Medicaid Program Redesign

The Long Term Care and Developmentally Disabled Programs

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Bruce Pyenson, FSA, MAAA
Kathryn Fitch, RN, MEd
Susan Pantely, FSA, MAAA

Principals

Milliman, Inc.
New York, NY

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Preface

This report was commissioned by the Wyoming Health Care Commission in mid July 2006.

We, the authors, owe thanks to the more than 30 people we interviewed from Wyoming's community involved in the Long Term Care (LTC) and Developmentally Disabled (DD) programs. These people came from state government, vendors and providers. Numerous others worked to provide us information in a very short timeframe. We are struck by the openness and trust of these individuals. We are outsiders, and feel humbled by the insight and knowledge of the Wyoming citizens who work to provide care to people in the LTC and DD groups.

Ideally, the alternatives presented here are consistent with information that Wyoming's providers, program administrators and, especially, citizens would provide in a thorough survey. We hope that we can provide some fresh, useful insights and alternatives, and hope that we did not miss any important issues during the very fast progress of this report.

Wyoming has many innovative programs, both current and under way, for Medicaid beneficiaries in its LTC and DD programs. We hope our insights will provide support for these programs and help advance quality and efficiency in the services Medicaid provides for these people.

We have heard about issues several years ago involving potentially improper Medicaid payments to providers, and this issue appears to cast a shadow over the enthusiasm expressed by so many people we met. We hope this report, which looks to the future, will help focus efforts and thoughts on the numerous available alternatives.

Any errors in this report should not reflect on individuals who worked with us or shared information with us. However, readers understand that we could not audit the data we received, relying on the State of Wyoming for its accuracy.

Executive Summary

The Wyoming Health Care Commission engaged Milliman, Inc. to produce this report on ways to redesign and restructure Wyoming's Medicaid program for people with eligibility through Long Term Care (LTC) and Developmental Disability (DD) programs. Our charge was to think boldly but reasonably and suggest programs that can improve the quality and cost-effectiveness of care for these people. Although we had only about 6 weeks to develop this report, we received extraordinary cooperation from Wyoming government officials and people involved in providing care to these populations.

The Wyoming Department of Health has a number of innovative programs underway and has applied for several grants for new or expanded programs. Some of these grants fit well with our suggestions. Our charge was to find opportunities beyond current programs, so our report should not be seen as an evaluation of the strengths and weaknesses of the Department.

Why Focus on the Long Term Care and Developmentally Disabled Programs?

Medicaid pays for safety-net care. Most Medicaid recipients are young – about half are under 18 and not disabled; about 75% are under age 65 and not disabled.[1] The age, income and medical need eligibility criteria for these people mean their Medicaid eligibility is often relatively short term. By contrast, many people receiving LTC or DD benefits continue to receive these benefits until they die. While the LTC and DD programs have many fewer people than Medicaid programs serving younger and generally healthier populations, the average cost per individual is much higher.

Many states have improved the quality and efficiency of their younger populations through managed care programs. Nationally, over 60% of Medicaid beneficiaries were enrolled in some form of managed care in 2004, and most of these were children or non-disabled adults.[2] These programs may use HMOs to manage care and pay medical costs. Improving services to the LTC and DD beneficiaries has proved more difficult, although the movement to treat people in their home rather than in an institution has dramatically improved the lives of many. The aging of America adds to the concerns for the LTC programs[3] as it seems more and more people will need Medicaid for their elder years.

In this report we explain some of the challenges to improving quality and efficiency in the care of people in the LTC and DD programs. We also offer suggestions, which include building on successful programs already in place in Wyoming, adapting programs used elsewhere, and exploring new options.

Better Value for People in the LTC and DD Programs

In general terms, we have tried to apply ideas and methods from the managed care industry, including concepts of evidence based medicine, quality measures, accountability for results, and aligning incentives so providers get paid more for superior care. In particular, our suggestions fall into the following broad categories, which are not mutually exclusive:

A. Integrating Personal and Medical Care. Personal care (such as nursing home, housekeeper, bathing, meals) and medical care can act synergistically. Because Medicare pays for most acute care (plus other reasons we describe), Wyoming, like most states, has focused on the "social" side of care. We suggest ways to integrate the two kinds of care to produce better results.

B. Managing Transitions. Over months and years, individuals in LTC and DD programs live through transitions such as entering a hospital, moving to a nursing home or entering the end of life. These are critical moments where astute and timely care management can produce better outcomes.

C. Combining Financing Streams. In a variety of ways, Wyoming can gain more authority over how benefits are funded, and it then can direct spending to achieve better quality and efficiency. For example, Wyoming's Medicaid Program could consider itself to be an insurance company and obtain fixed funding from the federal government. Such a program could redeploy Medicaid spending in ways that best meets Wyoming needs and possibly generate a surplus.

D. Labor Force and Reimbursement. Recent decades have seen dramatic improvements in how care is provided including technology and skills. The nature of employment available to Wyoming residents has also changed as the extraction industry created opportunities that attract workers. Reimbursement and related policies need to keep pace to help provide the workforce and skills required by LTC and DD beneficiaries.

E. Development of Assisted Living Facilities (ALFs). ALFs are lower in cost than nursing homes and they give people more independence, however Wyoming has a shortage of ALFs. We identify some sources or approaches for expanding this resource.

F. Improving End of Life Care. Fortunately, Wyoming does not "send" people to hospitals to die, which seems to happen in other states. However, the very low use of hospice may mean that these people do not receive needed palliative care, which means there is an opportunity to improve the quality of end of life care.

We offer a number of details in the text of the report. We also share some of our opinions about the Medicaid program's operation that may be relevant to the above suggestions. Given the aging population and continued medical inflation nationally, it makes sense to pay attention to costs. Some, but not all, of our suggestions offer ways to reduce spending.

We would characterize many of our suggestions as moving the Medicaid system from managing entitlement to managing care processes. Much of the data collected and information reported about the LTC and DD programs are intended to demonstrate compliance with entitlement rules rather than support care management. A future that provides more efficient, better quality care will have strong capabilities to manage care processes.

About Milliman

Milliman is, at its core, an actuarial consulting firm. We consult mostly on technical, financial and numeric matters such as the appropriate rates or reserves for various kinds of insurance. While most of our clients are private insurers and HMOs, we do consult to many State Medicaid programs on these issues. We are also experts in the impact of medical management, provider reimbursement and benefit design. With this background, it may not surprise the reader that the first section of this report contains summary actuarial statistics about the Wyoming Medicaid program.

Important Information

This report is produced for the sole benefit of the Wyoming Health Care Commission and is intended to benefit no other party. This material does not represent a financial forecast or projection – a much more thorough examination of information would be needed to produce these. In addition, this document shows the results of the authors' research and does not represent the endorsement of any position or legislation by Milliman.

The body of the report contains important details and technical information not contained in this Executive Summary, and the reader should obtain appropriate professional advice before applying it. In particular, we present data obtained from the Medicaid Department that may have important limitations.

I. Actuarial Statistics on Wyoming's LTC and DD Programs

This section contains summary statistics on Wyoming's LTC and DD beneficiaries. The statistics presented here were developed from data provided to Milliman by the Wyoming Medicaid Department. For a variety of reasons, some of these data are not entirely consistent with summary numbers reported elsewhere, but we believe the details and dynamics we report here are useful and reasonable. Important information about our data sources is in Appendix I.

Highlights of this section are,

- The LTC / DD program with the greatest number of beneficiaries is the LTC Non-Waiver program (nursing homes).
- The LTC population is mostly female and older, while the DD population is mostly male and younger.
- Within a given year, a meaningful portion of LTC people will move from less restrictive settings such as home to more restrictive settings such as a nursing home. A high portion of LTC people die each year, especially nursing home residents.
- The majority of people in the LTC and DD Medicaid programs also have Medicare coverage.
- Except for the LTC Waiver (home) population, Medicaid spends more on waiver costs than medical care for people with LTC and DD.
- Medicaid spends significantly more on people who do not have Medicare coverage. For most groups of beneficiaries, the Medicaid higher spending is due to higher spending on medical care.
- For 2005, the highest Medicaid spending was for the DD Non-Waiver people (State Training School) at about $16,000 per person per month. The lowest Medicaid spending was for LTC Waiver (home) and ALF Waiver people, at about $1,400 per person per month.

We term these actuarial statistics because these are the sorts of figures that would be used to develop premium rates and expenses for a Medicaid HMO or Special Needs Plan.

Table 1 provides the number of members and the member months in the waiver programs for 2005. More than half of the beneficiaries are in the LTC programs. Average member months during 2005 are less than 12 because some beneficiaries may have entered or left the program during the year. Entries might be due to newly eligible beneficiaries or transfers from another program. Beneficiaries might have left the program because of death, moving out of state, loss of eligibility or transferring to another program.

Table 1: Number of Beneficiaries by Program and Average Months in Program During 2005

Program	Site	Number of Beneficiaries	Average Months in Program During 2005
ALF Waiver (ALFW)	Assisted Living Facility	166	8.0
LTC Waiver (LTCW)	Home	1,565	8.9
LTC Non-Waiver (LTCNW)	Nursing Home	2,619	8.1
ABI Waiver (ABIW)	Home	134	8.8
DD Waiver Adult (DDWA)	Home	1,261	10.8
DD Waiver Child (DDWC)	Home	806	9.9
DD - Non-Waiver (DDNW)	State Training School	73	11.0
Total		**6,624**	**9.0**

Note: Some beneficiaries may have transitioned between programs during the year.

Appendix II shows the beneficiaries' age-sex distribution by program for 2005. Most people in the LTC programs are elderly and female. This is consistent with the demographic fact that, on average, women live longer than men and tend to marry men who are older, with the result that there are more widows than widowers. In addition, because a person is less likely to require LTC services from Medicaid if a spouse is alive, most LTC beneficiaries are women. On the other hand, most people in the ABI and DD programs are male and they are, on average, younger than the LTC groups.

Tables 2 and 3 show how people moved in, out and between programs in 2005. For example, in 2005, 10.8% of the LTCW people moved to LTCNW. The Death / Loss figures show people who left the program but did not transfer to another program. Most of these are deaths, but reasons for leaving include moving out of state, losing eligibility, or entering a hospice. The number of transitions out of a program approximately equals the number of new entrants, assuming a "steady state" from year to year. The transitions shown are defined by the individual's Medicaid status. For example, an individual who moves from a nursing home to home at the same time he looses eligibility status would be shown in the "Eligibility Loss" column.

Among the LTC programs, the deaths/losses are highest among the LTCNW, as expected. Only about 5% of people in LTCNW (nursing home) went to the less intense ALF or

LTCW (home) in 2005. However, about 25% of ALF residents and 11% of LTCW (home) beneficiaries moved to the more intense LTCNW (nursing home) in 2005.

There are relatively fewer transitions among ABI / DD programs than for the LTC populations (see Table 3). Close to 7% of DDWC (child) people "graduated" to DDWA (adult) in 2005. A smaller portion of DD or ABI people die than for any of the LTC programs.

Table 2: LTC Program Transitions in 2005

From / *To*	*ALFW*	*LTCW (home)*	*LTCNW (nursing home)*	*Death*	*Eligibility Loss*
ALFW (assisted living facility)	n/a	1.9%	25.4%	10.7%	4.6%
LTCW (home)	2.7%	n/a	10.8%	7.7%	12.4%
LTCNW (nursing home)	0.8%	4.8%	n/a	21.7%	17.9%

Table 3: ABI and DD Transitions in 2005

From / *To*	*ABIW*	*DDWA*	*DDWC*	*DDNW*	*Death*	*Eligibility Loss*
ABIW	n/a	1.0%	0.0%	0.0%	1.0%	7.1%
DDWA (adult)	0.4%	n/a	n/a	0.1%	0.4%	2.5%
DDWC (child)	0.0%	6.7%	n/a	0.2%	0.3%	4.9%
DDNW (State Training School)	0.0%	1.5%	0.0%	n/a	1.5%	1.5%

Most people in the LTC and DD programs are "Dual Eligibles" -- eligible for both Medicaid and Medicare. This is an important financial issue for Medicaid because Medicare pays for most acute care for dual eligible people. For example, if someone in the LTC, ABI or DD programs does not have Medicare, Medicaid will pay for all hospital, physician and drug costs. On the other hand, if the individual has Medicare coverage, most of these costs will be paid by the federal Medicare program. Table 4 shows the portion of beneficiaries in LTC, ABI and DD who are dually eligible in 2005. Not surprisingly, few DD Waiver children qualified for Medicare.

Table 4: Portion of Beneficiaries with Dual Medicare/Medicaid Eligibility in 2005

Program	Percent Dual Eligible
ALF Waiver	94%
LTC Waiver	80%
LTC Non-Waiver	93%
ABI Waiver	66%
DD Waiver Adult	65%
DD Waiver Child	1%
DD - Non-Waiver	86%

Note: Percentage calculated based on member months using Part B buy-in data.

