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

2010

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

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I. ACKNOWLEDGEMENTS

This 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
- VACANT, AARP
- VACANT, Elder Rights Alliance of New Jersey
- Jim Donnelly, Chief Executive Officer, Senior Care Centers of America, representing Adult Day Health Services Association
- Frank Byrne, Vice President of Public Policy, New Jersey Association of Homes & Services for the Aging
- Susan Lennon, Executive Director, Warren County Division of Aging and Disability Services, representing New Jersey Association of Area Agencies on Aging
- Paul Langevin, President, Health Care Association of New Jersey
- Charles Newman, Director, Union County Office for the Disabled, representing New Jersey Association of County Disability Services
- Milly Silva, Executive Vice President, 1199 SEIU United Healthcare Workers East.
- Lorraine Scheibener, Director, Warren County Division of Temporary Assistance and Social Services, representing County Welfare Directors Association of New Jersey
- Marsha Rosenthal, M.P.A., Ph.D., Rutgers Center for State Health Policy

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

- Brian Francz, Senior Analyst, Office of Management and Budget, Department of the Treasury
- Elena Josephick, Assistant Division Director, 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. INTRODUCTION

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

The Medicaid Long-Term Care Funding Advisory Council (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 as detailed in the Report's Acknowledgements.

At the December 2, 2009 meeting, a motion was taken and unanimously approved that the submission of the 2010 Independence, Dignity and Choice in Long-Term Care Annual Report be delayed until Governor Chris Christie took office and the Administration and Legislature were in place. The Council also included these recommendations to be put forward in the 2010 Annual Report:

1. Ensure that New Jersey systemically examines the entire policy and operational structure for making Medicaid eligibility determinations, both financial and clinical. Part of this examination should include implementation of a web-based eligibility determination benefit and service delivery process for Medicaid long-term care services and other related programs through the Department of Human Services (DHS) in the shortest time frame. The Consolidated Assistance Support System (CASS), which is now in the process of being put into operation at DHS, is a step toward a fully integrated, automated information system and offers web-enabled access for users with a secure portal into the system.
2. Work cooperatively with the private long-term care industry (as represented on this Council) to help advance state initiatives through public-private partnerships that will benefit consumers of the long-term care system.
3. Publicize and promote through the responsible State agencies in collaboration with private sector partners New Jersey's Long-Term Care Partnership Program that guarantees coverage and financial protection for beneficiaries, business for insurers, and budget protection for Medicaid by encouraging beneficiaries to buy the insurance. New Jersey's State Plan Amendment for the Long-Term Care Partnership Program was approved on February 12, 2008 and on July 1, 2008, Long-Term Care Partnership policies became available for sale. However, consumer information is not readily available from the responsible departments of State government for potential purchasers.

4. Create mechanisms for upward mobility to help attract and retain direct care workers in the long-term care field.
5. 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.

III. EXECUTIVE SUMMARY

The charge under Public Law 2006, chapter 23 is to advance a Medicaid long-term care system where there would be more options for community care, greater consumer choice and allow for maximum flexibility between nursing homes and home and community based services (HCBS). The 2010 Independence, Dignity and Choice in Long-Term Care Annual Report shows that the trajectory of rebalancing New Jersey's long-term care system is moving in the right direction according to the new Global Budget Projection model produced by Mercer Government Human Services Consulting (Mercer).[1] However, significant opportunities for improvement continue to exist.

The Global Budget Projection model reveals positive trends for New Jersey's Medicaid long-term care system. Based on the tenets of the Independence, Dignity and Choice in Long-Term Care Act (Act), the model illustrates the reduction in the projected growth of Medicaid expenditures for nursing home care by transitioning or diverting consumers from nursing homes to home and community based services (HCBS). While State Fiscal Year (SFY) 2008 is the date in the legislation that the State had to begin measuring rebalancing, the State had already been working towards this goal for many years. Using data from the State's fiscal agent UNISYS and taking into consideration the State's rebalancing efforts, the Global Budget Projection model forecasts that the projected reduction in LTC growth between SFY2008 to SFY2011 will be (state and federal dollars) a total of $138,362,417. The projected reduction in Medicaid nursing home spending (federal and state dollars) should be viewed in the context of cost avoidance. Rather than look at what was saved in terms of public long-term care expenditures as shown in the Global Budget projection model, these savings represent what might have been spent if the Act had not been in effect.

For State fiscal years 2008 through 2013 the Act calls for funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care (State dollars only), plus the percentage anticipated for programs and persons eligible for federal matching dollars, to be reallocated to HCBS.

