

**Rebalancing Long-Term Care Systems in Arkansas:
Experience up to July 31, 2005**

Abbreviated Report

submitted to the

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The overall project is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. This baseline case study covers a period through July 31, 2005; updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was discussed at A CMS Open Door Forum, February 22, 2006. 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. We thank the Arkansas Liaison to the study, Herb Sanderson, Director, Arkansas Division of Aging and Adult Services.

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Rebalancing Long-Term Care Systems in Arkansas: Abbreviated Report

Highlights

Given the age, disability, income distribution and Medicaid participation rates in Arkansas, demand for publicly funded long-term care services is high. Yet as one of the nation's poorest states, its ability to generate state revenue to meet the demand is limited. Despite these challenges, Arkansas has made great strides in expanding home and community-based services (HCBS) for seniors and people with physical disabilities, increasing investments in HCBS, and registering substantial success in changing the balance of service utilization away from institutional care.¹ Arkansas has been less successful in reducing expenditures on nursing homes or in reducing dependence on institutions for people with developmental disabilities. The State can be characterized as innovative, oriented towards collaboration, and creative in marshalling resources, including grant resources.

- With full support of the Governor and the legislature, Arkansas has articulated a strong vision of community integration and consumer choice. In 1998 Arkansas became the first state to implement the National Cash and Counseling Demonstration, a randomized controlled trial of cashing out Medicaid benefits. After the research phase, Arkansas made this program permanent. The State now seeks to incorporate further consumer direction into other programs and further cash-out options.
- The Governor's Integrated Services Task Force (GIST) is a focal point for Olmstead-related planning in Arkansas; its members represent a wide range of advocacy and provider organizations. High-level government agency heads participate actively. GIST adopted a resolution in the Spring of 2005 to promote HCBS services in Arkansas which reads, in part: "it is the policy of the State of Arkansas to promote and maximize the use of home and community-based services, so older people and persons with disabilities can be integrated in their communities." This resolution carries particular conviction because it was negotiated with provider representatives in the group. Intensive stakeholder involvement is the norm in all program initiatives.
- Arkansas has made excellent use of federal and foundation grant funds to develop and test new programs before bringing them to scale. The State has successfully employed a model whereby it studies program options developed in other state jurisdictions, adapts them to Arkansas in a pilot in some area of the state, makes adjustments based on the pilot, and implements statewide. Arkansas's strategy has been to apply for a huge

¹ This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Arkansas, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, will appear over the next few months on the website [HCBS.org](http://www.hcbs.org) and on the University of Minnesota's Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington. The report covers a period up to July 31, 2005; subsequent reports will update the case study as of July 2006 and July 2007.

number of grants and ensure that the personnel are in place to manage them, buttressed by contracts with experts around the country.

- Organizationally Arkansas planned to further consolidate its umbrella agency to incorporate the Department of Health into a new Department of Health and Human Services; the reorganization was expected to facilitate quality management efforts and stronger prevention and chronic disease management initiatives.
- Arkansas has developed outstanding web-based applications that providers and case managers can use to better assist their clientele and that consumers can use directly to insert self-assessment information and be directed to resources.
- Arkansas has developed a Quality Management unit in its Medicaid agency.
- Arkansas has developed housing initiatives and, in the case of assisted living, has adopted the strategy of regulating a sector prior to its development.
- Arkansas modified its Nurse Practice Act to exempt forms of health maintenance activities associated with consumer directed care.

Obstacles to rebalancing in Arkansas, besides fiscal limitations, include strong lobby groups for nursing homes, state institutions for MR/DD, and home health agencies. Historically, the State has had difficulty in creating a single-entry case-managed system because of the way Area Agencies on Aging and home health agencies evolved in the state. Rather than launching a frontal attack on State Human Development Centers and ICF/MRs, Arkansas is attempting to model community care for MR/DD, especially emphasizing programs for children, and is also investing in improving the state institutions, using their therapeutic expertise in outreach for community care, and modeling better living settings and community work programs within the context of the Human Development Centers.

