through county social services and public health agencies; the counties do financial eligibility assessment. The Long-Term Care Consultation assessment and screening tools must be used,

¹¹ OPPAGA. Aging and Disability Pilot Sites are Making Progress; Future of other Centers Uncertain. Report No. 06-20. March 2006. <http://www.oppaga.state.fl.us/reports/health/r06-20s.html>

¹² A slide presentation delivered at the NCBS waiver conference in Minneapolis on October 4, 2006 describes the history of managed long-term care in Minnesota and the current transition to the SNP MSHO plans. See <http://www.nasua.org/waiverconference/hcbs2006/17%20Bailey.ppt>, last visited on February 8, 2007.

and many MSHO plans, especially in rural areas, have contracted with the counties to continue the LTC Consultation screening process. Health plans can negotiate provider rates or use those established by the counties; they are expected to provide all the services, including the consumer directed support services offered under EW fee-for-service and they are expected to provide transition services to those in hospitals or in nursing homes for post-acute care.¹³

Minnesota's policies to resize its nursing home industry include financial incentives for nursing homes to reduce the number of their beds or to close altogether. If present trends continue (aided by the state's voluntary planned closure, layaway, and single bed incentive programs), the state will lose 14,000 additional NH beds in the next 15 years, leaving fewer than half the beds the state had at its peak in 1987 of 48,307 beds. A 2005 report from the Department of Human Services to the legislature suggested that the state may wish to slow the loss of additional beds, at least in some counties to avoid a shortage of beds (in the 2-year period ending in 2005, bed supply declined by 2,348 beds, or 6%) and that, indeed, the state "may also be approaching a time where the addition of limited numbers of new beds" in some regions of the state "needs to be considered."¹⁴

Planning efforts have historically been intrinsic to Minnesota's management strategies, and continued during the year under consideration, with an emphasis both on rebalancing and on creating more opportunities for private payment for LTSS. Conspicuously on the Website of the Minnesota Department of Human Services, the goal is enunciated as follows: "Older Minnesotans will receive the long-term care services they need in their homes and communities, will be able to choose how they receive services, and will have more options for using their personal resources to pay for long-term care."¹⁵ Thus the twin goals of community care and increase of private money are joined in a single statement: achievement of the goals is to be measured by proportion of nursing home days paid by funding source, proportion of elders served in institutional versus community care and proportion of public long-term care funds expended in institutional versus community settings. During the year under consideration, Minnesota determined to develop a Public-Private Partnership for Long-Term Care Insurance as permitted by the Deficit Reduction Act of 2006, and prepared an amendment to the Medicaid State Plan to establish the program. (The Amendment was approved by CMS in November 2006 and the program will be marketed in early 2007.)¹⁶

An Office of System Transformation was created to spearhead multiple planning efforts. A process called Transform 2010, a partnership between the Department of Human Services and

¹³ A slide presentation delivered at the NCBS waiver conference in Minneapolis on October 4, 2006 describes the history of managed long-term care in Minnesota and the current transition to the SNP MSHO plans. See <http://www.nasua.org/waiverconference/hcbs2006/17%20Bailey.ppt>, last visited on February 8, 2007.

¹⁴ Minnesota Department of Human Services. 2006. *Status of Long-Term Care in Minnesota 2005: A Report to the Minnesota Legislature*. Minnesota Department of Human Services, Aging Initiative.

¹⁵ See Department of Human Services Website at <http://www.departmentresults.state.mn.us/hs/index.html>, last visited February 7, 2007.

¹⁶ The Partnership Program is described on the Web at: http://www.dhs.state.mn.us/main/ideplg?IdeService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_137036, last visited February 17, 2007.

the Minnesota Board on Aging, the Department of Health and other state agencies, was initiated to identify the impacts of the aging of Minnesota's population on the state, and developing a plan with both short- and long-term goals to transform the state's infrastructures and services, so that Minnesota can support a permanent change in the age of the state's population. Throughout the year a series of hearings and mini-conferences were held, including 11 regional meetings and 4 meetings with tribal groups and members of ethnic and minority communities held between January and March 2006. Transform 2010 also repeated parts of the county-by-county GAPS analysis done some years earlier to identify needs and issues at the local level. The analysis concluded that for the most part services were readily available though specific gaps were identified in various counties.

Finally, in 2006, Minnesota introduced a Home and Community Based Waiver Review Process, which entailed detailed reviews of lead agencies for HCBS in each of Minnesota's counties on staggered basis to be completed over a 3 year period. A contractor, the Improve Group, has been conducting on-site evaluations designed both to review the extent to which the programs meet the standards of the CMS framework for quality and to identify barriers to community services. In 2- to 4-day site visits, a combination of record review, interviews, and focus groups have been undertaken to gather this information.¹⁷

New Mexico

The 2004 legislation that created the Aging and Long-Term Services Department (ALTSD) included a mandate that the Secretary of ALTSD provide the legislature with "a comprehensive plan to provide long-term services (LTS) and related services for all populations" by November 2006. In the summer of 2005, ALTSD assumed responsibility for Adult Protective Services. New Mexico received a \$2,736,384 Systems Transformation Grant for CMS in September 2005, which facilitated strategic planning. The focus of the grant was to develop new models of service delivery such as self-directed care, to create a quality management program for all home and community based services, and to design and implement new information technology platforms and systems to link all sources of information needed by consumers and providers to ensure the quality of individual plans of care. As mandated by the grant, the state submitted its strategic plan to CMS on June 20, 2006.

In June 2006, New Mexico submitted its waiver application for MiVia (My Way), a Self-Directed 1915(c) waiver, which is open to enrollees in all the State's existing waivers. Enrollment began in November 2006. With a monthly budget based on an individual's specific needs, participants can hire personal assistance workers and pay for home modifications and other expenditures. Consultants will work with consumers to develop and revise individual budgets. The Self-Directed Waiver Subcommittee (comprised of consumers and their families, advocates and state staff) helped develop the waiver application and will provide feedback to guide the program's implementation.

¹⁷ Reports by county for the waiver review project are posted on the Department of Human Services website at: http://www.dhs.state.mn.us/main/ideplg?IdeService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136600, last visited on February 17, 2007.

The state plan Personal Care Option (PCO) program continues to be a major plank in New Mexico LTSS, and continues to include a consumer directed and an agency option. The Behavioral Health Collaborative completed its first year of activity and received unusually high ratings of consumer satisfaction in a study reported in July 2006.¹⁸

In the 2006 legislative session, New Mexico passed the Money Follows the Person in NM Act (HB353) requiring the ALSTD to obtain federal funds and approval for a money follows the person program. The bill mirrors the federal Money Follows the Person initiative that would allow “elderly or disabled individuals” who are institutionalized a choice to live in the community and have the money expended on their institutional care follow them to provide for community based care. The bill also requires the ALSTD to develop and implement a quality improvement system to evaluate participation in the program and ensure the quality of services and support provided.

In June 2004, the Department of Human Services, Medical Assistance Division (the Medicaid agency) issued an RFP seeking contractors to design and implement a managed long-term care program in New Mexico. The state aims to have this program, called the Coordinated Long Term Care (CLTC) in place in 2007. As of July 31, 2006, the state was negotiating with two potential contractors but had not yet filed the waiver requests with CMS to implement the program. The CLTC is tentatively described as a “fully integrated system of care” that would provide eligible individuals “a comprehensive package of benefits across the continuum of care, including acute, long term and home and community-based services.” Advocacy organizations in New Mexico have voiced concerns about the CLTC initiative and criticized the Medical Assistance Division for advancing the program with little input from consumers, families, and advocates. In response, the state has initiated a series of community meetings soliciting feedback on the proposed framework for the CLTC system. These meetings have resulted in further delay, leaving uncertain the program’s parameters and timeline.