The Global Budget Projection model also calculates the total spending among the different long-term care services. If rebalancing efforts are working, then the percentage of nursing home spending (NF) should decrease over time with a corresponding rise in HCBS spending, including waiver, Adult Day Health Services (MD) and Personal Care Attendant (PCA). As a percentage of the State's total Medicaid long-term care budget, the model

[1] The Department of Health and Senior Services (DHSS) engaged Mercer to assist in the creation of the Global Budget Projection model. By leveraging federal grant funding with State funds, the DHSS was able to hire Mercer through an amendment to the national consulting firm's contract with the Department of Human Services.

shows a slight drop in nursing home spending with a corresponding rise in HCBS. Again based on the Act, data from SFY2007 was used as the baseline to measure change going forward. Between SFY2007 and SFY2009, nursing home spending dropped from 73 to 72 percent of total Medicaid long-term care spending while the Waiver percentage, including the Divisions of Aging and Community Services and Disability Services, increased from 7 to 8 percent of total Medicaid long term care spending.

Another metric to measure the State's progress towards rebalancing is to look at the members identified using the hierarchy developed for the Global Budget Projection model. According to the model, the number of nursing home clients decreased 3.1 percent to 29,812 or 42 percent of the population, while the number of clients in a long-term care waiver increased 9.9 percent to 9,566 (or 14 percent of the population) for an overall system increase of 2.6 percent.

Furthermore, New Jersey's demographics illustrate that rebalancing is working, but additional and continuous improvement is needed. Between SFY2007 and SFY2009, the percentage of Medicaid clients receiving long-term care services in nursing homes (NF) dropped while the percentage of those getting home and community based care increased slightly. During this same timeframe, the average age of Medicaid nursing home (NF) clients decreased slightly while the average age of waiver clients increased. The average age of nursing home clients showed a slight decrease from 79.1 years to 78.8 years, while the average age of waiver clients increased from 73.8 to 74.4 years of age. There was a difference with the adult population in Adult Day Health Services (Medicaid), where the average age in SFY09 was 70.4 years of age.

This Annual Report highlights progress that the State has made to satisfy the Act's other mandates in addition to the development and implementation of the new Global Budget Projection model. They range from the implementation of a data system, consumer assessment instrument and quality management systems to the development of HCBS models. Because there was no State funding attached to the Act, the DHSS has made it a priority to secure all possible federal opportunities offered by the Centers for Medicare & Medicaid Services and the Administration on Aging geared to long-term care reform. In 2009, the Department of Health and Senior Services secured $3.6 million in federal funding in addition to the $3.8 million previously awarded from 2006 to 2008 to New Jersey for long-term care reform.

An integrated data application known as the Social Assistance Management System (SAMS) is providing the IT solutions for the Aging and Disability Resource Connection (ADRC) business processes, including easy access to long-term care support services, streamlining clinical eligibility determination, authorizing and coordinating long-term care services and management, and compiling federal reports. It is the Older Americans Act federal reporting process that is serving as the foundation and testing ground for the larger and more complex ADRC/SAMS implementation process. The Department must make full statewide implementation of this system a top priority for the next year.

In addition to the two initial ADRC counties of Atlantic and Warren, Middlesex, Gloucester, Bergen, Hunterdon, Mercer, Morris, Somerset and Camden are in various stages of ADRC development. According to the Global Budget Projection model, the two pilot counties have shown improvement in HCBS penetration. In Atlantic County, nursing

home expenditures decreased from 79 percent in SFY2007 to 74 percent in SFY2009, while in Warren County, nursing home costs decreased from 91 percent to 87 percent in SFY2009. This trend bodes well for New Jersey once the ADRC model is fully implemented. Given the success in the pilot counties, the ADRC implementation must remain a Department priority.

In 2009, the Department of Health and Senior Services (DHSS) made strides in increasing its ability to provide greater support for community living. The Department consolidated its three Medicaid-supported HCBS programs into a single program called Global Options for Long-Term Care (GO). Enrollment in GO as of December 31, 2009 includes 9,953 participants – up by 1,840 or 23 percent from the program's start in January 1, 2009. In Calendar Years 2007, 2008 and 2009, a total of 1,550 clients were transitioned from nursing facilities to community-based settings under the GO-Nursing Home Transitions initiative.

