Independence, Dignity and Choice in Long-Term Care Act

Annual Report

July 1, 2009

Jon S Corzine
Governor

Heather Howard
Commissioner

INTRODUCTION

Each year, in accordance with Public Law 2006, chapter 23, *"The Commissioner of the Department of Health and Senior Services (DHSS), in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this Act, shall no later than January 1, 2008, present a report to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), that documents the reallocation of funds to home and community-based care pursuant to section 4 of this act, and present an updated report no later than January 1 of each succeeding year until the commissioner determines that total Medicaid expenditures for long-term care have been sufficiently rebalanced to achieve funding parity between nursing home care and home and community based care, at which point the commissioner shall document and certify to the Governor and the Legislature that such funding parity has been achieved."*

The Independence, Dignity and Choice in Long-Term Care Act, which became Public Law 2006, chapter 23, specifically requires the Commissioners of the Departments of Health and Senior Services (DHSS) and Human Services (DHS), together with the State Treasurer, to create a new budgetary process for expanding home and community-based services within the existing budget allocation by diverting persons from nursing homes to allow maximum flexibility between nursing homes and home care options (C:30:4D-17.26).

Accordingly, the DHSS engaged Mercer Government Human Services Consulting (Mercer) to assist in the State's efforts to develop a process for reallocating funds that advances rebalancing and achieves funding parity between nursing homes and home and community-based services. By leveraging federal grant funding with State funds, the DHSS was able to hire Mercer through an amendment to the national consulting firm's contract with the DHS. Approval for the amendment to Mercer's contract with the DHS was finalized in August 2008. It was at that time that Mercer's creation of a new Budget Projection model was initiated.

Also at the center of the Act's mandates is the implementation of a client-tracking system that advances the Aging and Disability Resource Connection's (ADRC) objectives, including easy access to long-term care support services, streamlining eligibility determination and coordinating long-term care service and management. The SAMS integrated data application provides intake, case management, service planning and provisioning, and invoicing; and the federal reports required for New Jersey under the Older Americans Act. In August 2008, the waiver of advertising contract to purchase the Social Assistance Management Systems (SAMS) application from Harmony Information Systems, Inc. (Harmony) was approved after being originally submitted in November 2006. The ADRC is now able to expand statewide from its test phase in Atlantic and Warren Counties in coordination with the rollout of the SAMS application.

In order to provide a meaningful update on the creation of the Budget Projection model and the implementation of the SAMS client tracking system, the Medicaid Long-Term Funding Advisory Council unanimously passed a motion at its September 17, 2008 quarterly meeting. The proposal was to recommend to the DHSS Commissioner that the 2009 Annual Report be delayed from January until July 2009. (See Appendix A on Page 12 for the Council's members.) By then, the

budget projection model created by Mercer would be complete and the implementation of the client tracking system would be underway, two objectives which are central to the Act.

This mid-year status report outlines the achievements since January 2008 in meeting the Act's requirements, including the budget projection model's development and the implementation of the SAMS initiative – both fundamental to advancing rebalancing of long-term care in New Jersey. This document fulfills the requirement of providing an Interim Report in 2009 prior to the issuance of the January 1, 2010 Annual Report.

CREATION OF THE BUDGET PROJECTION MODEL

The State of New Jersey (State), Division of Aging and Community Services (DACS) engaged Mercer Government Human Resources Consulting (Mercer), a part of Mercer Health & Benefits LLC, to create a budget rebalancing model to track DACS and Division of Disability Services (DDS) waivers, Adult Day Health Services (ADHS) and nursing facility (NF) expenditures, as well as project future expenditures.

The Independence, Dignity and Choice in Long-Term Care Act aims to rebalance long-term care away from an over-reliance on institutional care toward more HCBS options. Through the Act, there is the mandate to expand HCBS services which shall be funded by diverting persons in need of long-term care from NF placements to HCBS. According to the Act, for the State fiscal years 2008 through 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for NF care (State dollars only), plus the percentage anticipated for programs and persons that would receive federal matching dollars, shall be reallocated to HCBS.

