Independence, Dignity and Choice in Long-Term Care Act Report

June 21, 2006 - October 1, 2007

Jon S. Corzine
Governor

NEW JERSEY
DEPARTMENT
of
HEALTH
and
SENIOR SERVICES

Fred M. Jacobs, M.D., J.D.
Commissioner

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I. Acknowledgements

The report was made possible by the work and commitment of the following members of the 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
- Thomas D. Begley, Jr., Begley & Bookbinder, PC, 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
- Maria Galvan, Supervisor, Somerset County Office on Aging, representing New Jersey Association of Area Agencies on Aging
- Gary Gilmore, Executive Director, Wiley Mission, representing New Jersey Association of Homes and Services for the 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, President, SEIU Local 1199NJ
- County Welfare Directors Association
- 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:

- Christopher Bailey, Budget Manager, 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

II. Executive Summary

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 (Council) established pursuant to this law, is required no later than October 1, 2007, to 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). The report must include a detailed budget and management plan for effectuating the purposes of this law: the Independence, Dignity and Choice in Long-Term Care Act (the Act). It must entail a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms.

In 2003, New Jersey was one of 12 states awarded an Aging and Disability Resource Center (ADRC) grant by the federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to improve access to information and services, and to streamline the Medicaid eligibility process. In New Jersey, the grant was renamed the Aging and Disability Resource Connection (ADRC) initiative. The ADRC initiative was the first joint venture between the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) to create a “no wrong door” coordinated single entry system for persons of all ages, physical disabilities and long-term chronic illnesses regardless of income. The State introduced the concept beginning with Atlantic and Warren Counties as pilot programs. An algorithm, as a client pathway, was created as an operating framework for the service delivery system.

As early as 2004, the DHSS had begun developing and implementing a global budgeting process and fast track eligibility process for Medicaid long-term care support services. For the first time in State Fiscal Year 2006, $30 million in state and federal funds were allocated to rebalance the Medicaid long-term care budget to reflect a more equitable distribution of funding between nursing homes and home and community-based services (HCBS). Since that time, the State budget has included a line item dedicated to the global budget initiative.

It is the ADRC model – with its partnerships, products and processes – that provides the framework underpinning the Independence, Dignity and Choice in Long-Term Care Act signed into law by Governor Jon S. Corzine on June 21, 2006. The creation of the ADRC model included the testing of a clinical assessment tool and a Medicaid Fast Track Eligibility process, the purchase of a web-based client tracking system, and the design of a new business process to transition individuals from nursing homes to HCBS.

The ADRC is expanding to five additional counties (Mercer, Camden, Hunterdon, Morris and Bergen) under an additional two-year grant awarded to

New Jersey in October 2006 from the AoA. Counties were selected based on their county's leadership and support to participate, their demographics (rural versus urban) and size.

Concurrently, the DHSS has begun the deployment of its web-based client tracking data system in a six-month incremental rollout. It is the Social Assistance Management Systems (SAMS) application that advances the ADRC's objectives as described in the Act.

Federal funding opportunities through the Deficit Reduction Act of 2005 and grant awards from the AoA and CMS (ADRC and Systems Transformation) are also advancing New Jersey's efforts to reform its long-term care system. With the budgetary support and commitment from Governor Corzine, the partnership of DHSS and DHS responsible for developing strategies to carry out the Act's requirements and the input and guidance from the Medicaid Long-Term Care Funding Advisory Council, the State is making progress toward fulfillment of the Act's mandates.

The Council was created within the DHSS and has been meeting quarterly since November 2006. There are 12 public members and three designees from the Commissioners of Health and Senior Services and Human Services, and the State Treasurer. These are the Council's recommendations to Governor Corzine and the Legislature:

- Expand the ADRC model, clinical assessment, fast-track eligibility process, and client-tracking system piloted in Atlantic and Warren Counties, statewide based on the evaluation and analysis of the pilot.
- Establish a task force including representatives from the DHSS Division of Aging and Community Services (DACS) and the DHS, Division of Medical Assistance and Health Services (DMAHS) to prepare and evaluate a State budget and cost impact analysis for the potential expansion of the home and community based Medicaid waiver programs to include the Medically Needy population. Also determine if legislative action would be necessary to implement such an expansion. The Medically Needy Program provides Medicaid benefits for persons whose income exceeds the Medicaid Program's eligibility requirements because of documented medical expenses.
- Strengthen collaboration between DHSS, DHS and the Department of Labor and Workforce Development to maximize and coordinate the resources of the Workforce Investment Boards and other programs/funding for the benefit of the workforce, health care providers and the State.
- Create mechanisms for upward mobility to help attract and retain direct care workers in the long-term care field.
- Redesign the nursing home rate setting methodology so that Medicaid rates are stable, predictable and adequate.

- Develop and implement a flexible budgeting methodology that provides the State with the authority to allocate and coordinate Medicaid long-term care dollars to support consumer choice across departments, programs, and populations.
- Review the adequacy of reimbursement for Medicaid funded home care services, including rates for skilled visit services, private duty nursing, and home health aide services to ensure that rates are adequate to cover the costs associated with direct care delivery, inclusive of ongoing nursing supervision.
- Transfer the home health aide certification program and process from the Board of Nursing in the Division of Consumer Affairs at the Department of Law and Public Safety to the DHSS.
- Include individuals with mental illness in New Jersey's long-term care reform efforts as written into the Act. The U.S. Supreme Court ruling in *Olmstead v. L.C.* upholds that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act.

III. Accomplishments under the Independence, Dignity and Choice in Long-Term Care Act

Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act (the Act) into law on June 21, 2006. The Act calls for the reallocation of Medicaid long-term care expenditures and the creation of a more appropriate balance between funding for nursing homes and home and community-based services. Governor Corzine also included $30 million in his State Fiscal Year 2007 budget – despite severe State fiscal constraints – for New Jersey's global budget initiative. The program, known as Global Options for Long-Term Care (GO for LTC), is continuing the restructuring of New Jersey's long-term care systems.

The Act also directs the Department of Health and Senior Services (DHSS) to implement a system of statewide long-term care service coordination and management; to identify home and community based long-term care models that are efficient and cost-effective alternatives to nursing home care; develop and implement a consumer assessment instrument that is designed to expedite the process to authorize the provision of home and community based services through fast-track eligibility prior to formal financial eligibility determination; develop a quality assurance system; seek to make information available to the general public, and create a Medicaid Long-Term Care Funding Advisory Council.

In this section, the mandates in **Public Law 2006, chapter 23** have been extracted to provide a clear progress report on accomplishments to date:

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use statewide.

In State Fiscal Year 2007 (SFY07), data shows that 23 percent of New Jersey's long-term care public funds were allocated to home and community-based services (HCBS) with the remainder (77 percent) allocated to nursing home care. The total state allocation for long-term care in SFY07 was $882 million plus matching federal funding. In SFY97, however, only 7 percent was allocated for home care options – and 93 percent on nursing homes. Total State funding reached almost $592 million back then. Indeed, New Jersey has made significant gains in rebalancing long-term care to more funding for HCBS.

Global Options for Long-Term Care (GO for LTC) is New Jersey's first step in a multi-year change process to rebalance spending for long-term care services by providing a more equitable distribution of public funds between cost-effective home and community-based services and institutionally-based care. GO for LTC reflects a system-wide transformation — from a fragmented service delivery system currently provided to New Jersey seniors and persons 18 years and older with physical disabilities to a single entry system for both populations.

GO for LTC provides a broad array of HCBS to consumers who are financially eligible for Medicaid and clinically assessed as meeting nursing home level of care. Participants are eligible for all NJ Title XIX Medicaid State Plan services[1] authorized in a plan of care. In addition to State Plan services, participants are eligible for 14 waiver services such as assisted living, homemaker services, respite care, environmental accessibility adaptations, personal emergency response systems, home-delivered meals, special medical equipment and supplies and participant-employed providers (i.e. ability to hire family/friend to provide supportive services).

GO for LTC launched two initiatives: (1) transitioning nursing home residents to alternative home and community-based long-term care options, which was rolled out statewide, and (2) piloting the fast track eligibility process in the two Aging and Disability Resource Connection (ADRC) counties. Here are the accomplishments to date:

1. A New Business Process

Building upon the DHSS' successful Community Choice Counseling Program, a new business process, known as GO-Nursing Home Transitions, was developed to support consumer choice through a more comprehensive service planning and coordinated team approach. GO-Nursing Home Transitions was developed to reach those individuals most at risk for nursing home placement through early intervention by:

- Identifying and counseling individuals at-risk of inappropriately being placed or remaining in nursing homes, on the full range of home and community-based support services;
- Establishing an Inter-Disciplinary Team (IDT) approach that strengthens communication, collaboration and coordination among hospital and nursing home discharge planners, Community Choice Counselors, and NJ EASE care managers;
- Supporting a consumer directed service planning process that offers greater flexibility and choice of services, and
- Providing on-going service coordination and care management in the community.