New Jersey also opened its first two Program of All-Inclusive Care for the Elderly (PACE) sites. PACE is an integral part of the State's strategy to increase home and community based options. PACE should yield additional savings for the Medicaid long-term care budget, once the number of individuals being served reaches a critical mass.

IV. GLOBAL BUDGET REBALANCING FORECAST

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

The Act aims to rebalance long-term care away from an over-reliance on institutional care and toward more HCBS options. According to the Act, for the State fiscal years 2008 through 2013, funds equal to the amount of the reduction in the projected growth of Medicaid expenditures for nursing home care (State dollars only), plus the percentage anticipated for programs and persons that would be eligible to receive federal matching dollars, shall be reallocated to HCBS.

The DHSS engaged Mercer Government Human Resources Consulting (Mercer), a part of Mercer Health & Benefits LLC, to create a budget rebalancing model to track DACS and Division of Disability Services (DDS) waivers, Adult Day Health Services (MD), Personal Care Assistance (PCA) and nursing home (NF) expenditures, as well as project future LTC expenditures.

The purpose of the model is two-fold:

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

Throughout the development of the model, Mercer met with DACS, the Department of the Treasury's Office of Management and Budget (OMB), and stakeholder groups to discuss the model and its intentions, as well as obtain input into what data should be included from both DACS and DDS. It was found that in order to determine the rebalancing cost savings, the following Medicaid waivers[2] would need to be included in the model:

- Global Options for Long-Term Care (GO) – DACS
- Community Care Program for the Elderly and Disabled (CCPED) – DACS
- Assisted Living (AL) – DACS
- Assisted Living Residence (ALR) – DACS
- Adult Family Care (AFC) – DACS
- Caregiver Assistance Program (CAP) – DACS
- Alternate/Comprehensive Personal Care Homes (CPCH) – DACS
- Traumatic Brain Injury (TBI) – DDS
- AIDS Community Care Alternatives Program (ACCAP) – DDS
- Community Resources for People with Disabilities (CRPD) – DDS

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

New in the 2010 Annual Report is documentation of the state of rebalancing long-term care expenditures in New Jersey based on the newly created Global Budget Projection model.

Based on the tenets of the Act, the first and most important graph in the model illustrates the reduction in the projected growth of Medicaid expenditures from moving or diverting clients from a nursing home (NF) into home and community based services (HCBS). As previously stated, July 1, 2007 (State Fiscal Year 2008) is the date cited in the Act that the State must begin measuring cost savings. It should be noted, however, that the State had already been working toward rebalancing long-term care costs from institutional based care to HCBS for many years, but did not have a model to measure the cost savings.