Therefore, the purpose of the model is two-fold:

- To estimate the State and federal budgets for waivers and direct care costs that fall under the responsibility of DACS and DDS
- To quantify the impact of the Act by estimating the cost savings of the rebalancing efforts made by the State by redirecting Medicaid clients from a NF to HCBS

Data

Mercer partnered with the State and its fiscal agent, UNISYS, to determine the data needed for use in the budget model. A data request was developed and submitted to UNISYS, and subsequent data sets were delivered to Mercer. After receiving a data set from UNISYS, Mercer and the State performed data validations to ensure that the level and content of the data were appropriate. After issues were identified, follow-up requests were sent to UNISYS until a final version of the data set was decided upon.

Throughout the development of the model, Mercer met with DACS and stakeholder groups to discuss the model and its intentions, as well as obtain input into what data should be included from both DACS and DDS. It was found that in order to determine the rebalancing cost savings, the following Medicaid waivers would need to be included in the model:

- Global Options for Long-Term Care (GO) – DACS
- Community Care Program for the Elderly and Disabled (CCPED) – DACS

- Assisted Living (AL) – DACS
- Assisted Living Residence (ALR) – DACS
- Adult Family Care (AFC) – DACS
- Caregiver Assistance Program (CAP) – DACS
- Alternate/Comprehensive Personal Care Homes (CPCH) – DACS
- Traumatic Brain Injury (TBI) – DDS
- AIDS Community Care Alternatives Program (ACCAP) – DDS
- Community Resources for People with Disabilities (CRPD) – DDS

Effective January 1, 2009, all DACS waivers were consolidated into the GO waiver, but historical data from these programs is used in the model to project GO costs.

The model uses 36 months of enrollment data, along with 36 months of claim data based on date of service. The data includes cost and utilization totals for the DACS and DDS waivers as listed above, along with NF, ADHS and Personal Care Attendant (PCA) services. Since enrollment totals for clients receiving NF, ADHS or PCA services was not available, Mercer developed a hierarchy to assign membership for a particular group to a DACS Category of Aid (DCOA). This allows the model to calculate and project cost per member per month and utilization per member statistics, and ensures that each member is only counted once.

Data is received from UNISYS and then imported into an Access database where it is summarized and derived fields (i.e., DCOA) are built. Results of output queries from the database are then pasted directly in the Driver workbook for use in the model. Here is an overview of the hierarchy:

1. If a client was in a waiver, then the eligibility is listed as waiver (DACS or DDS)
2. If a client was not in a waiver but had a NF claim, then the eligibility is listed as NF
3. If a client was not in waiver or NF but had an ADHS claim, then the eligibility is listed as ADHS
4. If a client was not in waiver, NF or had an ADHS claim, then the eligibility is listed as PCA

Model Overview

The model is split up into five different Excel workbooks which are all connected by live links. Live links are formulas in Excel workbooks that dynamically feed information from one workbook to another. Each of the workbooks is utilized to perform a specific function.

Driver Workbook

The Driver workbook is where the user will make selections and launch the model. This workbook will have the most user interaction.

The user has several options (i.e. trends, Incurred but Not Reported, specific adjustments and the projection period) from which to choose before running a projection. Once the user makes their selections, they can run the projection which will open the other workbooks, perform the necessary calculations, build the output reports and populate the Rebalancing workbook.

Trend
The user will select options to calculate utilization trend, unit cost trend and enrollment trend. These options allow the user to determine how trend factors are calculated from the base data and applied to develop the projection. Among the choices the user can make are the historical time period used to calculate trend, hard coding either trend factors or final projection values and choosing a method that is more or less sensitive to outlier months.

Incurred but Not Reported (IBNR)
The user will select options to adjust the base data by estimating the impact of unpaid claims based on historical payment patterns. “On an incurred basis” refers to the point in time when the service takes place. The user will choose from different methods that are more or less sensitive to outlier months.

Other Adjustments
The user can also choose other adjustments to be applied to the projection. If there are any program changes that occurred after the base data period (i.e., fee schedule change or removal/addition of covered services), the user can enter a factor which will be applied to the projection. The user can also adjust the age band mix by county to account for demographic shifts or can use the historical distribution. Additionally, the user can update the Federal Medical Assistance Percentage (FMAP) percentage, should it change, which will provide an accurate split between State and federal dollars.