Because Medicare will pay for the majority of acute care costs for people with dual eligibility, and because the majority of people in most programs are dually-eligible, the financial benefits of reducing hospitalizations and other acute care will mostly accrue to the federal Medicare program, not Medicaid.

Table 5 shows Medicaid costs for waiver services and medical services (including hospital, physician, etc.) by important demographic characteristics:

- Which LTC or DD Medicaid program a person belongs to.
- Whether the individual has Medicaid coverage only or also has Medicare coverage.

These data show:

- Except for people on the LTC Waiver (home) program, Medicaid spends more on waiver services than medical care for people with LTC and DD.
- Medicaid spends significantly more on people who do not also have Medicare coverage. For most groups of beneficiaries, the higher Medicaid spending is due to higher spending on medical care.
- For 2005, the highest Medicaid spending was for the DD Non-Waiver people (State Training School) at about $16,000 per person per month. The lowest Medicaid spending was for LTC Waiver (home) and ALF Waiver people, at about $1,400 per person per month.

We show spending as "Per Member Per Month" (PMPM), which follows the convention set by Medicare and the managed care industry. This is the average spending during one month of eligibility. We calculated these amounts by taking the total spending of the particular population during 2005 and dividing it by the total months of eligibility for that population. As shown above, during 2005, the average months of eligibility for all groups was less than 12.

Table 5: Medicaid Spending on Beneficiaries by Program, Medicare Eligibility and Kind of Care

Program	Eligibility	Waiver Care*	Institutional Care*	Medical Care	% of Spending that is Waiver
		Medicaid Spending $ PMPM			
ALF Waiver	Medicaid + Medicare	$934	$14	$445	67%
	Medicaid Only	$903	$55	$1,456	37%
	Both Groups	$932	$17	$503	64%
LTC Waiver (home)	Medicaid + Medicare	$524	$22	$654	44%
	Medicaid Only	$431	$16	$1,508	22%
	Both Groups	$506	$21	$825	37%
LTC Non-Waiver (nursing home)	Medicaid + Medicare	$0	$2,573	$455	0%
	Medicaid Only	$0	$2,212	$1,279	0%
	Both Groups	$0	$2,546	$516	0%
ABI Waiver	Both Groups	$2,883	$1	$689	81%
DD Waiver Adult	Medicaid + Medicare	$4,626	$0	$549	89%
	Medicaid Only	$4,907	$0	$646	88%
	Both Groups	$4,724	$0	$583	89%
DD Waiver Child	Medicaid + Medicare	$1,391	$0	$104	93%
	Medicaid Only	$1,428	$0	$566	72%
	Both Groups	$1,428	$0	$563	72%
DD - Non-Waiver (State Training School)	Both Groups	$0	$15,739**	$87	0%

Note: ABI Waiver and DD – Non-Waiver are not show separately for the Medicaid + Medicare and Medicaid only because of the small numbers involved.

* Institutional costs are net of beneficiary contributions to nursing home reimbursement.

** Data provided to Milliman was federal share only. We estimated total Medicaid spending by dividing by the estimated CY 2005 FMAP rate of about 57%. This figure does not include several million dollars in non-Medicaid reimbursable costs.

Table 6 shows how much Medicaid spends per person on medical (non-personal) care, by type of service. Highlights of this are:

- Medicaid spends less on medical care for people with Medicare coverage. This is expected, as Medicare will pay for most of these costs if the person has Medicare coverage.

- Drug spending is the highest PMPM cost for most populations. For people with Medicare coverage, this spending was be assumed by Medicare Part D in 2006.

- Medical spending is very low for the DD Non-Waiver (State Training School) people, and no claims appear for Drugs or Dental. This suggests that some aspects of medical care spending are included with personal care or may not be recorded as claims. We note the PMPMs for DD Non-Waiver may not account for the entire State Training School cost. We did not examine financial statements, but summary reports appear to show total costs significantly higher than those we show.

Table 6: Medicaid Spending on Medical (non-Waiver, non-Institutional) Care for 2005. Per Member Per Month

Program	Eligibility	Inpatient	Outpatient	Rx	Dental	Other	Total
		Medicaid Spending, $ Per Member Per Month					
ALF Waiver	Medicaid + Medicare	$58	$13	$321	$2	$52	$445
	Medicaid only	$334	$548	$298	$0	$276	$1,456
	Both Groups	$73	$43	$320	$2	$64	$503
LTC Waiver (home)	Medicaid + Medicare	$39	$73	$442	$1	$98	$654
	Medicaid only	$493	$252	$424	$4	$334	$1,508
	Both Groups	$130	$109	$439	$2	$145	$825
LTC Non-Waiver (nursing home)	Medicaid + Medicare	$83	$26	$312	$1	$32	$455
	Medicaid only	$637	$134	$315	$2	$189	$1,277
	Both Groups	$124	$34	$312	$1	$44	$516
ABI Waiver	Both Groups	$79	$48	$379	$4	$179	$689
DD Waiver Adult	Medicaid + Medicare	$11	$18	$406	$2	$111	$549
	Medicaid only	$61	$54	$354	$2	$175	$646
	Both Groups	$28	$31	$388	$2	$134	$583
DD Waiver Child	Medicaid + Medicare	$0	$6	$45	$17	$36	$104
	Medicaid only	$75	$74	$202	$12	$204	$566
	Both Groups	$75	$73	$201	$12	$203	$563
DD - Non-Waiver (State Training School)	Both Groups	$54	$10	$0	$0	$23	$87

Note: ABI Waiver and DD–Non-Waiver are not shown separately for the Medicaid + Medicare and Medicaid only because of the small numbers involved. Significant amounts of expenses for the DD-Non-Waiver group may not appear through the Medicaid claims system.

We note the categories of Waiver, Institutional and Medical are supported by the Medicaid Dept. internal information system. While these categories are useful for certain purposes, they reflect the reporting needs of Medicaid administration rather than the information needed to manage patient care.

Health plans typically monitor cost distribution patterns and medical cost trends for a number of service categories and subcohorts to identify unplanned trends that require

further examination and response. Credible benchmarks for the distribution of medical spending for LTC and DD populations are limited, and it is difficult to make meaningful comparisons to other states because states vary in benefit coverage, populations, contracted provider rates and mandates. We did not examine management reports generated for administration of Wyoming's LTC and DD population but would encourage reporting that provides intelligence for those administrators managing these populations.

II. Integrating Care Management Services

The Wyoming LTC and DD waiver programs have a personal care/social care focus rather than a health maintenance focus, according to people we interviewed. We believe integrating care management services for personal/social care needs and health maintenance care needs can help keep people healthier and avoid hospitalizations and institutional placement.

Background

This section gives a high level summary of the LTC and DD waiver programs. We cannot capture all details of these programs here, but focus on certain aspects.

- **LTC**: Waiver services include those personal care and supportive services that keep a nursing home qualified patient safe and adequately functioning in the home or assisted living facility with a goal of preventing admission to a nursing home. Services include home delivered meals, shopping, light housekeeping, bathing, transportation, adult day care, personal emergency response system (PERS) and respite care. Each waiver patient has a case manager (an RN or social worker) who makes a monthly home visit to evaluate the adequacy and effectiveness of the personal care service delivery and corresponding care plan.

- **DD**: Waiver services include those that assist a DD patient to function safely and independently in the community and avoid the need for institutionalization. Services include habilitation training, supported employment, occupational, speech, language and physical therapy, behavior management, companion services, respite care, personal care and environmental accessibility adaptations. Each waiver patient has a case manager (not required to be an RN or social worker but required to have a high school degree) who develops and monitors individualized care plans.

Need for Health Maintenance

Through our review of the Wyoming waiver programs, we identified a gap in "medical case management" services provided under the waiver programs, which was confirmed by the LTC and DD providers we interviewed as well as State program administrators. Although waiver case managers, or in some cases a personal care attendant, can make referrals for skilled home care services or contact the patient's physician if they perceive a medical issue, proactive medical case management does not appear to be occurring for the waiver populations.

Medical case management involves attention to the patient's medical treatment plan, response to and compliance with medical treatments and monitoring medical follow up. For example, a patient with congestive heart failure may be contacted by the medical case manager once a week (or more often if indicated) to remind the patient about medication dosages, inquire as to weight gain, ankle edema, increased shortness of breath,

compliance with dietary restrictions, physician visits and will be available for contact by the patient or family for health related questions. Medical case management is intended to enhance health maintenance, thereby avoiding chronic medical condition exacerbations which can result in hospital admissions (often the precursor to LTC nursing home placement). Another role of medical case management is to coordinate services to support end of life needs in the home/residence if appropriate, thus avoiding an acute care end of life or nursing home stay. Medical case managers follow patients across the continuum of care (home, hospital, nursing home). The service is typically directed at chronically and complexly ill patients, many of whom can be found in both the LTC and DD populations.

Hospitalizations are a key metric of the value of health maintenance. However, the Medicaid program apparently does not require that hospitals report admissions if Medicare is the primary payer, which is the case for the majority of LTC and DD people. Even with the limited admission data available, we note a significant portion of admissions for the LTC and DD population could have been avoided. These avoidable admissions are referred to as ambulatory care sensitive (ACS) admissions. The partial admission data available for our analysis shows about 25% of the admissions are ACS admissions. Although the majority of waiver patients are dual eligible, 20% are Medicaid only with the state paying all hospitalization costs.

The concept of ACS admissions is well established and used in multiple research studies including those conducted by the Agency for Healthcare Quality and Research. ACS admissions involve diagnoses where timely and effective ambulatory care can help prevent or reduce the risk of hospitalization.[4] Timely and effective ambulatory care includes medical case management services as well as physician care. We are aware that the Office of Medicaid is addressing this issue with its application for a Primary Care Case Management (PCCM) grant which financially incentivizes physicians to provide enhanced primary care. We discuss the PCCM model in the section on financial models below.

In addition to noting a significant number of avoidable admissions, we note multiple admissions appear high. Because we have incomplete data for dual eligibles, we closely examined the admission claim data for the minority of patients who do not have Medicare, assuming this data was more complete as Medicaid is the primary payer. LTC beneficiaries without Medicare who had a hospitalization in 2005 were admitted 1.8 times, on average.

Options for Establishing Medical Case Management Services

We believe current resources can be deployed over a one year period to bring medical case management services to people on the LTC and DD waivers.

- Create a system to identify and prioritize waiver patients needing medical case management. A health risk assessment (HRA) tool can be created by waiver administrators and administered by the waiver case manager for each patient at the point of entry into the waiver program and at each key transition in status. A

risk stratification assignment based on HRA information would determine those needing medical case management. For example, HRAs could be scored to produce three risk levels, with the 10% to 20% of beneficiaries with the highest scores assigned "level 3" and targeted for medical case management services. Patients could move up or down among risk levels based on re-evaluation by both the waiver case manager and the medical case manager.

- Establish protocols for medical case management activity according to the patient's risk level. Case management services should be performed across the care continuum working closely with patients, families and providers including home care and hospice agencies providing skilled services and hospital and nursing home discharge planners in the event of an admission. The majority of case management services can be performed telephonically.

- Redeploy existing resources such as the *Healthy Living* services to implement integrated care management. Currently, the state waiver administrators are aware of the potential to use these services in this capacity but our provider inquiries indicated a lack of both provider knowledge about this service as well as a lack of process to integrate medical case management services with the waiver personal / social case management services.

- Consider extending medical case management services to beneficiaries in the *Community Based In Home Services Program* provided by senior centers under the Older Americans Act Funding (including those 150 patients on the LTC HCBS waiver waiting list). We call these people the "pre-long term care population." We have been informed this program has approximately 2,500 recipients, of whom approximately 50% would qualify for Medicaid if they became LTC eligible. Although current expenditures average much lower for this population than those on the waiver ($76/month), this is for a minimal set of services. The risk for nursing home placement could be significant while these people are on the waiting list. Extending medical case management to this population would involve administering the HRA to this group and providing medical case management services to those from this group in the high risk level.

III. Transition Management

Figure 1 below depicts a continuum of service sites for managing the LTC (and pre LTC) and DD populations. The cost of care delivery increases and independence is reduced as an individual transitions from left to right and top to bottom on the service site continuum. Reinforcing services at critical transition points along this continuum can improve opportunities to maintain/establish maximal independence and most efficiently use LTC and DD Medicaid dollars.