Pennsylvania

The planning begun under the Governor’s Office for Health Care Reform culminated in a high-level retreat in the fall of 2005 and the creation, in November 2005 of the Long Term Living Council (LTLC), a subset of the Governor’s “Health Care Reform Cabinet.” The Council was to realign the management structure for LTC programs and improve coordination, communication, and consolidation in the formulation of LTC policy. The 6 senior state officials comprising the Cabinet-level Council are the secretaries of the departments of Aging, DPW, Budget, and Policy; the Director of the Office of Health Care Reform; and the Governor’s Deputy Chief of Staff. The LTLC’s Executive Director, Mike Nardonne, had overall management responsibility for coordinating long-term living policy and operations. The creation of the LTLC addresses Pennsylvania’s historically fragmented administration of LTC programs. The Commonwealth anticipates that placing waiver programs and the nursing home programs in

¹⁸ For a press release with a further link to the actual study, see <http://bhc.state.nm.us/pdf/BHCSatisfactionNR.pdf>, last visited February 7, 2007.

the same office should facilitate re-balancing Medicaid dollars from institutions to the community.¹⁹

The expressed goals of the LTL Council (and progress as of July 2006) were to:

- Enhance and expand efforts to assist nursing home residents who wish to leave a facility-based care setting and can safely return to their home or community. Ensure that the supply of nursing home beds appropriately meets the need for such care, while providing opportunities for facilities to expand their continuum of care.
- Ensure consistency in the application of eligibility criteria for long-term living services, while removing barriers to receiving home and community-based waiver services; and
- Maximize available waiver resources to serve as many consumers as possible, while ensuring provision of high-quality care and services

Progress towards these goals includes 600 reported transitions in the year under study. A pilot NH transition project that targeted lower acuity NH residents in 6 counties was launched in FY 2005/2006 and helped effectuate these results. To deal with consistency in the application of eligibility criteria, a new streamlined Level of Care Assessment tool was introduced in July 2006, and the State began an audit function to better inform itself about its case-management program and the program's quality. On a demonstration basis an Enhanced Community Transitions program has been established through which every two weeks Area Agencies on Aging receive the name or all those admitted to nursing homes in their Planning and Service Area, classified as to expected discharge date (if known), and transition activities are expected to follow.

As reported in the baseline study of Pennsylvania, the Commonwealth had introduced a fast-track-to-service capability in 10 counties with the hope to expand that program state-wide. During the year under consideration, the fast-track program expanded to Allegheny County; although the expansion is to one county only, incorporating the city of Pittsburgh and its suburbs was an important addition that includes a large additional population and reaches an area that is particularly dominated by nursing home care for seniors. In July, 7 2006 Governor Rendell signed PACE+Medicare into law, which enabled enrollees to keep PACE coverage while receiving Part D medications.

An expansion of HCBS waiver services for Developmental Disability was in the planning Stage to be launched in 2007. Also planned is legislation to clarify the status of Assisted Living and personal care homes in Pennsylvania and end the prohibition against people needing the nursing-home level of care to live in these settings (which has precluded funding LTSS services for those residents under Medicaid waivers, which require nursing home level of care).

¹⁹ In January 2007, Governor Rendell announced the appointment of Michael Hall as Executive Director of the Long Term Living Council and implementer of the next steps in the Commonwealth's directions towards HCBS services. Mr. Hall has had substantial leadership in developing HCBS services in both Maine and Vermont. Mr. Nardonne will return to the Department of Department of Public Welfare as Deputy Secretary for Medical Assistance Programs.

Considerable detail about LTSS in Pennsylvania was provided in a report provided by Thomson & Medstat in March 2006. This report was written in part as a model that CMS could use to assist other States in evaluating their own LTC systems. Its findings, which are highly compatible with the baseline case study of Pennsylvania prepared under the Rebalancing Research, compliments the State on its down-sizing of nursing homes and its Community Choice expedited service program in 10 counties. Among the findings emphasized: the lack of any waiver program covering people with developmental disabilities without co-existing mental retardation; systematic barriers in rebalancing services for older people; the continuing lack of alternative community living sites for people with severe nursing-home level disabilities, and the uneven abilities among the Area Agencies on Aging to manage and monitor programs.²⁰

Texas

Texas has continued to expand HCBS services and consumer directed models, and to build on its early Money Follows the Person programs. The 2005 Legislature appropriated funds to assess and serve substantial numbers of additional persons on the Interest Lists for HCBS waivers.

The Texas Money-Follows-the Person program, originally launched and continued under “riders” (Rider 37 and Rider 28) to the State’s budget appropriations process was codified into statute in 2005 (Texas HB 1867). In its statutory form, the Texas’ MFP initiative has now become “a full-fledged program with peripheral supports in place statewide, including relocation contractors, transition assistance funds, and interdisciplinary transition teams.”²¹ It received a separate line item budget appropriation of \$65 million for FY 2006 and \$78.7 million for FY 2007. Texas used its 36-month RCSC/MFP grant (\$730,422 received in 2003) to help implement the more permanent statutory MFP program and create a system to help each region to more efficiently and effectively help clients transition to the community.²² As of June 30, 2006, the Texas MFP initiative has helped 11,300 nursing facility residents transition to the state’s HCBS waivers: of those, 5,661 were still receiving services under the MFP program.²³ Nursing facility residents of all ages, with a wide range of physical and mental disabilities and different levels of need for assistance, have used the program to transition to the community. About one out of three transitioned to assisted living facilities. Younger residents, those in urban counties, and Hispanics were more likely, whereas elderly residents with dementia, non-elderly residents with behavioral problems, and residents requiring the highest level of care were less likely to use Rider 37/28. The most difficult barriers to transitioning to the community included finding suitable housing, accessible transportation, and a personal physician. Monthly per client costs were about 10 percent higher for Rider 37/28 than for the Community-Based Alternative (CBA) waiver, in which all but a handful of Rider participants entered upon leaving a nursing facility.²⁴ Data are not yet available for the operational system. In the 2005 legislature, Rider 46 was passed to allow for a pilot “money follows the child” program for children residing in

²⁰ Thomson Medstat. *Home and Community Based Services Reform and Rebalancing Feasibility Analysis*. Cambridge, MA: Thomson Medstat. March 2006

²¹ Ormond B.A., A.S. Sommers, and K.J. Black. *Examination of Texas Rider 37: A Medicaid “Money Follows the Person” Long-Term Care Initiative*. (Funded under a grant from OASPE). Washington, DC: The Urban Institute. May 30, 2006

²² Anderson, W.L., J. M. Wiener, and J. O’Keeffe. *Money Follows the Person Initiatives of the Systems Change Grantees: Final Report*. RTI International. July 2006. <http://www.hcbs.org/files/96/4769/MFP.pdf>

²³ Anderson, W.L. et al. 2006

²⁴ Ormond, B.A., et al. 2006.

ICF/MRs. Because MFP was available only for those leaving nursing facilities, this expansion gave an important opportunity to expand the initiative to persons with MR/DD.

The stakeholder members of the Promoting Independence Advisory Committee (PIAC), the state's Olmstead committee, continued to function actively and, as required by statute, submit an annual report to the Health and Human Services Commission, commonly referred to as the "Stakeholder Report." Although prepared with the assistance of DADS staff (who also provide staff support to the entire PIAC), a footnote in the report makes clear that the PIAC Stakeholder Report "reflects the views and opinion of a consensus of the non-agency stakeholders" of the PIAC and not necessarily the policy of the HHSC, DADS, or any state agency represented on the PIAC. (In December 2005, the 19-member PIAC included 8 state agency representatives, 8 representatives of advocacy organizations, and 3 provider representatives.) The 2005 Stakeholder Report includes a status report of existing programs and initiatives, the non-agency stakeholders' policy directives for the upcoming year (FY2006), and a set of general policy stances ("resolutions"), of which the majority call for the "promoting independence principles and philosophy" to be incorporated into various programs and policies (including "any discussion of Medicaid reform" – Resolution 2).²⁵

During the year Texas worked on expanding its Houston-based STAR+Plus Program of capitated services into 3 additional multi-county areas (about 28 counties total) in the southeast and south-central regions. Details were worked out for competitive choice of MCOs in each area and the implementation was expected to begin on January 1, 2007. However, the federal waiver for the expansion had not yet been approved as of February 1, 2007, and enrollment activities that had already begun were temporarily suspended.²⁶

Vermont

In late 2005, Vermont received approval for two Section 1115 Medicaid waivers. The "Choices for Care" waiver restructures the state's Medicaid long-term care services and the "Global Commitment" waiver restructures Medicaid's acute care services in the state (discussed above). In combination, the waivers make Vermont the only state facing fixed dollar limits on the amount of federal funding it receives for its Medicaid program.