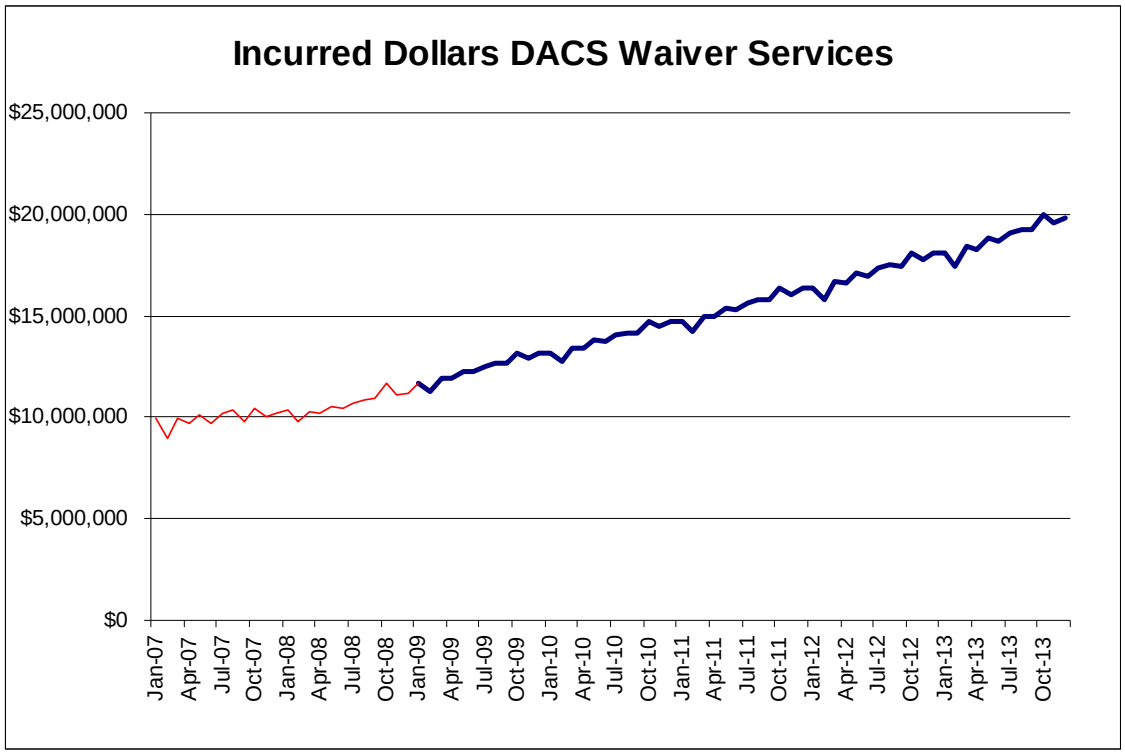
Projection Period
Once the user enters all of his or her assumptions, the user then can choose the projection period. The user can choose anywhere from one month to sixty months, from the end of the base data period based on the end date of the base data. Shorter projections will run quicker. Once this is selected, the user will click on a button to run the projection.