This process is designed to advance a "Money Follows the Person" (MFP) methodology that moves away from allocating "slots" per county to one that provides nursing home residents with equal access to HCBS statewide. The new delivery and financing system, however, still provides the State with the necessary control of overall costs and assures budget neutrality for HCBS.

[1] Medicaid State Plan Services range from inpatient and outpatient hospital treatment; laboratory tests and X-rays; and home health care and physician services; to early and periodic screening, diagnostic and treatment services, among other standard and optional services for beneficiaries in specific programs.

Since implementing GO for LTC in SFY06, 811 nursing home residents have been transitioned to alternative LTC options throughout New Jersey. Of those discharged, 306 individuals were enrolled in GO and 505 were discharged home with non-waiver services, i.e. State Plan Services or no formal services for a total cost of $5,702,403. GO has serviced 406 persons to date for an average monthly cost of $1,124 per person, compared to $4,724 per month for nursing home costs, which is a savings to the State of $3,600 per month.

2. Creation of New Client Pathway with Aging and Disability Resource Center (ADRC)

In 2003, New Jersey was one of the original 12 states to receive the Aging and Disability Resource Center (ADRC) grant funded by the Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) to simplify and ensure "one stop shopping" for all LTC supportive services for older adults and persons with disabilities. In New Jersey, the ADRC stands for Aging and Disability Resource Connection.

The ADRC grant is enabling the DHSS' DACS, in collaboration with the Department of Human Services (DHS)' Division of Disability Services (DDS) and the Division of Medical Assistance and Health Services (DMAHS), to redesign the State's aging and disability service delivery systems by:

- Creating a system that is visible, trusted and easy to access for information and assistance (I&A) on the broad array of home and community based services (HCBS);
- Addressing the changing needs of older adults, persons 18 years and older with physical disabilities and their caregivers, including those from culturally-diverse populations and all income levels across the lifespan;
- Supporting individuals to make informed quality of life and quality of care choices; and
- Streamlining the clinical and financial eligibility process for long-term care Medicaid services.

Because of the grant, New Jersey had the funding to develop and pilot the ADRC model in Atlantic and Warren Counties – which is now serving as the framework for developing and implementing the mandates established under the Act. An algorithm for the ADRC model was created to identify a new client pathway and decision-making process for determining clinical and financial eligibility and accessing information. The algorithm consists of these six steps: (1) building organizational capacity; (2) initiating contact with consumers; (3) identifying consumers' needs; (4) counseling consumers on LTC options; (5) coordinating consumer directed care plans, and (6) integrating a continuous quality management framework into the ADRC model.

In Atlantic County, the ADRC pilot is advancing a "no wrong door" approach through a single entry system. As a result of being selected as one of

the two original pilots, county officials designated the Division of Intergenerational Services to serve as the regional NJ211 call center for Atlantic and Cape May Counties. The dual designation ensures a seamless, coordinated point of access for all consumers regardless of their age, disability, need or income.

In Warren County, the primary focus of its ADRC model has been on standardizing and streamlining the clinical and financial screening and assessment process for older adults and younger persons with physical disabilities seeking long-term supportive services. Warren County is now a paperless operation with all client transactions being conducted electronically.

3. A New Clinical Assessment Tool

The ADRC initiative researched, evaluated, and selected the MI-Choice assessment tool, developed by the University of Michigan to be tested in the pilot counties. The assessment tool, which is based upon the Inter*RAI* MDS-HC assessment, is nationally and internationally validated. New Jersey modified the electronic tool to create a suite that includes: (1) minimum data elements for Information and Assistance (I&A) intake; (2) a "Screen for Community Services," a set of 20 clinical and 10 financial questions that I&A specialists ask consumers over the phone to assess their potential need for long-term care support services; and (3) the MI-Choice clinical assessment tool. Five levels of services are triggered, which are I&A, homemaker, intermittent personal care, home care, and nursing home level of care.

In SFY07, the Atlantic and Warren pilot counties had the following results:

- Provided I&A referrals to 37,588 consumers;
- Pre-screened 1,462 callers who were seeking LTC service;
- Conducted 623 in-depth clinical assessments, and
- Assessed 175 physically disabled consumers.

4. Medicaid Financial Fast Track Eligibility Determination

The ADRC is testing an expedited financial eligibility determination process that allows consumers, who appear to have a high probability of being eligible for Medicaid, to be authorized to receive HCBS for up to 90 days while they complete the full Medicaid application and determination process. Because Federal Financial Participation is not available for services delivered to applicants who are not eligible for Medicaid, the State of New Jersey would pay for services should the applicant be determined ineligible.

Under the MI-Choice assessment tool previously described, the Screen for Community Services triggers the Fast Track Eligibility process: the names of consumers whose service needs indicate a high probability of being eligible for Medicaid long-term care benefits are forwarded to the ADRC assessor for an in-depth clinical assessment. Once the assessment is scored, the results are uploaded to a central database, whereby the DHSS reviews the assessment and

approves or denies nursing facility level of care (NFLOC). Names of individuals who meet this requirement are forwarded to the DHSS, Division of Senior Utilization and Benefits Management (SUBM) to check income and resources against the Medicare Part D Low Income Subsidy (LIS) database. Within two business days, SUBM forwards the financial information to the ADRC for them to review and approve or deny Medicaid benefits under the Fast Track process. If the person is approved for Fast Track, a temporary Medicaid number is assigned and State Plan services and care management are authorized for up to 90 days. Within 30 days the person must schedule an appointment with the county welfare agency to complete the full Medicaid application process or risk being terminated from the Fast Track program.

Consumers can now be clinically assessed, financially screened, and approved within five to seven business days to receive services for up to 90 days while the full Medicaid financial eligibility determination process is completed. In SFY06, the Atlantic and Warren pilot counties had the following results for fast track eligibility:

- Screened 425 individuals through the Low-Income Subsidy database; and
- Approved 16 individuals for Fast Track Eligibility.

5. Launch of a Computerized Client-tracking System

In November 2006, the Department of Treasury approved a six-month piloting of a web-based client tracking data system in seven counties at a cost of $338,360: the Social Assistance Management Systems, also known as SAMS. The projected cost to deploy the application statewide will be $1.93 million.

The rollout plan is as follows: In June 2007, care management staff from Mercer and Somerset Counties were trained and began testing the application. In July 2007, SAMS was deployed in Atlantic, Warren, Union, Passaic and Cape May Counties. The six-month pilot concludes October 1, 2007 at which time the DHSS must submit a report to the State Office of Information and Technology (OIT) outlining the overall effectiveness in achieving the desired outcomes identified in the Act. Once OIT evaluates the pilot's success, DHSS will begin rolling out the client-tracking system statewide.

The SAMS client-tracking system is one component in the DHHS' efforts to develop an integrated Information Technology system that can collect and analyze data for clinical assessment needs, service utilization and costs; budget projection and effectiveness of reimbursement payment; and quality management and performance standards.

As a result of the evaluation report submitted by the ADRC evaluator and testing of SAMS, the DHSS has drafted an implementation plan for rolling out the ADRC model throughout New Jersey. The timeframe for statewide rollout,

however, is contingent upon the successful completion of the client-tracking application currently being piloted in seven counties.

6. Progress Towards Statewide Implementation

The Act states that "commencing March 1, 2008, the expansion of services and measures… to all of the remaining counties…subject to the commissioner conducting an evaluation of the pilot programs in Atlantic and Warren Counties, determining from the evaluation that the pilot programs are cost-effective and should be expanded Statewide."

Through the ADRC grant, an independent evaluator has been retained to focus on the model's effectiveness; consumer direction and satisfaction; quality of services and sustainability. The evaluator is responsible for receiving information and data and providing continuous feedback to the DHSS, DHS and the Atlantic and Warren pilot counties. Consumer survey tools have been created and consumer focus groups have been conducted to measure progress and implications of the performance and outcome measures.

A preliminary evaluation report on the ADRC model is attached in Appendix C. The report shows that clients, who are the initiative's primary focus, are very satisfied with all ADRC services according to consumer satisfaction surveys conducted over the past three years. Highlights of the major ADRC achievements, range from the new algorithm or client pathway to the state-of-the-art clinical assessment tool, client-tracking application and the standardized long-term care processes, policies and protocols. These main accomplishments ensure the model's sustainability.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

This document fulfills the obligations of the Department of Health and Senior Service (DHSS) Commissioner to present an October 1, 2007 report to the Governor and the Legislature. No later than January 1, 2008, the DHSS Commissioner will present a report to the Governor and the Legislature that shows the reallocation of funds to HCBS.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

The Department of Health and Senior Services (DHSS) in collaboration with the Department of Human Services (DHS) has made the following progress on mandated activities in this section:

1. Movement to Funding Parity

The DHSS is creating a multi-pronged approach to rebalancing the State's long-term care budget that will facilitate the further growth and development of

home and community-based services (HCBS), while spending no more than the current allocations for long-term care. To advance this mandate, the DHSS has allocated funds in the Systems Transformation Grant from the Centers for Medicare and Medicaid Services (CMS) to hire a national consultant to assist the DHSS in the development of a flexible budget projection model and a more effective reimbursement methodology. Through the Systems Transformation Grant, a request for proposal will be issued to recruit and hire an actuarial consultant.

