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State Health Policy

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**Global Budgeting: Promoting Flexible Funding
to Support Long-Term Care Choices**

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Executive Summary: This paper explores states' use of "global budgeting" to promote a public policy of supporting consumers' long-term care choices. Prepared for New Jersey policymakers who are developing a plan to implement global budgeting procedures, this report defines global budgeting in the context of long-term care, provides five state models, and offers lessons learned about determining what is "in the globe," legislative and administrative language to advance it, and how it can be implemented.

Background

Many states are actively working to "rebalance" their long-term support programs and budgets to support consumers' choice and offer them more options to live in their homes and communities. Developing and implementing public policy that supports consumer choice and direction is complex, with many barriers that must be overcome. One major barrier is states' budgeting procedures. Most states budget separately for each long-term support service: Medicaid state plan services like nursing home care, adult day health services, home care, personal care, Medicaid home and community-based waivers, Administration on Aging programs, and other state-funded programs. This practice makes it difficult to support the goal of "money following the person" to different settings as needs and preferences change.

New Jersey is one state that has been deliberately striving to rebalance long-term care away from an over-reliance on institutional care toward more home and community-based options (Reinhard & Fahey, 2003). This state consolidated all policies, programs, and budgets for older adults into one department, the New Jersey Department of Health

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and Senior Services (NJDHSS). It has developed new seamless home and community-based programs that support consumer direction, funded with both Medicaid and state-only funding, so that people do not need to change services if they “spend down” to Medicaid. Each year, the Legislature adds new funding for more home and community-based options. These programs, combined with a robust nursing home transition program, have reduced Medicaid nursing home census by 10.4% in the last three years.²

New Jersey policymakers and consumer advocates, notably AARP NJ, are now seeking to take the next step in realizing the policy goal of supporting consumer choice. Through the Governor’s Executive Order 100 (March 2004), the state is exploring methods to make it easier to allocate dollars to support a “money follows the person” framework. This work begins with an exploration of selected states’ budget innovations and provides lessons learned for New Jersey and other states that are interested in developing improved financing mechanisms. It is based on literature reviews, the authors’ experiences, and discussions with federal and state officials.³

The Concept of Global Budgeting

Global budgeting is one financing mechanism that can be used to promote more balanced long-term care programming and improved cost effectiveness. Also known as “pooled financing,” global budgeting has two dimensions. The first is a limit or cap on total spending. The second is the administrative freedom to manage costs within the spending limit.

Historically, the concept saw widespread use in Canada and Europe during the 1970s and 1980s as a way to control health care costs, especially hospital costs. For example, hospitals could be reimbursed by developing separate rate-setting methodologies for inpatient, outpatient, lab, and administrative costs. However, good budgeting and policy practices call for setting a spending limit for all of a hospital’s operations while providing its administration the freedom to manage the complexity within that spending limit. Since the 1970s, the use of global budgeting has spread to schools and general administration, such as the global spending limit that each Swiss Federal Department operates under. The concept has also spread to other countries such as Australia, Taiwan, and the United States.

In the United States, the concept was extensively discussed in the early 1990s as the merits of the Clinton Health Plan were debated by economists, provider groups, health policy analysts and government officials. This debate generated considerable discussion

² The reduction in nursing facility usage is based on Centers for Medicare and Medicaid services data from the CMS 2082 data system and the CMS Medicaid Statistical Information System (MSIS). Cost per case continues to increase due to inflation and other cost increases.

³ Since this work was an exploratory review of major issues and not a study, the authors did not seek permission from the state and federal officials we met with to publish their identities. They are all public officials who shared public information. These interviews were supplemented by a search of online data sources such as state budget documents and federal financial sites.

of global budgeting as a cost containment strategy, how the European experience was relevant to the United States, and how it differed from managed care, managed competition, and line-item budgeting. Global budgeting is used at the federal level by the Veteran's Administration.

State governments began considering global budgeting approaches in state operations during this period. Examples of its use include New York, Rhode Island, and Minnesota. Helped by the Robert Wood Johnson Foundation, during 1994-1999 New York provided spending limits to selected hospitals and let the hospitals manage within those limits. Rhode Island has been using global budgeting since 1974 for hospital reimbursement but has not called it by that name. The 1996 Budget of the Minnesota Governor used a global budgeting concept to set caps on state spending.

In recent years, concern over the numbers of persons without health insurance has led to global budgeting being proposed as part of the standard solution to resolve access problems. For example, legislation was introduced calling for its use in Illinois in both the 1999 and 2000 sessions. Global budgeting was featured as a cost containment strategy in the single payer debates in Maine and Vermont, and consulting firms such as the Lewin Group include global budgeting in their cost forecasts for states such as Maryland when studying access solutions.

It is the second dimension of global budgeting, the administrative freedom to manage costs within the spending limit, that has interested state long-term care programs. As it is with hospitals, the administrative freedom to manage costs within a spending limit is an appropriate policy for state long-term care programs, given the interrelated complexity of their programs. Persons receiving state funded long-term care services differ based on their preferences for home versus institutional settings, their ability to perform activities of daily living such as walking or bathing, their cognitive alertness, and their social support from friends and family. As these preferences, abilities, and supports change, there is a continual movement of clients among long-term care programs. The result is that the programs form an interrelated whole that is best managed when state officials have the freedom and flexibility to control caseloads and costs within a single spending authority.

The Federal Perspective

Policies of the Center of Medicare and Medicaid Services (CMS) and the Administration on Aging (AOA) create the framework through which state policies flow. Federal policies are broadly defined by the Social Security Act (SSA) and implemented by the Code of Federal Regulations (CFR). A search of Federal Registers from 1995 to 2004 yielded no pertinent references to "global budgeting." A search of Title XIX of the SSA yielded no references. A search of 42 CFR shows no references to global budgeting.

There appear to be no federal policies regarding “global” or “pooled” budgeting. This impression is reinforced by a search of the CMS website which showed one reference to “global budgeting” as used in the Heart Bypass Center Demonstration.