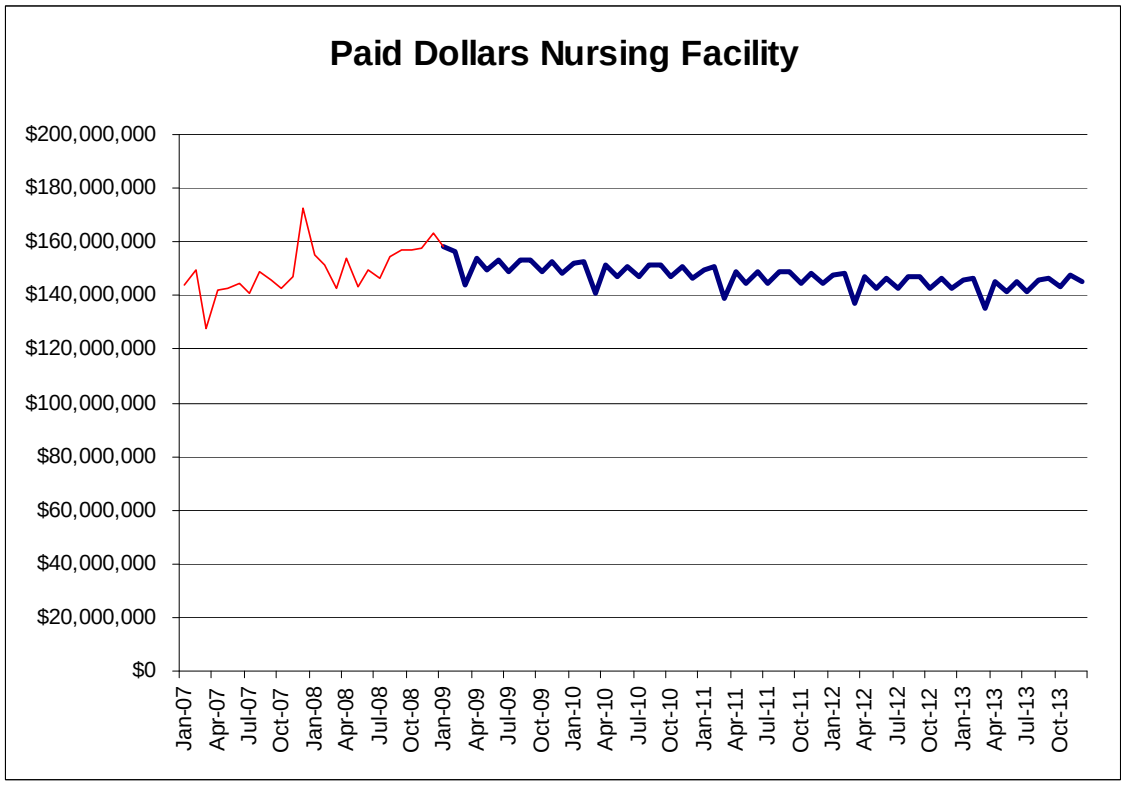
Calculations Workbook
The Calculations workbook does not have any interaction with the user. This workbook utilizes the inputs and data from the Driver workbook and feeds the Projection workbook. This workbook performs the IBNR functions and converts the incurred projected dollars into paid dollars and develops factors that will be applied in the Projection workbook. It also takes into account historical payment patterns due to seasonality and the number of Wednesdays in a month to adjust incurred projections to a paid basis.

Projection Workbook
The Projection workbook also does not require any interaction with the user, although the user can open it to get detailed projected data. This workbook performs the projection based upon the user input and the factors developed in the Calculations workbook; feeds the Output and Rebalancing workbooks; and projects utilization, unit cost, claim dollars and enrollment by month, category of service and county.

Budget Outputs Workbook
The Budget Outputs workbook will automatically open when the projection has completed running. This workbook includes summarized graphical and tabular representations of the

projected data from the model. Most budget output reports will also include historical data, including the most recent 24 months of data. There are charts and tables that show total dollars, per member per month cost, utilization and enrollment by month, category of service and category of aid. Examples of the charts are shown below.





Rebalancing Workbook

The Rebalancing workbook is where the model will estimate the cost savings from moving clients from a NF into HCBS. As the Act came into effect on July 1, 2007, Mercer selected that date as the date when rebalancing first started. It is understood that the State had been rebalancing for many years prior to the start of the Act but, in order to estimate costs more accurately, Mercer assumed that there were no cost savings prior to July 1, 2007.

Mercer relied on the specific language of the Act when determining how the Rebalancing Workbook should function. The Act's language specifies which services should be included in rebalancing, how they should be compared and over what duration. Per the Act, HCBS includes DACS and DDS waiver services and ADHS services.