Figure 1: Key Transitions for Long Term Care and Developmentally Disabled Populations

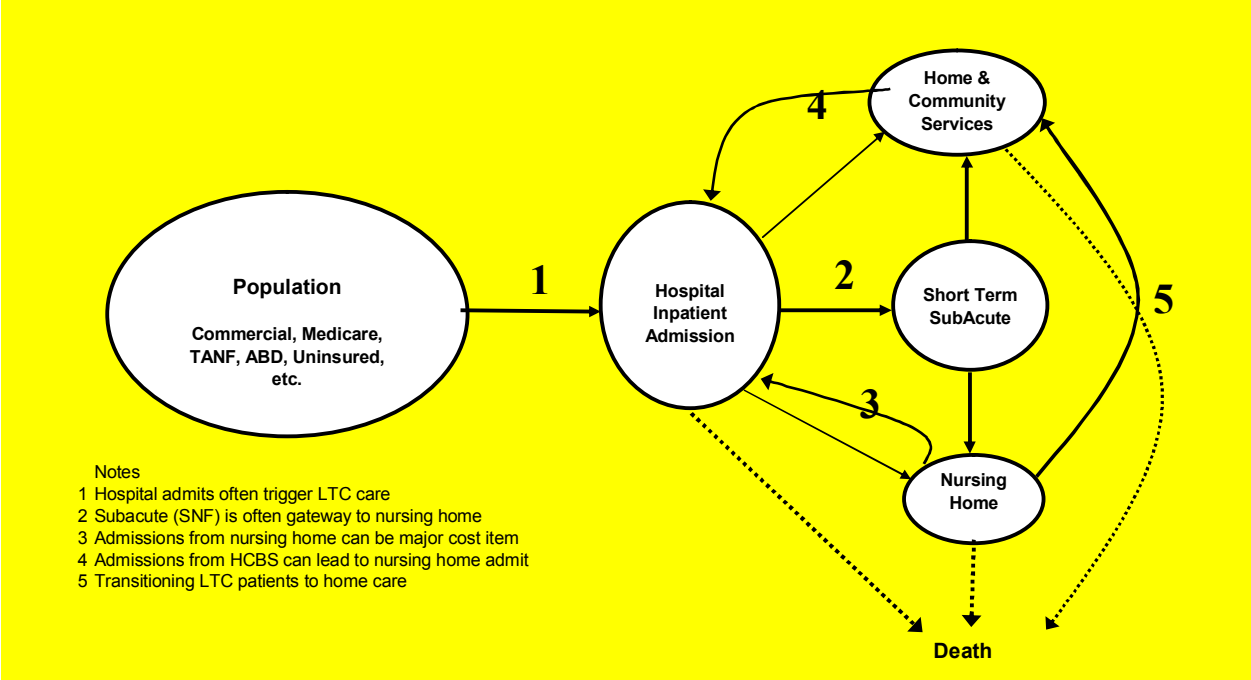
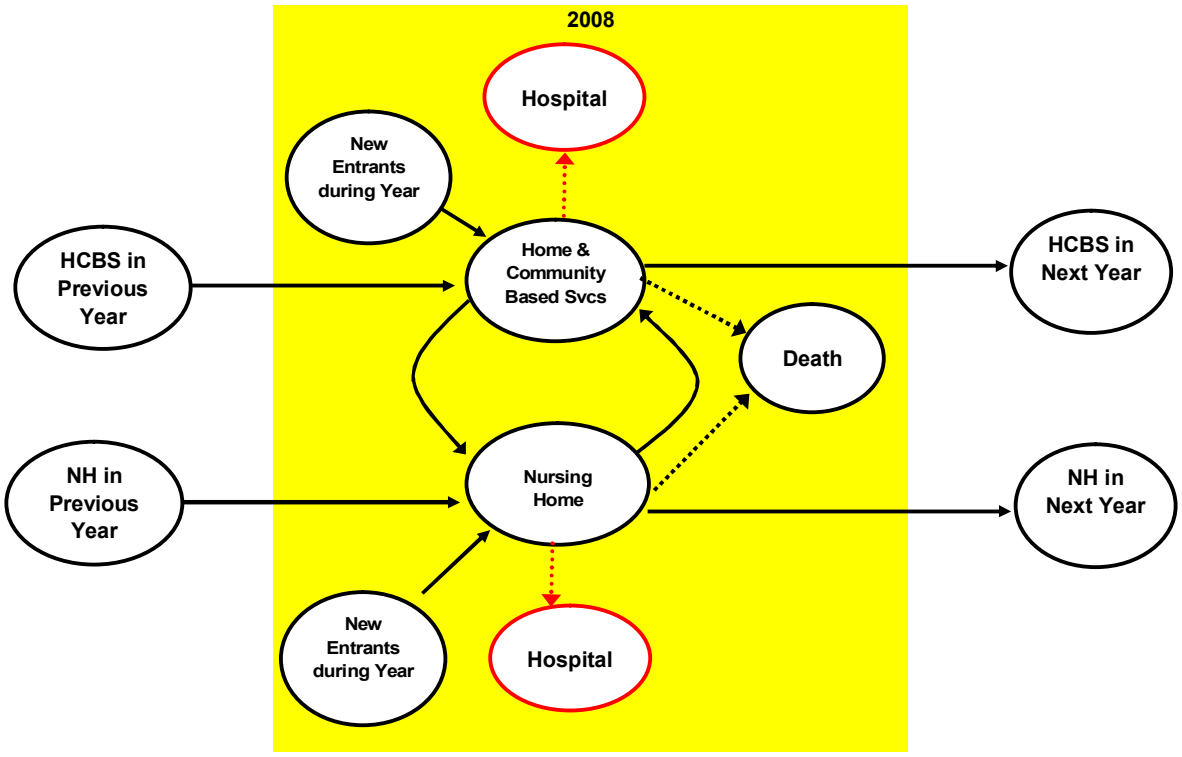


Figure 2 shows how transitions can move patients from one status to another during a year. We show the transitions across time leading into and out from 2008 (2008 chosen for illustration).

Figure 2: Transition of Patients in the Long Term Care Stages



The goal of transition management is to keep beneficiaries in the least restrictive and lowest cost setting possible, or to help beneficiaries move in that direction.

Background

Transitioning patients from nursing home and intermediate care facilities for the mentally retarded (ICF/MR) to the community has been the cornerstone of increasing independence and reducing Medicaid costs for LTC and DD patients. Since the *Olmstead v. L.C.* Supreme Court 1999 decision, affirming the right of individuals with disabilities to live in the most integrated setting that is appropriate to their needs, there has been increased federal funding to support states efforts to transition LTC and DD patients from institutions to the community (often referred to as "rebalancing").

Wyoming has had much success in their efforts to transition the majority of DD institutionalized to community settings, which reduced the number of institutionalized at the State Training School (the only ICF/MR in Wyoming) from more than 700 patients in the 1970s, to approximately 90 patients today after the *Weston et al. v. WSTS* lawsuit. Wyoming is ranked the 13th best performing state for percentage of Medicaid dollars spent on the DD population for community-based services vs. institutional based services. In Fiscal Year 2005, Wyoming spent 80.7% of its DD dollars on community-based services compared to 58.4% nationally. [5]

The Project Out program, funded under the Real Choice System Change Grant in 2003, has had significant success transitioning LTC nursing home residents to the community.

The process involves routinely evaluating nursing home residents to identify likely candidates for transition and determining program assistance and support services for making the transition successful. The grant for Project Out recently expired and the state has appropriated funds to continue the program. Two Independent Living Centers provide Project Out services: Wyoming Services for Independent Living (WSLI) and Wyoming Independent Living Rehabilitation (WILR). State administrators and program providers report that the project exceeded targets with a total of 123 individuals transitioned from nursing homes to the community in its first three years, and it expects to transition an additional 80 nursing home residents to the community this year. We provide suggestions for enhancing the new *Project Out* diversion initiative.

Potential for Transition Management

We recommend the Medicaid program measure and monitor transitions across service sties for the LTC and DD populations to identify the impact of programs and need for program enhancements. Refer to Tables 1 and 2 of section I for the summary of transition statistics we mention below.

Potential Transition Management for LTC

Our claims data/eligibility analysis indicates that in 2005, the majority of LTC Medicaid beneficiaries are living in nursing homes: 2,619 in nursing homes compared to 1,731 managed in the LTC and ALF waiver programs. Among states, Wyoming is 29th in the portion of Medicaid dollars spent on community-based services for the aged and disabled LTC population compared to institutional based services. For Fiscal Year 2005, Wyoming spent 20.0% of its LTC dollars for community-based services compared to 27.1% nationally.[6]

While variations in reporting, cost levels and data quality limit the value of such national data, we believe Wyoming can maintain more people in the community by enhancing transition management initiatives for the LTC and near-LTC populations. We suggest program and process enhancements below. Some of these can be operationalized quickly at no cost to the state, while others will require time and budgeting.

1. Expanding Project Out

We note that Project Out has recently expanded its efforts to divert hospitalized patients from LTC placement in nursing homes. Staff has begun educating hospital discharge planning staff about the LTC and ALF HCBS waiver options and the short term services Project Out can provide for those at risk for nursing home placement. The Project Out administrator indicates their services can only be provided to Medicaid eligibles and not those pending Medicaid eligibility. This creates a service gap for a significant portion of those at risk for nursing home placement.

- We suggest considering modifying policies to grant presumptive eligibility (waiver while waiting) for those awaiting Medicaid eligibility for the HCBS waiver and expanding Project Out to intervene for these individuals at risk for

nursing home placement. Several states report that few people granted presumptive eligibility ultimately do not qualify for Medicaid. CMS does require patients to agree to financial liability for the waiver services provided if eligibility is not established.

- We suggest Project Out enhance its diversion program through two concepts: Rapid Response and Fast Track.

  Rapid Response: The focus of the Project Out diversion program is provider education and support. We suggest a rapid response process be established through which all hospitals are required to notify Project Out when they have a patient at risk for nursing home placement. The team would perform an assessment within 48 hours of notification to establish comprehensive options for discharge to the community, if possible.

  The notification and response effort would occur regardless of Medicaid status. The state should have a registry of all people meeting medical necessity criteria for LTC services, regardless of payer, because many will spend down and eventually become Medicaid eligible.

  The rapid response service can be extended to address new admissions to nursing homes that are at risk for LTC placement. Some patients are placed in nursing homes with an expected short stay, but they are at risk for converting to LTC. The nursing home would be educated to notify Project Out staff if they received an admission that meets at risk criteria. Project Out would assess these patients while they are in the nursing home with reassessment at appropriate intervals (2-4 weeks).

  Another component of nursing home involvement would be the contractual requirement that all nursing homes notify Project Out of all LTC admissions, regardless of payer, with the intent of catching patients when hospitals failed to provide such notification. In a later section, we describe an information system which enables Medicaid program administrators to monitor and manage at risk and current LTC patients.

  The rapid response program can be extended to cover the pre LTC population, particularly those on the LTC HCBS waiver waiting list and those in the *Community Based In Home Services Program* provided under the Older Americans Act programs. If medical case management is extended to this population, *Project Out*'s services would not be needed for this purpose.

  We suggest the State consider requiring Medicaid certified hospitals to report all Medicaid beneficiaries' admissions even if the admission is covered by Medicare. This notification will enable the State to establish accurate utilization statistics and activate the alert process needed to

trigger rapid response by Project Out staff as well as medical case management discharge planning activities.

Fast Track involves expediting Medicaid eligibility. Some states have established staff at hospitals to expedite the Medicaid application. We are not aware of State efforts and suggest potential options be analyzed.

We note that the Aging & Resource Center grant received by Wyoming Institute for Disabilities (WIND) can provide the resources for a single point of entry and can help identify recipients who are at risk of placement in an institution.

2. Barriers to transitioning eligible patients out of nursing homes.

The Assisted Living Facility Waiver (ALFW) had more than 45 people on its waiting list in late FY 2006.[7] State administrators, waiver providers, and nursing home administrators indicate a shortage of ALF facilities to serve the LTC population and note that patients could be transitioned out of nursing homes if ALF facilities for low income people were available.

- Encourage creating additional low income ALF capacity. The feasibility of utilizing The Assisted Living Conversion Program (ALCP)[8] for the frail elderly for nonprofit owners, offered by the US Department of Housing and Urban Development should be investigated. Funding is provided for physical conversion of existing project units, common and service space. Private nonprofit owners of Section 202, Section 8 project-based including Rural Housing Services' Section 515, Section 221(d)(3) BMIR, Section 236 housing developments that are occupied by the elderly for a minimum of five years are eligible for this funding.[9]

  Section 202 Supportive Housing for the Elderly Program has two current grant initiatives. Under the first, HUD finances construction, rehabilitation or acquisition of structures that serve as housing for very low-income elderly persons and provides rent subsidies for the projects to help make them affordable.[10] The second initiative provides rental assistance funds to cover the difference between the HUD-approved operating cost for the project and the renter's contribution towards rent. Project rental assistance contracts are approved initially for 5 years and are renewable based on the availability of funds[11].

  While Section 8 vouchers through HUD for rental subsidy seem focused on the DD population, we believe at least one state has used these to help with assisted living facilities for the LTC population. Typically, the tenant pays 30% of their adjusted monthly income toward rent (including utilities) and the housing authority pays the difference. The vouchers cannot be used to pay for meals or services and cannot be used for continual medical or nursing care[12].