2. Better Coordinated Approach for Discharge Planning

As a part of Global Options for Long Term Care (GO for LTC), the Nursing Home Transition initiative implemented an Inter-Disciplinary team (IDT) approach to coordinate discharge planning for nursing home residents whose level of service needs can be supported with home and community-based services (HCBS). The IDT is critical to the GO for LTC process and supports the resident/family to direct and create a person-centered transition plan. In addition to the resident and family, the IDT members typically include the nursing facility social worker/discharge planner, Community Choice Counselor, NJ EASE care managers, and other professionals essential to planning and coordinating HCBS. Since July 2006, the DHSS has conducted multiple regional training sessions for more than 400 nursing home discharge planners/social workers, NJ EASE care managers, and Community Choice Counselors. As a result, 193 residents were transitioned to alternative long-term care options in SFY06.

3. New Assessment Instrument

As previously detailed, the Aging and Disability Resource Connection (ADRC) is piloting the MI-Choice clinical assessment tool in Atlantic and Warren Counties. Working with the University of Michigan, the algorithm is being analyzed to ensure that the automated scoring meets New Jersey regulations. Additional research is underway to include cognition as a part of the algorithm. The DHS has requested that factors related to memory impairment, level of consciousness and executive function be included in the criteria for determining nursing facility level of care. Once the analysis is complete, the MI-Choice algorithm will be modified and rolled out to the ADRC pilot counties.

4. **Quality Management Initiative**

The DHSS primary concern is improving the quality of services and care offered to the aging and disability populations. To reduce overuse or misuse of services and address cost-effectiveness strategies used by care managers, health providers and other organizations, the integration of a standardized model is required. It is the adoption of the HCBS Quality Framework that is serving as the cornerstone for building a system improvement protocol and offering additional support to the overall rebalancing initiative. The Division of Aging and Community Services (DACS) Quality Management Initiative developed under the ADRC grant incorporates these essential quality components:

- Adherence to the quality definition and HCBS quality framework established by CMS including the quality management functions of design, discovery, remediation and improvement;
- Alignment of the Medicaid Waiver assurances using the HCBS Quality framework with the NJ ADRC algorithm and DACS quality outcomes;
- Design of a quality system infrastructure emphasizing roles and responsibilities at DACS and requiring accountability through feedback mechanisms;
- Emphasis on quality performance measures with the outcomes of design, visibility/trust, efficiency, responsiveness and effectiveness;
- Integration of quality throughout the DACS system using multi-level performance evaluation checkpoints with the Quality Review Committee (QRC) and the DACS Quality Management Panel (QMP);
- Data collection through specially designed survey tools such as client satisfaction, home interviews, on-site monitoring of care management sites, and consumer file reviews, will result in the ability to measure overall system performance against established indicators on a regular basis. In consultation with the DACS Quality Review Committee and the DACS Quality Management Panel, overall findings will be reviewed and performance improvement methodologies will be identified and implemented on an on-going annual basis, and
- Sustainability of the DACS initiative through a phased-in approach beginning with individual team training and culminating in the institutionalization of all policies and processes within the Division.

The DACS Quality Initiative will ensure quality outcomes for all DACS services and activities and contribute to the primary goal of successfully meeting the health needs of all New Jersey seniors. At a minimum, it is expected that the Quality Initiative will (1) improve administrative and fiscal accountability at all levels; (2) ensure that the client's health, welfare, and personal preferences are at the center of how their care is provided; (3) preserve consistency in how programs are administered, and (4) promote continuous quality improvement.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.

As required in the Act, the Medicaid Long-Term Care Funding Advisory Council (Council) in the Department of Health and Senior Services (DHSS) has been established with 12 public members and designees from the Commissioners of Health and Senior Services and Human Services, and the State Treasurer. The DHSS is providing staff and administrative support to the Council.

Commissioner Jacobs appointed the Council's 12 original public members in a letter dated September 25, 2006. While there have already been some changes in the public members since then, their 12 organizations are listed in the

Act and remain constant as specified in the Act. Following is a listing of the original 12 members:

- 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
- Winifred Quinn, Associate State Director-Advocacy, 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
- Maria Galvan, Supervisor, Somerset County Office on Aging, representing New Jersey Association of Area Agencies on Aging
- Gary Gilmore, Executive Director, Wiley Mission, representing New Jersey Association of Homes and Services for the 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, President, SEIU Local 1199NJ
- Jeff Daly, Director, Sussex County Division of Social Services, representing County Welfare Directors Association
- Susan C. Reinhard, Ph.D., Co-Director, Rutgers Center for State Health Policy

In addition, the following State staff is participating 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:

- Christopher Bailey, Budget Manager, 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

At the first meeting held on November 9, 2006, DHSS Assistant Commissioner Patricia Polansky asked those members interested in serving as chair to contact her office by December 1 and that the DHSS would handle the role of secretary unless there is outside interest in such administrative duties. Sherl Brand of The Home Care Association of New Jersey and Theresa Edelstein of the New Jersey Hospital Association volunteered to serve as co-chairs and began fulfilling their responsibilities in this capacity at the January 10, 2007 meeting.

Since the original appointments of the public members, there have been changes in membership. Thomas D. Begley, Jr., Begley & Bookbinder, PC, has been appointed at the recommendation of AARP (to replace Winifred Quinn) and Marsha Rosenthal, M.P.A., Ph.D. has been appointed to represent the Rutgers Center for State Health Policy (and replace Dr. Susan Reinhard). A recommendation for appointment is pending for the County Welfare Directors Association following the retirement of Jeff Daly from the Sussex County Division of Social Services.

Since the Act was signed into law on June 21, 2006, the Council met November 9, 2006 for the first time. In 2007, the Council met January 10 and May 9, with other meetings scheduled for September 19 and November 14.

C.30:4D-17.30 Waiver of federal requirements.

The Department of Health and Senior Services (DHSS), Division of Aging and Community Services (DACS), is working in collaboration with the Department of Human Services (DHS), Division of Medical and Health Services (DMAHS), to consolidate the 1915(c) Medicaid waivers operated in DACS by January 1, 2008. The Centers for Medicare and Medicaid Services (CMS) has given authorization to New Jersey to proceed with its plan. A Medicaid waiver is a tool used by states to obtain federal Medicaid matching funds from CMS to provide long-term care to people in settings other than nursing homes.

Currently the DHSS offers Medicaid waiver services that compete against each other:

- The Community Care Program for the Elderly and Disabled (CCPED) offers four State Plan services and four Medicaid waiver services – the others offer all State Plan services and up to 12 additional Medicaid waiver services.
- Assisted Living (AL) offers Medicaid waiver services in residential settings while the Enhanced Community Options (ECO) waiver offers services in the home.

In addition, Medicaid capitated rates vary, with CCPED offering two to three times the amount allowed for the Caregiver Assistance Program (CAP), a program in the ECO waiver. Each Medicaid waiver is also uniquely administered with some being managed centrally with the use of slots and others being managed by designated county government entities based upon annual allocations.

Consolidating the various Medicaid waivers into a global budget would have these advantages:

- Equitable consumer access to all Medicaid and State Plan services;

- Fair distribution of service funds to consumers based upon objective criteria;
- Increased flexibility for modifying consumer services packages as needs and preferences change;
- Greater consistency in and simplification of Medicaid waiver administration;
- Administrative cost savings for the State;
- Greater consistency in the provision of local care management services, and
- Expanded access to a full range of qualified providers.

A consolidation supports the tenets of the Independence, Dignity and Choice in Long-Term Care Act and the Deficit Reduction Act (DRA) of 2005 to promote independence, dignity and choice. Through the flexibility offered by the DRA, states are encouraged to make changes to their Medicaid programs for more equitable consumer access to a full range of qualified providers and greater consistency.

CMS has told the State that a new waiver will not be necessary in order to combine New Jersey's 1915(c) Medicaid waivers, and has encouraged DACS to proceed to amend the CCPED waiver to reflect a consolidation with the other two waivers (Assisted Living and Enhanced Community Options). Individuals receiving services under the current Medicaid waivers will be grandfathered into the consolidated waiver.

C.30:4D-17.31 Tracking of expenditures.