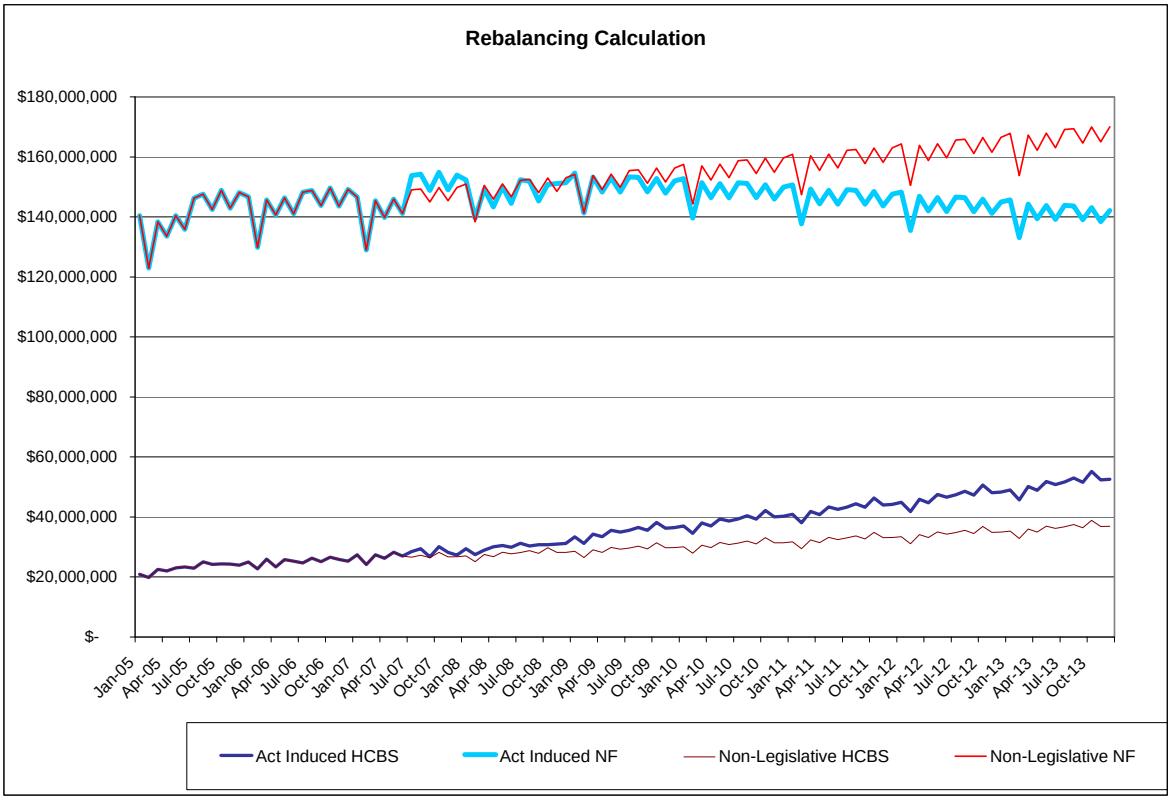
The Act creates two scenarios which the model must address: what are actual costs and expenses since the passage of the Act and what would costs have been for HCBS and NF had the Act not been passed? The Rebalancing Model contains two scenarios which evaluate this:

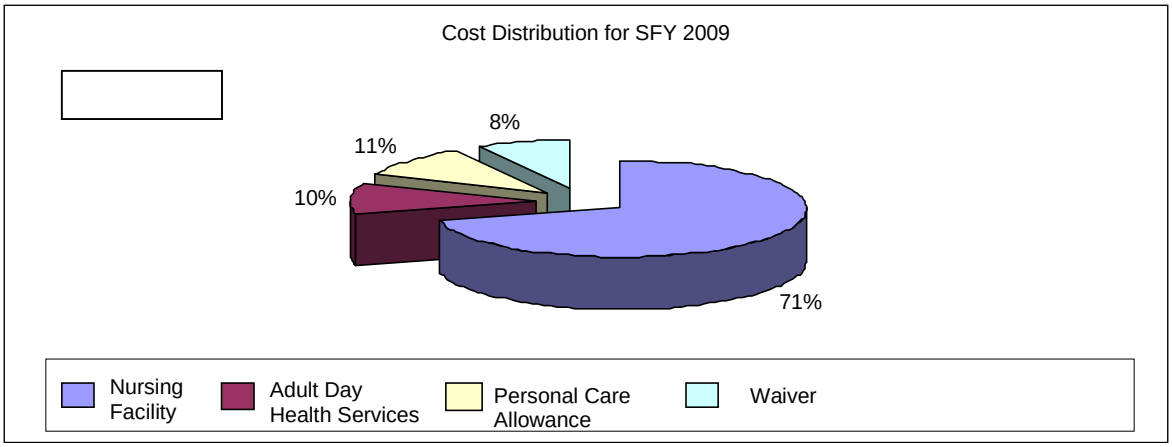
- Actual or Act Induced: These are costs for HCBS and NF services since the passage of the Act.
- Anticipated or non-Legislative: These are costs for HCBS and NF services that would have occurred had the Act not been in place.