Choices for Care, implemented in October 2005, allows the state to offer an entitlement to home- and community-based services.²⁷ The program has been implemented without much controversy and has functioned as it was designed. There have been no surprises, according to the Commissioner of DAIL. Choices for Care enrolled all elderly and persons with physical disabilities who were currently receiving Medicaid services in a nursing home or through waivers. Spending is managed under a capped global budget (\$1.236 Billion over 5 years) so as to avoid creating a "runaway" entitlement. The theory behind Choices for Care is that by leveling the playing field between institutional care and HCBS and giving consumers multiple options and the right to choose services in their preferred settings, more consumers will choose HCBS, enabling the state to serve more people with the same amount of funding, since HCBS on

²⁵ The Stakeholder 2005 Report is at http://www.dads.state.tx.us/providers/pi/piac_reports/piac_2005.pdf, last visited on January 30, 2007.

²⁶ Information about the Star+Plus program, its planned expansion areas, the MCO providers in each area, and the implementation delays are found at the programs website at <http://www.hhsc.state.tx.us/starplus/starplus.htm>, last visited on February, 8, 2007.

²⁷ The Choices for Care program established 3 categories of Medicaid beneficiaries: Highest Needs group, High Needs group, and Moderate Needs group. Only the "Highest Needs" group will have an entitlement to HCBS.

average costs less than institutional care. The state's interim goal was for at least 40% of Choices for Care enrollees to reside in home and community based settings and not more than 60% in nursing facilities. As of July 2006, the 40/60 balance existed in 7 of the state's 14 counties. Once the interim goal is achieved statewide, the goal shifts to a 50/50 balance.

At the program's inception (October 2005) 2286 Medicaid enrollees were in nursing facilities and 1161 in other settings (including HCBS and "enhanced Residential Care"). By July 2006, the number in nursing facilities had declined to 2134 and the number in other settings to 1799. Over the same time period, average monthly care costs declined from \$3655 to \$3557 for HCBS for enrollees in the highest and high need categories, but increased from \$1794 to \$1840 for enrollees in the Enhanced Residential Care waiver.

As anticipated, the Choices for Care program has prompted expansion in Vermont's home and community based services, including:

- increased capacity and plans for future expansion among Adult Day Service providers (DAIL approved a new adult day program in Newport in March 2006);
- expansion of assisted living, with 7 new providers in various stages of development;
- a Certificate of Need (the first in many years) granted to a new home health agency (Professional Nurses Services)²⁸

Washington

As already indicated, the Governor established and co-chairs a high-level Task Force aimed at achieving access to health care for all Washingtonians by 2012. A similarly high-level initiative was undertaken related to long-term care. Governor Gregoire requested and the Legislature approved establishment of a joint legislative and executive task force on long-term care financing and chronic care management. The 8-member Long Term Care Task Force will make recommendations related to:

- Composition of a long term care system adequate to meet needs;
- Efficient models that will effectively sustain funding of LTC;
- Laws and regulations that should be revised and/or eliminated to reduce or contain cost;
- Feasibility of private options which will enable individuals to pay for LTC;
- Options that support the needs of rural communities;
- Chronic care management and strategies to prevent disabilities to reduce health care and LTC costs to individuals and the State.

Three advisory committees facilitate direct input from community stakeholders. Final Task Force recommendations to the Governor and Legislature are due June 30, 2007.

Washington continued its emphasis on consumer-directed and independent provider models and its refinement of its CARES assessment and quality information system. The Home Care Quality Authority continued its oversight and support of the independent provider model of care. The State continued its emphasis on refining and improving its system to better serve individuals with behavioral problems.²⁹

²⁸ Wasserman J. *Shaping the Future of Long Term Care and Independent Living*. Vermont Department of Aging & Independent Living. May 2006.

²⁹ Washington is one of the 17 States chosen to participate initially in the national Money Follows the Person Demonstration and to receive an enhanced federal Medicaid match for the first year of the transition. The State expects to use that program to effect transitions among the most difficult-to-relocate participants.

Strong union representation by the Service Employees International Union (SEIU) of individual providers/home care workers in Washington is impacting the LTC system. In the 2005-2007 budgets, the state was required by law to consider the collective bargaining agreement negotiated between home care workers and the Governor's Office. Improved wages and benefits obtained through collective bargaining raised the average per capita cost of an in-home Medicaid client to 33% of the average nursing home resident in November 2005, up from 25% 3 years ago. The state's Aging & Disability Services Administration (ADSA) notes that, "since residential care and home care compete for the same workforce, increases to wages in one area have a significant relationship to the ability of the other to attract workers," potentially undermining ADSA's ability to maintain an appropriate range of home- and community-based services.³⁰

In 2005, the Legislature created a new type of ADSA licensed facility called Enhanced Services Facility. These facilities will serve individuals who are not appropriate for existing licensed facilities and have a mental disorder, chemical dependency disorder, or both; have an organic or traumatic brain disorder or a cognitive impairment requiring supervision and facility services; and have other qualifying behaviors or complex needs.³¹

Update on Quantitative Markers of Rebalancing

For this interim report, we added one more year of data to examine rebalancing milestones. Figure 1 compares the numbers of participants served by selected waiver and institutional programs in each state in 2000 and 2005. The number in nursing homes is greater than those served in elderly and disabled waivers in every state except Washington. By contrast the numbers of MR/DD participants served in waivers consistently outnumber those served in MR/ICFs.

The change in the numbers of participants between 2000 and 2005 is shown in Figure 2. Two states (AR and FL) show a slight decrease in aging and disabled participants and two (TX and WA) show slight increases, whereas the others show substantial growth. The growth in this waiver group exceeds that for MR/DD except for AR, FL, NM and TX. The numbers of participants in nursing homes dropped for five states (AR, MN, NM, VT, and WA).

³⁰ *ADSA Strategic Plan 2007 – 2011*. Aging & Disability Services Administration, Washing State Department of Social and Health Services. July 1, 2006.

³¹ E2SSB 5763. An act relating to the omnibus treatment of mental and substance abuse disorders act of 2005. "Enhanced services facility" means a facility that provides treatment and services to persons for whom acute inpatient treatment is not medically necessary and who have been determined by the department to be inappropriate for placement in other licensed facilities due to the complex needs that result in behavioral and security issues. RCW Section 70-97-010