In order to provide the State of New Jersey with the necessary tools to implement a flexible budget methodology and assure parity between institutionally based services and home and community based services (HCBS), additional Information Technology (IT) solutions are needed to link data from the Social Assistance Management Systems (SAMS) client-tracking system to the Medicaid Management Information System (MMIS) and the clinical assessment databases. The interface between these databases will provide the DHSS with information needed to analyze service utilization and costs by consumers' level of service needs. The goal of the IT strategy is to permit comparisons of client characteristics across departments, divisions, programs and settings regardless of funding streams.

Under the federally funded Systems Transformation grant, the IT workgroup will issue a request for proposal to hire a systems architect to evaluate current long-term care data systems and recommend strategies to integrate/link the Medicaid long-term care services across departments, divisions, programs and populations.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.

Governor Corzine included a unique global budget appropriations line item for Medicaid long-term care expenditures in the annual appropriations act in the amount of $30 million, including State funds with federal match, for State Fiscal Year 2007 (SFY07). In SFY08, the global budget appropriations line item is $28 million State and federal dollars combined.

IV. Long-Term Care Reform Progress

A. Congruency of P.L. 2006, Chapter 23 with Long-Term Care Reform Efforts

Governor Corzine signed the Independence, Dignity and Choice in Long-Term Care Act (Act) into law on June 21, 2006. As a result of this historic bill signing, the State's long-term care funding structure is being adjusted to provide more options for older adults through budgetary rebalancing.

In 2003, New Jersey had already been selected by the federal Administration on Aging (AoA) and the Centers for Medicare and Medicaid Services (CMS) as one of 12 states to receive an Aging and Disability Resource Center (ADRC) grant to improve access to information, services and streamline the Medicaid eligibility process. The ADRC initiative was the first joint venture between the Department of Health and Senior Services (DHSS) and the Department of Human Services (DHS) to create a "no wrong door" coordinated single point of entry system for persons of all ages, physical disabilities and long-term illnesses regardless of income. The State introduced the concept beginning with Atlantic and Warren Counties as pilots. An algorithm, as a client pathway, was developed as an operating framework for the service delivery system.

The ADRC is being developed and implemented as the "no wrong door" single point of entry system for all persons of all ages regardless of income: not just for individuals receiving Older Americans Act or Medicaid services. As such, the importance of planning for one's own long-term care needs is ─ and will be increasingly ─ an important public service message for those residents who have resources for private financing and will be ineligible for public assistance.

In 2004, the DHSS received a CMS-funded technical assistance award from the National PACE Association to conduct a feasibility study in three counties to determine the viability of PACE (Programs of All-inclusive Care for the Elderly) in New Jersey. PACE is the only approved managed care model by CMS providing a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate. The PACE program, while not yet operational in New Jersey, will help to contribute to New Jersey's long-term care reform agenda to reflect a more equitable distribution of funding between nursing homes and home and community-based services (HCBS).

New Jersey's first PACE will be at St Francis Hospital in Trenton — the hospital was awarded a Robert Wood Johnson Foundation grant for administrative start-up costs. It is expected to be ready for participants in winter 2008 and will be opening under the name LIFE (Living Independently for Elders).

At this time, requests for technical assistance to develop other PACE sites in New Jersey have been received from agencies in Somerset and Camden Counties. Feasibility studies for additional PACE sites are being conducted in Burlington, Hudson and Salem Counties. An upper payment limit has been approved and the capitated rate methodology for PACE is being formulated.

Between 2004-2005, two New Jersey governors with the support and encouragement of AARP signed executive orders directing the DHSS to develop and implement a global budgeting process and fast track eligibility process for Medicaid long-term support services. For the first time in State Fiscal Year 2006, $30 million in state and federal funds were allocated to rebalance the nursing home budget from an institutional bias to expand home and community-based services.

New Jersey's efforts to reform its long-term care system have been recognized nationally by the federal government, namely the AoA and CMS. New Jersey was the only state to receive the three following federal grants effective October 1, 2006 to support its long-term care transformation:

1. Real Choice Systems Change Grant for Community Living—The DHSS, in partnership with the DHS, was awarded a five-year Systems Transformation Grant (STG) of $2.3 million from CMS. It serves as a catalyst for continued infrastructure, process and delivery of long-term support services changes for older adults and persons with disabilities across all income levels. This outcome will be achieved through a person-centered approach to service delivery that promotes dignity, choice and independence in the most integrated community setting.

New Jersey's three impact goals under the STG focus on development and implementation of State models with a system-wide focus are to: implement a "one-stop" service delivery system to make it easier for consumers to access necessary services; develop an Information Technology (IT) strategy that will replace the existing patchwork of individual systems with an integrated model; and change the funding methodology to a more flexible State budgeting process that better manages long-term care funds to promote HCBS so that "Money Follows the Person."

Because of its strong leadership commitment and its significant progress in enhancing and expanding long-term care support services, New Jersey is well positioned to undertake this system redesign. CMS has identified many of the initiatives already being implemented in New Jersey as best practice precursors for major systems change. Over the past several years through State initiatives and the federally funded New Freedom Initiatives (NFI) grants funded by CMS, New Jersey has developed and implemented strategies to change consumer service delivery. They are based upon CMS's four key building blocks of access, services, financing, and quality improvement and include:

- Cash and Counseling Demonstration
- Real Choice Systems Change (NFI grant)
- Nursing Facilities Transitions (NFI grant)
- Aging and Disability Resource Connection (NFI grant)
- Quality Assurance and Quality Improvement (NFI grant)
- Independence, Dignity and Choice in Long-Term Care Act

By building upon and integrating the successful outcomes from these previous efforts, the STG is creating a consumer-driven human services delivery system for people of all ages with all types of disability — "money will follow the person" allowing the consumer and caregiver to receive necessary supports in the community setting of their choice rather than in a nursing home or intermediate care facility. IT systems will also be restructured to facilitate the delivery of services and support consumers to control their own service plans and budgets.

2. Aging and Disability Resource Center (ADRC) Initiative: Building Upon Success—The DHSS, in partnership with the DHS, was awarded a two-year ADRC grant of $400,000 from AoA. The additional funding for the ADRC allows New Jersey to expand its model over the next two years from its testing in Atlantic and Warren Counties.

Greater access to long-term care support options is the cornerstone of the DHSS' efforts to reform the long-term care system and shift the focus from institutional to home and community-based settings. The ADRC is setting the groundwork for that transformation while making it easier for seniors and people with disabilities to learn about and access long-term care service options. The original three-year grant, awarded in 2003, was for $798,041.

3. Empowering Older People to Take More Control of their Health through Evidence Based Prevention Programs—The DHSS was awarded a three-year federal grant from the AoA of about $600,000. New Jersey was among 16 states selected to implement low-cost, community-based disease and disability prevention programs that have proven to reduce the risk of disease and disability among older adult participants. These programs were developed by Stanford University through funding by the Agency for Healthcare Research and Quality. New Jersey's grant initiative will build upon the Department's existing wellness activities for older adults, specifically the HealthEASE physical activity model and health education efforts.

While the roadmap to Medicaid long-term care reform in New Jersey began well before the February 2006 passage of the Deficit Reduction Act (DRA), the federal legislation gave New Jersey additional tools to help rebalance its long-term care system. For instance, the Money Follows the Person (MFP) Rebalancing Demonstration initiative provides incentives for states to move

people from institutions to community settings. This initiative is the largest federal demonstration program in the history of Medicaid.

Under the MFP demonstration, New Jersey was awarded a grant by CMS that may total up to $30.3 million over five years, from May 1, 2007 through September 30, 2011. It represents a partnership of the DHS Divisions of Developmental Disabilities, Disability Services, and Medical Assistance and Health Services and the DHSS Division of Aging and Community Services. New Jersey's plan will assist people who are elderly and/or physically or developmentally disabled to live and receive services in local communities rather than in an institution.

CMS will award New Jersey an enhanced federal medical assistance percentage (FMAP) for each qualified transition: 75 percent federal match versus 50 percent. As in the regular Medicaid program, New Jersey will still need to spend State funds to draw down the amount of the grant, which is in the form of enhanced federal funding participation. But a higher matching rate of 75 percent of the State's cost for services will be paid to the State for one year after an individual moves out of an institution and into the community. The demonstration proposes to transition 590 individuals: 329 from developmental centers and 261 from nursing homes.

In summary, New Jersey is witnessing a fundamental change in its long-term care policy for older adults and persons with disabilities across all incomes. It is a transformation that is directed at giving more people more control over their care and providing more support for community living. The plan for New Jersey is a "Money Follows the Person" long-term care system: a person-centered approach of providing service delivery promoting dignity, choice and independence in the most integrated community setting.