Context

Arkansas has high levels of poverty and disability and a high demand for publicly financed services. Its volunteer legislature, which meets every second year, has developed a positive attitude towards consumer centered services as has the Governor.

The Area Agency Network has evolved somewhat unusually in Arkansas, with most AAAs being service providers and, therefore, state-employed personnel acting as eligibility assessors. On the one hand, the network shows strengths in its ability to take leadership in a wide variety of joint ventures, including web-based assessment, assisted living development, and PACE site co-sponsorship. On the other hand, the Network tends to guard its prerogatives and somewhat resists innovations such as cash and counseling. Analogous comments can be made about many strong licensed MR/DD providers in the State.

Real Choice Systems Change (RCSC) Grants

Arkansas has received funding for 7 RCSC grants between 2001 and 2004, for a total of \$5,151,706. The state has used these funds strategically to pilot system elements for state-wide implementation and to address system gaps, improve information and accountability, and support efforts to increase consumer direction.² The theme of Choice permeates these grant-funded projects, which are designed to work synergistically. It is noteworthy that Arkansas has been the recipient of many other grants during that same period and earlier that have been applied to projects related to Re-Balancing, including grants from the Robert Wood Johnson Foundation and the U.S. Department of Human Services Office of the Assistant Secretary for Planning and Evaluation.

Programs and Services

The Arkansas Division of Aging and Adult Services (DAAS) operates 3 HCBS waivers: including Elder Choices, Alternatives for Persons with Physical Disabilities, and an assisted living waiver. The Alternatives waiver is structured as a consumer-directed attendant program. The Division of Developmental Services (DDS) operates the Alternative Care Services (ACS) waiver for persons with MR/DD in a parallel track. ACS has historically had a waiting list, though it has been winnowed down because of recent ear-marked legislative appropriations. The DDS waiver programs and programs funded from other sources include a variety of crisis intervention teams and assertive community services teams, designed to serve dually diagnosed individuals with behavioral health needs closer to their own communities.

The Medicaid state plan includes a growing personal care option. The Independent Choices program uses the authority of an 1115 waiver to “cash out” personal care in cash allowances for those who opt for that service. Since the beginning of the program, 2/3 or more of those choosing the cash are over age 65, but a higher proportion of personal care option clients under age 65 opt for the cash programs.

² Grants included a Systems Change and a Community-Integrated Personal Assistant Services (C-PASS) grants in 2001, a Nursing Facility Transition Grant in 2002, a Respite for Children’s Services grant in 2003, and an Integrating Housing and Services grant, a QA/QI, and an Aging and Disability Resource Center Grant in 2004, the latter from AOA. All awards were to the Division of Aging and Adult Services, except for the C-PASS grant, which went to the Division of Developmental Services to develop consumer-directed models for developmental disability and the Respite Services for Children grant to the Department of Human Services. The gaps addressed by sponsored projects and the lasting effects of the grants are discussed in the full report. In 2005 (beyond the scope of this baseline study), Arkansas was awarded a System Transformations Grant of about \$2.8 million to effect major system changes over a five year period.

Featured Management Approaches

Independent Choices and other Cash Options

Arkansas developed the Independent Choices program as part of a 3-state national demonstration the use of cash allowances for Medicaid programs. Arkansas was the first of the 3 states to implement the program, the first to complete enrollment, and the first to generate outcome data. Adults age 18 and over who were eligible for the State Personal Care Option were eligible for Independent Choices. During the demonstration phase consumers willing to accept cash allowances were randomly assigned to the experimental group or the control group, which received usual services. State-employed nurses conducted the eligibility assessments as required by Arkansas law for the Personal Care Option.