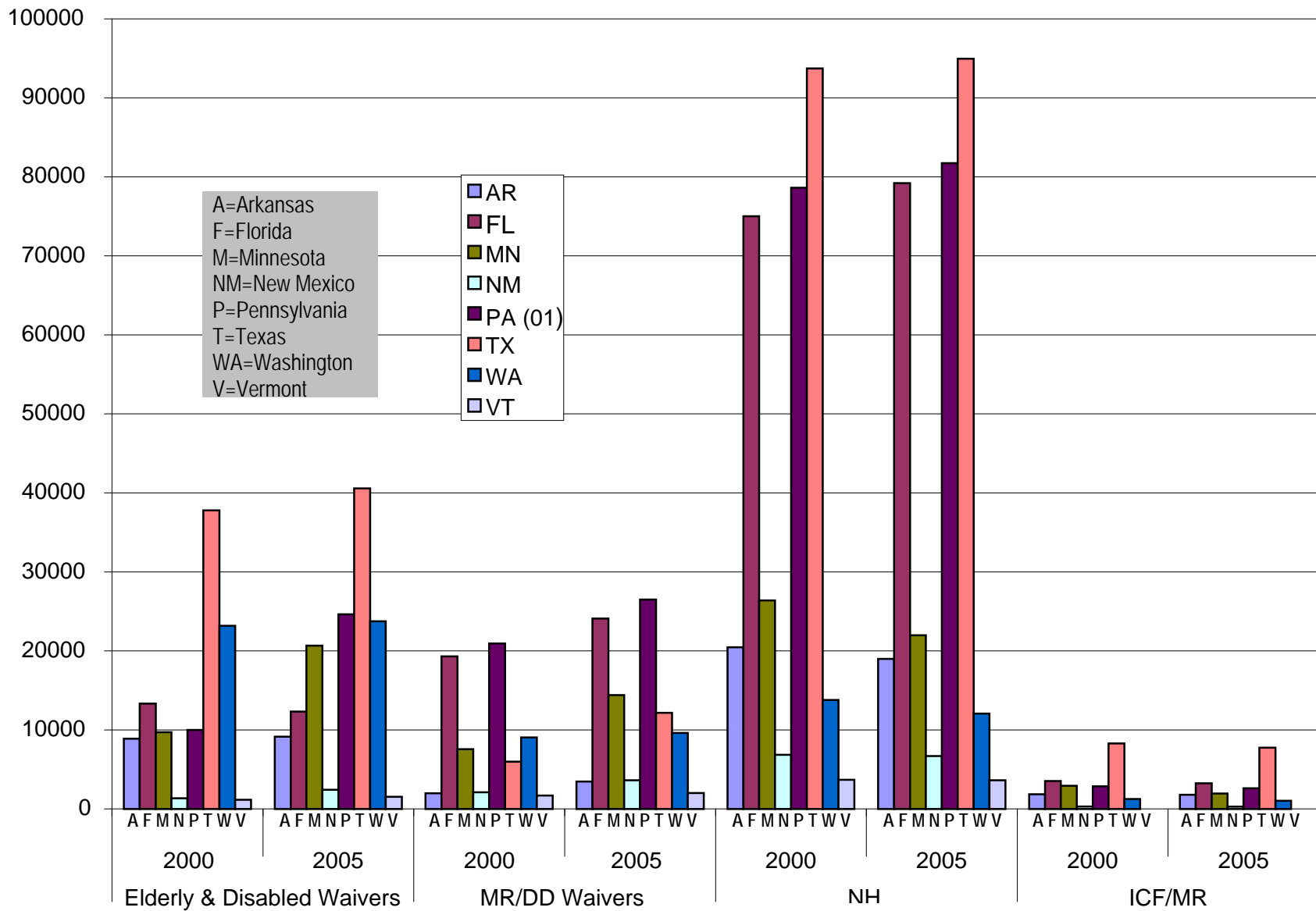


Figure 1: Numbers of LTC Participants Served in Waivers and Institutions, 2000 and 2005

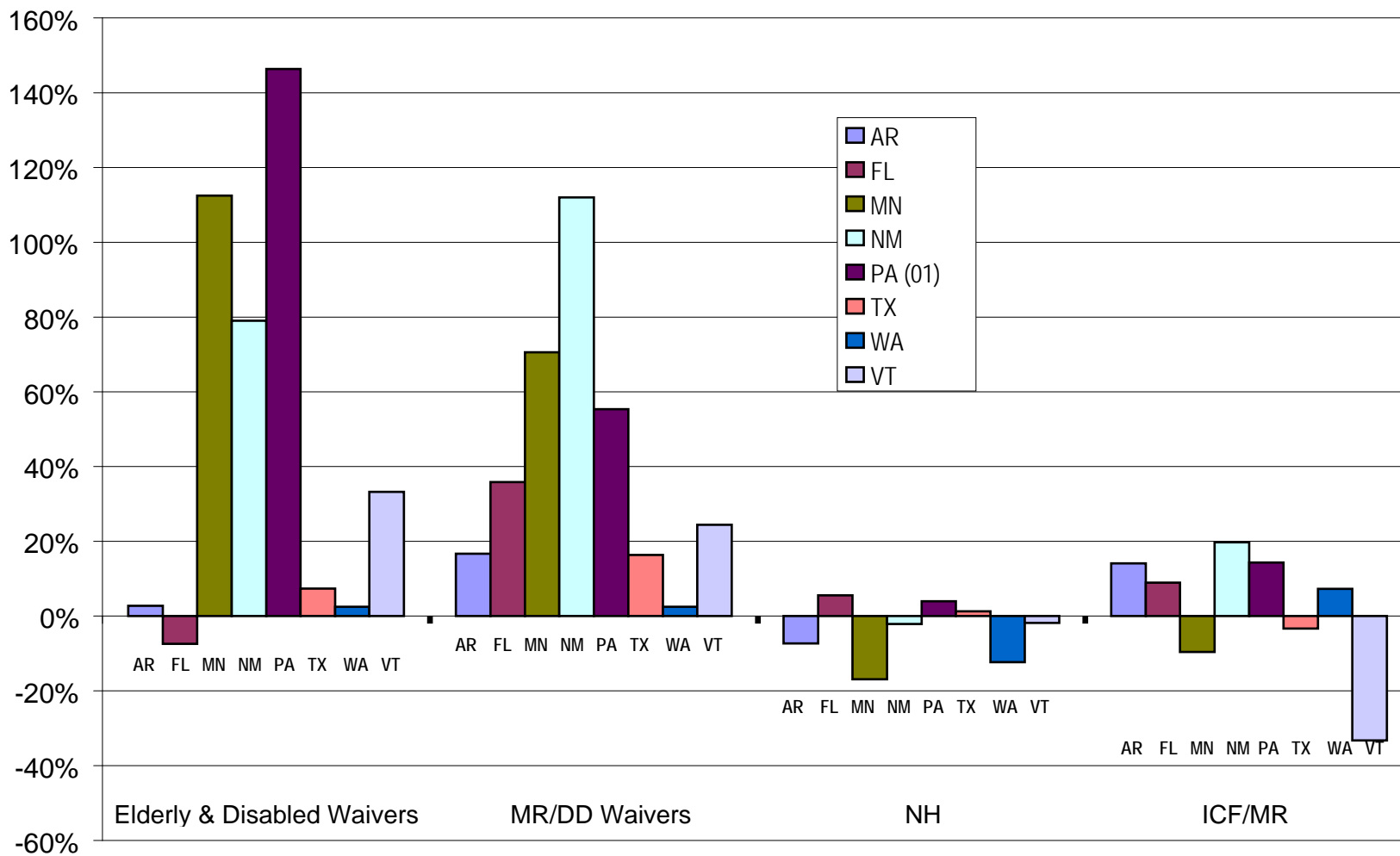


Figure 2: Changes in the Numbers of Participants Served 2000 to 2005

Figure 3 contrasts the expenditures on the same programs described in the previous figures. . Nursing homes receive the most funds, matched only by MR/DD waivers in NM. Elderly and disabled waiver payments exceed MR/DD waivers in Texas and Washington.