Actual (or Act Induced) expenses are pulled directly from the budget model and represent the best estimate for historical and projected HCBS and NF expenses. The user has several inputs, such as trend, program changes and a morbidity adjuster, to generate anticipated (or non-Legislative) expenses. The morbidity adjuster quantifies the effect of moving a client from one setting to another on the overall acuity level for each setting. For example, the least frail client in a NF could be the frailest client if moved to HCBS, and the frailest client in HCBS could be the least frail client if moved to a NF.

As stated above, there is a second scenario which includes PCA along with the other HCBS options. It was decided that although PCA was not included in the Act, it is an important part of the services available and should be taken into consideration along with the waiver services.

Examples of charts from the Rebalancing workbook are shown below:





Global Budget Rebalancing Model Implementation and Next Steps

The budget rebalancing model was rolled out to the State in April 2009 and was demonstrated to the Medicaid Long Term Care Funding Advisory Council on May 6, 2009. Since then, Mercer has made some changes to the model based on feedback and validation testing, and rolled out a final working version in June 2009. Mercer will continue to serve in an advisory capacity should issues arise and will be able to develop and implement future updates to the model.

Going forward, the State will now request the data from UNISYS and refresh the model monthly. Individuals in DACS, Office of Management and Budget (OMB), and the Department

of Health and Senior Services (DHSS) budget office will be using the model to forecast long-term care costs and to then quantify the effects of the Act on the long-term care system.

IMPLEMENTATION OF CLIENT-TRACKING SYSTEM

Background

In November 2006, the Department of Health and Senior Services (DHSS) submitted a waiver of advertising to purchase a complex web-based client tracking data system from Synergy Software Technologies, Inc. (now, Harmony Information Systems) It is the integrated application – the Social Assistance Management Systems (SAMS) application – that advances the Aging and Disability Resource Connection's (ADRC) objectives as described in the Independence, Dignity and Choice in Long-Term Care Act. The integrated application includes intake, case management, service planning, service provision, service invoicing, and the federal reports mandated for the State of New Jersey under the Older Americans Act (OAA) known as the National Aging Program Information System (NAPIS).

The State Office of Information and Technology (OIT) first required the DHSS to conduct a six-month pilot in seven counties (Atlantic, Cape May, Mercer, Passaic, Union, Warren and Somerset) to validate the application's capacities to support its data requirements across State and county offices, their grantees, and provider agencies in administering Older American Act programs, the ADRC, Medicaid Waiver Services, and other State funded programs. The SAMS pilot phase began in 2007 and was measured against six objectives established by DACS: (1) compile data for federal/state reports; (2) screen and target consumers at risk of nursing home placement; (3) capture and analyze clinical and financial eligibility data; (4) facilitate service planning and coordination; (5) collect data to meet federal quality assurance requirements, and (6) collect data elements for rebalancing long-term care funding streams.

The Act accelerated the statewide implementation of Information Technology (IT) solutions included in the original waiver of advertising approval. It required a web-based client-tracking system to support clinical eligibility determination, fast-track financial approvals, service coordination, and quality assurance beginning March 2008. When the waiver with Harmony was approved in August 2008, the start of the statewide rollout of the SAMS project began.

SAMS Project Overview

Much progress towards a statewide implementation of SAMS has been made. The waiver included professional services in addition to the hosting and licensing software fees. Harmony is providing project management, technical analysis and development services as well as an education component to ensure that the project approach, goals and objectives are managed within the timeframe, scope and budget parameters of the waiver.

A project team was created with membership from both Harmony and State staff. The project includes a three step plan that aligns with the Act: (1) to deploy SAMS – the client tracking system – by the end of 2009 to the 21 Area Agencies on Aging (AAAs) and the 400 provider agencies for federal reporting, (2) to implement SAMS in support of New Jersey's ADRC core business process statewide, and (3) to use the full range of SAMS' capabilities to support the

already developed Budget Projection model.

(1) SAMS Statewide Deployment
By October 2009, SAMS will be able to serve as the single database to collect, analyze and transfer federally required data elements to the Administration on Aging. There are 1,200 estimated licensed SAMS users for this first step of the project, representing the most extensive part of the implementation.