V. Recommendations

The Medicaid Long-Term Care Funding Advisory Council (Council) was created within the Department of Health and Senior Services (DHSS) as mandated in the Independence, Dignity and Choice in Long-Term Care Act (Act) and is required to meet at least quarterly. It was organized in 2006 following passage of the law and met for the first time on November 9, 2006. In 2007, the Council met January 9 and May 9,and is scheduled to meet September 19 and November 14.

It is the consensus of the Council that the following recommendations should be made to the Governor and Legislature:

1. Council Recommendation vis-à-vis Medically Needy Population

The Act (C.30:4D-17.24.2h.) says that "older adults with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting." While the term Medically Needy is not mentioned in the Act's language, Council members agreed that the Act's intent is to pay for the Medically Needy population for home and community based services under Medicaid as they are covered in a nursing home.

According to New Jersey's Medically Needy program regulations found at N.J.A.C. 10:70, its purpose is to provide Medicaid benefits for persons whose income exceeds the Medicaid Program's standards. This program features a "spend down" provision in which documented medical expenses can be used to reduce monthly income to meet the program requirements.

To qualify for services in New Jersey, an individual must be aged 65 years or over and persons determined blind or disabled; a pregnant woman or a needy child (under age 21). Eligible individuals are entitled to most Medicaid services, excluding inpatient hospital care and prescribed drugs. Long-term care services in nursing homes are covered under Medically Needy, but the Medicaid Waiver programs do not include the Medically Needy populations.

A filing application consists of the individual applying (and in the case of a couple who are both applying, both members of the couple). In considering income and resources eligibility, the income (after certain disregards) and resources of a spouse or the parents of a child will be deemed to the applicant.

For 2007, the Medically Needy Income Level (MNIL) is $367 for a single person and $434 for a couple per month. There is a retroactive eligibility period of three months immediately preceding the month in which the application for benefits is made. The prospective eligibility period is the six calendar months beginning with the month of the application. For Medically Needy, there is a resource eligibility limit of $4,000 for a single individual and $6,000 for a married couple. Countable resources are liquid and non-liquid resources, excluding the home.

The maximum income level permitted under federal regulations is 133⅓ percent of the Aid to Families with Dependent Children (AFDC) income standards. Under federal regulations, a state has the option of establishing a Medically Needy Income Level (MNIL) above 133⅓ percent of the AFDC payment level, but federal funding is not available to cover these costs. It was noted that New Jersey has not changed its AFDC income level since at least 1996.

At the May 9, 2007 Council meeting, members agreed that the income eligibility limits for Medically Needy are low and few people are likely to qualify. The State needs to look at how to turn this into a feasible option, enabling people to stay at home rather than go into nursing homes. There are about 3,000 individuals on Medically Needy, most of who live in nursing homes.

Raising the MNIL by allowing a disregard is an option, yet according to the Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), this alternative would need to apply to a specific population within the Medically Needy program, not just the waiver program.

In addition, allowing the Medically Needy population to be covered under the waiver program needs to be explored. The DMAHS will be preparing a study of this proposal, including a cost analysis and the required legislative action that would need to be taken. It was also recommended that a workgroup be convened to examine the proposal.

2. Council Recommendation vis-à-vis Home Care Workforce

The Act (C.30:4D-17.29.7b1.) says that the Council shall "develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs."

At the January 10, 2007 Council meeting, it was agreed that there would be a workgroup created to develop recommendations on home care workforce issues. Included in the Workforce workgroup were Council members Sherl Brand, President, The Home Care Association of New Jersey; Theresa Edelstein, MPH, LNHA, Vice President of Continuing Care Services, New Jersey Hospital Association; Gary Gilmore, Executive Director, Wiley Mission, representing New Jersey Association of Homes and Services for the Aging; Paul Langevin, President, Health Care Association of New Jersey; and Milly Silva, President SEIU Local 1199NJ. In addition, Zoe Baldwin, SEIU Local 1199NJ, and June Duggan, President of the New Jersey Association of Homes and Services for the Aging, participated in the workgroup.

The three preliminary recommendations, the result of two Workforce workgroup meetings and representing the consensus, were presented at the May 9th Council meeting as follows and can be read in more detail in Appendix C.

- The workgroup's first recommendation focuses on the importance of creating mechanisms for upward mobility to help attract and retain direct care workers in the long-term care field. While more opportunity for career development is not a new issue, it is still very relevant in today's job marketplace.

- The second recommendation is to create awareness around the need for a redesign of the nursing facility rate setting methodology so that Medicaid rates are stable, predictable and adequate. In the area of Medicaid funded home care services, a review of the adequacy of reimbursement rates for skilled visit services, private duty nursing and home health aide services is necessary to ensure that rates are adequate to cover the costs associated with direct care delivery. New Jersey needs a sustainable solution with a complete overhaul: there has not been one for about 10 years.

- The third recommendation proposes that the home health aide certification process be transferred from the Board of Nursing in the Division of Consumer Affairs, Department of Law and Public Safety, to the Department of Health and Senior Services for greater efficiency and to enable the more flexible deployment of certified nursing assistants and certified home health aides. Cost savings may even be achieved.

3. Council Recommendation vis-à-vis Individuals with Mental Illness

The Act (C.30:4D-17.24.2e.) says that the federal “New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in *Olmstead v. L.C.* and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities.”

A concern about the exemption of individuals with mental illness in the Medicaid Waiver programs was voiced at the May 9, 2007 Council meeting. The U.S. Supreme Court ruling in *Olmstead v. L.C.* affirms that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act. Council members proposed that individuals with mental illness be included in New Jersey’s global budget rebalancing efforts to reform long-term care under the Act.

4. Council Recommendation vis-à-vis Retention of a National Consultant to Develop Payment Methodology

The Act (C.30:4D -17.26.4.a. (1)) says that beginning in State Fiscal Year 2008 (SFY08), and in each succeeding fiscal year through SFY13, the Commissioner of the Department of Health and Senior Services (DHSS), in consultation with the State Treasurer and the Commissioner of Department of Human Services (DHS) and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the DHSS for long-term care services through the expansion of home and community based-services (HCBS) for persons eligible for long-term care. The expansion of HCBS shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and HCBS.

To advance this mandate, the DHSS has allocated funds in the Systems Transformation Grant from the Centers for Medicare and Medicaid Services (CMS) to hire a national consultant to assist the DHSS in the development of a flexible budget projection model and a more effective reimbursement methodology. The Global Budget Workgroup, whose membership includes the Council co-chairs, will be responsible for writing a request for proposal to recruit and hire an actuarial consultant to assist the DHSS in the development of a budget projection model and reimbursement methodology.

Appendix A

P.L. 2006 CHAPTER 23
AN ACT concerning long-term care for Medicaid recipients and supplementing Title 30 of the Revised Statutes.
BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*
C.30:4D-17.23 Short title.
1. This act shall be known and may be cited as the "Independence, Dignity and Choice in Long-Term Care Act."
C.30:4D-17.24 Findings, declarations relative to long-term care for Medicaid recipients.
2. The Legislature finds and declares that:
a. The current population of adults 60 years of age and older in New Jersey is about 1.4 million, and this number is expected to double in size over the next 25 years;
b. A primary objective of public policy governing access to long-term care in this State shall be to promote the independence, dignity and lifestyle choice of older adults and persons with physical disabilities or Alzheimer's disease and related disorders;
c. Many states are actively seeking to "rebalance" their long-term care programs and budgets in order to support consumer choice and offer more choices for older adults and persons with disabilities to live in their homes and communities;
d. New Jersey has been striving to redirect long-term care away from an over-reliance on institutional care toward more home and community-based options; however, it is still often easier for older adults and persons with disabilities to qualify for Medicaid long-term care coverage if they are admitted to a nursing home than if they seek to obtain services through one of the Medicaid home and community-based long-term care options available in this State, such as the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, or Community Resources for People with Disabilities Private Duty Nursing;
e. The federal "New Freedom Initiative" was launched in 2001 for the purpose of promoting the goal of independent living for persons with disabilities; and Executive Order No. 13217, issued by the President of the United States on June 18, 2001, called upon the federal government to assist states and localities to swiftly implement the 1999 United States Supreme Court decision in *Olmstead* v. *L.C.* and directed federal agencies to evaluate their policies, programs, statutes and regulations to determine whether any should be revised or modified to improve the availability of community-based services for qualified persons with disabilities;
f. Executive Order No. 100, issued by the Governor on March 23, 2004, directed the Commissioner of Health and Senior Services, in consultation with the State Treasurer, to prepare an analysis and recommendations for developing a global

long-term care budgeting process designed to provide the Department of Health and Senior Services with the authority and flexibility to move Medicaid recipients into the appropriate level of care based on their individual needs, and to identify specific gaps and requirements necessary to streamline paperwork and expedite the process of obtaining Medicaid eligibility for home care options for those who qualify;

g. Executive Order No. 31, issued by the Governor on April 21, 2005, established a "money follows the person" pilot program and set aside funding in fiscal year 2006 for home and community-based long-term care;

h. Older adults and those with physical disabilities or Alzheimer's disease and related disorders that require a nursing facility level of care should not be forced to choose between going into a nursing home or giving up the medical assistance that pays for their needed services, and thereby be denied the right to choose where they receive those services; their eligibility for home and community-based long-term care services under Medicaid should be based upon the same income and asset standards as those used to determine eligibility for long-term care in an institutional setting; and

i. The enactment of this bill will ensure that, in the case of Medicaid-funded long-term care services, "the money follows the person" to allow maximum flexibility between nursing homes and home and community-based settings when it does not compromise federal funding or services in the nursing home and, in so doing, significantly expands the choices available to consumers of these services and thereby fulfills the goal of personal independence so highly valued by the growing number of older adults and persons with disabilities in this State.