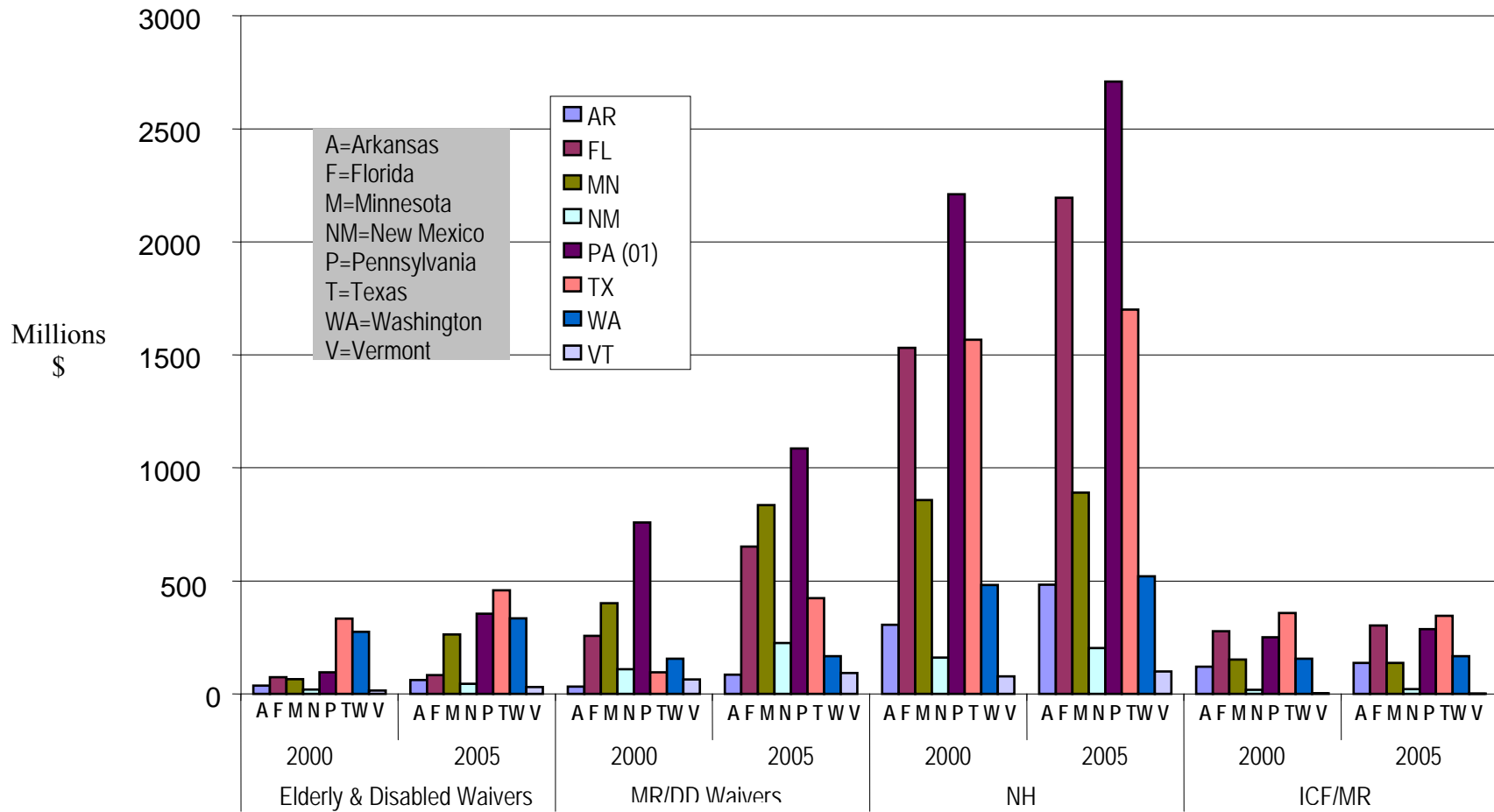


Figure 3: LTC Expenditures in 2000 and 2005

The change in expenditures from 2000 to 2005 is shown in Figure 4. The growth in waivers exceeds that in institutions in almost every instance. The exception is for Florida's expenditures on nursing homes, which grew more in that five years than did expenditures on elderly and disabled waivers; in that interim Florida enacted mandatory nursing staffing ration, and the resulting rate increase for Florida nursing homes was the largest in the nation. The growth in elderly and disabled waivers is greater than that for MR/DD waivers in MN, NM, PA and VT. Expenditures on MR/ICFs decrease in MN, TX and VT.

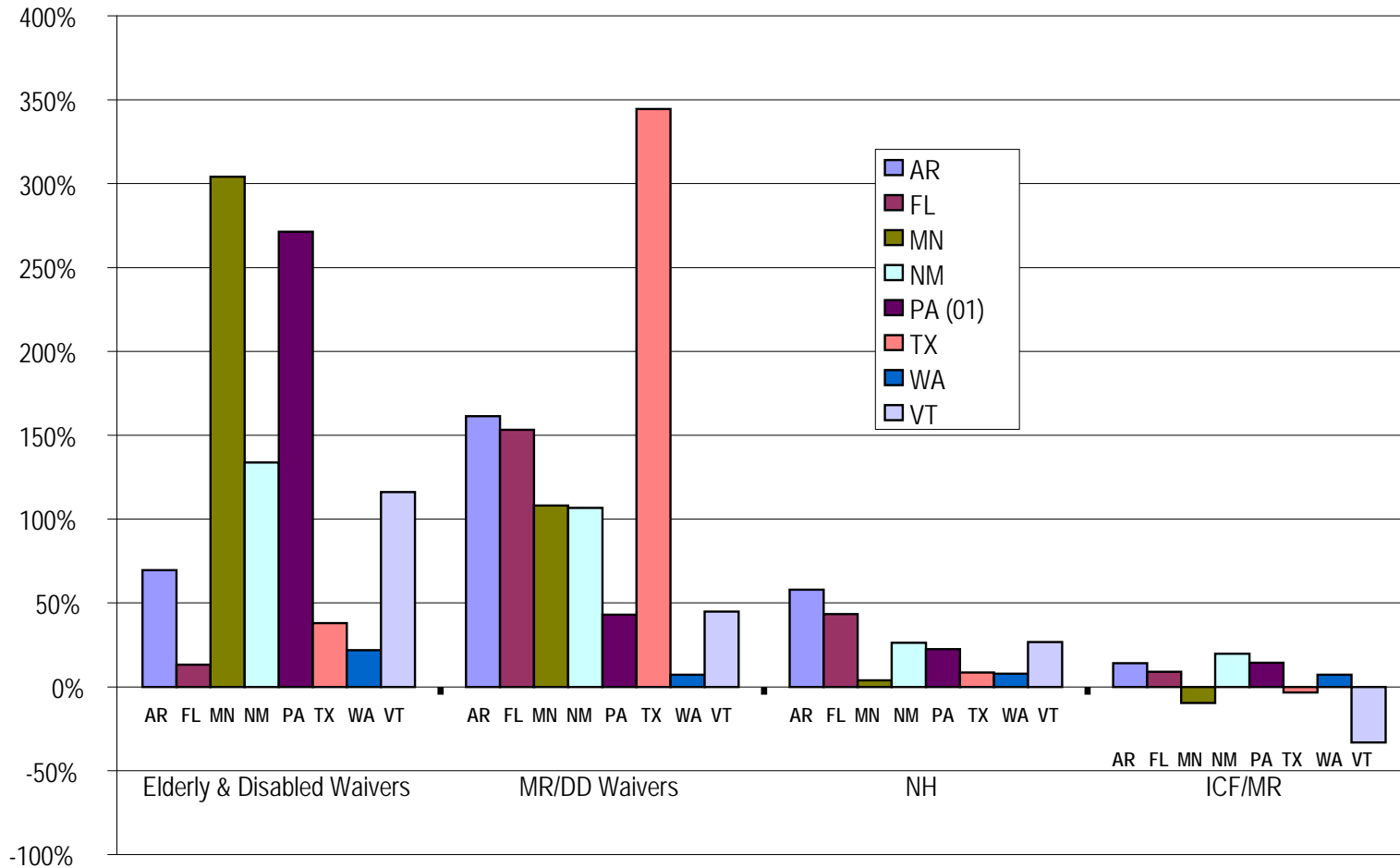


Figure 4: Change in LTC Expenditures from 2000 to 2005

Figure 5 traces the change in nursing home case mix (in terms of both ADLs and cognition scores) on admission and at three months for the same five-year time period covered by the utilization and expenditure data. One might expect that as the investment in HCBS grows, the nursing home case mix, especially at 3 months, would become more acute. Although a number of states (MN, NM, PA, and VT) show substantial growth in HCBS participants and expenditures, there is little change in nursing home acuity.³²