The two relevant waiver programs—ElderChoices and Alternatives for Persons with Physical Disabilities—were not cashed out, and consumers were able to simultaneously use both programs if they had the need and eligibility. The dollar amount of the allowance for Independent Choices was based on the number of hours in the individual’s personal care plan at \$8.00 an hour minus an adjustment to achieve budget neutrality. Arkansas did not permit consumers to hire spouses, but otherwise family members could be hired.

Consumers prepared a written spending plan with a counselor (called a “consultant”) indicating the services and goods they wished to purchase. Goods needed to be related to managing the disability, but Arkansas took a liberal view of allowable expenses. Portions of the allowance could be saved for larger one-time purchases. Consumers also could elect to receive 10% to 20% of their allowance as cash for incidental expenses—for example, taxi fares. If the consumer’s allowance was managed through a representative, such representatives were prohibited from paying themselves as personal care providers. Payroll tasks were preformed by fiscal agents, called “bookkeepers” in Arkansas. Unlike the other two states in the demonstration, Arkansas combined the counseling and the fiscal agent function and was the only state not reporting quality problems with the fiscal agent. In Arkansas, about 10% of the seniors receiving personal care and 15% of the younger adults opted for the cash demonstration; almost half of the seniors also chose to use a representative to handle their spending plans.

The operational lessons from Arkansas’ startup period were: 1) combining the counseling and fiscal agency function seemed desirable; 2) home visits at convenient hours for family members were important for initial recruitment; 3) the agency doing counseling needed a sizable caseload to work effectively in the role, which argues for fewer contractors for this function; 4) timeliness in making the first allowance payment available seemed essential to avoid consumers dropping out of the program; 5) fraud was virtually non-existent.

Outcomes for consumers, family caregivers, and workers were highly favorable to the experimental group in terms of participant satisfaction and reduction of unmet needs. No adverse health consequences were identified. An unintended result was that the control group members were likely to receive no services or fewer services than planned at an unexpectedly high rate. This problem was related to difficulties agencies were having in recruiting labor and spoke to the advantages of flexible arrangements through Cash and Counseling. The evaluation also

suggested that Cash and Counseling participants used nursing homes and hospitals less frequently than the control group participants.

After the demonstration period ended in 2003, Arkansas incorporated Independent Choices into its operations. In June 2005, the program has almost 1500 enrollees and had expended about \$4.8 million up to that point in the year. The state is developing a new option to exchange Medicaid nursing home benefits for a daily cash allowance for consumers who opt to leave nursing homes and choose HCBS. Called Next Choice, the complexities of planning include establishing the eligibility requirements (e.g., length of time in a nursing home) and conducting data analyses to establish the maximum allowance. Once again counseling and fiscal intermediary services will be part of the program.

Web-based Information Systems: SA-HELLO and AR-GetCare

Arkansas modeled a unique collaborative effort in South Arkansas that resulted in a statewide web based directory of services and information system for seniors and people with disabilities in the region, Called SA-HELLO (South Arkansas Health Education Living and Life Options). The web application has an arm for consumers and one for providers, who may enter information about their programs.

Consumers may turn at any time to an 8-question self-assessment form. Based on responses to these questions, a list of potential services is generated. Consumers may then learn more about the services generically (clicking to download educational material) or may go directly to a local list of providers. Thus, SA-HELLO has an educational as well as a linking function. Consumers may also enter the data base by skipping the self-assessment and simply seeking information about categories of services. Once the SA-HELLO program was deemed effective, it was developed for state-wide use in the AR-GetCare system.

Together We Can

Together We Can is an effort to develop community planning, consumer direction, and advocacy capability for MR/DD. The C-PASS grant was a catalyst to establish a services network in 17 counties to improve funding for family and individual supports in Arkansas. A multi-agency approach to service planning was developed based on long-term individually-centered goals. During the final phase of the grant, “family circles” were established in three counties and received \$5,000 each to begin supporting several families. DDS is using information gleaned from the Together We Can project to design a statewide effort to enhance consumer direction and community integration in the MR/DD world.