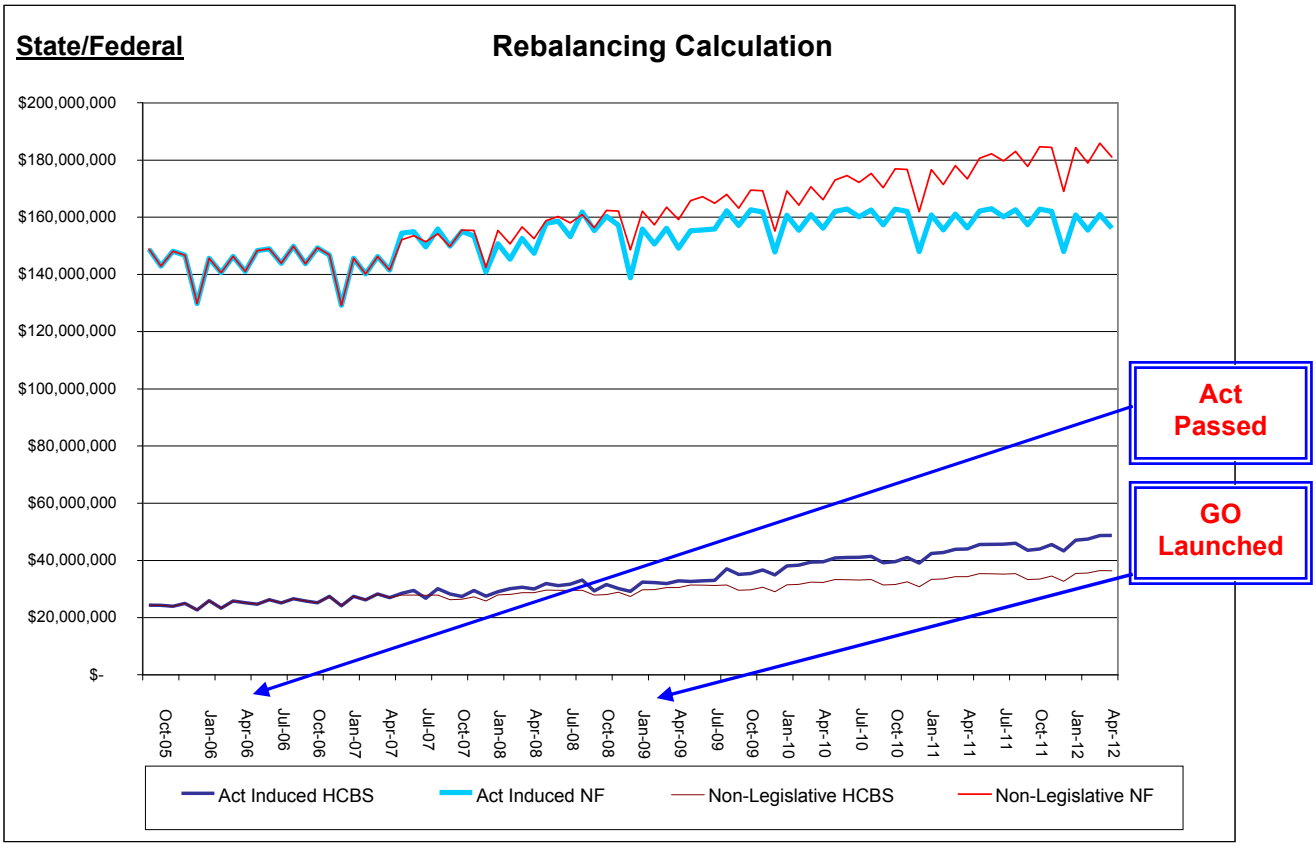
Rebalancing the State's long-term care budget can also be estimated by determining what would have been spent if the Act had not been passed. The budget projection model calculates historical and projected savings as a result of rebalancing efforts. In the chart below, the "Act Induced" lines represent the total cost of nursing facility and HCBS services respectively after the passage of the Act. The non-Legislative lines represent what might have happened had the Act not been passed.

[2] See Appendix E for more details on the HCBS Waiver programs in the Global Budget Projection model.

The nursing home (NF) savings are derived by calculating the difference between the nursing home (NF) costs had the Act not passed (non-legislative) and the nursing home (NF) costs due to the Act. The difference between the "Act Induced" HCBS costs and non-legislative HCBS costs are then subtracted from the nursing facility savings to arrive at projected net savings due to rebalancing.

As a result, the reduction in the projected growth of Medicaid expenditures (state and federal dollars) for the State due to its rebalancing efforts can be projected as follows:

SFY2008: $ 2,738,461
SFY2009: $ 27,776,999
SFY2010: $ 40,640,095
SFY2011: $ 67,206,862

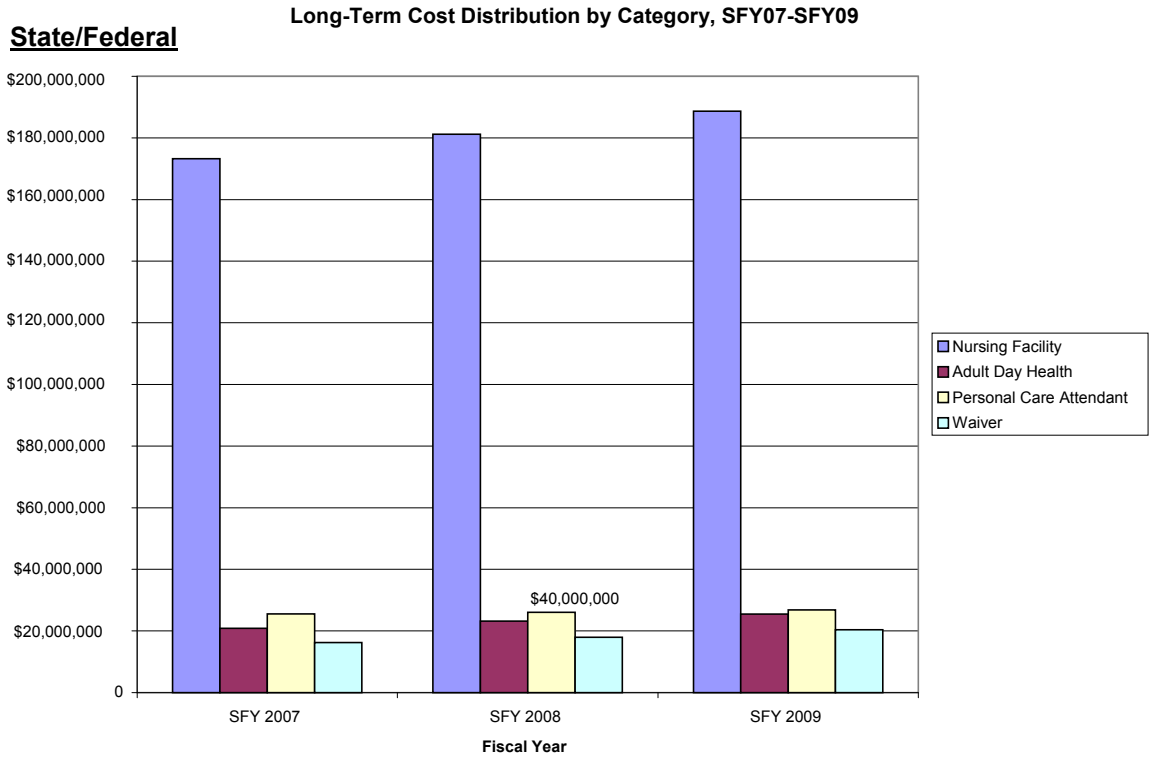


Another way to measure the effectiveness of the State's rebalancing efforts to date is to calculate the percentage of total spending among the different long term care services[3]. If rebalancing efforts are working, then the percentage of nursing home spending should decrease over time with a corresponding increase in HCBS spending,

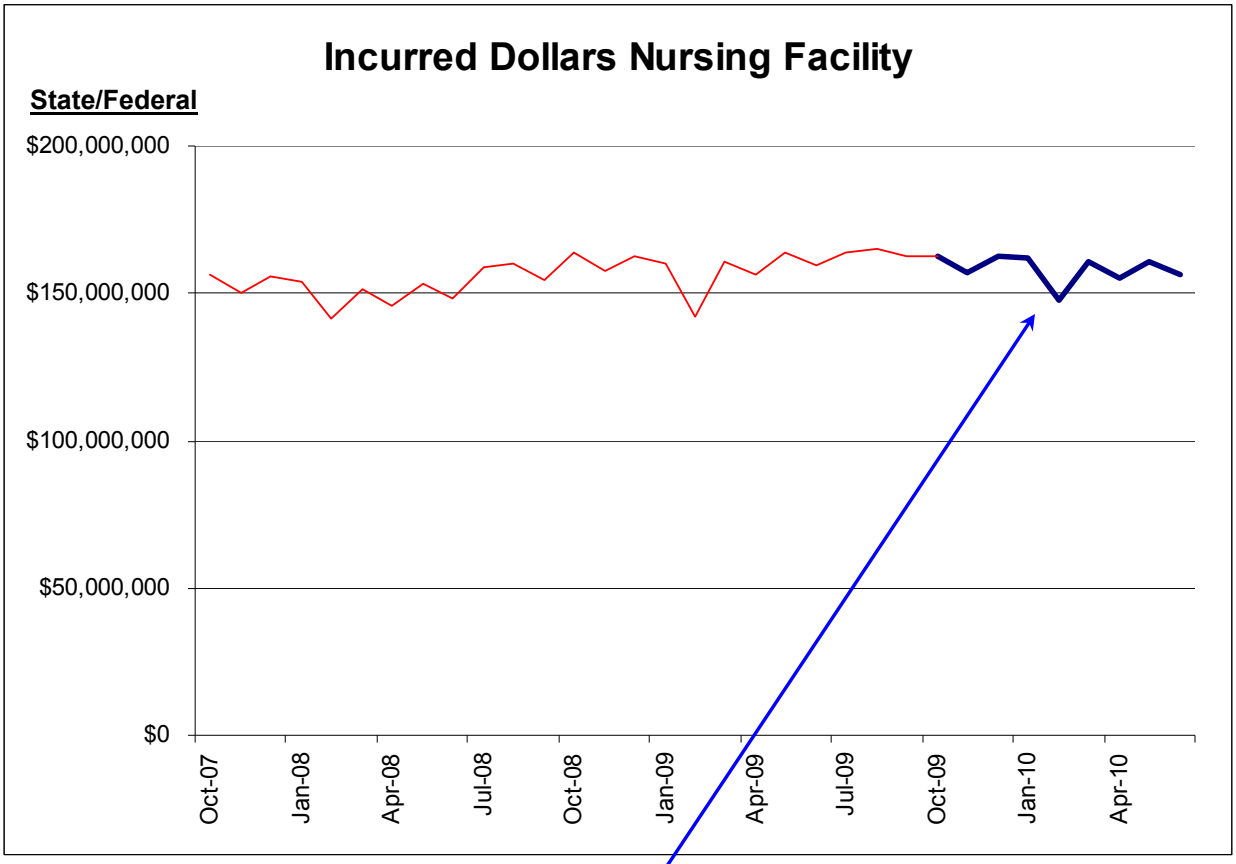
[3] The latest national data from Thomson Reuters (formerly Medstat) shows data on Medicaid Long-Term Care Expenditures for the United States for Federal Fiscal Year 2008 (October 2007 through September 2008). In this report, Medicaid long-term care expenditures for New Jersey amounted to $3,527, 583,428. The data is based on the CMS 64 reports: It includes nursing home services and ICF/MR services under institutional services. Community-Based Services include HCBS waiver services, Personal Care, Home Health, HCBS authorized under Section 1115 waivers and HCBS authorized under Section 1929. The Independence, Dignity and Choice in Long-Term Care Act includes Adult Day Health Services as an HCBS option while the ICF/MR expenditures are not included. New Jersey's provider tax further adds to the distortion of the State's institutional expenditures.