C.30:4D-17.25 Definitions relative to long-term care for Medicaid recipients.

3. As used in this act:

"Commissioner" means the Commissioner of Health and Senior Services.

"Funding parity between nursing home care and home and community-based care" means that the distribution of the amounts expended for these two categories of long-term care under the Medicaid program reflects an appropriate balance between the service delivery costs of those persons whose needs and preferences can most appropriately be met in a nursing home and those persons whose needs and preferences can most appropriately be met in a home or community-based setting.

"Home and community-based care" means Medicaid home and community-based longterm care options available in this State, including, but not limited to, the Community Care Program for the Elderly and Disabled, Assisted Living, Adult Family Care, Caregiver Assistance Program, Adult Day Health Services, Traumatic Brain Injury, AIDS Community Care Alternatives Program, Community Resources for People with Disabilities, and Community Resources for People with Disabilities Private Duty Nursing.

C.30:4D-17.26 Process to rebalance allocation of funding for expansion of long-term care services; pilot program, use Statewide.

4. a. (1) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, the commissioner, in consultation with the State

Treasurer and the Commissioner of Human Services and in accordance with the provisions of this section, shall implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services for long-term care services through the expansion of home and community based services for persons eligible for long-term care as defined by regulation of the commissioner. The expansion of home and community-based services shall be funded, within the existing level of appropriations, by diverting persons in need of long-term care to allow maximum flexibility between nursing home placements and home and communitybased services. The State Treasurer, after review and analysis, shall determine the transfer of such funding to home and community-based services provided by the Departments of Health and Senior Services and Human Services as is necessary to effectuate the purposes of this act.

(2) Beginning in fiscal year 2008, and in each succeeding fiscal year through fiscal year 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care pursuant to paragraph (1) of this subsection, for State dollars only plus the percentage anticipated for programs and persons that will receive federal matching dollars, shall be reallocated to home and community-based care through a global budget and expended solely for such care, 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. Any funds so reallocated, which are not expended in the fiscal year in which they are reallocated, shall be reserved for expenditures for home and community-based care in a subsequent fiscal year.

(3) Subject to federal approval, the home and community-based services to which funds are reallocated pursuant to this act shall include services designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act.

(4) Notwithstanding the provisions of this subsection to the contrary, this act shall not be construed to authorize a reduction in funding for Medicaid-approved services based upon the approved State Medicaid nursing home reimbursement methodology, including existing cost screens used to determine daily rates, annual rebasing and inflationary adjustments.

b. The commissioner, in consultation with the Commissioner of Human Services, shall adopt modifications to the Medicaid long-term care intake system that promote increased use of home and community-based services. These modifications shall include, but not be limited to, the following:

(1) commencing March 1, 2007, on a pilot basis in Atlantic and Warren counties, pursuant to Executive Order No. 31 of 2005:

(a) the provision of home and community-based services available under Medicaid, as designated by the commissioner, in consultation with the Commissioner of Human Services and the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, pending completion of a formal Medicaid financial eligibility determination for the recipient of services, for a period that does not exceed a time limit established by the commissioner; except

that the cost of any services provided pursuant to this subparagraph to a person who is subsequently determined to be ineligible for Medicaid may be recovered from that person; and
(b) the use of mechanisms for making fast-track Medicaid eligibility determinations, a revised clinical assessment instrument, and a computerized tracking system for Medicaid long-term care expenditures; and
(2) commencing March 1, 2008, expansion of the services and measures provided for in paragraph (1) of this subsection to all of the remaining counties in the State, subject to the commissioner conducting or otherwise providing for an evaluation of the pilot programs in Atlantic and Warren counties prior to that date and determining from that evaluation that the pilot programs are cost-effective and should be expanded Statewide.

C.30:4D-17.27 Duties of commissioner relative to report on budget, management plan.

5. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:
a. no later than October 1, 2007, 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 provides a detailed budget and management plan for effectuating the purposes of this act, including a projected schedule and procedures for the implementation and operation of the Medicaid long-term care expenditure reforms required pursuant thereto; and
b. 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.

C.30:4D-17.28 Duties of commissioner relative to funding parity, coordination, assessment instrument.

6. The commissioner, in consultation with the Medicaid Long-Term Care Funding Advisory Council established pursuant to this act, shall:
a. Implement, by such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences. The data system shall include, but not be limited to: the number of vacant nursing home beds annually and the number of nursing home residents transferred to home and community-based care pursuant to this act; annual long-term care expenditures for nursing home care and each of the home and community based long-term care options available to Medicaid recipients; and annual percentage

changes in both longterm care expenditures for, and the number of Medicaid recipients utilizing, nursing home care and each of the home and community based long-term care options, respectively;
b. Commence the following no later than January 1, 2008:
(1) implement a system of Statewide long-term care service coordination and management designed to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need;
(2) identify home and community based long-term care service models that are determined by the commissioner to be efficient and cost-effective alternatives to nursing home care, and develop clear and concise performance standards for those services for which standards are not already available in a home and community-based services waiver;
(3) develop and implement with the Commissioner of Human Services a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of home and community-based care to a person through fast track eligibility prior to completion of a formal financial eligibility determination; and
(4) develop and implement a comprehensive quality assurance system with appropriate and regular assessments that is designed to ensure that all forms of long-term care available to consumers in this State are financially viable, cost-effective, and promote and sustain consumer independence; and
c. Seek to make information available to the general public on a Statewide basis, through print and electronic media, regarding the various forms of long-term care available in this State and the rights accorded to long-term care consumers by statute and regulation, as well as information about public and nonprofit agencies and organizations that provide informational and advocacy services to assist long-term care consumers and their families.

C.30:4D-17.29 Medicaid Long-Term Care Funding Advisory Council.
7. a. There is established the Medicaid Long-Term Care Funding Advisory Council within the Department of Health and Senior Services. The advisory council shall meet at least quarterly during each fiscal year until such time as the commissioner certifies to the Governor and the Legislature that funding parity has been achieved pursuant to subsection b. of section 5 of this act, and shall be entitled to receive such information from the Departments of Health and Senior Services, Human Services and the Treasury as the advisory council deems necessary to carry out its responsibilities under this act.
b. The advisory council shall:
(1) monitor and assess, and advise the commissioner on, the implementation and operation of the Medicaid long-term care expenditure reforms and other provisions of this act; and
(2) develop recommendations for a program to recruit and train a stable workforce of home care providers, including recommendations for changes to provider reimbursement under Medicaid home and community-based care programs.

c. The advisory council shall comprise 15 members as follows:
(1) the commissioner, the Commissioner of Human Services and the State Treasurer, or their designees, as ex officio members; and
(2) 12 public members to be appointed by the commissioner as follows: one person appointed upon the recommendation of AARP; one person upon the recommendation of the New Jersey Association of Area Agencies on Aging, one person upon the recommendation of the New Jersey Association of County Offices for the Disabled; one person upon the recommendation of the Health Care Association of New Jersey; one person upon the recommendation of the New Jersey Association of Non-Profit Homes for the Aging; one person upon the recommendation of the New Jersey Hospital Association; one person upon the recommendation of the Rutgers Center for State Health Policy; one person upon the recommendation of the New Jersey Elder Rights Coalition; one person upon the recommendation of the County Welfare Directors Association of New Jersey; one person upon the recommendation of the New Jersey Adult Day Services Association; one person upon the recommendation of a labor union that represents home and community-based health care workers; and one person who is a representative of the home care industry.
d. The advisory council shall organize as soon as possible after the appointment of its members, and shall annually select from its membership a chairman who shall serve until his successor is elected and qualifies. The members shall also select a secretary who need not be a member of the advisory council.
e. The department shall provide such staff and administrative support to the advisory council as it requires to carry out its responsibilities.

C.30:4D-17.30 Waiver of federal requirements.
8. The Commissioner of Human Services, with the approval of the Commissioner of Health and Senior Services, shall apply to the federal Centers for Medicare and Medicaid Services for any waiver of federal requirements, or for any State plan amendments or home and community-based services waiver amendments, which may be necessary to obtain federal financial participation for State Medicaid expenditures in order to effectuate the purposes of this act.