As background, the first part of the rollout consisted of a process of discovery whereby the team initially met with the initial seven pilot counties, including their SAMS users, and conducted a post-implementation review. The review cited a significant interest in more training. The pilot training approach followed a train-the-trainer model whereby AAA staff was trained as trainers, who in turn, were responsible for teaching the remaining users.

An outcome of the pilot review was for the Harmony rollout training to include hands-on training for all new users. Following the post-implementation review, the team agreed to the following rollout plan: (a) implement SAMS to the remaining 14 counties with staggered launches between July and October 2009, (b) conduct an initial orientation telephone call with each of the 21 AAA offices, (c) present the Project Overview in an open meeting for all AAA staff, grantees and provider agencies, (d) implement a series of role-based training courses via online instructor led classes and onsite computer lab classroom training, (e) provide data conversions of client demographic information from existing databases and finally (f) conduct a final 'Readiness Assessment' directly prior to providing onsite support at the start of SAMS in each AAA. Following are the highlights:

Initial Planning Calls with the AAAs
As pilot ADRC counties, Atlantic and Warren were visited by the SAMS project team in December 2008, while the remaining 19 AAAs were contacted by phone during January and February 2009. The topics of discussion during the call included: how to identify the SAMS users, requirements for hardware/internet connectivity, hearing about the AAA business process, advising about the training approach and identification of AAA data conversion needs.

Project Overview Meetings
A series of 12 open forum meetings were held in New Jersey between March and June 2009. Approximately 500 people attended these meetings which were open to all AAA staff, their providers and ADRC partners.

Training Course Development and Delivery
Nine courses were developed prior to the start of training delivery which began in April 2009. Each AAA was asked to identify up to three staff who would be first to learn SAMS and also act as the main contacts for their AAA staff and provider network. As of June 2009, about 1,000 new SAMS users have attended hands-on computer classroom training representing six new and three pilot AAA organizations.

As we approach the first additional counties to begin using SAMS in July 2009, the final steps will include; data conversion, start-up activities and development and communication of a well structured, robust internal support plan.

(2) Enhanced ADRC Core Business Process

As stated in the Independence, Dignity and Choice in Long-Term Care Annual Report in January 1, 2008, DACS identified a second objective as follows – to have the capacity to screen and target consumers at risk of nursing home placements**.** In February 2009, a standardized ADRC Information & Assistance and Screening Process for New Jersey was developed. The objective was met when Atlantic and Warren Counties, the two pilot ADRC counties, began using SAMS to capture the Consumer Profile and Screen for Community Services data elements. Included in the Screen were the financial eligibility questions that enabled the Fast Track process to begin.

A successful data conversion occurred from the ADRC pilot database which allowed for all prior consumer demographic information and Screen results to be migrated to the SAMS application. Additionally, Atlantic and Warren counties began using SAMS Information & Assistance, for call tracking which supports the ADRC 'No Wrong Door' entry for Home and Community Based Services. Six additional ADRC counties (Bergen, Camden, Hunterdon, Mercer, Morris and Somerset) will begin using the standardized ADRC Information & Assistance and Screen process as part of each county's ADRC launch. The statewide rollout of the ADRC as the core business process is expected to be accomplished by the end of 2010.

To perform the intake, community screening and financial fast-track approval processes that direct consumers to the most appropriate programs, staff at the AAA pilot sites successfully entered client data into the consumer details module. This module satisfied the federal requirements to target consumers most in need and to track unduplicated county participants.

To achieve the additional mandates identified in the Act, Harmony had to expand the intake and screening data elements by incorporating New Jersey's screen for community services into its Beacon Information and Referral (now, SAMS Information & Assistance) module. This additional component was critical to support the Medicaid Eligibility Fast Track Determination (Fast Track) process indentified in the Act.

(3) Utilization of SAMS to Support Rebalancing

With the ADRC initiative as the primary catalyst for rebalancing long-term care in New Jersey, this third and final step of the project will enable DACS to achieve the following IT objectives that are mandated in the Act:

Computerization of Clinical Eligibility Data

To support the clinical assessment process and determination of nursing facility level of care (NF-LOC) needs and services, the ADRC has successfully piloted a computerized comprehensive clinical assessment tool, which incorporates the internationally validated InterRAI clinical assessment. This tool, known as NJ-Choice, will become the clinical assessment tool for the Pre-Admission Screening (PAS).