We noted that few high acuity patients were enrolled in the LTC HCBS waiver; the $900 PMPM waiver budget cap (or limit) seems designed to support relatively low acuity patients. Although higher acuity patients will require more waiver services (and budget),

skilled home care services and medical case management, the cost should be less than for nursing home care and the quality of life enhanced for appropriate patients. The state can further analyze the feasibility of creating a high acuity LTC HCBS waiver for this special population by examining the potential to deinstitutionalize some LTC nursing home people with more intense support.

3. Potential to enhance waiver services and waiver slots to reduce nursing home placement of waiver patients.

The data indicate 25% of ALF waiver patients and 11% of HCBS waiver patients transitioned into nursing homes in 2005. Medical case management may help reduce this transition rate, but enhanced waiver services may also help, so we suggest analyzing the ALF waiver population to determine appropriate triggers and opportunities to intensify waiver services to avoid institutionalization.

Currently 150 patients are on the HCBS LTC waiver waiting list.[13] We understand some waiting list patients are placed in nursing homes while on the waiting list. We suggest conducting a budget feasibility study of expanding the waiver slots.

Waiver services may be enhanced with a shift to more LTC patients accessing self directed care. Currently 150 patients in the LTC HCBS waiver utilize self directed benefits. These are mostly disabled younger people (spinal cord injuries, multiple sclerosis etc.). Under self directed care, individuals are given a budget for their care needs which can be administered by the individual to purchase the services they deem necessary. This approach is believed to allow for more efficient and effective utilization of services.

Potential Transition Management for DD

There is little opportunity to shift site of care for the DD waiver population, and we address the issue of the non-waiver, Wyoming State Training School (WSTS) in a subsequent section. We do not detail opportunities for transitions from the WSTS to the community, but note that several knowledgeable people familiar with DD waiver programs suggest most residents can be transitioned.

An initiative is underway to apply for funding under the Systems Change Grant Money Follows the Person Program to promote moving DD patients to self directed care. This may provide DD patients with enhanced services in the community, improve their ability to avoid institutional placement, and improve independence. Self directed care is the preferred model in many states for DD people who are deemed capable.

DD providers and state administrators have strongly indicated that mental health services under all DD waivers are limited due to workforce and budget issues. Although a specialty provider exists to care for people with dual mental illness / DD diagnoses, direct geographic reach and funding of this provider are limiting factors. Consideration of DD/BH waiver to provide additional services by qualified staff may avoid admission to the state hospital, acute inpatient facilities, and nursing homes.

We did not explore the feasibility of Project Out like services for dually diagnosed (DD and mental health) residents of the State Hospital but offer this as a potential opportunity.

Transition Management Information System

Medicaid information systems focus on paying claims and recording eligibility. The data collected is typically not as detailed as for Medicare or large insurers. Many of the 50 state Medicaid programs are smaller than many insurers and certainly smaller than Medicare, so these programs have not had the scale to justify strong information system development. Furthermore, unlike the commercial world, detailed information offers no competitive advantage to a Medicaid program.

We believe that, by themselves, none of the current information systems used in Wyoming's Medicaid programs could effectively support transition management. For effective transition management, administrators and providers need real time information about the at-risk population and need a system that triggers intervention by appropriate staff. We call this a Transition Management Information System (TMIS).

A TMIS system can either be assembled from existing systems -- the SAMS system for the Older American Act programs, the waiver database, the MMIS claims and eligibility system for example. Another option is to purchase or build a web based system that will interface with claims, eligibility and the SAMS system. In either case, waiver administrator staff would need to provide oversight. Waiver providers would enter their care plan and service delivery data, and hospital and nursing homes providers would input the essential data on their at risk or actual LTC patients. This information would trigger rapid response efforts. Project Out staff would record the findings of the rapid response and plans for any transition out of nursing home. Of course, policies and procedures for data, triggers and alerts and response would need to be established and documented.

The reports and real time access that the system would allow can be used to better manage internal staff and provider activity.

Potential Funding Opportunities

Some of the above suggestions would require extending Medicaid services to people who are not otherwise eligible for Medicaid. In general, CMS requires demonstrating two advantages:

I. Cost neutrality. The extra cost of the proposed service is offset by other savings.

II. Improved quality.

Under cost neutrality, the Medicaid program would not pay more in total if it provides the proposed service. As an example, the proposal would need to demonstrate that providing transition management to frail elderly who are not Medicaid eligible reduces the need for nursing home care, and the extra cost of transition management would need to be offset by the savings coming from reduced nursing home care.

The Deficit Reduction Act of 2005 has replaced several 1915(c) waiver programs with the requirement that the state create a State Plan Amendment, and this method can be used to extend waiver programs. As a result of the DRA, states may provide a full range of home and community based services (HCBS) through their state plan to the elderly and developmentally disabled beginning in January 2007. Previously, the majority of these services could only be provided through HCBS waivers. Individuals with disabilities and the elderly with incomes up to 150% of the FPL would be eligible for services. Individuals would not need to meet criteria for institutionalized care, as it is currently required of HCBS waiver participants[14]. Unlike most other state plan services, states may establish: enrollment caps; waiting lists; and exceptions to state wideness requirements (to provide services in all areas).

We also suggest that Wyoming consider the use of a Section 1115 waiver, which is designed to promote testing of new ideas through demonstration projects. CMS considers a Section 1115 waiver as a research platform for testing innovations or issues of interest to CMS[15].

We have been told that the waiver program has limited respite care and providing more respite care can avoid some nursing home admissions. Potential funding for respite care may be available through Real Choice Systems Change grants.[16]

Regional Health Information Organizations

Regional Healthcare Information Organizations (RHIOs) are emerging, experimental systems that assemble complete clinical information about a patient and bring that information to a provider in real time. We include this section because of the national attention being given to RHIOs in the health community and publications. We understand Wyoming has developed WyHIO to increase the healthcare information technology in Wyoming.[17] This would be a much more ambitious enterprise than the Transition Management Information System we describe above.

RHIOs can collect data from physicians, labs, hospitals, pharmacies, patients, public health departments, nursing homes and payers. Under most designs, electronic medical records are an essential source of data for RHIOs. Data is typically stored in one central repository (or data warehouse) and providers input data into a registry, which is sent directly to a RHIO for addition to the repository. Appendix III illustrates one possible RHIO structure. These are not Medicaid-specific organizations, and because Medicaid covers only about 15% of the Wyoming population[18], we do not expect the Medicaid Department to lead efforts for a Wyoming RHIO. We note that, because some population centers have large concentrations of Medicaid recipients, Medicaid programs in other states can play a dominant role in local RHIO efforts.

More than 150 RHIO-type organizations have been formed to date[19], although few, if any, are fully functional. Inland Northwest Health Systems/Northwest RHIO (Washington), Taconic Health Information Network and Community (New York), and California Regional Health Information Organization[20] are three examples. The programs can span a

metropolitan area, region, or entire state. These systems are experimental, and many different designs and approaches are being tested.

RHIOs can help long term care and DD programs by bringing acute care information to the long term care provider, bringing long term care information to the acute care provider, and by reducing the isolation of providers. RHIOs allow a participating provider to have a patient's full medical history at his or her finger tips —whether or not the patient has seen that particular provider in the past. Guidelines can be embedded in medical records and alert the provider of the need for preventive care for a patient.

A RHIO can assist case management by giving the care manager a longitudinal view of a patient's medical history, changes in patient health or lab values. Disease management organizations can use RHIO data to conduct better population management. For example, RHIO data can help a DM company notify all diabetic patients whose blood tests are overdue or generate a report of all patients with test scores in the abnormal range as a prelude to more intervention. In a RHIO, the information is generally obtained automatically and directly from the provider, without the delays of waiting for payer data.

Challenges in developing a RHIO in Wyoming include high startup costs, shortage of high speed internet access, and general reliance on paper medical charts. Much useful information such as history of diagnoses, procedures, hospitalizations and prescriptions can be obtained from administrative data such as payer's claims. Obtaining such information is much easier than obtaining certain medical chart data, so this represents a lower cost approach to creating a RHIO.

RHIOs have their strong advocates.[21] We are skeptical of the more aggressive claims of cost savings and quality improvements and would warn against underestimating the difficulty of implementing a RHIO. RHIOs are experimental, and it is not clear which approaches will prove viable and which will be abandoned. However, we believe RHIOs and electronic medical records will be an important part of improving the health care system. We recommend that the Medicaid department participate in WyHIO to ensure that Long Term Care and DD programs are well represented and have a role.

RHIOs need funding for both the initial start up and on-going operations. Grants can come from the federal Agency for Healthcare Research and Quality (AHRQ) or Health Resources and Services Administration (HRSA) for system development. Other funding sources include grants through Section 646 of the Medicare Modernization Act. Section 646 is a 5-year demonstration program under which CMS will test major changes to improve quality of care while increasing efficiency across an entire health care system. The Demonstration recognizes the use of health IT to improve quality.[22] Other sources of funding include private businesses, such as major local insurers and healthcare providers. Most RHIOs plan to fund at least some of their on-going operations through user or membership fees.

WyHIO has established collaboration with AHRQ and the potential of funding from AHRQ has been raised.[23]

Consolidation of Senior Centers

Each of Wyoming's 23 counties has at least one senior center, with a total of 37 main senior center corporations (plus two meals-on-wheels programs) serving over 81 sites throughout the state. These centers are partially funded through the Aging Division, by means of federal Older Americans Act and other grants to the state from the federal Administration on Aging. The State provides varying amounts of matching funds for these projects, and the community grantees provide any remaining match amounts.

The senior centers provide or arrange for a variety of supportive care services to seniors, both Medicaid eligible and otherwise. Senior centers' services can supplement services received by HCBS LTC waiver patients, and they help to avoid or delay the need for other seniors or disabled adults to access more intensive Medicaid-supported LTC services.

The small size of some of the centers suggests it would be very difficult for some to support the transition management information system or the medical case management approach we suggest here. Several stakeholders we interviewed suggested that it may be useful to explore possible options for regionalization of targeted grant programs' administrative functions (grant writing, reporting, fiscal management, data input) to assist very small providers in meeting their federal and state accountability requirements. As this can be a major challenge, a pilot project may be established to determine whether or not such an arrangement, or coalition, of providers can be successful in our very rural state. It seems likely to us that this targeted regionalization can be accomplished.[24]

III. Financial Model Options

This section identifies options for Wyoming to use managed care funding techniques to create positive changes for the LTC and DD beneficiaries. We focus on the advantages of the State working within fixed budgets, with a strong financial incentive and the freedom to deploy resources and spending. We offer very high-level descriptions. While we identify some important advantages of these models, we would caution that a great deal of work and planning is required to launch successful integrated programs.

By "managed care funding" we mean obtaining advanced funding from CMS equal to the level of expected expenses. If the Medicaid program can deploy this money more efficiently than in the past, it will generate a surplus that it could use to expand services or service additional people. This approach means accepting the financial risk that costs may be higher than expected. In a sense, the state lives with that risk currently with the risk that Medicaid spending can be higher than budgeted, but the federal government would normally share in Medicaid expenses beyond the budget.

One option for advanced funding is to work with CMS to set fixed funding several years into the future. This option would, at a high level, have the following features:

- The advanced funding would be set on a per-capita basis for each program. This option has the advantage that funding would vary appropriately if more or fewer people enrolled in a program.

- Wyoming Medicaid and CMS would agree to per-capita budgets for several years in advance. These budgets would meet federal budget neutrality requirements.

- A historical baseline spending figure including administrative fees (such as 2005 spending) would be rolled forward using an agreed upon annual trend.

- Federal revenue to the state would equal the federal matching percent multiplied by the budget. The state would pay for excess spending beyond the budget without federal match.

Under this program, many, but not all, federal Medicaid requirements would be waived; if Wyoming can identify ways to save Medicaid funds, it can use those savings to expand coverage.

Table 7 provides a simple example of how advanced funding could work using illustrative numbers. An actual program covering both medical and person care would probably set separate budgets for each program that varies by whether the person also has Medicare coverage.

Table 7: Illustration of Advanced Funding

	Budget	Actual Spending	Savings
	$ Per Member Per Month (PMPM)		
Historical Baseline (2005)	$1,000	$1,000	$0
Agreed Upon Trend	5%		
2008 (3 years trend applied to 2005 baseline)	$1,158	$1,128	$30
2009	$1,216	$1,166	$50
2010	$1,276	$1,196	$80
2011	$1,340	$1,240	$100
2012	$1,407	$1,287	$120

Many states have used a similar approach to fund their Medicaid Managed Care programs, under which HMOs bid to take responsibility for managing and paying HMO claims. In these cases, the HMO usually bears financial liability if spending exceeds their bid. However, Wyoming has very low HMO enrollment: 12,000 in 2003[25]. While other states have shifted Medicaid enrollees (mostly in the TANF population) to private managed care plans, the lack of managed care organizations seems to preclude this option. We believe that Wyoming can establish its own state-wide managed care program using existing categories of vendors. Along these lines, we consider options for the following:

- Medicaid-only Program. The State can work with CMS to obtain fixed funding. This may apply to certain categories of services (such as LTC) or to all Medicaid expenditures.