including waiver, Adult Day Health Services (MD) and Personal Care Attendant Services (PCA). Again based on the Act, data from SFY2007 was used as the baseline, while data from SFY 2009 was used to measure change. As additional counties migrate to the ADRC model, the rebalancing projections will change for the better as well.

Shown below, in SFY07, nursing home (NF) expenditures represented 73 percent of Medicaid Long-Term Care spending or $1,732,655,619, while Waiver expenditures, including DACS and DDS, represented only 7 percent of spending or $162,487,713. Also depicted here is ADHS (MD), which accounted for $208,625,784 in expenditures and PCA, which was $255,683,739. In SFY2009, Nursing Facility expenditures decreased to 72 percent of Medicaid Long-Term Care spending, while Waiver expenditures, including DACS and DDS, increased to 8 percent of spending indicating a slight statewide shift. In dollar terms, this represents $1,886,920,971 in nursing home (NF) expenditures; $254,446,282 in ADHS (MD) expenditures; $268,156,874 in PCA expenditures and $203,992,519 in Waiver expenditures.

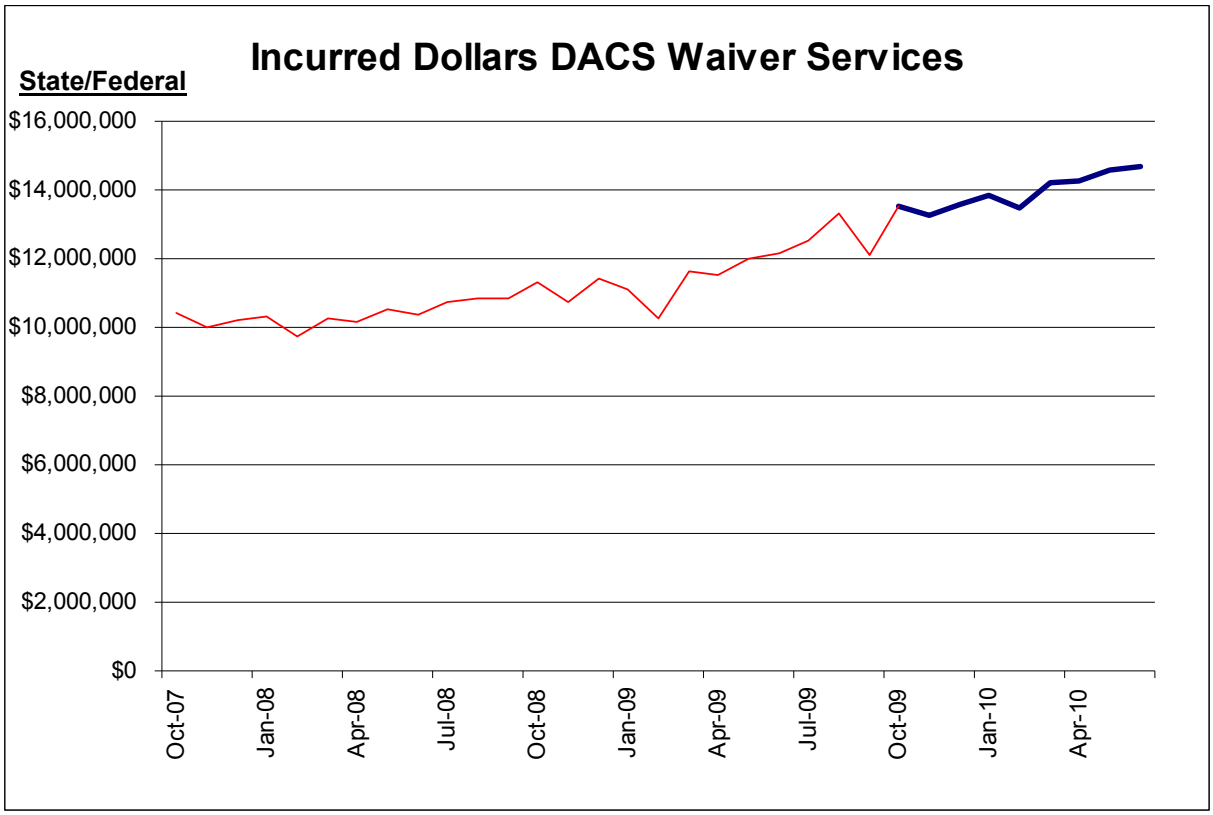


In SFY09, $2.6 billion was spent on Medicaid long-term care services, with $1.8 billion spent on nursing homes (NF). However, nursing home (NF) spending increased slightly through SFY 2008 and SFY 2009 and is projected to increase at a slower rate going forward. Incurred dollars in the graph below refers to the point in time when the service took place. Based on the Global Budget Projection hierarchy, nursing home (NF) costs are projected to be an estimated $2.0 billion.



NOTE: Trend line changes to **bold** to show movement with projected data, and not actual data.

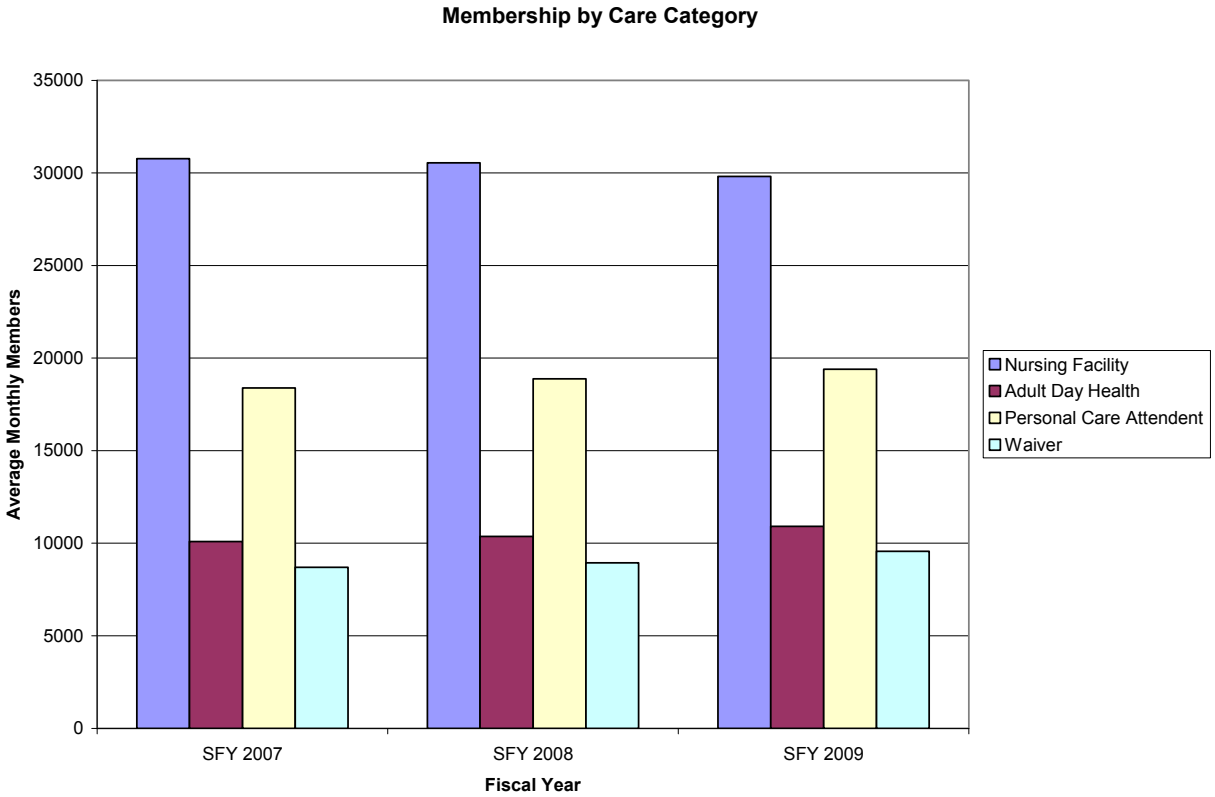
Of the $2.6 billion long term care budget, there was $134 million in DACS Waiver Services which includes the new Global Options (GO) Waiver. Spending in this waiver increased rapidly as rebalancing has allowed the State to serve an additional 1,840 clients in GO within the same budget. GO costs are projected to be approximately $183 million in SFY 2011.