However, this regulatory framework is interpreted and administered by CMS headquarters and regional staff that have their own expectations based on their understanding of the regulatory framework, current CMS policy, and their long experience with different state programs. Discussions with federal officials indicate that CMS staff members believe the use of global budgeting to remove barriers to community living is consistent with federal policy direction.

Medicare policy staff have indicated that Medicare has no position on global budgeting and such budgeting done in the context of long-term care is a Medicaid issue. Staff in the Division of Benefits, Coverage and Payment and a regional office said that CMS has no position on global budgeting.

Federal staff did express some concerns about how global budgeting would be implemented should the state budget need to be reduced. Two concerns were expressed. First, across the board budget cuts in waived services are not acceptable. Plans of care should be driven by medical necessity, and health and welfare, not by the budget. Second, there is a concern with global budgeting through a county-based system. When a statewide program is cost neutral at a county level, the result may be that different services are provided to persons with similar needs. A state can waive statewideness but services must be comparable in the counties included in the waiver.

With these concerns in mind, CMS staff emphasized that the use of global budgeting is consistent with current CMS policy directions. CMS policy is that the services a person needs should not be dependent on where the money is budgeted.

The 2001 *New Freedom Initiative* promotes the goal of community living for people with disabilities. Under this initiative, ten federal agencies have collaborated to remove barriers to community living. Since fiscal year 2001, CMS has awarded Real Choice Systems Change Grants to states and territories to improve community-integrated services and remove barriers to community living. In its 2004 solicitation announcement for Real Systems Change Grants, CMS sought proposals that included “efforts to remove barriers within state budgets that prevent funds from moving from allocations earmarked for institutional supports to home and community-based supports.”

Current State Budgeting Practices

The increasing use of “money follows the person” policies by states has been reported by CMS and other researchers. The references at the end of this paper show the broad national impact that these policies have had.

Based on these reports and the authors' experiences, five states were selected for budgeting practice analysis. Oregon, Texas, Washington, Wisconsin and Vermont have legislation or established budget approaches that link savings from reduced nursing home stays to increased home and community service funding. Discussion with officials in these states focused on their legislation or budget approaches that enable them to take savings resulting from reduced nursing home use and redirect those savings to home and community-based programs. We focused on four areas:

- How is the total amount of the long-term care budget arrived at? That is, what is "in the globe?"
- What legislative or administrative language impacts budgeting?
- How does the state control program expenditures?
- How is budgeting done and what is the role of the statewide budget office?

Oregon

In 2002, approximately 3,500,000 persons lived in Oregon and in December 2002, approximately 561,000 of them were in the Medicaid program. The biennial budget for FY 2004 and FY 2005 contains \$439 million in-state, federal and other funds to pay for about 5,000 persons a day in nursing homes and \$1.125 billion to pay for substitute homes and in-home care for 27,500 persons.

In other words, 85% of the persons using long-term care services receive them in their home or in a community placement. About 14% of Oregon's long-term care general fund expenditures, \$109.1 million out of \$702.6 million, is spent on nursing homes. In 2001, the nursing home occupancy rate was 73%.

The statutory underpinning of this remarkable program dates back to 1981 when the legislature established a long-term care policy and put it in statute at Oregon Revised Statutes (ORS) 410.010. The first two subsections of this policy are:

"410.010 State policy for seniors and people with disabilities.

(1) The Legislative Assembly finds and declares that, in keeping with the traditional concept of the inherent dignity of the individual in our democratic society, the older citizens of this state are entitled to enjoy their later years in health, honor and dignity, and disabled citizens are entitled to live lives of maximum freedom and independence.

(2) The Legislative Assembly declares that the policy of this state is to provide and encourage programs necessary to fulfill the commitment stated in subsection (1) of this section and that the purpose of policies stated in this section and ORS 410.020 is to provide a guide for the establishment and implementation of programs for older citizens and disabled citizens in this state."

The Legislature was also direct in emphasizing the importance of home and community

services in how its policy was to be carried out. This direction included the emphasis on avoiding institutional placements. In ORS 410.020 the Legislature directed the state to:

“(1) Coordinate the effective and efficient provision of community services to older citizens and disabled citizens so that the services will be readily available to the greatest number over the widest geographic area; assure that information on these services is available in each locality, utilizing whenever possible existing information services; and assure that each new service receives maximum publicity at the time it is initiated.

(2) Assure that older citizens and disabled citizens retain the right of free choice in planning and managing their lives; by increasing the number of options in life styles available to older citizens and disabled citizens; by aiding older citizens and disabled citizens to help themselves; by strengthening the natural support system of family, friends and neighbors to further self-care and independent living; and by encouraging all programs that seek to maximize self-care and independent living within the mainstream of life.

(3) Assure that health and social services be available that:

(a) Allow the older citizen and disabled citizen to live independently at home or with others as long as the citizen desires without requiring inappropriate or premature institutionalization.”

There is one other statute, ORS 410.555, that defines how the long-term care budgeting shall be done. ORS 410.555 created a Medicaid Long-Term Care Quality and Reimbursement Advisory Council. The legislation directed the Department of Human Services to submit “for the council’s review and recommendation, any proposed change or modification to the Oregon Medicaid reimbursement system for long-term care services and community-based care services.”

There is no other statutory or administrative language controlling how long-term care budgets are organized. The state has traditionally consolidated nursing home and home and community budgets in the same administrative subdivision within the Department of Human Services. It is now called Seniors and People with Disabilities. Historically, home and community-based waiver services have been treated as entitlements. All persons requesting long-term care services were assessed, and if a person meets the functional eligibility for admittance to a nursing home, then the person is offered alternative home or community services.

The Governor’s Office and the Legislature set the total amount that will be spent on long-term care. Project projections are made by program and caseload, however, the budget is managed to the bottom line. The Governor’s budget office, part of the Department of Administrative Services, does not go into line items and remove savings from particular programs. Thus, nursing home savings have routinely been used for years to increase home and community alternatives.