- Combined Medicaid and Medicare Program for LTC and/or DD. This would give the State control over both funding streams.

Combining Medicaid and Medicare funding streams is attractive because so many LTC and DD are covered by both programs. In addition, combining funding streams allows the two programs to work synergistically – basically to improve coordination between waiver and medical care.

These models can be implemented over several years; for example, the State can begin with a Medicaid only program and expand it to include Medicare funding.

Limitations of the Current Care Funding Model

Current funding models from Medicaid and Medicare pose special challenges for LTC and DD beneficiaries. These beneficiaries receive two types of care:

1. Waiver care, which includes housekeeping, shopping, food preparation, personal care, habitation training, employment support, etc.

2. Medical care, which includes physician, registered nurse, hospital, pharmacy, DME and hospice services.

The goals of both kinds of care should be the same – better patient outcomes. Better waiver care can reduce the need for medical care and better medical care can reduce the need for waiver care.

Under the traditional Medicare and Medicaid programs, integration of custodial and medical care has not occurred for several reasons, including different certifications, isolated professionals, lack of a central point of coordination and different reimbursement depending on the payer. Notably, funding streams are often different, especially when both Medicare and Medicaid are involved.

While Medicaid can pay for both personal and medical care, many LTC and DD Medicaid eligibles can also receive Medicare benefits. Medicare has very limited long term care benefits compared to Medicaid. The rules for these "dual eligibles" are that Medicare pays first, and providers may bill Medicaid for Medicare cost sharing, such as the Medicare Part A deductible or the Part B coinsurance. Prescription drugs for dual eligibles flow through the new Medicare Part D program.

The funding models we describe below can help address some of these challenges.

Medicaid Only Model

Under traditional Medicaid programs, expenditures are shared jointly between state and federal funds. The federal Medicaid matching funds (FMAP) vary by state based on the state's average per capita income level compared to the national average income level. FMAPs vary from 50 percent to 77 percent of spending. Although budgets are set, the expenditures are not known until all the claims are paid, because providers are paid on a fee for service basis.

The State of Vermont received a Section 1115 Medicaid waiver that provides fixed federal funding for Medicaid long-term care expenditures over five years. The State also received a Section 1115 Medicaid waiver that provides fixed federal funding for acute care services. While the mechanics of these two waivers operate somewhat differently, the underlying concept behind the "Global Commitment" and the "Choices for Care" is the same.[26] [27]

Effectively, the state becomes a public insurer (or HMO) receiving a capitation payment (or premium). Table 8 provides an example of a Medicaid Capitation Program funding rates. The capitation payment is a fixed monthly fee per beneficiary to deliver a set of services to a specified group of beneficiaries. The capitation payment rate is determined based on the projected cost of services for a specific population. If the average per member per month cost is greater (lower) than the capitation payment, the insurer loses

(makes) money. In the case of the state receiving a fixed amount of money, if the average per member per month cost is lower than the capitation payment, these funds can be used to provide additional services or fund other health related programs. However, if expenditures per beneficiary exceed the fixed amount, the state will not receive additional federal funding.

The state of Wyoming could apply for a similar waiver for long term care or developmentally disabled beneficiaries. Wyoming would need to create a managed care organization (MCO), likely using vendors to administer aspects of the program. The program would attempt to generate savings by providing care in more efficient, less costly settings, and avoiding inefficiencies. Financial management of such a program involves concepts of prefunding that are not commonly used by governments, but the expertise for this exists widely in the insurance industry. Savings would be used to enhance long-term care benefits, with increased flexibility for the services covered and eligibility, compared to the traditional Medicaid program.

Table 8: Illustrative Example of Medicaid Capitation Program

Number of Beneficiaries	1,000
Capitation Rate	$3,000 per beneficiary per month ($1,500 federal funds, $1,500 state funds)
Total Income	$36,000,000 (1,000 x $3,000 x 12)
Actual Expenditures	$30,000,000 ($2,500 per beneficiary per month x 1,000 people x 12)
Funds Available for Additional Programs	$ 6,000,000

One program for improving Medicaid LTC services is Medicaid Managed Long Term Care (MMLTC).[28] This is structured as an agreement between a Medicaid agency and a contractor (HMO, community services agency, provider organization or other entity) in which the contractor accepts financial risk through a capitated payment for providing long-term care benefits to Medicaid beneficiaries. MMLTC programs exist in Arizona, Florida, Massachusetts, Minnesota, New York, Texas, and Wisconsin. Wyoming's low population density may pose an obstacle to the financial and operational feasibility of MMLTC to private risk takers. However, a state-wide, universal MMLTC is similar to the one aspect of the Vermont approach, and could be feasible in Wyoming.

We note that the Office of Medicaid is considering establishing a Primary Care Case Management (PCCM) program, which combines elements of fee-for-service and managed care. PCCMs were authorized through section 1915(b) of Title XIX of the Social Security Act. Over half of the states are using or have used this model, which can be voluntary or mandatory, state-wide or regional. Typically, the state pays a primary care physician (PCP) a small "case management" fee to manage care for Medicaid

patients. Services performed by the PCP are reimbursed on a fee-for-service basis. The Medicaid members must receive referrals from their PCP for specialist services.[29]

While this model can promote more efficient care, it seems to fit with the larger TANF (Temporary Assistance for Needy Family) Medicaid population. Obstacles for PCCM to work effectively with Wyoming's LTC and DD populations include,

- The coordination needs of LTC and DD involve personal as well as medical care and many primary care physicians are not as aware of those needs.

- A PCCM program can pay to a PCP a small case management fee for each TANF member because most of these members are healthy and need little attention from the PCP. By contrast, all LTC and DD people have continuous needs for personal or medical care, so a per-capita case management fee would need to be much higher for these groups.

- Most PCPs will have many more patients in the larger TANF populations and may focus their case management thinking on the different needs of those patients.

Combining Medicaid and Medicare Funding Streams

This section describes basic issues in combining the Medicaid and Medicare funding streams. As with the Medicaid-only model, the existing history has been with private managed care organizations (MCOs also referred to as HMOs) who accepted financial risk.

For well over a decade, Medicare has delegated its funds and responsibilities to HMOs under Medicare Advantage plans and their predecessors by various names (Medicare Risk Plans, Medicare Plus Choice Plans, etc.). Under these programs, the HMO must pay for all Medicare approved benefits and can offer additional benefits. The HMO member essentially removes themselves from the traditional Medicare program and must follow HMO rules, including rules about utilization management and network restrictions, although those rules are tightly regulated by CMS.

Under Medicare Advantage Plans (now called "Medicare Advantage – Prescription Drug Plans" because these plans must also offer Part D benefits), CMS pays the HMO a monthly amount for each beneficiary who joins the HMO. CMS pays the HMO slightly less than the average amount that person would have cost the Medicare program. In recent years, the calculation for that amount has become more sophisticated, and it considers factors such as medical condition by diagnosis, age, sex, locale, institutional status, and eligibility for Medicaid. In future years, CMS expects to add a "Frailty Adjuster" to the calculation.

CMS has offered four models for integrating Medicare and Medicaid.[30] Each of these relies on private MCOs and the Medicare and Medicaid programs provide funding for certain services covered through the MCO or provided alongside the MCO's services.

Although there are HMOs licensed in Wyoming, they have relatively low enrollment. The HMOs that have succeeded with Medicaid lives have, historically, specialized in serving that population, and, until the development of Special Needs Plans, relatively few have developed the specialized skills and networks needed to serve and manage the LTC or DD populations.

We believe that none of CMS' four models are appropriate for Wyoming because of low HMO presence. However, we believe the State could create a virtual HMO consisting of the entire LTC and DD populations. Combining funding streams in this way would require a Demonstration Project, but it would have many elements of the commercial Special Needs Plans that CMS has been funding for several years.

Under a virtual HMO, the State (or, perhaps, an independent authority) would manage the Transition Management and Integrated Care Management Services described above. These functions could be performed directly or delegated to vendors. As payer, the State would have the added power to link payment to performance. We would envision this program to be mandatory for the LTC and DD programs. Unlike a traditional HMO, this program would not require a marketing or sales force. Claims could be adjudicated through existing mechanisms (including the Part A and Part B Medicare intermediaries) and vendors. CMS is using a type of "virtual HMO" accounting in its High Cost Beneficiary Demonstration Project.

Developing a demonstration project in this way would involve a major commitment by the State, including a team to develop detailed financial and operational plans that meet CMS' requirements and, possibly, legislative authorization. Even with an aggressive immediate commitment, this option would not likely be able to begin before 2009. We note that this approach would likely best be considered as building on one of the Medicaid-only options described above.

We note that CMS has launched Rural PACE grants under the Deficit Reduction Act of 2005 (DRA). PACE stands for Program for All-Inclusive Care for the Elderly, and the first programs were started in 1990. Traditionally, PACE programs are small, with a few hundred members, and they are run by private organizations located in urban areas with a "bricks and mortar" adult day care center. PACE programs provide an array of services to dual eligible beneficiaries who meet nursing home requirements and are at least 55 years old. PACE programs provide an array of services ranging from personal care to hospital services.[31]

The DRA created rural PACE site development grants and technical assistance to encourage the growth of PACE in rural areas. Up to 15 qualified PACE providers will be chosen. While the deadline for the rural PACE has passed for FY 2006, we suggest Wyoming consider encouraging larger providers in the state to explore this option if additional funds become available[32].

Medicare 222 or Medicaid Section 1115 waivers can fund a demonstration project on integrated funding streams. Medicare 222 allows for demonstrations relating to Medicare payment methodology, while Section 1115 allows for program innovations. Minnesota

developed the Minnesota Senior Health Options (MSHO), which combines financing and acute and long-term care delivery systems.[33] Minnesota obtained both Medicare 222 and Medicaid Section 1115 waivers for this project. Under MSHO, older Medicaid or dual eligible people can join one of several Minnesota HMOs, which assumes financial risk for required services.

Illustration of Combined Medicare and Medicaid Funding

Table 9 shows illustrative figures for the funding available by combining Medicare and Medicaid sources. The majority of enrollees are Medicaid + Medical (dual) eligibles for all programs except DD Waiver Child. The purpose of this table is to illustrate the additional resources that could be coordinated through an integrated program. The Medicare funds cover mostly acute care and prescription drugs and relatively little personal care. The figures are estimates not based on extensive data or analysis. We present funding as "Premium Rates" such as an HMO would receive.

Table 9: Illustrative 2008 Premium Rates for Combined Medicare and Medicaid Funding

Program	Eligibility	Medicaid Funds PMPM	Medicare Funds PMPM	Total Funds PMPM
ALF Waiver	Medicaid + Medicare	$1,175	$1,575	$2,750
	Medicaid only	$2,300	N/A	$2,300
LTC Waiver (home)	Medicaid + Medicare	$825	$1,475	$2,300
	Medicaid only	$1,675	N/A	$1,675
LTC Non-Waiver (nursing home)	Medicaid + Medicare	$3,000	$1,725	$4,725
	Medicaid only	$3,500	N/A	$3,500
ABI Waiver	Medicaid + Medicare	$3,200	$1,375	$4,575
	Medicaid only	$3,650	N/A	$3,650
DD Waiver Adult	Medicaid + Medicare	$5,200	$1,375	$6,575
	Medicaid only	$5,700	N/A	$5,700
DD Waiver Child	Medicaid + Medicare	$1,600	$1,325	$2,925
	Medicaid only	$1,950	N/A	$1,950
DD - Non-Waiver (State Training School)	Medicaid + Medicare	$7,500	$2,500	$10,000
	Medicaid only	$10,000	N/A	$10,000

Note: Medicare funds include the cost of prescription drugs under Part D.

IV. Human Capital Approach to Reimbursement and Labor Force

Wyoming faces serious shortages of health care workers and professionals. Some of these shortages are historical and associated with Wyoming's rural areas. Other shortages are more recent and associated with Wyoming's current tight labor market. As Wyoming addresses these issues, we suggest Wyoming consider its labor force and its skills as a long term investment.

Especially with care workers, wages are very closely linked to reimbursement. In particular, margins for smaller home care agencies appear tight, and many home care agencies have closed in recent years.

We identify several options:

- Comprehensive revision of fee schedules with labor force and technology change issues in mind
- Encouraging self-directed care with the beneficiary having "employer authority," which has been demonstrated to expand the labor pool
- Labor force / education and related funding opportunities
- Amending the Nurse Practice Act to allow greater delegation to unlicensed workers.

The traditional approach to attracting workers in a tight labor market is to increase wages. While we believe increasing wages is an important part of the solution, the reimbursement system, including performance-based incentive elements described below, should be altered to also shift skills and services toward more efficiency and quality. In other words, reimbursement strategy should be used to shift the system in a desired direction, not just to solve the need for more labor.