Consumer Empowerment/Aging and Disability Leadership Academy

Stakeholder involvement is a serious endeavor in Arkansas, and sufficient DAAS personnel are assigned to staff the activities pursuing this goal, including the state’s Olmstead Working Group, comprised of consumers, advocates, providers and stakeholders, and the Governor’s Integrated Services Task Force GIST, a similarly heterogeneous group comprised of persons with disabilities, guardians, advocates, and providers. The GIST completed a comprehensive working plan for the state’s long term care system in March 2003 that included a detailed, prioritized list of recommendations. The GIST monitors accomplishments against the priorities

in the plan. The GIST also has an educational function in the development of activated consumers.

DAAS has gone beyond staffing functions to support consumer groups. Using grant funds, it created the Aging and Disability Leadership Academy. Those interested in attending the weekend sessions in Little Rock may apply, including information about their own interests, experience, and goals. Those selected attend sessions at the expense of DAAS. At the time of this report, 3 classes had graduated from the Academy. This strategy is designed to establish networks of informed and activated consumers throughout the state. The application process for the Academy also provides DAAS with information about the concerns of stakeholders.

Consumer Directed Care Act/Nurse Delegation

The number-one priority established in the GIST Olmstead plan was to “clarify the Nurse Practice Act to encourage flexibility in caregiving while ensuring quality.” The choice of a technical priority such as this suggests the amount of education and self-study undertaken by the GIST. Essentially, the GIST came to believe that registered nurses needed protection from perceived liability so they can delegate medication management to trained unlicensed assistive personnel, or that some comparable step needed to be taken for efficient management of health care tasks in the community.

As a result of this recommendation, the 2005 Legislature enacted Act 1440, the Consumer Directed Care Act, which exempts home health maintenance activities from the Nurse Practice Act. This enables competent adults to designate a care aide to perform health maintenance activities, i.e., activities that enable a minor child or adult to live in his or her home such as assisting the individual to take prescribed medications.

Primary Care Case Management

DAAS proposes to develop and implement a system of primary care case management targeting dually eligible persons and others with chronic illnesses. The goals are: maintain participants’ health and function; promote self-care; reduce service delivery fragmentation; and, reduce inappropriate emergency room use, hospitalizations, and nursing facility placement caused by preventable conditions. Arkansas will adapt the Georgia SOURCE model, beginning with a pilot in two regions of the state. PCCM services will be provided by case management agencies, which will contract with primary care physicians and a medical director, probably a geriatrician. Enrollees will choose a participating PCP as their physician. PCPs will conduct thorough patient evaluations, manage medical services, and meet quarterly with patients’ case manager. PCPs will receive case management fee from the agency (\$15-20 per patient per month in Georgia), in addition to Medicare and Medicaid reimbursement for services. These payments reflect the extra time required for communicating with case managers, plus the medical complexity of dually eligible persons. Other medical and HCBS services will remain fee-for-service, and PCPs will continue to bill Medicaid for other services provided to participants.

PCCM case managers will play a major role. They will conduct thorough in-home assessments, arrange and monitor community services, encourage compliance with medical appointments and medications, and promote self-care of chronic conditions. Case managers may accompany clients to doctors’ appointments, if needed, to discuss compliance and other issues.

Participants will be instructed to contact their case manager prior to any hospital or nursing home admissions, so case managers can help avoid unnecessary admissions and help plan discharges and transitions back to the community. PCCM agencies will be responsible for meeting emergency needs around the clock.

Georgia's Care Paths will be adapted as protocols for planning supports and services, and monitoring outcomes. The Care Path is customized for the participant, using his or her preferences, health status, and service needs. The Care Path shows who is responsible for each goal, including the participant, case manager, physician, and personal care aide. Performance on each goal is rated quarterly.