Forecasting, rate setting, and budget control is done at the department level. Budgets are reprojected quarterly. Staff from the Department of Administrative Services monitor the Department's budget but do not become involved in day-to-day operations.

Cost control in the home and community programs is not done by limiting the number of slots or having a waiting list. There are no slots and there is no waiting list. Rather, the assessment instrument, known as the Client Assessment Planning System (CAPS), is used to assign a number of hours of service to persons seeking in-home services.

Substitute homes such as residential care facilities and adult foster homes are given a base rate of pay for each person depending on the person's degree of impairment. The rates are not negotiable, although 5% of persons receive exceptions above the base rate if their assessment shows complicating factors.

The assessment instrument assigns persons to one of seventeen categories depending on their ability to perform daily activities, with those in the lowest levels requiring the most assistance. These categories are called "survival levels." For example, persons in levels twelve and thirteen need assistance with eating, walking and using the bathroom. An example of their use in budgeting occurred in early 2003 when services to people in levels ten to seventeen were eliminated in budget reductions. During the 2001-2003 biennium, the Department of Human Services' budget took \$273 million in reductions due to the state's declining revenue forecasts. This amounted to a 3.2% reduction in the department's overall budget. Development of the 2003-2005 budget began while cuts were being made to many state services.

The 2003-2005 legislature restored services to persons in level eleven, made service restoration to 1,200 persons in levels twelve and thirteen dependent on federal approval of new revenue, and did not restore services to some 3,600 persons in levels fourteen through seventeen.

The use of survival levels as a budgeting concept creates a different policy debate over budget reductions. Cuts by survival level impact multiple provider types since persons affected are served in nursing homes, in their own homes and in substitute homes. Survival level cuts do not pit provider groups against one another since all are impacted by the reduction. The practice of basing budget reductions on assessment results has the policy merit of reducing services to the least impaired while maintaining them for the most impaired.

The legislature still makes funding decisions affecting different provider groups. For example in the 2003-2005 biennium, assisted living providers received a 2.6% CPI each year, but nursing facilities and adult foster homes did not get a CPI.

Texas

Texas is a large and diverse state. In 2002, approximately 21,250,000 persons lived in Texas and in December 2002, approximately 2,700,000 of them were in the Medicaid

program. Health and human services in Texas are delivered through twelve agencies underneath the umbrella of the Texas Health and Human Services Commission (HHSC). These agencies employ approximately 50,000 persons operating in over 1,000 offices statewide.

In SFY 2003, Texas spent \$3.6 billion on its long-term care programs. Approximately \$1.9 billion was spent on hospice care and nursing homes for 3,000 hospice clients and 61,000 nursing home residents in 1,200 nursing homes. About \$1.3 billion was spent to provide home and community services to 135,000 Medicaid and non-Medicaid eligible persons. In other words, Texas spends about 40% of its budget on home and community services and 60% on nursing facilities. In 2001, the nursing home occupancy rate was 69%.

Texas human service programs underwent a consolidation and reorganization in 2004. Effective September 1, 2004, twelve agencies were combined into four in an effort to obtain \$1.1 billion in savings and to eliminate 4,000 positions. The new Department of Aging and Disability Services is responsible for the nursing home and all home and community waivers. The main home and community Medicaid waiver program for aged and persons with disabilities is called Community-Based Alternatives (CBA). In 2002, it had an average monthly enrollment of 28,000 persons.

Two successive Texas Governors, George Bush and Rick Perry, signed Executive Orders directing the Texas Health and Human Services Commission (HHSC) to develop community alternatives for persons living in institutions. Governor Bush's order, GWB 99-2, of September 28, 1999, said:

“The Texas Health and Human Services Commission (HHSC) shall conduct a comprehensive review of all services and support systems available to people with disabilities in Texas. This review shall analyze the availability, application, and efficacy of existing community-based alternatives for people with disabilities. The review shall focus on identifying affected populations, improving the flow of information about supports in the community, and removing barriers that impede opportunities for community placement.”

Governor Perry's Executive Order, RP 13, of April 18, 2002 contained similar directions to HHSC:

“The Texas Health and Human Services Commission (HHSC) shall review and amend state policies that impede moving children and adults from institutions when the individual desires the move, when the state's treatment professionals determine that such placement is appropriate, and when such placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state-supported disability services.”

In 2001, the 77th legislative session approved Rider 37 to the Texas Department of Human Services Appropriations Act. The rider was called the “promoting independence

initiative.” According to the rider, “It is the intent of the legislature that as clients relocate from nursing facilities to community care services, funds will be transferred from the nursing home to community care services to cover the cost of shift in services.” By its end on August 31, 2003, 2,979 clients had transitioned to the community under Rider 37.

A rider was necessary to break through the difficulty of making budget transfers. In Texas, program budgets are grouped into “strategies.” For example, nursing facilities and hospice are in one strategy and set of line items, while home and community-based services are in a different strategy. It is difficult to make transfers among the strategies. On paper, there is the capability for making the transfers, but the reality is that budget control practices make such transfers difficult. The passage of the Rider by the legislature thus created a cost-effective exception to a budget control process that could not initiate cost-effective changes.

In the 78th legislative session, Rider 37 was replaced with Rider 28 and language was added to make a new Rider 37. Appropriations to the Texas Department of Human Services on page II-77, Chapter 1330, Acts of the 78th Legislature, Regular Session, 2003 (the General Appropriations Act), was amended to read as follows:

“37. Community Care Waiver Slots. It is the intent of the Legislature that the Department of Human Services will not expand the base number of appropriated waiver slots through Rider 28 transfers. Clients utilizing Rider 28 shall remain funded separately through transfers from the Nursing Facility strategy, and those slots shall not count against the total appropriated community care slots. Rider 28 funding through the nursing facility strategy shall be maintained for those clients as long as the individual client remains in the transferred slot. When a Rider 28 client leaves a waiver program, any remaining funding for the biennium shall remain in the nursing facility strategy.”