C.30:4D-17.31 Tracking of expenditures.
9. The commissioner, in consultation with the Commissioner of Human Services, shall track Medicaid long-term care expenditures necessary to carry out the provisions of this act.

C.30:4D-17.32 Inclusion of budget line for Medicaid long-term care expenditures.
10. There shall be included a unique global budget appropriation line item for Medicaid long-term care expenditures in the annual appropriations act for fiscal year 2008 and each succeeding fiscal year in order to provide flexibility to align these expenditures with services to be provided during each fiscal year as necessary to effectuate the purposes of this act.
11. This act shall take effect immediately. Approved June 21, 2006.

Appendix B

MEDICAID LONG TERM CARE FUNDING ADVISORY COUNCIL
WORKFORCE WORK GROUP
PRELIMINARY RECOMMENDATIONS
MAY 3, 2007

RECOMMENDATION 1

Creating mechanisms for upward mobility would help attract and retain direct care workers in the long term care field. An inventory of available workforce training/development funding sources and programs needs to be compiled by the Department of Health and Senior Services, in collaboration with the Department of Labor and Workforce Development and Department of Human Services. Further, the Departments should collaborate to maximize and coordinate the resources of the Workforce Investment Boards and other programs/funding for the benefit of the workforce, health care providers and the State. Such a coordination effort could begin on a pilot basis, but should quickly be implemented statewide. This should be a continuous effort that includes education and technical assistance from the Departments, in conjunction with the provider associations and labor organizations representing healthcare workers.

Use available funds to support existing and new standardized training programs, such as the universal Certified Nurse Aide/Home Health Aide (CNA/HHA) curriculum, designed to allow caregivers to work in both facility and home-based settings, and to support education for advancement into licensed nursing and administrative positions. This would establish clear career paths, making the field more attractive.

RECOMMENDATION 2

Sustainable solutions to the way long-term care services are provided in New Jersey require adequate, stable, predictable funding over time. To this end, the Department of Health and Senior Services should redesign the nursing facility rate setting methodology so that Medicaid rates are stable, predictable and adequate. The new system should be case-mix sensitive and significantly link increased reimbursement to improved patient care and investments in more efficient care delivery. This newly designed Medicaid reimbursement methodology should include a feedback mechanism to ensure that funds are dedicated to direct patient care services in the proportion and amount intended by the system.

Further, in the area of Medicaid funded home care services, a review of the adequacy of reimbursement rates for skilled visit services, private duty nursing,

and home health aide services is necessary to ensure that rates are adequate to cover the costs associated with direct care delivery, inclusive of ongoing nursing supervision. This is particularly critical as the needs of the at-home population become more complex and technological in nature.

RECOMMENDATION 3

The Department of Health and Senior Services should work with the Department of Law and Public Safety, Division of Consumer Affairs, Board of Nursing to transfer the home health aide certification function to DHSS so as to achieve greater efficiency and to enable the more flexible deployment of certified nursing assistants and certified home health aides.

Appendix C

A Preliminary Review of the Aging and Disability Resource Connection Initiative: Summary Statement

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Introduction

New Jersey's Division of Aging and Community Services (DACS) was one of only 12 states that received a 2003 -2006 grant from AOA/CMS to develop an *Aging and Disability Resource Connection* (ADRC) initiative for improving access and linking services for seniors and the adult disability population needing long term care supports. The New Jersey ADRC six impact goals focus on development and implementation of a state long-term care model with a system-wide perspective. The State is introducing the ADRC concept beginning with two pilot counties (Atlantic and Warren) and then disseminating the model throughout each of New Jersey's 21 counties. The next ADRC pilot cohort includes Bergen, Camden, Hunterdon, Mercer and Morris counties.

The Division's ADRC development and implementation efforts have received national recognition with the awarding of a supplemental, two-year "Building on ADRC Success" grant for 2007-2008. Other major grants directly attributable to ADRC achievements include: Systems Transformation Grant, Administration on Aging Planning Grant, and Empowering Older People to Take More Control of their Health through Evidence Based Prevention Programs Grant.

ADRC Major Accomplishments

Presented below is a short summary for each of the critical components developed and/or integrated into the new the ADRC Model:

- ADRC Algorithm/Client Pathway - The first priority for DACS was the development and validation of the ADRC algorithm as a conceptual base. Each of the ADRC six process phases (Infrastructure, Initiate, Identify, Indicate, Implement, Inquire) have been translated into a client pathway to serve as the operating framework for DACS services that are provided at the county level. The final phase "Inquire" also serves as a continuous quality improvement mechanism. This approach assures statewide standardization and county accountability for both the long-term care and disability populations.

- Clinical Assessment Tool – This consumer and provider-friendly instrument is an automated and validated tool that screens for at-risk

individuals and determines five levels of service needs, including nursing facility level care.

- Information Technology Synergy – SAMS is a database system that will enable DACS to manage the model components and implement quality assurance/quality improvement measures that will be readily available to state and county stakeholders.

- Streamlining Initiative – The ADRC initiative, through a variety of targeted activities, is the primary change agent for aligning long-term care services in New Jersey:
    - Education/Outreach Focus - Educating the consumer on the Medicaid financial eligibility determination/application process.
    - Fast Track Eligibility - Process steps through which consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria receive home and community based services for up to 90 days while they complete the full Medicaid application and eligibility determination process.
    - Hospital At-Risk Criteria Screening Initiative – DACS successfully tested a screening instrument that collects both clinical and financial data and is then reviewed by the State in order to authorize transfer of a consumer from the hospital to a nursing facility. The Hospital At-Risk screening Initiative will be implemented throughout the state by March, 2008.
    - Global Options –A targeted and system-wide effort to reform long-term care by balancing public funds so that there is a more equitable distribution of funding between home and community based services and institutionalization.

- DACS Quality Initiative - DACS has established five guiding principles to ensure that all activities and efforts optimally meet the needs of older adults. These principles include: leadership, advocacy, consumer direction, cultural competency and quality assurance/quality improvement. To satisfy the goal of quality performance by *all* DACS offices, a DACS Quality Initiative (DACS QI) was introduced during 2006. The DACS QI aligns the Medicaid Waiver assurances using the HCBS Quality framework with the NJ ADRC algorithm and DACS quality outcomes.

- Multi-Level ADRC Management Teams - DACS instituted a state management team approach to ensure appropriate executive participation and success of the ADRC initiative. The Systems Transformation Grant State Management Team, led by Assistant Commissioner Patricia Polansky, is comprised of the leadership from the Division of Aging and Community Services and the Department of Human Services, Divisions of Medical Assistance and Health Services (Medicaid), Disability Services and Developmental Disabilities. DACS also strategically entered into

informal and formal partnerships (internally and externally) to facilitate intra-, inter- and multi-agency partnerships. This project step is also being duplicated at the county level. To facilitate the phase-in county implementation process, Pilot Roll-Out Teams composed of cross-discipline and/or cross-department members were established.

ADRC Performance Measures

In addition to the AOA/CMS required Semi-Annual Reports (SART), DACS has undertaken several activities to create baseline measures and monitor ADRC progress at the state and county levels.

Preliminary ADRC Pilot County Outcomes

For the first time, DACS was able to accurately report contacts made to the ADRC in the two pilot counties. From January 1, 2006 through June, 2007, the total number of consumer contacts was 30,565[2] with approximately one-quarter of the callers requesting information about health/medical care and in-home services. The total number of individuals screened for community services was 1,700 and 1,035 of the screened individuals potentially met New Jersey's Nursing Facility level of care. The remaining 467 consumers were informed of community supports through the options counseling process and possibly opted for home and community based services instead of nursing home placements. The total number of physically disabled completing assessments for both pilot counties was 175 individuals.

Consumer Satisfaction Surveys

Due to DACS emphasis on consumer direction and quality services, the client remains the primary focus for the ADRC initiative and efforts to improve the ADRC model are evaluated within the context of consumer satisfaction. During the past three years, consumer satisfaction surveys were administered in pilot counties and compiled by DACS. Results show consumers very satisfied (highest rating) with all ADRC services.

ADRC Implementation Assessment Review

As part of NJ DACS three-year review of the ADRC initiative, a comprehensive assessment process was instituted. Stakeholder surveys were developed, administered and analyzed for pilot county staff, county stakeholders and the DACS state ADRC Management team. In addition, personal interviews were conducted with both pilot county directors and two focus group conference calls were completed with I and A personnel and Assessors in Warren and Atlantic Counties. Results show the need for additional ADRC training, sustained in-county presence, commitment of county staff along with local political support, information technology enhancements and longer lead times for understanding new tools and processes.