Background

Wyoming's unemployment rate is 3.0% compared to the national average of 4.8%[34] (see Table 10). Of course, most people view a low unemployment rate positively, but it does create a labor shortage, and all providers and Medicaid administrators we interviewed mentioned Wyoming's tight labor market and the shortage of care workers and professionals. The overwhelming sentiment is expressed is that the shortage is becoming more profound and is beginning to or will shortly impact the quality of care delivery and the reach of care delivery.

Although Wyoming wages for homecare workers are comparable to those of neighboring states, Wyoming has lower unemployment:

Table 10: Unemployment Rates

State	Unemployment Rate[35]	Average Hourly Wage, Home Health Aide [36]
Wyoming	3.0%	$9.42
Colorado	4.7%	$9.72
Montana	3.8%	$8.73
Nebraska	3.2%	$9.99
Idaho	3.6%	$8.86
National	4.8%	$9.34

We understand the high number of unfilled positions poses significant challenges to some agencies and nursing homes.

As Table 11 shows, Wyoming also has significantly fewer physicians and psychiatrists than national average although it is somewhat more comparable to neighboring states:

Table 11: Physicians Per 100,000 Residents

State	Physicians per 100,000 residents[37]
Wyoming	191
Colorado	268
Montana	224
Nebraska	243
Idaho	175
National	281

Wyoming has fewer healthcare professionals than most other states. Table 12 shows statistics from 2000.[38]

Table 12: Wyoming Healthcare Professionals National Ranking

	Ranking
People Employed in the Health Sector	39th
Physicians Per Capita	46th
Licensed Practical/Vocational Nurses	44th
Pharmacists Per Capita	6th
Psychiatrists Per Capita	49th
Psychologists Per Capita	12th
Social Workers Per Capita	49th
Home Health Aides Per Capita	41st
Nursing Aides, Orderlies, & Attendants	28th
Hospital Beds	10th

CMS statistics[39] for skilled nursing facilities (SNFs) provide an indication of the labor force needs. SNFs provide much more medical services than nursing homes, so these figures are not directly appropriate for the custodial care in nursing homes that is described in this report.

While the federal statistics show that key quality measures for Wyoming SNFs exceed the national average, the statistics do suggest a shortage of labor and a higher rate of deficiencies than national average (see Table 13).

Table 13: Quality Metrics for Skilled Nursing Facilities

Measure	**Wyoming**	**National**
Average Number of Residents	41	48.3
Licensed Nursing Staff Hours per Day per Resident	1 hour 54 minutes	2 hours 36 minutes
Registered Nurses	1 hour 18 minutes	1 hour 30 minutes
Licensed Practical Nurses	36 minutes	1 hour 6 minutes
Certified Nursing Assistant Staff Hours per Day per Resident	2 hours 42 minutes	2 hours 36 minutes
Average Number of Health Deficiencies	12	8

Revision of Fee Schedules to Better Promote Goals

Fee schedules define the payments to care providers for particular services. Inflation and changes in medical and care practice are reasons for revising fee schedules. Often, fee schedules reflect historical decisions and updates are not made systematically. Modernizing a reimbursement structure is a significant project and can take many months. We provide general guidance and principles of such a change here.

While we have not performed a comprehensive review of the Medicaid fee schedule, we have identified relationships among fees that could be obstacles to incentivizing the provision of most effective care delivery. In particular,

- Day habilitation reimbursement is higher than supported employment.
- Group home day supervision reimbursement is higher than supported living supervision.

We recommend Wyoming seek funding to support a systematic review of its fee schedule with the following goals in mind:

- Consistency with other established based fee schedule relativities, such as Medicare's Resource Based Relative Value Scale (RBRVS)[40], where the relativities are based on the resources consumed in providing the service.
- Encouraging services that enable beneficiaries to stay in lower intensity settings (home instead of nursing home).
- The close link between reimbursement and wages, and the potential for higher wages to increase the supply of workers for categories with many unfilled positions.

We understand that a "Continuation Budget" approach has been proposed to the Wyoming legislature that would create a systematic budget approach and give the Medicaid director authority to set reimbursement structures.

We note that some providers have suggested creating a "Local Economy Differential" for the counties whose labor market has been tightened by the energy extraction industry. We note that Centers for Medicare and Medicare Services (CMS) uses a geographic wage index to determine Medicare reimbursement rates, but it uses only one factor for all of Wyoming, although surrounding states are differentiated by region. Table 14 shows the wage index used by CMS.

Table 14: CMS 2007 Proposed Wage Index for Wyoming and Surrounding Areas[41]

Geographic Region	Wage Index
Wyoming (urban and rural)	0.9303
Idaho – Rural	0.8674
Idaho Falls, ID	0.9300
Utah – Rural	0.8163
Logan, UT	0.9049
Colorado – Rural	0.9331
Fort Collins, CO	0.9594
Nebraska – Rural	0.8691
South Dakota – Rural	0.8485
Rapid City, SD	1.0359
Montana – Rural	0.8591
Billings, MT	0.8740

The absence of distinctions in CMS's wage index among regions of Wyoming means Wyoming would need to conduct its own study to justify such a differential.

Principles of Pay for Performance and Benchmarks

Pay for Performance is a widely publicized reimbursement approach to promote quality and efficiency. Both Medicare and private payers are adopting systems that increase or decrease reimbursement to providers depending on patient outcomes and provider performance. The goal of these programs is to reward providers who produce superior outcomes and to penalize those who produce inferior results. For example, some HMOs provide bonuses to primary care physicians whose patients have high compliance with mammograms or influenza vaccinations. These kinds of rewards / penalties also apply to disease management companies and other vendors.

HMOs have used performance incentive payments for years with their networks. Other payers such as CMS are adopting these techniques. Several state Medicaid programs have started to use performance measurements in their contracts with disease management vendors. We expect that in future years Wyoming's Medicaid program will seek to apply incentives in several ways.

Key ingredients of these programs, sometimes called Pay for Performance (or P4P) are,

1. The program should use clinically meaningful but practical outcomes. A disease management company's success may be measured on how many people with high

cholesterol have filled at least one prescription for a statin. However, this makes little sense, as the goal of controlling cholesterol is to have people on a statin continuously (12 30-day prescription in a year, not simply one or more). An even better measure would be the patients' laboratory values of cholesterol, but this is usually impractical as few organizations have the data or systems in place to track such outcomes.

2. The provider should have significant control over the outcomes being measured. It makes little sense to judge a dermatologist on how often his or her patients visit an emergency room (ER) – the dermatologist does not control ER visits. By contrast, many organizations reward pediatricians if they achieve a high rate of childhood immunizations among their panel of patients, because pediatricians can have a significant influence on immunizations.

3. The benchmarks and system needs to be designed intelligently. A system that simply requires an improvement over the previous year will penalize the best practice providers: a pediatrician who has reached 90% compliance with childhood immunizations will find it impossible to improve by 20%, while one with 35% compliance will find it easy to improve by 10%. A dysfunctional reward system would pay a bonus to a pediatrician for improving from 35% to be 42%, but not reward the pediatrician already performing very well.

4. The measurements need to be statistically meaningful. The LTC and DD populations are small, and the numbers of LTC and DD beneficiaries being treated by a single provider will mostly be small. If a provider is being measured based on their results with only a few patients, the numbers might reflect statistical fluctuation rather than medical practice.

Needless to say, fairly sophisticated data systems and management oversight are needed to successfully administer these programs.

Nurse Practice Act Issues

The future supply and demand for nurses has been a focal point for public policy debate[42], which, of course, falls outside the scope of this report. We note that other states have amended their Nurse Practice Acts to allow non-licensed employees to perform certain functions. Several people we interviewed mentioned this issue in connection with labor shortages. In addition, we were informed of issues relating to the administration of LPN qualifying exams that may be an obstacle for some potential LPNs.

Changes to Wyoming's Nurse Practice Act would be needed to allow care givers including family members to administer oral medications. Because of the important role of this regulation to the entire health care system beyond the LTC and DD populations, Wyoming may want to gather information on other states' amendments to their nurse practice acts.

Using Self Directed Care to Expand the Workforce

A market-based approach to more effective spending for HCBS is to allow the beneficiary to choose the kinds of services and the particular providers. This is intended to not only encourage better care but to encourage home care over institutionalization. These programs can allow the beneficiary to hire family members. Program evaluations have demonstrated quality improvement and expansion of the workforce.[43] [44]

To quote from the CMS website[45], the "Independence Plus" programs offer two methods of self-direction:

- Participant Employer Authority. Under the Employer Authority, the participant is supported to recruit, hire, supervise and direct the workers who furnish supports. The participant functions as the common law employer or the co-employer of these workers. When the Employer Authority is utilized, the participant rather than a waiver provider agency carries out employer responsibilities for workers.

- Participant Budget Authority. Under the Budget Authority, the participant has the authority and accepts the responsibility to manage a participant-directed budget. This authority permits the participant to make decisions about the acquisition of waiver goods and services that are authorized in the waiver service plan and to manage the dollars included in a participant-directed budget.

We understand that Wyoming currently uses a participant budget strategy for some LTC Waiver people for HCBS that involves local planning teams, and that the Medicaid Dept. expects to expand this to the DD population. Extending this program through the "Participant Employer Authority" may help alleviate the shortage of care workers. We note that this enhanced beneficiary decision-making requires additional protections and administrative oversight by the Office of Medicaid.

V. Promoting Better End of Life Care

Because of the LTC population's frailty and age, we expect high mortality rates, and end of life care becomes a critical issue. One measure of poor healthcare quality is the portion of deaths that occur in a hospital. Fortunately, Wyoming ranks among the lowest in the nation in this measure (see Table 15).

Table 15: Wyoming Has Fewer Medicare Deaths in Hospital than National Average

State	Percent of Medicare deaths occurring in hospital[46]
Wyoming – Casper	25.3%
Colorado – Fort Collins	21.3%
Montana – Great Falls	23.3%
Nebraska – Omaha	28.0%
South Dakota – Rapid City	24.6%
Idaho – Idaho Falls	23.9%
National	30.4%

On the other hand, Wyoming's hospice enrollment is among the lowest in the nation (see Table 16). This suggests that there may be a gap in palliative care services, which reduces the quality of end of life care.

Table 16: Wyoming has Low Hospice Use

State	Percent of decedents enrolled in hospice during last six months of life[47]
Wyoming	16.3%
Colorado	39.3%
Montana	20.3%
Nebraska	24.5%
South Dakota	14.6%
Idaho	23.5%
National	27.2%

Several Medicaid administrators and providers noted shortage of hospice providers. Ways to alleviate this shortage include,

- Encourage home care agencies to create hospice units
- Promote hospice use through education and conferences, especially to oncologists and primary care physicians
- Solicit leadership from within Wyoming's hospice community to develop turn-key programs to help establish hospice services.

VI. Future of the State Training School

The Wyoming State Training School (WSTS) at Lander provides intensive services for fewer than 100 developmentally disabled Medicaid beneficiaries, with a FY 2008 budget of about $25 million. WSTS is the only Wyoming ICF-MR facility available for families needing this option, and, with 470 employees, it is a major employer in Lander. The viability of this facility has been questioned in the recent past and is a controversial issue. Emerging improvements and trends that encourage treatment of Developmentally Disabled individuals in the community will continue to raise these questions. Advocates for community services have suggested to us that some or all of the State Training School's residents could be well managed in community sites and at a lower cost, and any exceptionally difficult cases could be appropriately cared for at the Wyoming State Hospital in Evanston.

The staff to patient ratio is about 4.7:1.[48] Because of the School's fixed costs, we would not expect expenses to vary much with the number of residents, so reducing the school's population will not reduce costs pro-rata. That is, a 25% reduction in the number of residents would reduce costs by less than 25%.

Background on the State Training School

Established in 1912, the Wyoming State Training School (WSTS) is a state-supported facility under the Department of Health providing services to those with developmental disabilities. It is a certified ICF/MR facility with an Acquired Brain Injury Unit. Currently, WSTS has about 90 developmentally disabled patients, a huge decrease from the enrollment peak of 740 people in 1972[49].

These patients reside at WSTS and receive 24-hour care, 365 days a year. There are 19 life-safety code living units on the campus. Most units house six to eight individuals. WSTS also provides day programming to teach these individuals the skills necessary to become more independent and to live and work in the least restrictive environment possible. Health services provided include inpatient and outpatient care, as well as physician, nursing, respiratory therapy, laboratory, pharmacy, dental, and x-ray. Therapeutic services include physical, occupational, speech, aquatic, and horse therapy.

WSTS' Acquired Brain Injury Unit offers long-term care and rehabilitation services to adults over age 21 who do not qualify as developmentally disabled. Residential, medical, vocational, psychological, and therapy services are provided. This program is funded within the current WSTS budget, using the same staff and facilities as those for the developmentally disabled. The population in the Acquired Brain Injury Unit varies from eight to fifteen individuals.