The cap on costs was individual-specific and the effect of the rider’s language was to control funding levels in the Medicaid CBA waiver program. A likely explanation for this very different budget approach was that the state budget authorities and legislature were concerned about budget problems in general and rising home and community care costs specifically. For example, the Medicaid State Plan services of attendant care and day activities were growing at 10% a year. As of May 1, 2004, 1,776 clients were receiving service under Rider 28.

Both versions of the riders allow individuals who are in a nursing home to obtain home and community-based care without being placed on a waiting or interest list. The persons must be both financially eligible for Medicaid and be assessed as needing a nursing home level of care before obtaining the wavier services.

Prior to the implementation of the Rider there was extensive public discussion as to whether or not a person had to be in the nursing home for a certain number of days before they could use the Rider. For example, one advocacy argument against a time

requirement was that a nursing home is like a jail and why require persons to stay there. After discussion, it was decided to have no time limit. Do some folks go into the nursing home to bypass the lists for home community services? State staff reports that this is not an issue.

The money actually does not follow the person. Texas staff reports that in talking about how Texas does its budgeting, some persons thought budgeting was done on a client-by-client basis, figuring out how much money was being spent on each individual person in a nursing home and then moving that money prospectively. Rather the budgeting is more like a global, after-the-fact, periodic transfer of funds. The state identifies what is being spent on the home and community services for individuals who left the nursing homes and then the state transfers that amount.

The forecasting problem is to project what the nursing home and home and community budgets would be, both with and without the operation of the Riders. What should the base budgets be and how are the trend lines to be projected?

The Riders are by definition cost-effective because the amount paid for a person in a home and community setting cannot exceed the amount paid for that person in a nursing home. Texas has a case-mix nursing home reimbursement. The instrument used is the Texas Index for Level of Effort (TILE). Texas has had about 61,000 persons per year in its nursing homes for the years SFY 2001, SFY 2002 and SFY 2003. All persons entering a nursing home and the CBA waiver are scored into one of eleven TILE categories. For example, 24% of the persons in nursing homes are at the lowest TILE category. The rate paid for their care is tied to their TILE category.

Texas has a long-standing low occupancy rate in its nursing homes. In 2001, forty-two states had a higher nursing home occupancy rate. The Texas rate is 69% versus a national average of 82.5%. The low rate helps assure that when persons leave the nursing home the beds are not “backfilled” by other persons who are waiting for an empty bed to become available in the home.

The department attempted to use the TILE system in responding to a mandated 12.5% budget reduction for the SFY 2004-2005 biennium. One strategy proposed was to eliminate eligibility for services for the least impaired. However, the eventual budget approach used temporarily froze enrollment in the waiver programs and cut attendant hours by 15%. The cut to attendant hours was mitigated by additional federal funds when increased match rates took effect. Enrollment in the CBA program was suspended from September 2003 to June 2004, effectively filling only slots that become open when someone left the program.

There is a list of 64,000 persons who have expressed an interest in receiving home and community-based services. State staff describes this as an “interest” list because Medicaid eligibility has not been established. State staff report that about 54% of the persons expressing an interest will, in fact, be eligible for Medicaid and 50% of the persons on the list are already getting other Medicaid services.

The umbrella agency, the Health and Human Services Commission (HHSC), retains budget authority over the human service agencies. Proposed rate increases, rules, and budget transfers are reviewed and approved by them. Theoretically, you can transfer money among Medicaid programs. The authority is in Rider 13. However, in practice HHSC controls the transfers. Operating staff have little authority to take action in changing the caseload levels or rates paid to providers.

The HHSC has approved the use of State General Funds for staff to help persons leave the nursing homes. This approval is consistent with the Governor's and legislature's direction to help persons leave institutions.

Vermont

In 2002, approximately 600,000 persons lived in Vermont and in December 2002, approximately 148,000 of them were in the Medicaid program. The Vermont Department of Aging and Disabilities administers the state's long-term care programs for elders and persons with disabilities. In FY 2004, Vermont spent approximately \$43.2 million on 1,200 home and community care slots in its two Medicaid waiver programs, and approximately \$98.8 million on 3,045 nursing home residents. In other words, Vermont spends about 30% of its budget on home and community services and 70% on nursing facilities. In 2003, the nursing home occupancy rate was 91%.

In 1996, Vermont passed H. 782, Act 160. The legislation was supported by the Governor and backed by legislators and advocacy groups. This legislation mandated four years of reductions in nursing home budgets and the transfer of these savings to fund home and community-based services. Home and community-care clients grew from about 500 before the Act to about 1,600 unduplicated persons in the period Feb. 2003 to March 2004. Act 160 further required the Vermont Agency of Human Services to:

- Implement data systems to track long-term care expenditures, services, consumer profiles and consumer preferences,
- Implement a system of statewide long-term care service coordination and case management to minimize administrative costs, improve access to services and minimize obstacles to the delivery of long-term care services to people in need,
- In consultation with the nursing home industry, consumer advocates, consumers and other long-term service providers, propose and implement methods to contain costs and encourage the reduction of Medicaid nursing home expenditures, and
- Design and implement a voucher program that permits appropriate consumers to direct, manage and pay for their home and community-based care services.

In discussing the implementation of ACT 160, the Legislature further stated in Section 3 that the long-term care system should include:

“(F) Long-term care service models that are alternatives to nursing home models, provided that the alternative models are comparable in cost or more cost effective than the nursing home models which provide equivalent services. Any alternative long-term care service models shall be financially viable, cost effective, promote consumer independence, participation and noninstitutionalization and, when appropriate, consumer direction and may include one or a combination of services such as assisted living, adult foster care, attendant care and modifications of the residential care home system.”

The legislation successfully accomplished its purpose. Nursing home expenditures as a percent of the total long-term care budget dropped from 88% in 1996 to 70% in 2004.

The two HCBC waivers have modest waiting lists. In July of 2004 there were 1,038 people served by home-based waiver, and 48 were on the waiting list. There were 161 people served by the enhanced residential care waiver, and 28 were on the waiting list.