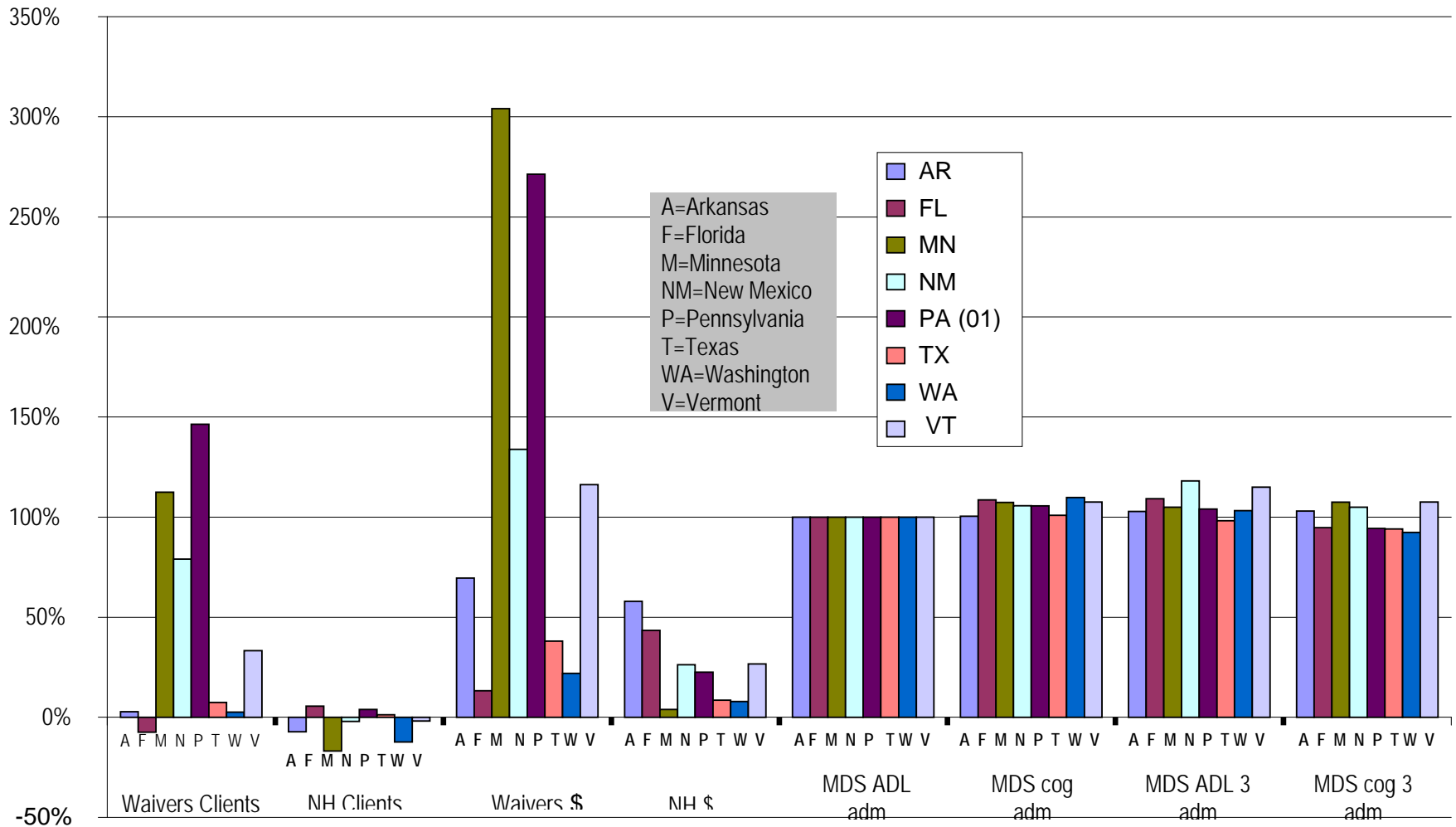


Figure 5: Change in Nursing Home Case Mix and LTC Utilization from 2000 to 2005

³² These data are based on incomplete 2005 MDS data and may be modified when the full data set is run.

Figure 6 contrasts the expenditures per participant served on elderly waivers per se in 2005 for the three States that have separate waivers for elderly and disabled. Two patterns emerge: 1) More is spent on persons with MR/DD than on elderly persons; 2) For each group, more is spent on institutional care than on waivers.

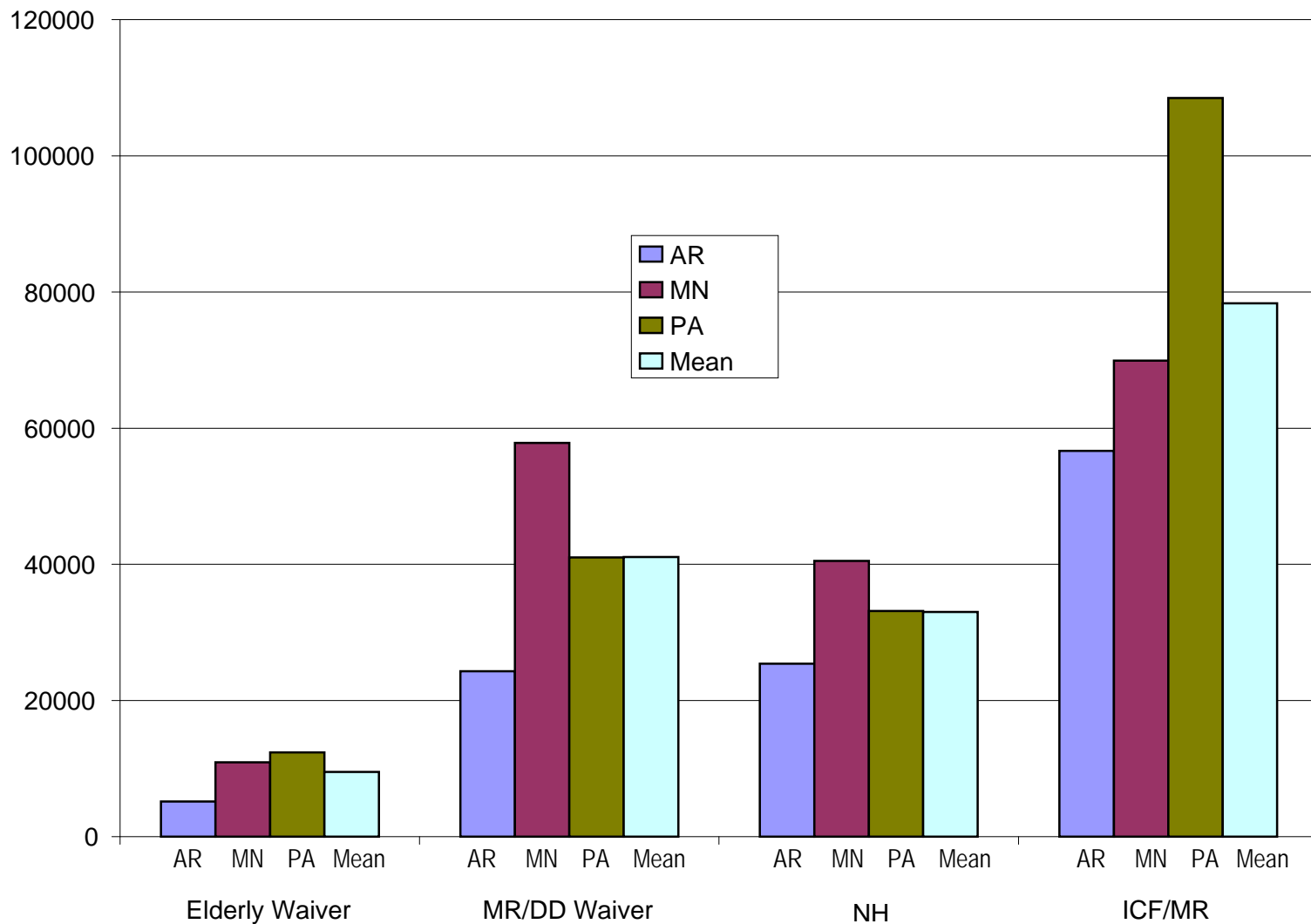


Figure 6: Cost Per Participant Served, 2005

Figure 7 makes some of these differences clearer by converting them to ratios. The first portion compares institutional to waiver expenditures per participant served for the two participant groups: MR/DD and elderly. Both show a strong institutional bias. The mean ratio for MR/DD is just over 2; for the elderly it approaches 4. Looked at the other way, the ratio of expenditure per participant served comparing MR/DD participants to elderly participants is 2.5 for institutions and almost 4.5 for waivers.