The WSTS also houses a therapeutic equipment division that customizes wheelchairs and adaptive equipment for residential patients and individuals in the community.

The General Fund supports the WSTS. The institution's participation in Title XIX of the Social Security Act as an ICF/MR facility generates revenue to the General Fund that effectively reimburses about 50-55% of the operational costs. Projected revenue for

fiscal years 2005 through 2008 is approximately $20 million per annum. Revenue varies depending upon the number of clients residing at the WSTS who are eligible for participation in Medicaid and the federal match rate.

Potential Future Directions

We understand that, in an effort to maximize the WSTS' value to the State, the WSTS administration is investigating additional services that could use the School's resources. One service that has been mentioned is the development of nursing home beds specializing in Traumatic Brain Injury and ventilator care. Currently, Wyoming has no nursing homes with such resources, and some of these patients are moved to other states.

Applying the national portion of nursing home beds that are ventilator beds[50] to total nursing home beds to WY's licensed nursing home beds[51] suggests that Wyoming could support about 10 to 15 ventilator beds. We understand that currently the State Training School currently has 6 occupied ventilator beds with additional capacity.

We have no information on the bed occupancy of these units in other states, but show these figures as a starting point for the sort of analysis that would be need to identify the feasibility of expanding the School's services in this way.

A full financial feasibility study of the service and financial consequences of expanding, contracting, or shutting the School falls outside the scope of this study. However, because of the high cost of the School, the Legislature may want to commission such a study. We understand other studies have been performed but were unable to review them due to time limitations.

VII. Expectation for Increased Private LTC Funding

The expected growth of Medicaid LTC expenditures has led to calls for greater private sector funding of LTC.[52] Three sources for additional private sector funding are,

1. Increased use of LTC insurance, including as LTC Partnership programs.

2. Increased funding from an individual's or family's assets, income or insurance, such as the LTC Compact concept[53].

3. Reverse Equity Mortgages (REMs) and Home Equity Conversions Mortgages (HECMs), under which a home owner can convert home equity into income to pay for LTC expenses directly, purchase LTC insurance, or other purposes.

Both LTC Partnership programs and the LTC Compact would preserve estates if an individual agrees to pay for some of their LTC costs and also reduce the perceived need for transferring assets. Appendix IV show the very small amounts that current Medicaid programs recover from the estates of LTC recipients; these figures suggest to us that either,

1. LTC recipients have very low recoverable assets, and hence there is little short-term opportunity to increase private funding, or

2. Substantial estate assets are shielded, transferred or otherwise missed by Medicaid estate recovery programs.

Detailed national or local data that could suggest which of these alternatives is true are not available[54]. However, currently, there appears to be little reason why an individual would try to avoid Medicaid LTC programs by using their own resources. Promises of estate preservation in exchange for private funding would appear to be poor motivation for partial self-payment as state estate recoveries are currently so small.

We suggest that Wyoming first obtain significant data relating to the degree of asset transfer prior to application for Medicaid, and the potential for increased asset recovery before investing heavily in incentives for increased private sector funding.

<u>Proposed Mechanisms for Increasing Private Funding</u>

Significant proposals call for the following compromise:

1. The individual pays for a substantial but limited portion of LTC out of pocket or through a previously purchased LTC insurance policy, and

2. The state agrees to simplify the application process and eligibility requirements and to provide catastrophic coverage for very large LTC costs.

In other words, the state provides catastrophic coverage for LTC; for example, beyond the limits of a qualifying LTC policy or a Compact agreement.

We note that some banks, insurance companies and real estate companies have an interest in promoting increased private LTC funding. Some private vehicles may offer tax or administrative benefits for individuals. However, discussion of regulations or consumer protections for insurance, finance and real estate transactions fall outside the scope of this report.

LTC Partnership Insurance

The Deficit Reduction Act of 2005 (DRA) extends to all 50 states the potential for the LTC Partnership,[55] which allow individuals who have purchased qualifying LTC policies to avoid spending down their assets. We understand Wyoming intends to pursue opportunities available through the DRA.

Under these programs, the assets of an individual with certain LTC insurance policies would be protected, even if the individual eventually became eligible for Medicaid LTC benefits.

Although the LTC Partnerships have been available in four states (California, Connecticut, Indiana, and New York) since the early 1990s, enrollment has been low, with only about 172,000[56] policies in force. This compares to a 65+ population of 7.3 million[57] in the four states, although we note most policies are sold to those under age 65.We suggest Wyoming study the results of the pilot states and address design challenges before implementing a partnership program.

LTC Compact

This concept has been promoted by insurance companies who sell LTC policies. The elements of the LTC Compact are the following:

1. This is a voluntary agreement between the state and an individual made at the time an individual becomes chronically ill.

2. The individual may pledge up to a certain portion of their assets to pay for LTC services, after which Medicaid will provide LTC services. The pledge could be met through LTC insurance.

3. If the pledge is the maximum pledge required by the State (for example, pledging the average nursing home daily cost for five years), no further requirements are needed for Medicaid eligibility.

4. If less than the maximum pledge is made, there will be the requirement of means tested eligibility for Medicaid assistance, but the concept presumes some simplification of the application process.

There currently appears to be little incentive for individuals to enter such a compact. However, the concept assumes that the Medicaid application process would be simplified to avoid the ability to exempt assets, therefore increasing the incentive for participation.

Reverse Mortgages and Home Equity Conversion Mortgages

Reverse mortgages allow senior homeowners to borrow money from their home equity. The loan can be used for directly long term care services, to purchase LTC insurance, to buy a home more suitable for older people, or for other purposes. These programs offer seniors flexibility in financing long term care. Reverse mortgages could be used to remodel or buy a more accessible home and therefore promote home care instead of nursing home care. However, this may not be a significant source of net additional funding for long term care, as the home asset can be liquidated to pay for long term care without the use of a reverse mortgage.

About 21 million homeowners are 62 or older and have an estimated $2 trillion in housing wealth.[58] Nearly half of that could be tapped by reverse mortgages. Currently there are only 180,000 reverse mortgages outstanding,[59] and only 43,000 were issued nationally in 2005.[60]

A reverse mortgage allows a home owner to take out a loan for a portion of the equity in his or her home. Under federally-backed programs, if the property value exceeds the amount of the loan at death the heirs inherit the difference, and the heirs will not be liable if the house is worth less than the bank receives on the sale of the property. To qualify, the homeowner must be 62 or older. If the home is jointly owned, both owners must be at least 62.

There are two federally-backed options plus private options. The two federally-backed options are,

- Home Equity Conversion Mortgages (HECMs)**,** offered by Fannie Mae, are federally insured reverse mortgages, backed by HUD. The amount of money a borrower can get is based on the home's location and value, current interest rates, age of the borrower, and amount of equity in the home. In general, the older the owner is and the more the house is worth, the more money the individual can get. The 2006 limit for homes in high-priced areas is about $363,000. The lower loan limit, which generally applies to rural and non-metropolitan areas, is around $200,000. HECMs constitute more than 90% of the market.

- The Fannie Mae Home Keeper reverse mortgages are similar to HECMs but have different requirements and interest rates and a higher limit, currently $417,000.

Options

Increasing private LTC funding through promotion of LTC insurance or LTC Compact programs is appealing. These programs would return Medicaid to a "safety net" policy for everyone, including LTC coverage for very high, catastrophic LTC expenses for those with LTC insurance or an LTC Compact.

However, it appears that that the current combination of Medicaid eligibility rules and estate planning techniques offer little motivation for individuals to plan to privately fund

their future LTC needs. In other words, there appears to be little financial incentive for most people to use either LTC insurance or a Compact program as opposed to legal estate planning. Promoting these programs would seem to require tightening of the application process and estate recoveries.

We believe the potential for increased private funding is connected to potential for increased estate recovery in absence of private funding. Given lack of data, we recommend Wyoming commission a study that will identify the following:

- The effectiveness of estate recovery programs in Wyoming from the standpoint of the potential maximum recovery under current federal and state rules
- Consistency of Wyoming estate recovery rules with federal rules from the standpoint of maximizing potential recoveries
- The degree of "artificial impoverishment" or other estate planning techniques by people in Wyoming

Suggested study scope:

- Review the state's implementation of various federal legislation to determine whether Wyoming is taking full advantage of private funding sources. Legislation includes OBRA '93 (Omnibus Budget Reconciliation Act of 1993), HIPAA '96 (Health Insurance Portability and Accountability Act of 1996), BBA '97 (Balanced Budget Act of 1997) and DRA 2005 (Deficit Reduction Act of 2005).
- Obtain complete look-back of a sample of deceased Wyoming LTC beneficiaries to identify potential asset recovery opportunities under different scenarios. In addition to means and medians, the survey should identify the portion of beneficiaries with no recoverable assets, and the portions at various dollar amounts.
- Develop a casebook of Medicaid estate planning techniques used in Wyoming, under which individuals qualify for publicly financed LTC benefits through "artificial impoverishment." Quantify the practice of Medicaid estate planning.
- Determine whether and the extent to which particular changes in rules or administration could identify those not truly impoverished and lead to greater recoveries.
- Flow chart Wyoming's lien and estate recovery programs, including state statutory authorities, regulations, administrative policies and program practice, and the integration of eligibility controls with estate collections.

If the study finds little potential for improved estate recoveries or stricter eligibility, we see little incentive for people to invest in either LTC insurance or to make an LTC

Compact. However, if the study finds substantial potential for improved recoveries, we recommend proceeding sequentially as follows:

A. Are the changes needed for improved estate recoveries feasible? Such changes may face significant political opposition from consumer groups and advocates for the elderly.

B. Are the changes needed to block artificial impoverishment feasible? These changes may face significant political opposition from those involved in estate planning and advocates for the elderly.

C. If improved estate recoveries are feasible, a comparative study of the merits in Wyoming of an LTC Partnership, LTC Compact, HEC and RAM promotion. These programs are not mutually exclusive. The study should include an outline of needed regulatory changes and protections.

If Wyoming proceeds in this way, it would be taking a national leadership role and generate information that other states would use.

VIII. Medicaid, the New Accountability and the Need for Better Information

Implementing the suggestions in this report will impact the Medicaid Dept, Dept of Aging, vendors and providers. This section presents what we see as opportunities to improve administration and meet future demands for more sophistication, rather than offer any particular programs, options for funding or criticisms. The reader should bear in mind that a systematic review of departments and relationships falls outside the scope of our work, and the purpose of our interactions was to obtain data or information relevant to this report.

Observations

The following observations are incidental to our work and come from a limited view of Wyoming government processes. We understand efforts are underway relative to a number of these observations.

1. Wyoming personnel are generally optimistic, committed, open to sharing information, open to new ideas, and not at all defensive. This applies to government, vendor and provider personnel and suggests to us that Wyoming has maintained a healthy work and business environment.

2. Program operations are sensitive to funding. The healthy work and business environment for providers related to LTC and DD appears to be fragile, and inadequate funding could lead to significantly diminished quality and quantity of care.

3. Data was available quickly. We attribute the excellent responsiveness to our data requests to the positive attitudes of staff, the small population of beneficiaries and the simplicity of the databases.

4. Some data had quality issues. The difficulty we had in obtaining complete and consistent data suggests that the available data has not been used in the ways we requested. In addition, the databases do not seem to capture or have readily available key information such as Medicare hospital services paid by Medicare.

5. Medicaid databases and processes appear fragmented. We noted that data collected in the eligibility process was not readily available for estate recovery processes. Similarly, notifications of death were not automatically generated.

6. Management information seems limited. The kinds of information we requested for this project show important quality and cost drivers. It is our impression that these types of data are not routinely generated.

7. High reliance on vendors. Wyoming seems to rely on vendors for key processes and knowledge of processes. This reliance may be consistent with what appeared to us to be a small government staff. While this structure can offer efficiencies, it places a high burden on the administrators responsible for vendor

management, including functions for surveillance, accountability, documentation, and contracting.

We emphasize that these comments should not be seen as the result of any systematic evaluation.

Future Demands

We believe dominant trends in the healthcare system will include the following:

1. More intensive information including electronic medical records and more sophisticated billing and payment systems.

2. Applying evidence based medicine principals and criteria throughout the system.

3. Measurement of quality and outcomes and payment based on those outputs. Payment based on measured outcomes is also called, "Pay-for-Performance."

These trends mean future healthcare managers will need skills to aggressively manage care processes to meet specific targets.

IX. Summary of Suggestions

We are struck by the comprehensive programs and efforts to manage Wyoming's LTC and DD populations. As described more fully in the text of our report, we did find a number of opportunities to bring better value, and we list important opportunities below. Each of these is intended to improve the quality and efficiency of care. Many of these opportunities would be part of shifting the system from managing entitlement to managing care processes.