Spreadsheets obtained from Vermont financial staff showed that monthly expenditures are tracked by program, and estimates are made of the savings that occur each year. For example, the state’s FY 2005 Budget Recommendations show an estimated savings of \$35 million in FY 2004 and a projected savings of \$41 million in FY 2005. Financial management of both nursing home and home and community programs are consolidated into one department. The department’s Commissioner is responsible for developing a spending plan including how the savings will be spent.

Vermont fiscal staff interviewed said that the budgeting went on much as normal after Act 160. The only change was that Act 160 contained a provision that unspent savings could be carried forward to the next fiscal year.

Normal budgeting practices are that the department’s Commissioner proposes a plan to the agency. The agency Secretary revises the plan and develops an inclusive plan covering all departments in the agency. The Governor revises that plan and submits the state’s budget to the legislature. The legislature and the Governor then decide on the funding levels.

The department can raise provider rates or change caseloads as long as the overall budget is cost neutral. Waiver cost control is not done by placing caps on individuals. Rather the cost control is the amount of appropriations that the legislature provides to run the program. The department manages to this budget by controlling the number of persons served at any one time, and monitoring actual cash expenses on a monthly basis.

Data are collected on the Activities of Daily Living (ADLs) and the Instrumental Activities of Daily Living (IADLs) of persons receiving waiver services. There is no specific cap or dollar level set by this, but there are time guidelines for each level of functional need for each activity. A case manager can request a “variance” to provide more assistance than suggested by the guidelines, and most of these are approved. The biggest challenges in the use of the assessment toll are in home-based services serving

people who need supervision or standby assistance due to a cognitive impairment, especially when the person does not live with family or other caregivers.

The assessment tool is not used as a cost control mechanism. Nor is there a need to use these assessment data in global budget making. State policy makers have made a decision to fund increased home and community programs. The question is how much can incrementally be afforded each year given all the competing demands on the state funds.

"The statewide budget staff does not get involved in internal day-to-day department decision making." The statewide staff is involved in the budget preparation on both revenue and expenditure assumptions used in the Governor's budget. There is ongoing communication among statewide budget staff, agency staff, and department staff. Vermont is a small state and the staff has worked together for years. Therefore, there is good communication, understanding, and agreement that the goals of Act 160 represent sound fiscal and social policy.

Washington

In 2002, approximately 6,000,000 persons lived in Washington and in December 2002, approximately 916,000 of them were in the Medicaid program. Authorized spending for long-term care services in the 2003-2005 biennium is \$2.4 billion in state and federal dollars. Of this amount, \$942.3 million will be spent on home and community-based services and \$1.035 billion on nursing homes. In other words, Washington is spending approximately 48% of its long-term care budget on home and community programs and 52% on nursing homes.

Approximately 73% of its clients are served in a home or community setting and 27% are served in a nursing home. In July 1995, there were 16,200 persons in nursing homes. Now there are 12,200. In 2001, the nursing home occupancy rate was 83%. In-home care is provided to over 25,000 clients. Additionally, over 9,000 clients receive services in community residential settings. These include adult family homes, adult residential care, assisted living facilities, and a Program of All-Inclusive Care for the Elderly (PACE).

The Revised Code of Washington (RCW) at 74.39 lays out the purposes of the state's long-term care program and emphasizes the use of home and community care. The purposes outlined at RCW74.39.005 include:

“(1) Establish a balanced range of health, social, and supportive services that deliver long-term care services to chronically, functionally disabled persons of all ages,

(2) Ensure that functional ability shall be the determining factor in defining long-term care service needs and that these needs will be determined by a uniform system for comprehensively assessing functional disability,

(3) Ensure that services are provided in the most independent living situation consistent with individual needs.”

RCW at 74.39A directs the state to expand the use of home and community services where possible. For example see RCW 74.39A.030 where paragraph 1) reads:

“To the extent of available funding, the department shall expand cost-effective options for home and community services for consumers for whom the state participates in the cost of their care.”

The legislature clearly stated its intent that the state help persons leave nursing homes and reside in the community. For example, RCW 74.39A.030 (2) contains the direction:

“By June 30, 1997, the department shall undertake to reduce the nursing home medicaid census by at least one thousand six hundred by assisting individuals who would otherwise require nursing facility services to obtain services of their choice, including assisted living services, enhanced adult residential care, and other home and community services.”

Staff report that global budgeting is embedded in the way Washington creates its budget. The 58th Legislature passed the Engrossed Substitute House Bill 2459 effective April 4, 2004. This is the state’s appropriations act and covers the biennium containing FY 2005 and FY 2006. Section 206 shows the long-term care budget for the Department of Social and Health Services. Both nursing home and home and community programs are contained in this section.

Within the department, the funds are administered by the Aging and Disability Services Administration. This administration sets rates for nursing homes and administers the home and community programs. Washington uses a de facto global budgeting since all long-term care funds are within the same administrative unit within the larger department.

The budgeting process is that the departments prepare the costs and costs per case and use the caseload projections from the Caseload Forecasting Council. This statutory council creates caseload projections for the major Washington social service programs. The enabling legislation is contained in Chapter 43.88C of the Revised Code of Washington (RCW). The projections span significant programs. “(7) “Caseload,” as used in this chapter, means the number of persons expected to meet entitlement requirements and require the services of public assistance programs, state correctional institutions, state correctional noninstitutional supervision, state institutions for juvenile offenders, the common school system, long-term care, medical assistance, foster care, and adoption support.” The code creates a high-level council, a supervisor, and a staff work group

consisting of persons from all agencies whose budgets are impacted by the projections of the Council.

Department staff monitors the programs monthly. Each month the administrator and the directors of the Aging and Disability Services Administration meet with the chief financial officer, the Deputy Secretary of the department, and budget staff. These “program review” meetings cover significant events and trends in the Administration.

The Administration exercises both an overall cost control and an individual level control on how much can be spent on a person’s care. The overall control is an effort to keep total average per person waiver costs at 90% of what the nursing home costs are. There are individual exceptions to this. In general, home and community services are less expensive. For example, many persons in Washington go to adult foster homes. The highest level of payment to a home is \$75, whereas in a nursing home it is \$140.