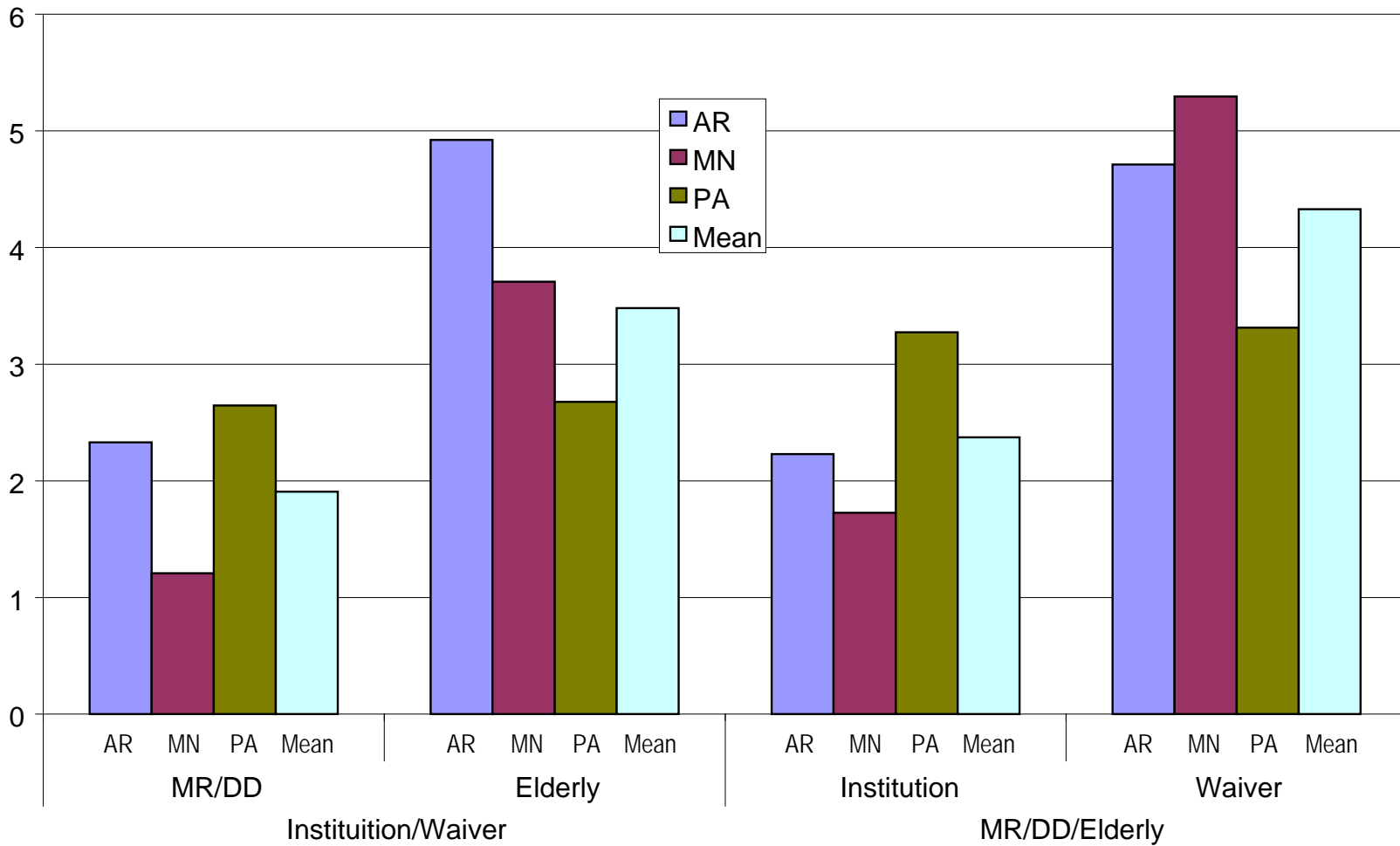


Figure 7: Ratios of Costs per Participant, 2005

The same ratio approach has been taken with expenditures (Figure 8). When the relationship between institutional and waiver expenditures is compared across the two age groups, a striking difference is noted. For elderly participants the relative institutional expenditure is much larger. Conversely, the waiver expenditure for MR/DD participants is much larger although the total institutional expenditure is comparable.

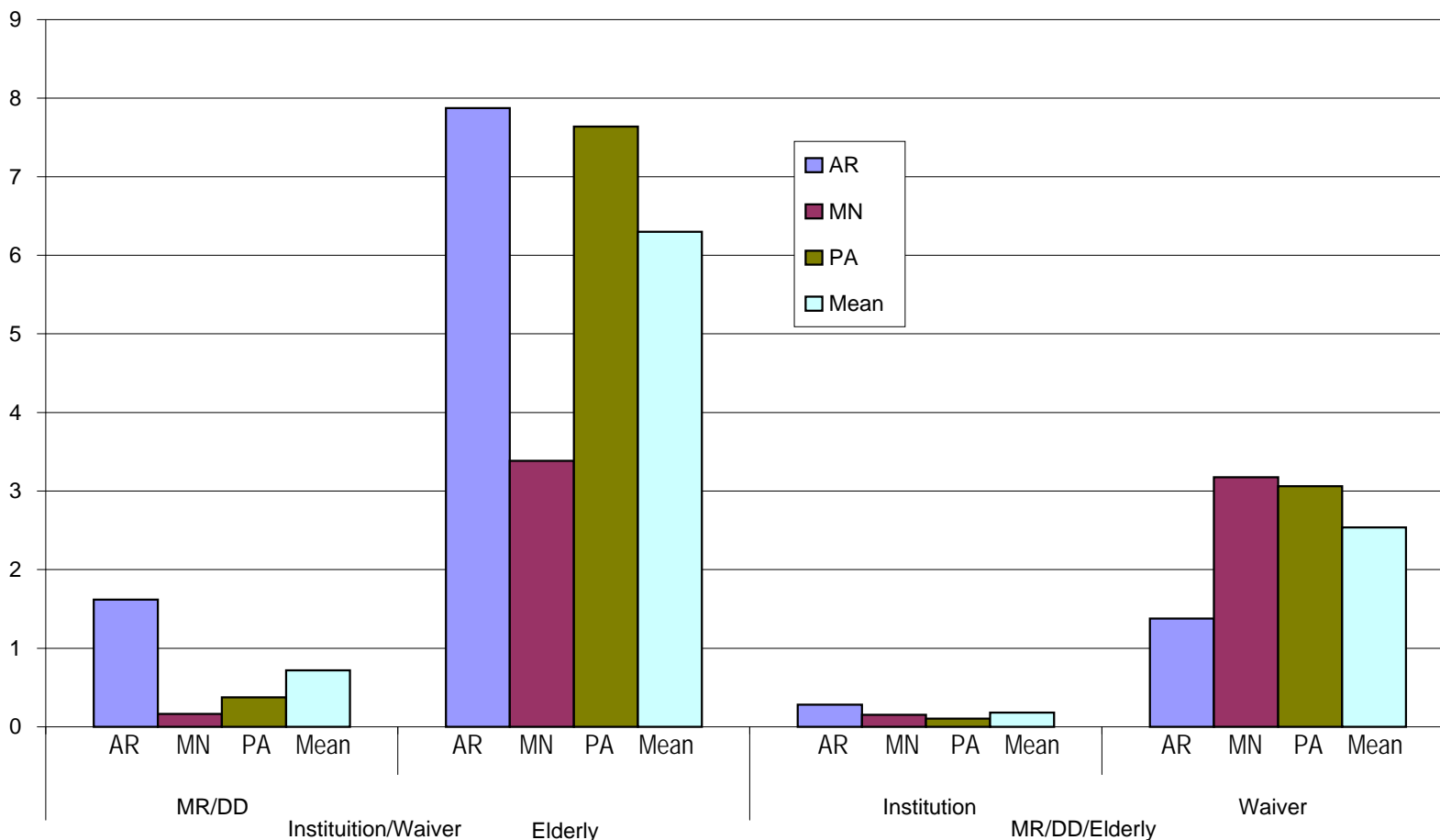


Figure 8: Ratio of Expenditures, 2005

Conclusions and Next Steps

The 8 States have all made progress over the past year, maintaining the directions and the strategies observed in the baseline studies. The patterns of change in utilization and expenditures between HCBS and institutional care vary across states and for target populations within States.

Three of the 8 States (Arkansas, Texas, and Washington) are in the first round of the Money Follows the Person demonstration, and others applied for the demonstration and may be funded later in 2007. Their abilities to make effective use of the enhanced match will be of interest. Minnesota has increased its managed care programs within long-term care for seniors and others; Florida, New Mexico, and Texas plan such changes in the near future. All the States are working on refining information systems and effective ways of accessing LTSS, and all are intent on increasing their ability to monitor quality.

As part of the more detailed third round of case studies to be performed in each of the 8 States in each State, emphasis will be placed on systematically looking at housing, case management, transportation, and quality initiatives that support rebalancing, and at teasing out distinctions and similarities across target groups. We will also examine rate-setting and payment mechanisms, which may themselves account for some of the quantitative results. We also track the following developments:

- Changes in rate-setting and payment mechanisms, which may themselves account for some of the quantitative results observed in this update
- The Medicaid long-term services reforms in the Deficit Reduction Act of 2005 (DRA), including new opportunities under the DRA for states such as the option to provide all HCBS waiver services without needing to get a waiver, the cash and counseling option allowing self-direction of personal assistance services without needing to get a waiver, and funding for Money Follows the Person demonstration projects
- The establishment or expansion in many of the 8 states of Medicaid managed LTC programs and how such programs integrate with and impact their Rebalancing agendas
- Changes in the political environment brought about by the mid-term elections and their impact on the direction, speed, and content of states' long-term care form initiatives
- Ongoing re-alignment of provider stakeholders in HCBS policy and programs, including the addition of new stakeholders such as unions, institutional provider organizations, and/or managed care organizations providing LTSS
- Efforts to address variations in LTSS services and expenditures across populations groups, particularly between the elderly and younger persons with disabilities