- Use medical case management to improve health maintenance of LTC and DD populations
    - For waiver patients, implement a medical case management program that integrates with waiver program services across the continuum of care
    - Consider extending medical case management to the high risk pre LTC population that may not be on Medicaid
- Build on existing programs to manage the transitions that are important moments in LTC patients' lives
    - Rapid response process focused on hospitals, nursing homes and waiver waiting list patients
    - Fast Track Medicaid eligibility process
    - Service higher acuity LTC patients in the community
    - Increase capacity for ALF placements (building ALF facilities)
    - Develop a transition management information system including a transition risk alert system and health status monitoring capability
    - Extend diversion efforts to the pre LTC population to avoid nursing home admissions
    - Consolidate senior center administrative functions
    - Add HCBS and ALF LTC waiver slots as financially feasible
- Consider new Medicare and Medicaid funding structures that can align incentives and risk for total population management
- Expand efforts to address labor force issues through additional tools
    - Study feasibility of a local economy differential wage index
    - Revise fee schedules
    - Pay for Performance initiatives
    - Amend the Nurse Practice Act for greater care delegation
    - Enable more waiver patients to use self directed care
- Encourage the expansion of hospice to improve the quality of end of life care
- Examine the financial and clinical feasibility of expanding, contracting or closing the State Training School
- Encourage private LTC funding options including
    - Compact program
    - LTC insurance designs
    - Estate recovery efforts

The body of the report contains additional details on each of these.

Appendix I: Data Sources

Claims	WYrcpR02.dbf - WYrcpR05.dbf, received on 8/22/06
Eligibility	WY_LTCeligs_REVpw_Jan02-Dec05.xls, received on 8/15/06
Medicare Eligibility	MCARE Extract.csv, received on 8/25/06

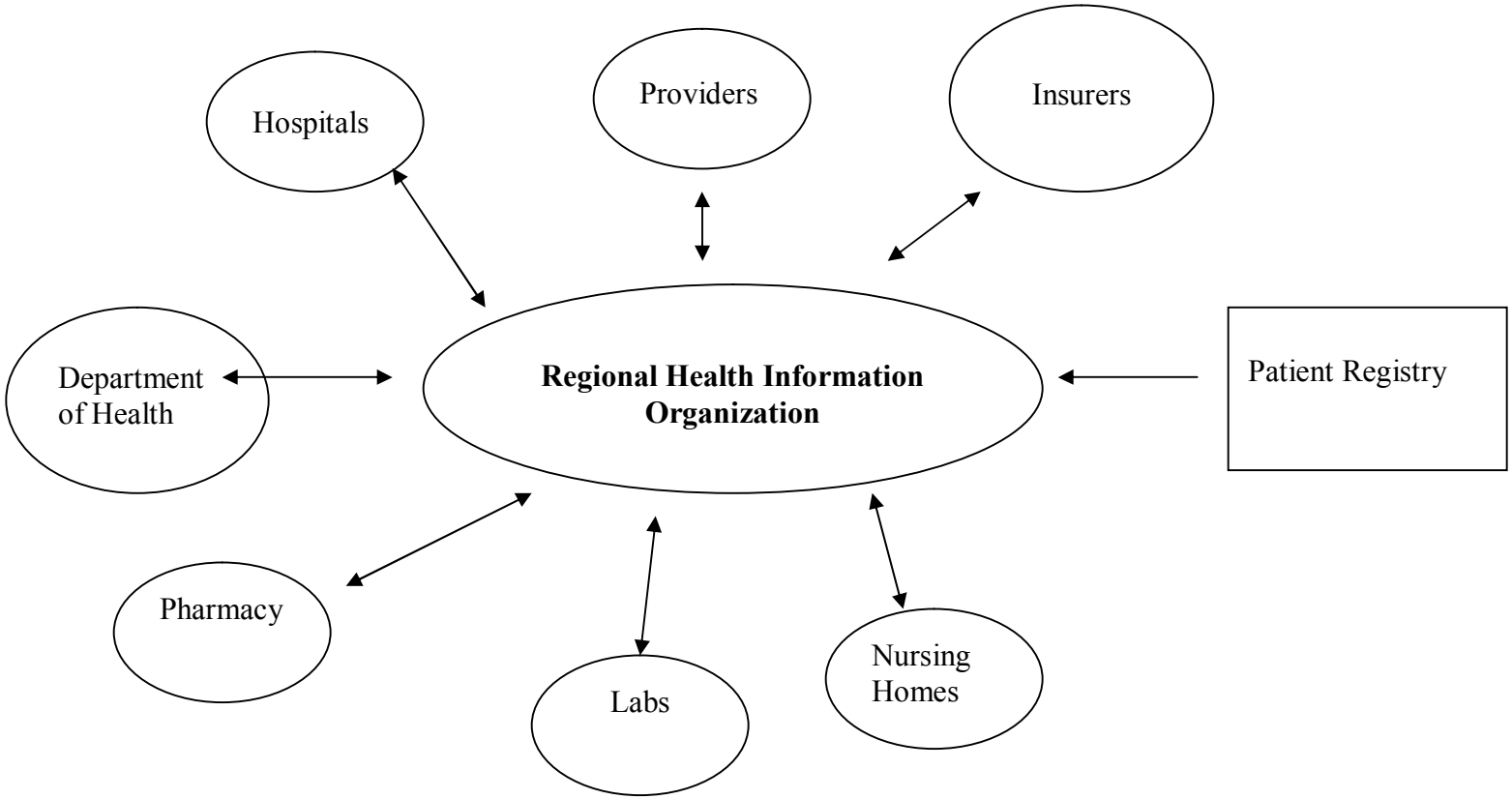
We did not audit these data, relying on our sources in the State of Wyoming for the accuracy and completeness of the data.

Appendix II: Age-Sex Distribution of LTC and DD Programs in 2005

sex	Age	ALF Waiver	LTC Waiver	LTC Non-Waiver	ABI Waiver	DD Waiver Adult	DD Waiver Child	DD - Non-Waiver
M	0-9						171	
M	10-19						239	
M	20-29		18		18	193	28	
M	30-39		30	9	11	161		
M	40-49		53	19	26	117		12
M	50-59		75	41	21	81		10
M	60-69	6	71	68		43		5
M	70-79	5	59	139		10		
M	80-89	14	26	152				
M	90-99		5	54				
M	100-109							
M	Total Male	25	337	482	76	605	438	27
F	0-9						82	
F	10-19						169	
F	20-29		9		13	182	16	
F	30-39		22	9	6	144		
F	40-49		85	17	10	109		13
F	50-59		154	41	7	81		8
F	60-69	7	186	96		34		5
F	70-79	20	162	222		11		
F	80-89	41	128	478				
F	90-99	15	35	296				
F	100-109			17				
F	Total Female	83	781	1,176	36	561	267	26

Note: We do not show any cells with fewer than 5 beneficiaries

Appendix III: Illustrative Diagram of a RHIO



Appendix IV: Medicaid Estate Recoveries by State

Table 1 and Table 2 below are taken from "Medicaid Estate Recovery Collections, Medicaid Eligibility for Long-Term Care Benefits, Policy Brief No. 6," Dept. of Health and Human Services.[61]

TABLE 1: Medicaid Collections and Expenditures -- Fiscal Year 2004

State	Collections: Probate FY 2004	FY 2004 Medicaid Nursing Home Expenditures	Collections as $ of Nursing Home Spending	State Nursing Home Spending as % of National Nursing Home Spending
Alabama	$6,204,836	$766,521,275	0.8%	1.7%
Alaska	$0	$107,091,559	0.0%	0.2%
Arizona	$2,403,306	$23,172,901	10.4%	0.1%
Arkansas	$2,104,052	$540,193,697	0.4%	1.2%
California	$44,668,847	$3,033,946,724	1.5%	6.6%
Colorado	$6,241,993	$423,944,387	1.5%	0.9%
Connecticut	$8,204,283	$1,015,579,338	0.8%	2.2%
Delaware	$436,370	$158,840,995	0.3%	0.3%
Florida	$13,478,207	$2,250,455,672	0.6%	4.9%
Georgia	$0	$1,466,092,237	0.0%	3.2%
Hawaii	$1,684,280	$182,705,650	0.9%	0.4%
Idaho	$5,695,851	$126,613,061	4.5%	0.3%
Illinois	$21,254,742	$1,608,092,952	1.3%	3.5%
Indiana	$7,649,409	$948,116,230	0.8%	2.1%
Iowa	$12,194,616	$426,181,610	2.9%	0.9%
Kansas	$4,866,505	$344,645,407	1.4%	0.8%
Kentucky	$5,391,045	$627,317,272	0.9%	1.4%
Louisiana	$103,853	$593,234,878	0.0%	1.3%
Maine	$6,178,845	$248,697,265	2.5%	0.5%
Maryland	$5,456,547	$867,262,512	0.6%	1.9%
Massachusetts	$32,577,301	$1,617,497,416	2.0%	3.5%
Michigan	$0	$1,704,056,909	0.0%	3.7%
Minnesota	$24,999,595	$904,205,889	2.8%	2.0%
Mississippi	$391,933	$563,151,164	0.1%	1.2%
Missouri	$8,597,322	$789,726,442	1.1%	1.7%
Montana	$2,363,322	$164,145,366	1.4%	0.4%
Nebraska	$1,125,970	$359,714,726	0.3%	0.8%
Nevada	$420,429	$141,377,842	0.3%	0.3%
New Hampshire	$4,362,641	$276,085,727	1.6%	0.6%
New Jersey	$8,329,882	$1,479,889,851	0.6%	3.2%

New Mexico	$78,037	$179,818,250	0.0%	0.4%
New York	$29,953,334	$6,486,722,331	0.5%	14.2%
North Carolina	$5,529,652	$1,096,619,059	0.5%	2.4%
North Dakota	$2,000,766	$166,456,173	1.2%	0.4%
Ohio	$13,987,964	$2,722,643,741	0.5%	5.9%
Oklahoma	$1,573,913	$462,935,035	0.3%	1.0%
Oregon	$13,843,592	$238,642,419	5.8%	0.5%
Pennsylvania	$5,888,558	$4,069,955,523	0.1%	8.9%
Rhode Island	$2,792,488	$292,744,235	1.0%	0.6%
South Carolina	$6,206,820	$461,865,198	1.3%	1.0%
South Dakota	$1,222,693	$118,375,810	1.0%	0.3%
Tennessee	$8,895,934	$1,006,485,725	0.9%	2.2%
Texas	$0	$1,781,030,713	0.0%	3.9%
Utah	$47,443	$105,854,730	0.0%	0.2%
Vermont	$402,156	$104,364,396	0.4%	0.2%
Virginia	$776,866	$656,180,320	0.1%	1.4%
Washington	$10,770,875	$593,061,233	1.8%	1.3%
Washington, D.C.	$1,789,570	$188,211,034	1.0%	0.4%
West Virginia	$214,656	$367,149,385	0.1%	0.8%
Wisconsin	$16,772,729	$917,421,595	1.8%	2.0%
Wyoming	$1,632,368	$60,552,927	2.7%	0.1%
United States	**$361,766,396**	**$45,835,646,786**	**0.8%**	**100.0%**

TABLE 2: Medicaid Collections as a Percentage of Nursing Home Expenditures--Fiscal Year 2004 State Rankings			
State	**Collections as % of Total Nursing Home Spending***	**State**	**Collections as % of Total Nursing Home Spending**
Arizona**	10.4%	**US -- all states**	**0.8%**
Oregon	5.8%	**Connecticut**	0.8%
Idaho	4.5%	**Indiana**	0.8%
Iowa	2.9%	**Maryland**	0.6%
Minnesota	2.8%	**Florida**	0.6%
Wyoming	2.7%	**New Jersey**	0.6%
Maine	2.5%	**Ohio**	0.5%
Massachusetts	2.0%	**North Carolina**	0.5%
Wisconsin	1.8%	**New York**	0.5%
Washington	1.8%	**Arkansas**	0.4%
New Hampshire	1.6%	**Vermont**	0.4%
California	1.5%	**Oklahoma**	0.3%
Montana	1.4%	**Nebraska**	0.3%
Kansas	1.4%	**Nevada**	0.3%
South Carolina	1.3%	**Delaware**	0.3%
Illinois	1.3%	**Pennsylvania**	0.1%
North Dakota	1.2%	**Virginia**	0.1%
South Dakota	1.0%	**Mississippi**	0.1%
Rhode Island	1.0%	**West Virginia**	0.1%
Washington, D.C.	1.0%	**Utah**	0.0%
Hawaii	0.9%	**New Mexico**	0.0%
Tennessee	0.9%	**Louisiana**	0.0%
Kentucky	0.9%	**Alaska**	0.0%
Alabama	0.8%	**Texas**	0.0%

* Listed in descending order.
** Arizona's estate recovery collections, as a percentage of nursing home spending, are not comparable to any other state because comprehensive prepaid managed care contracts dominate the state's Medicaid program, and nursing home care provided under these contracts is not identified separately for reporting purposes.

Footnotes

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