The individual level of control is made possible through the state’s assessment instrument, the CARE tool. The instrument took two and a half to three years to develop. It assigns a level of care to each person assessed or a number of home care hours if the person is receiving home care. A person’s rate is set by the computerized assessment. A committee reviews each request for an exception to the amounts. The use of the committee cut down the exceptions by 80% to 90%. The exceptions are called ETRs, Exceptions to Rule, since all of the algorithms used to set the payment levels are in rule now.

Exceptions are usually granted when there is a complex medical need coupled with behavioral problems, for example a sexual predator with mental illness. There are no negotiations with providers as to what the individual’s rate will be. Statewide there are only sixty exceptions now.

Rates are set at the beginning of the biennium and are rarely changed. The legislature will provide an inflation increment and that is the only change from year to year. You could change the rate but the process would be to prepare a policy analysis and request a supplemental budget.

Wisconsin

In 2002, approximately 5,400,000 persons lived in Wisconsin and in December 2002, approximately 619,000 of them were in the Medicaid program. In 2001, the nursing home occupancy rate was 85%. Nursing home caseloads have steadily decreased. In August 1999, there were 28,909 Medicaid-funded persons in nursing homes and in August 2004 there were 25,261 in the state’s 408 nursing homes. During the same period, home and community-based care for persons with disabilities and elderly increased from 7,520 to 18,636.

Wisconsin's waiver programs are administered by its seventy-two counties. The counties pay the home and community-based care providers and provide case management services. Costs in these programs are controlled by a combination of legislative spending authority, closing nursing home beds, and managed care programs. Wisconsin's largest Medicaid waiver program for the elderly and physically disabled is called the Community Options Program (COP-W). It is funded by a formula-set budget appropriation and not dependent on closing beds.

Another of Wisconsin's waiver programs is called the Community Integration Program for the Elderly and Disabled (CIP II) and it is funded by the closing of nursing home beds. Under this waiver, since 1986, when a nursing home delicensures a bed, then a slot can be funded under the CIP II program. Wisconsin staff does not use the phrase, but this approach is called a "cold bed" approach.

Until August 24, 1994, the federal Medicaid agency limited the number of waiver recipients in a state under the "cold bed rule." This rule required that each state document, for the federal agency's approval, that it either had an unoccupied Medicaid-certified institutional bed or a bed that would be built or converted, for each individual waiver recipient the state requested to serve in its waiver application. The policy was frequently implemented by requiring that a new person could not be served in a home or community-based program until it was shown that they had left a bed in a nursing home or state institution. A physical bed had to be empty or "cold" and thus the name "cold bed rule."

Wisconsin used this approach in the CIP II waiver program until SFY 2000 when it switched to a more budget-driven approach. The cold bed concept is in statute at 46.277(1)

“(1) Legislative intent. The intent of the program under this section is to provide home or community-based care to serve in a noninstitutional community setting a person who meets eligibility requirements under 42 USC 1396n (c) and is relocated from an institution other than a state center for the developmentally disabled or meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, except that the number of persons who receive home or community-based care under this section is not intended to exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department. The intent of the program is also that counties use all existing services for providing care under this section, including those services currently provided by counties.”

The cold bed rule is implemented in Wisconsin administrative code at HFS 122.04(2)(c) and is reiterated each year in Act 33 of the annual appropriations act. For example, see Section 1123 Wisconsin Act 33 for 2003.

The Medicaid agency puts a per diem amount into the budget each year, representing the amount that will be transferred to the county for each person who leaves a nursing home in that county. The amount is a statewide average and is the same for all counties, and for SFY 2004 it was \$41.86. Conceptually the amount is what the state would have spent for the person in a nursing home with offsets for cost sharing and Medicaid card costs such as personal care, drugs, and home health. In Wisconsin, cost sharing is 23% of the total nursing home per diem. The state allows the counties to use 7% of the per diem for administrative expenses.

In 1999, as directed by Wisconsin Act 9, the Department of Health and Family Services introduced a managed care program called Family Care to eliminate a perceived bias toward institutional care and streamlined what was felt to be a fragmented funding system for long-term care. Family Care is operative in about 20% of the state with Milwaukee being the largest county. It covers the frail elderly, and persons with developmental and physical disabilities.

Family Care was followed by a second program called Partnership that covers three areas: the counties in which Madison and Milwaukee are located, and a third multi-county area. Like Family Care, it covers nursing home and home and community-based care, and acute and primary services.

The CIP II program has been discontinued in those areas where Family Care and Partnership are operating.

There have been two distinct budgeting methodologies used for CIP II: before SFY 2000, there was a direct budget link between the nursing home budget and the CIP II program via a formal Memorandum of Understanding (MOU) between the Medicaid nursing home section and the department's long-term care section. For each county nursing home bed closed, a county received one CIP II slot. Each private nursing home bed was worth .6 of a slot. The funds were moved from the nursing home budget to the CIP II appropriation.

This methodology was changed in SFY 2000 to a "prospective" budgeting method. A budget request is submitted through the department's biennial budget process. The number of CIP II slots requested is based on actual numbers of past bed closures. The number of slots awarded through the budget process is recommended in the Governor's budget and determined by the Legislature.

From this "pool" of slots appropriated by the Legislature, slots are awarded to counties following the formula of one-for-one for county nursing home beds closures and are prorated to counties for private nursing home bed closures. Counties are also awarded a slot for a person who relocates to the community from a closed nursing home bed a county-owned home or a private home. Once the slots are awarded to a county, they can be used for anyone who needs home and community services.

Due to budget constraints, CIP II slots were not approved for each fiscal year: in SFY 2001 there were 222 slots approved; in SFY 2002 there were 686 slots; in SFY 2003 there were none; in SFY 2004 and in 2005 there were fifty slots. The state tracks the number of total nursing home beds closed and this number is higher than the number of budgeted CIP II slots.