Facilitation of Service Planning, Coordination and Quality Assurance

Since SAMS has the capacity to support a statewide, county-based care management network, DACS and Harmony are developing the tools that New Jersey's care managers will need to oversee and manage their client caseloads. A coordinated statewide system will enable professionals to provide and monitor care management services through the collection of routine demographic data; to conduct an assessment of care needs; to plan and authorize services and providers; to monitor care, and to verify service delivery. SAMS will permit DACS, for the first time, to monitor care management practices in an aggregate capacity.

Also, the applications must be customized to support the quality assurance standards set by the Centers for Medicare & Medicaid Services (CMS) and capture data for quality oversight such as provider qualifications, clinical needs assessment, service planning and coordination, and monitoring the health and welfare of participants.

Rebalancing Long-Term Care

Harmony and DACS are developing a strategy to meet the Act's requirements in terms of tracking and trending expenditures by individuals, services and funding streams. It is this information that will ultimately need to be incorporated into the Budget Projection model created by Mercer to support rebalancing. This year has been spent building the IT infrastructure that will provide the necessary support for the Budget Projection model.

NEXT STEPS

Effective June 2009, the State was able to move forward with requesting monthly data from UNISYS to refresh the model on an ongoing basis. Individuals in DACS, Office of Management and Budget (OMB), and the DHSS budget office can now start using the model to forecast long-term care costs and to then quantify the effects of the Act on the long-term care system. At this time, the State is working with the model, from studying trends over the last six months to comparing them to historical data. A process is also being developed to begin using this new information source as part of the budgeting process used by the DHSS and OMB.

The Harmony project is nine months into the implementation of an enterprise-wide application – one in which the enhanced core business process will be supported through the SAMS rollout of the ADRC. By the end of 2009, the rollout of the federal reporting system (NAPIS) for the Administration on Aging will be complete in the 21 counties. The statewide rollout of the ADRC as the core business process is expected to be accomplished by the end of 2010.

This will uniquely position New Jersey as a lead state in its long-term care reform efforts with the deployment of the ADRC core business process statewide, a Budget Projection model and a client-tracking system.

Appendix A
Medicaid Long-Term Care Funding Advisory Council

- Sherl Brand, President, The Home Care Association of New Jersey, and co-chair of the Medicaid Long-Term Care Funding Advisory Council
- Theresa Edelstein, MPH, LNHA, Vice President of Continuing Care Services, New Jersey Hospital Association, and co-chair of the Medicaid Long-Term Care Funding Advisory Council
- Linda Ershow-Levenberg, Fink Rosner Ershow-Levenberg, LLC, representing AARP
- Martin Cramer, Elder Rights Alliance of New Jersey
- Jim Donnelly, Chief Executive Officer, Senior Care Centers of America, representing Adult Day Health Services Association
- Michele Guhl, President & CEO, New Jersey Association of Homes & Services for the Aging
- Susan Lennon, Executive Director, Warren County Division of Senior Services, representing New Jersey Association of Area Agencies on Aging
- Paul Langevin, President, Health Care Association of New Jersey
- Charles Newman, Director, Union County Office for the Disabled, representing New Jersey Association of County Disability Services
- Milly Silva, Executive Vice President, SEIU Local 1199NJ
- Lorraine Scheibener, Director, Warren County Division of Temporary Assistance and Social Services, representing County Welfare Directors Association of New Jersey
- Marsha Rosenthal, M.P.A., Ph.D., Rutgers Center for State Health Policy

In addition, the following State staff participated in the work of the Medicaid Long-Term Care Funding Council as ex-officio designees of the Commissioners of the Departments of Health and Senior Services and Human Services and the State Treasurer:

- Brian Francz, Senior Analyst, Office of Management and Budget, Department of the Treasury
- Elena Josephick, Bureau Chief, Office of Policy Development, Division of Medical Assistance and Health Services, Department of Human Services
- Patricia Polansky, Assistant Commissioner, Division of Aging and Community Services, Department of Health and Senior Services