All ElderChoices (65+) and Alternatives (physically disabled, aged 21-64) waiver participants, and other adult Medicaid participants with chronic conditions will be invited to enroll. MMIS claims data will be used to identify individuals with chronic conditions and high costs. The proposed Next Choice waiver will likely be included as well. While the program will be voluntary for participants, a high level of participation is projected because participants will receive more intensive primary care and case management services, and will be actively involved in planning care and outcomes.

A number of hurdles must be met to implement this idea. For example, objections are anticipated from existing waiver program agencies, which want their participants to receive better primary care, but do not want to relinquish managing their waiver services. Also, Arkansas's any willing provider law is likely to hamper agencies' ability to select physicians, though they can still set standards and guidelines for participation. As is the pattern in Arkansas, the program will initially be piloted in two multi-county regions, including rural counties with access problems and low rates of health screening. The pilot will permit testing and adjustment before full-scale implementation.

Quantitative Markers of Rebalancing

Changing Patterns in Nursing Home Use as Marker of Rebalancing

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Arkansas nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in AR deteriorated slightly from the average ADL score of 14.03 in 2002 to an average ADL score of 14.99 in 2004 (the possible score of the ADL variable is between 0 and 24; a higher score means higher ADL

dependence). Moreover, the proportion of residents admitted with no ADL dependencies, or very few, decreased. During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 2.05 in 2002 to 1.95 in 2004 (the possible score for CPS is between 0 and 6; a higher CPS score means lower cognitive functioning). However, the rate of persons with no cognitive impairment or mild impairment increased slightly.

Table 1: Change in Nursing Home Acuity at Admission and 3 Months Post Admission in Arkansas, 2002-2004

	2002	2003	2004
At Admission			
Mean ADL	14.03	14.13	14.99
Mean CPS	2.05	2.04	1.95
3 Months Post Admission			
Mean ADL	12.34	12.27	12.30
Mean CPS	2.56	2.51	2.44

The ADL functioning at 3 months after admission improved slightly over the 3 year period. The average ADL scores in 2002, 2003, and 2004 were 12.34, 12.27, and 12.30, respectively, suggesting less disability over time. However, the proportion of persons with no and few ADL dependencies decreased. For cognitive functioning, the CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 was 2.05, dropped to 2.51 in 2003 and further dropped to 1.95 in 2004. Moreover the proportion with no cognitive impairment increased.

Relationships between HCBS and Institutional Care

Figure 1 shows the numbers of persons served by a variety of Medicaid state plan and waiver services and three forms of institutional care: state funded MR/DD Human Development Centers, nursing homes, and ICF/MRs. Not all persons counted received services for a full year. The numbers of persons in nursing homes is substantially greater than the numbers served by waivers. However, the number of persons served under the State Plan receiving personal care is considerable. The personal care coverage declined as those on waivers coverage grew. The numbers persons served by home health declined substantially in 2004.

Figure 2 traces the amount of money spent on each of these programs. The Medicaid expenditures for nursing home care dwarf the rest and have been rising the fastest. Waiver expenditures and MR-DD institutional services have been rising slowly, if at all.

Figure 3 examines the costs per client served. Care for persons with MR/DD is very expensive. The differences in per person between those cared for in state run facilities and those in MR-ICFs are modest. Both rate considerably more than the cost of MR-DD waivers, and all are higher than nursing home costs per client. Nursing home care is substantially more costly than community based care.