There are people both in and outside of nursing homes who are waiting for slots to open for home and community services. A list of such persons is maintained and is titled "Applicants Registered & Waiting for COP & Waiver Funded Services." As of December 31, 2002, the list contained 592 persons in institutions and 8,735 outside of institutions.

The Medicaid nursing home program and the home and community programs are both part of a large umbrella department. However, their budgets are not consolidated under a single administrator. Further complicating this is the financial risk incurred by the seventy-two counties in their role of administering the home and community programs. This complexity of differing interests creates a budget tension that is exacerbated by the state's funding difficulties in recent years.

The tension is expressed by concerns that more funds are needed to pay for the home and community expenses incurred by persons leaving nursing homes. The legacy of the cold bed approach further complicates matters due to the cumbersome administrative and budgeting procedures needed to track beds and their costs.

Concern with the Supreme Court's Olmstead decision and the desire to have persons live in the "most integrated" setting, resulted in Assembly Bill 920 being introduced in the 2003 legislative session. The bill was commonly known as "Life Lease," was supported by the department, and:

- Eliminated the requirement that a nursing home bed had to be delicensed,
- Provided for increased payments to the counties,
- Put a cost control cap saying that in the aggregate the costs of the waiver individuals could not cost more than their nursing home costs,
- Eliminated potential caseload limits on the individuals served, and
- Included a provision that the funds would be added back to the nursing home budget once the person left the waiver. So there would be no accumulation of slots on the waiver.

The February 18, 2003 fiscal estimate accompanying the bill stated that based on cost comparisons of nursing home costs versus CIP II home and community costs plus Medicaid card costs, there was \$33 savings per day per person if AB 920 were to pass. The routine fiscal process for the department's fiscals is to have department staff do them rather than staff in the statewide budget office or legislative fiscal staff. The bill was supported by:

- Wisconsin chapter of the National Multiple Sclerosis Society

- Coalition of Wisconsin Aging Groups Inc.
- Lutheran Social Services of Wisconsin & Upper Michigan Inc.
- Milwaukee Jewish Council for Community Relations, Inc.
- Wisconsin Coalition for Advocacy
- Wisconsin Coalition of Independent Living Centers

These groups have stated that similar legislation will be introduced in the next legislative sessions. AB 920 is more like a global budgeting concept than the cold bed approach now used. The spending control is the level of funding designated by the legislature and there is more administrative flexibility to alter caseloads and per diems.

Summary of Selected State Budgeting Practices

The most significant trend from this analysis is that all five states experienced savings in their long-term care budgets when more home and community care was offered.

Each state had statutory language encouraging the state to develop alternatives to nursing homes. Texas, Vermont and Wisconsin had statutory language authorizing the transfer of savings from the nursing home budget to the home and community-based care budget. The ability to transfer the money is embedded in budget practices in Oregon and Washington where home and community-based alternatives are treated as entitlements.

In Oregon, Vermont and Washington, both the nursing home and home and community-care budgets are in the same administrative subunit.

In Texas and Wisconsin, the nursing home and home and community-care budgets are not in the same administrative subunit. Both Texas and Wisconsin developed statutory language providing a limited ability to transfer the funds. Both states have waiting lists for home and community services. Neither state has an unrestricted ability to redirect nursing home savings to fund expanded home and community programs, and both have complicated budget projection situations.

The Texas language permits funding of home and community services for a person leaving the nursing home, but when the person no longer uses the services the money reverts to the nursing home budget. In Wisconsin's cold bed approach, the legislature allocates slots based on the anticipated closure of nursing home beds, but the number of slots awarded is less than the beds that are actually closed.

The five states exercise three types of controls over home and community-based care:

- Setting the overall spending authority by the Legislature,
- Capping the number of persons served in waiver programs, and
- Controlling the cost of individuals served in the waiver programs.

In all states, after reviewing the Governor's recommendations, the Legislature sets the total amount of the long-term care budget. Oregon and Washington use a de facto global budgeting approach without calling it by that name. Texas, Vermont, and Wisconsin use caseload caps, and Oregon and Washington do not.

Oregon, Texas and Washington use caps based on their assessment instruments to control the cost of individuals served in their waiver programs. Wisconsin uses a cost cap based on average nursing home costs. Vermont does not use its assessment information to control individual costs.

Budget authority over long-term care is split in Wisconsin between the administrative unit that supervises aging programs and the Medicaid unit. In Texas, the long-term care budget is distributed over two budgeting clusters, called strategies, but the Health and Human Services Commission appears to exercise significant budget-making decision and not the administrative units. In Oregon and Washington, the larger department-level staff seems to have significant roles. The small size of Vermont creates a more collegial, consensus atmosphere in which the Governor's budget staff, the agency, and the department all take part in the decision-making.

When asked what the upside of their current programs were, the most frequent answer of state staff was the expansion of home and community programs and their cost effectiveness. Staff in Texas and Wisconsin indicated that the complexity of budgeting procedures created practical, but surmountable difficulties.

Lessons Learned

What advice or lessons can be learned from the experiences of these five states? How should a state program proceed if it wishes to use a global budgeting approach in its long-term care programs? To answer these questions it is helpful to look at the four questions asked of each state.

How is the total amount of the long-term care budget arrived at?

The answers show that in all states, the larger department proposes to the Governor, who then submits a budget to the legislature. The resulting level of long-term care funding is a compromise based on funds available and the competing uses of the funds. State staff that work in the long-term programs do not have access to the decision-making used at the Governor's and legislative levels to arrive at the overall budget.

What legislative or administrative language impacts budgeting?

Language in statute and administrative code has a determining impact on the shape of the long-term care program. Two separate impacts are apparent in the five states. **First**, Governor's Executive Orders in Texas and legislative policy statements in Oregon, are decisive in setting the direction of policy. They educate the public and state staff at all levels of budgeting and program direction as to what the policy should be.