Appendix Table A-1. Litigation Update for 2005-2006

State	Summary of Updated Information
AR	<p>► In <i>Porter and Norman v. Knickrehm et al.</i> two residents of an Arkansas state institution for persons with DD challenged the states admission and discharge procedures. A November 2004 ruling required post-admission judicial reviews to prevent institutionalized individuals from being unnecessarily confined when they are determined to benefit from community placement. In July 2005, plaintiffs appealed to the 8th Circuit Court of Appeals on two issues: “whether adults with mental retardation who are "involuntarily confined" or at risk of "involuntary confinement" in a human development center should be entitled to pre and post confinement hearings which provide the full panoply of protections guaranteed by the Fourteenth Amendment Due Process and Equal Protection clauses of the United States Constitution.” Oral arguments were scheduled for June 2006.</p> <p>► Activity occurred related to a 2001 suit about EPSDT services in the State Plan, and the State’s right to cut back EPSDT services as a fiscal measure. Earlier the 8th Circuit Court of Appeals had held that although the state need not specifically list EPSDT services in its state plan it must provide them when they are ordered by a physician. The plaintiffs filed a 4th amended complaint filed in July 2004 alleging that the state’s prior authorization system for EPSDT services was operated to arbitrarily deny necessary services in order to reduce state expenditures. After additional challenges by the State, the court allowed this complaint to proceed to trial in 2005 to determine whether the prior authorization system resulted in the impermissible denial of services. Oral arguments were heard in February 2006.</p> <p>► In April 2006, the 8th Circuit reaffirmed that state officials could be sued in their official capacity for alleged violations of Medicaid law. The Circuit reaffirmed that the provisions of Medicaid law at issue in this litigation could be litigated in federal court, the Gonzaga decision notwithstanding.</p>
FL	<p>► <i>Dubois et al. v. Rhonda Medows et al.</i> is a class action lawsuit brought in 2003 on behalf of individuals with traumatic brain or spinal cord injury who had sought but not received waiver services. The suit alleged that the 200+ persons on the waiting list for Florida’s Brain and Spinal Cord Injury (BSCI) waiver were impermissibly denied HCB services (citing violations of the ADA, Sec. 504 of the Rehabilitation Act, Medicaid law, and the U.S. Constitution). The district court rejected the state’s move to dismiss the lawsuit, and if the parties do not reach a settlement, a trial was scheduled for November 2006.</p> <p>► A 1998 class action suit sought to prevent Florida from unnecessarily institutionalizing individuals with DD (<i>Brown et al. v. Bush et al.</i>) was brought on behalf of all individuals with DD residing in a Florida “Developmental Services Institution.” The settlement agreement reached in July 2004 would have reduced from 4 to 2 the number of state DSIs. This proposed settlement prompted objections from persons interested in preserving state institutional services. Following a hearing, a group of objectors filed an appeal with the 11th Circuit Court of Appeals to halt the settlement agreement’s implementation. The Circuit denied objectors’ petition. The court rejected the Medicaid claim, noting that two state facilities would remain open and approved the settlement order in August 2005. The objectors then filed a new appeal (05-15167) with the 11th Circuit in September 2005. Briefs have been filed. The State opposes the appeal, pointing out that the objectors sought to require that the state to continue to operate at the Gulf Coast Center. The State argued that federal law contains no specific basis that supports the assertion of a right to a placement in a <u>specific</u> facility or that requires a state to maintain the operation of a <u>particular</u> facility. Oral arguments were scheduled for June 2006.</p>
NM	<p>► In New Mexico, the long-running class action lawsuit (<i>Lewis et al. v. New Mexico Department of Health et al.</i>) initially filed in 1999 by the state’s P&A agency and the Arc of NM on behalf of persons with DD who were either on the waiting lists for HCB waiver services or in institutions and could benefit from waiver services, was dismissed in September 2005 when the court denied the plaintiff’s motion for contempt. The court rules that the State was obligated to furnish waiver services only to the extent supported by available funds, even if the number of persons enrolled in the waivers remained below the state’s federally approved caps.</p> <p>► In July 1987, parents of 21 people with DD filed a class action to correct what they claimed were unconstitutional conditions at New Mexico’s two state institutions for people with DD (<i>Jackson v. Fort Stanton</i>, 757 F.Supp. 1243 (D.N.M. 1990). This lengthy case eventually led to the closure of all NM state institutions for persons with developmental disabilities. In spring and summer 2004, the parties negotiated an agreement to resolve remaining issues, which was accepted by the Court. This negotiated agreement resulted in a <i>Joint Stipulation</i> with a list of “Agreed Actions” that the state must complete by November 2006. The “agreed actions” address the following areas: Case Management; Quality Enhancement; Incident Management; Behavior Services; Crisis Services; Sexuality Services; Supported Employment; Division of Vocational Rehabilitation.</p>

PA	<p>► The Pennsylvania class action filed on behalf of individuals with DD who were waitlisted for ICF/MR services, <i>Sabree et al. v. Richman</i>, was dismissed in September 2005 after a settlement agreement was reached with the state for the 3 named plaintiffs.</p> <p>► Residents of Norristown State Hospital brought suit in <i>Frederick L. et al. v. Department of Public Welfare et al.</i> claiming that their continued institutionalization, despite recommendations for community placement, violated the ADA. The district court found that accelerating waiver placements would increase state expenditures and thus amount to a “fundamental alteration” of the state’s long-term care services and programs and therefore denied the complaint. The 3rd Circuit Court of Appeals disagreed, ruled that budgetary considerations alone could not support a fundamental alteration defense, and remanded the case back to the district court. In September 2004, the district court dismissed the case, finding that the state’s existing deinstitutionalizing plan and process were sufficient under the requirements of the ADA. The plaintiffs have appealed this decision. In April 2006, the state submitted an 85-page four-year plan concerning community placement of Norristown residents. In May 2006, the plaintiffs informed the court that they believed that the plan complied with the 3rd Circuit decision and recommended that the court incorporate the plan into an order, require that the state comply with the plan and retain jurisdiction over the case to ensure compliance. Oral arguments were scheduled for June 2006 concerning the plan developed by the state.</p> <p>► The 3rd Circuit Court of Appeals issued a similar ruling in March 2005 in <i>Pennsylvania Protection & Advocacy v. Department of Public Welfare</i>. In the PPA suit, residents of a state-operated nursing facility claimed that their continued institutionalization violated the ADA. The Circuit Court vacated the lower court’s ruling in favor of the state, holding that a “fundamental alteration” defense requires more than a claim of predicted increases in expenditures. The case is back in the district court for further proceedings. In December 2005, the parties informed the court that they had arrived at a settlement and asked the court to suspend further proceedings unless the implementation of the settlement broke down. The Disability Law Project reports: “Under the terms of the settlement . . . DPW will evaluate whether SMRC residents are appropriate for discharge to community mental health programs by the end of April 2006. A qualified DPW employee (recommended by PP&A) will be in charge of the evaluations and responsible for the final decisions. The evaluators will also assess whether any individuals who are appropriate for discharge are opposed to discharge and, if so, they will take appropriate steps to overcome such opposition. After the evaluations are completed, the parties will meet to discuss a time line for placements.”</p>
TX	<p>► On and off negotiations have so far failed to reach a solution in <i>McCarthy et al. v. Hawkins et al.</i>, 381 F.3d 407 (5th Cir. 2004), in which a group of 11 Texans with mental disabilities and The Arc of Texas sued state agencies and state officials for violations of the ADA and the Constitution, arguing that the long waiting lists for the HCS and the Community Living Assistance and Support Services (CLASS) waivers (17,500 and 7,300, respectively, at the time of the suit) effectively denied them access. The case was set to go to trial in June 2006.</p>
WA	<p>In Washington, the court has consolidated two cases, <i>Arc of Washington State et al. v. Quasim et al.</i> and <i>Boyle et al. v. Braddock</i>, which alleged people with DD who are eligible for Medicaid services were not receiving services with reasonable promptness. In March 2005, the 9th Circuit Court of Appeals issued an important ruling concerning the interplay of the ADA and the Medicaid Act (when the two conflict, the more general ADA does not supersede the more specific Medicaid Act), and remanded the two cases to district court. Trial on the remaining issues – concerning whether current HCBS waiver participants are receiving all the services to which they are entitled – is scheduled for January 2007.</p>