Rebalancing Long-Term Care Systems in Arkansas

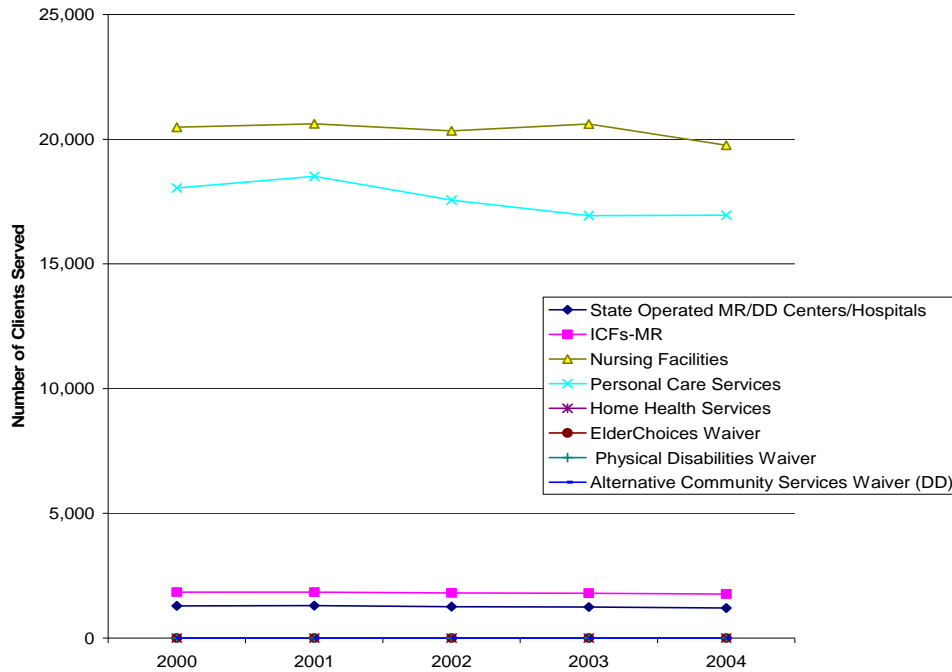


Figure 1. Clients Served in Selected Arkansas Programs, 2000-2004

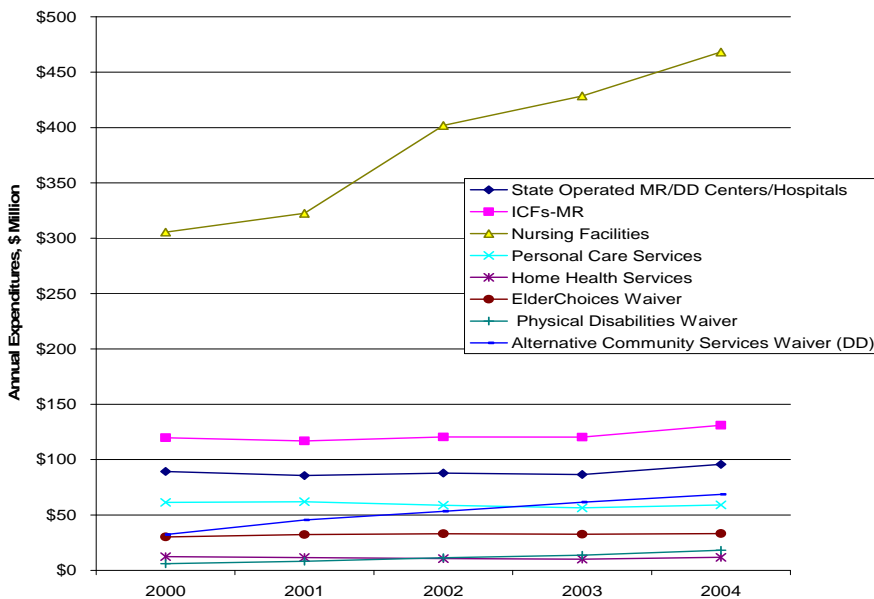


Figure 2. Expenditures for Selected Arkansas Programs, 2000 to 2004

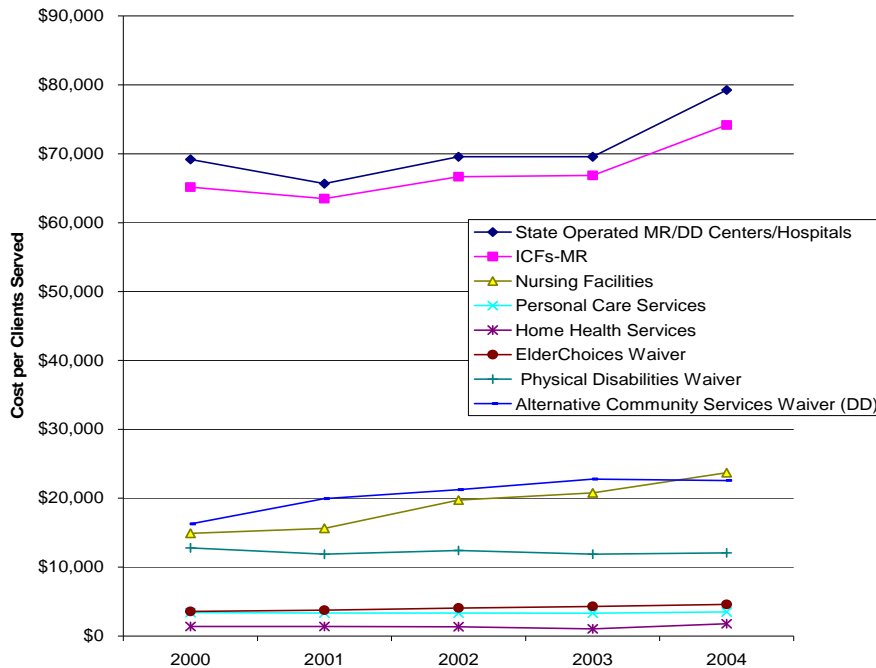


Figure 3. Costs per Consumer Served in Selected Arkansas Programs, 2000-2004

Conclusion

Arkansas is an innovative state in rebalancing its LTC system, drawing from programs and ideas from all over the United States, typically developing a pilot in one or two regions in the State and bringing the program to scale. Locations for various pilots offer chances for innovation to multiple areas.

The State enjoys strong stable leadership in the Department of Human Services, and the enthusiastic encouragement of its Governor. Arkansas has made good use of grant funds to develop and apply new programs, and is now entering into a period of strategic planning with even more grant funds available from the recently awarded Systems Transformation Grant.

Arkansas has achieved a strong degree of consumer direction and, after a good experience with cash grants in its Cash and Counseling demonstration, is exploring further application of cash options. Arkansas has invested heavily in web-based information efforts and the development of materials that can be used directly by an informed group of consumers. It has also invested strategically in enhancing the strength of consumer constituencies.

The Rebalancing bottom line is impressive with reference to utilization of services for seniors and persons with disabilities, but less so for persons with developmental disabilities, where institutional care still dominates. Expenditures for nursing homes also continue to consume disproportionate resources in Arkansas.

Issues for Future Observation

- Whether consumer directed options can become more widespread in the MR/DD area, and whether the institutional sector for MR/DD will finally dwindle.
- The future of the state's strategic planning, as that process is catalyzed by its System Transformation grant.
- The pros and cons of the DAAS proposal to merge its three waivers (Elder Choices, Alternatives, and Assisted Living) into a seamless waiver.
- Whether the MR/DD programs can become more unified with other long-term support program at both state and local levels.
- The information technology development and its application to improving access and quality, including efforts to create a way of triaging consumers and investing resources where they will most help in nursing home transitions or diversions.
- The ongoing housing initiatives and the struggle to evolve an assisted living program that combines heavy care and livability. Current regulations make the heavy care difficult although the livability is emphasized.
- Progress towards a single entry system utilizing a web-based assessment.
- The specification of the Next Choice program, a plan to offer cash allowances in lieu of Medicaid nursing home benefits for consumers intending to leave nursing homes.
- The results of the test of a primary care case management program modeled after Georgia's SOURCE program in terms of improving integration of acute and long-term care and its effect on existing long-term support programs. Similarly the implementation of the PACE program is of interest.
- The experience with the reorganization of state government to incorporate the Department of Health into the new Department of Health and Human Services.