The fact that there is a definite policy conditions future decision making. For example, when asked why the Texas Health and Human Service Commission should authorize the use of state general funds for a statewide expansion of relocation specialists, state staff responded that Commission staff knew what the policy was and were supportive of it.

Second, legislative language and administrative code condition how the general policy shall be applied. The kind of legislation passed thus affects program operations such as how fast home and community-based care programs can grow, and whether or not there will be a waiting list. For example, Wisconsin's continued use of the 1980s cold bed concept has contributed to cumbersome and difficult to administer procedures. To create a new policy, the administration and advocates are using a legislative approach that is embodied in the "Life Lease" concept. Life Lease will make it easier for the approximately 600 folks who are in institutions to leave them, but will not necessarily deal with the non-institutional persons on the waiting list.

Based on the demonstrated influence and importance of legislation, states should enact legislation if they wish to use a global budgeting approach and enhance administrative flexibility to move funds within the larger budget. The legislative language should include establishing a long-term care policy of providing a board array of services, consolidating long-term care budgets within a single administrative unit, and permitting funds to be transferred among programs for the purposes of creating and expanding programs, reducing waiting lists, and operating in a cost-effective manner.

How does the state control program expenditures?

As noted above, all states set an appropriations level. State staff reports that it is generally difficult to alter the initial appropriation level. Expenditures are maintained within the appropriated level by placing controls on caseloads and on the cost per case.

Controls on Caseloads

Long-term programs use three methods for controlling caseloads. **First**, all five of the states have made efforts to divert persons from entering nursing homes and to help them leave nursing homes after they enter. Texas, Vermont and Wisconsin received CMS Nursing Home Transitions grants. **Second**, three of the five states delay or deter use of home and community programs by placing persons on a list rather than providing them the services. Wisconsin and Texas, with the two largest lists, are difficult to compare since the Texas list includes persons who will not be found eligible for Medicaid. Whereas, the Wisconsin list contains persons who had a preliminary determination that they would be likely to be eligible for a home or community program.

Third, the assessment instrument is used to categorize persons and the categories are used for caseload control. The potential for this occurred during the recent budget difficulties in Texas with the use of the TILE categories and in Oregon with the use of its survival levels. In order to use the assessment instrument, clients must be assigned to

categories of impairment. It is not sufficient to simply conclude they are or are not eligible for services.

Controls on Cost per Case

All of the programs exercise some kind of control on the cost per case. The methodologies vary by state. States use a ceiling on the cost per case for home and community programs by saying it will not exceed the cost per case in a nursing home or some percentage of the nursing home cost per case. Methodologies differ in how the controls are done. Oregon, Texas and Washington link scores on the assessment instrument to levels of payment. Wisconsin relies on its counties to control the cost of a person's care rather than imposing a statewide cap.

Texas uses its TILE methodology to establish impairment categories and payment levels are assigned to each category. A person in a given category would not receive more for home and community care than the nursing home would have been paid for them. The budgeting advantage of using the assessment instrument is that it provides a standardized method for relating a person's impairments to the cost of their home and community care. States allow exceptions to the cost per case ceilings but the methodology of making exceptions differs. For example, Wisconsin central office staff monitors cases that cost more than \$300 per month even though there is no statewide cap.

The states use different assessment instruments. The key activity that these states have successfully done is to create categories of impairment and link payment to the categories.

How is budgeting done and what is the role of the statewide budget office?

All states report monitoring their caseloads and cost per case monthly, forecasting and reporting on the results. Three of the five states have consolidated their long-term care budgets in a single administrative unit. In Wisconsin, the budgets are located within a single umbrella department, but they are managed by separate administrative units within the department. In Texas, the budgets are in different budget strategies. The lack of consolidation limits the cost effectiveness of the long-term care programs and necessitates special legislation to bridge the absence of consolidation.

The Texas appropriations riders allow for savings from relocated nursing home residents to follow them to their community placement, and Wisconsin's cold bed strategy permits the movement of money for some relocated persons. A lack of consolidation limits the cost-effectiveness because savings from diverted or relocated persons cannot be easily transferred to the home and community care programs to take care of these persons. For example, neither Texas nor Wisconsin can easily transfer the cost savings generated by diverting persons from entering nursing homes.

In contrast, the consolidated budgets of Oregon, Vermont and Washington appear to have used administrative practices that balance the budget at the bottom line. Savings in one

program are shifted to cover increased costs in another without the need for legislative authorization to make the transfer.

Do long-term care programs that have not consolidated their budgets tend to have larger waiting lists? That is the pattern in this study of five states, but more states would need to be studied to see if this relationship exists in a larger sample of states.

State staff interviewed believes that relocating or diverting persons from nursing homes is cost-effective. This view is shared by program staff, department-level staff, and statewide budget office staff. Some states keep track of the savings such as Vermont, and others such as Texas and Oregon believe in its cost-effectiveness but have not published estimates of savings. Vermont's practice of allowing savings to be carried forward to the next fiscal year is worth consideration. All of the states have nursing home occupancy rates that are low enough to eliminate any arguments that there will be a backfill of a nursing home bed should a person leave it.

There are three layers of budget authority in long-term care programs: the administrative unit, the larger department, and the statewide budget office. States show significant variation in whether the administrative unit or the larger department carries out major program budget functions. For example, Oregon has completed a multi-year consolidation of all administrative functions at the larger departmental level. Whereas, the long-term care unit in Washington has operational responsibility for significant budget functions such as rate setting. There appears to be no optimal way of apportioning budgeting responsibilities between the administrative unit and the larger department.

Generally, the statewide budget office does not get involved in the day-to-day operations of the programs. The statewide staff monitors spending levels, asks about programs, and prepares the Governor's budget. For example, they do not get involved in projecting caseloads or cost per case.

Vermont is a small state. Statewide budget staff who work in the programs know them well and think that Act 160 was a very cost effective savings. In Wisconsin, Texas and Oregon, departmental-level budget staff appears to have the central budget responsibilities. In Washington, caseloads are forecasted by the Caseload Forecasting Council, which is statutorily responsible for projecting the caseloads of major human service programs.

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