[2] This number represents the total number of client contacts meaning that one person may have called multiple times, and not the number of individuals.

The ADRC state management group completed a survey to identify their perceptions and assessment of ADRC activities to date. Over 70 percent of DACS senior managers (N = 14) indicated satisfaction with the overall ADRC implementation process and agreed that the vision and purpose had been met. DACS managers ranked Technology and Financial Eligibility changes as the most difficult to implement and Leadership Support, Consumer Direction, and Personal Interactions activities as the easiest components of the ADRC implementation.

Sustainability

DACS, through the ADRC initiative, has become the primary catalyst for rebalancing the long-term care budget. The goal of securing a LTC global budget impacts other major state agencies and requires increased community capacity (resources) to support the ADRC initiative at county, regional and state levels.

The ADRC achievements and accomplishments of the past three years, (Algorithm /Client Pathway, Validated Clinical Assessment Tool, Statewide MIS client tracking and reporting, Standardized LTC processes, policies and protocols at both state and pilot county levels, System wide Quality Initiative) all ensure the ADRC model sustainability. The DACS ADRC initiative will accomplish not only its original goals, but the ADRC model will be replicated and enhanced as it is institutionalized throughout New Jersey.

The NJ ADRC initiative will maintain its focus on the system-wide long-term care change process as DACS continues to serve as the state leader for necessary infrastructure, process and delivery of long term care service changes for all seniors and the disabled population.

Appendix D

Abbreviations and Acronyms

Administration on Aging	AoA
Adult Family Care	AFC
Aid to Families with Dependent Children	AFDC
Aging and Disability Resource Connection	ADRC
Assisted Living	AL
Caregiver Assistance Program	CAP
Centers for Medicare & Medicaid Services	CMS
Certified Nurse Aide	CNA
Community Care Program for the Elderly and Disabled	CCPED
Deficit Reduction Act of 2005	DRA
Department of Health and Senior Services	DHSS
Department of Labor and Workforce Development	LWD
Department of Human Services	DHS
Division of Aging and Community Services	DACS
Division of Disability Services	DDS
Division of Developmental Disabilities	DDD
Enhanced Community Options	ECO
Division of Medical Assistance and Health Services	DMAHS
Federal Medical Assistance Percentage	FMAP
Global Options for Long-Term Care	GO for LTC
Home and Community-Based Services	HCBS
Home Health Aide	HHA
Information & Assistance	I&A
Independence, Dignity and Choice in Long-Term Care Act	Act
Information Technology	IT
Inter-Disciplinary Team	IDT
Jersey Assistance for Community Caregiving	JACC
Long-Term Care	LTC
Living Independently for Elders	LIFE
Low Income Subsidy	LIS
Medicaid Long-Term Care Funding Advisory Council	Council
Medicaid Management Information System	MMIS
Medically Needy Income Level	MNIL
Money Follows the Person	MFP
New Freedom Initiatives	NFI
Nursing Facility Level of Care	NFLOC
Office of Community Choice Options	OCCO
Office of Information Technology	OIT
Office of Management and Budget	OMB
Program of All Inclusive Care for the Elderly	PACE

Quality Review Committee	QRC
Quality Management Panel	QMP
Social Assistance Management Systems	SAMS
Senior Benefits Utilization & Management	SBUM
State Fiscal Year	SFY
Systems Transformation Grant	STG

Appendix E

Strategic Plan Timeline

Major Activity #1: Develop/Implement process to rebalance & expand HCBS	July 06-Dec 06	Jan 07-June 07	July 07-Dec 07	Jan 08 – June 08
1. Develop a flexible budget methodology: ▪ Under the Systems Transformation grant, the Global Budget (GB) workgroup will prepare/distribute request for proposal (RFP) to hire a national actuarial consultant to assist State in the development of a flexible budget projection model. ▪ GB workgroup will review and score proposals and submit recommendation to the State Management Team. ▪ Develop a flexible state budget methodology to rebalance New Jersey's long-term care budget to facilitate' expansion of HCBS.			X X	X
2. Develop and implement an effective payment methodology to increase participation of community agencies in Global Options for Long-Term Care (GO for LTC): ▪ Prepare RFP and issue through State Treasury. ▪ Hire consultant. ▪ Develop payment process for nursing home/intermediary care facilities transitions. ▪ Consultant develops a streamlined payment process to assure funds.			X X	X X

Major Activity #2: Service Coordination	July 06-Dec 06	Jan 07-June 07	July 07-Dec 07	Jan 08 – June 08
1. Develop and implement GO for LTC initiatives.	X			
2. Develop new business process for transitioning nursing home residents to alternative long-term care options statewide.	X			
3. Develop new service packet for GO for LTC initiative.	X			
4. Conduct regional training sessions for nursing facility social workers, discharge planners, county care managers, and DACS Community Choice counselors on new business process, service package, and Interdisciplinary Team (IDT) approach.	X			
5. Conduct regional in-service training meetings to get feedback and input into GO process for IDT members.	X	X	X	X
6. Based upon feedback, modify GO for LTC processes and service package to meet needs of consumers and IDT participants.		X	X	X
7. Conduct educational sessions on GO for LTC for community healthcare professionals and nursing home administrators.		X	X	X

Major Activitiy #3: Fast-Track Eligibility	July 06-Dec 06	Jan 07-June 07	July 07-Dec 07	Jan 08 – June 08
Develop and test streamlined clinical and financial eligibility determination process for Medicaid long-term care services.	X			
1. Test MI-Choice clinical assessment tool in Atlantic and Warren Counties. 2. Evaluate effectiveness of ADRC pre-screening and clinical assessment for long-term care services. 3. Based upon evaluation of assessment outcomes and performance measures, modify MI-Choice algorithm to ensure level of care complies with New Jersey's nursing facility level of care regulations. 4. Train and implement MI-Choice suite in Mercer, Camden, Morris, Hunterdon and Bergen counties.	X	X X		X
1. **Phase 1**; Test financial fast-track eligibility process in Atlantic and Warren counties. 2. Evaluate effectiveness of fast-track process. 3. Based upon evaluation of fast-track outcomes and performance measures, modify process to ensure accuracy and timeliness is maintained. 4. **Phase 2**: Train and implement fast-track eligibility process in Mercer, Somerset, Camden, Hunterdon, Middlesex, Morris, Burlington, Gloucester and Sussex counties. 5. **Phase 3:** Train and implement fast-track eligibility process in Bergen, Cumberland, Essex, Hudson, Monmouth, Ocean and Salem counties.	X X	X	X	X

Major Activity #4: Client-Tracking System	July 06-Dec 06	Jan 07-June 07	July 07-Dec 07	Jan 08 – June 08
Develop written implementation strategy for six-month pilot of client-tracking system				
1. Define user requirements for Administration on Aging reporting requirements:		X		
▪ Collect client detail information.				
▪ Collect service detail information.				
2. Define user requirements for ADRC:				
▪ Integrate ADRC Intake and pre-screening for LTC services into SAMS application.		X	X	X
▪ Collect client care plan data.		X	X	X
▪ Show integration of Older Americans Act and Medicaid funding.		X	X	X
▪ Track client services by funding and provider.		X	X	X
3. Input provider contract management:				
▪ Set up grantee/provider services with budgets.		X	X	X
▪ Track clients, services, and expenditures.		X	X	X
▪ Run client service and expenditure reports.		X	X	X
Design/implement 6-month pilot of client-tracking system (SAMS2000) in 7 counties:				
1. **Phase 1** – Mercer County: serve as beta test site.		X		
▪ Meet with Mercer County Area Agency on Aging (AAA) managers to identify county user requirements.		X		
▪ Conduct "Train-the-Trainer" sessions for Mercer County "Subject Matter Experts" (SME).		X		
▪ Conduct training sessions for AAA Information & Assistance (I&A) and care managers.		X		

Major Activitiy #4: Client-tracking System (continued)	July 06-Dec 06	Jan 07-June 07	July 07-Dec 07	Jan 08 – June 08
Meet with Mercer County staff to get feedback and modify training approach as necessary.		X		
Meet with Somerset County: serve as beta test site. ▪ Meet with Somerset County AAA managers to identify county user requirements.		X		
▪ Conduct “Train-the-Trainer” sessions for Somerset County SMEs. ▪ Conduct training sessions for AAA I&A and care managers.		X X		
▪ Meet with Somerset County staff to get feedback and modify training approach as necessary.		X		
▪ Train and implement SAMS2000 in Passaic, Union, Warren, Atlantic and Cape May counties.			X	
Phase 2: Train and implement SAMS2000 in Camden, Hunterdon, Middlesex, Morris, Burlington, Gloucester and Sussex counties.			X	
Phase 3: Train and implement SAMS2000 in Bergen, Cumberland, Essex, Hudson, Monmouth, Ocean and Salem counties.				X