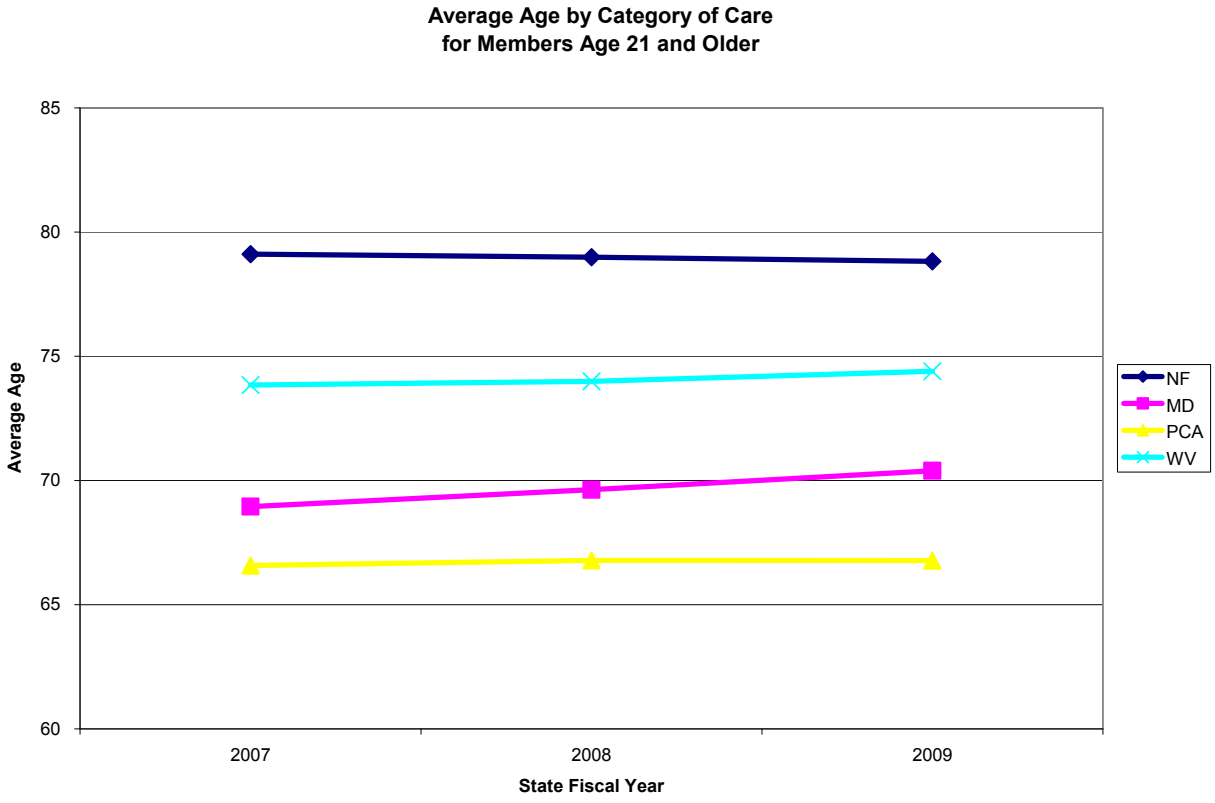
The demographics of the population can also help illustrate the effects of rebalancing. In SFY07, 30,768 individuals receiving long-term care services were in nursing homes (NF) or 45 percent of the Medicaid population. At the same time, 8,704 individuals or 13 percent were on a long-term care waiver as illustrated in the following graph. By SFY09, however, the number of Medicaid clients in nursing homes (NF) decreased 3.1 percent to 29,812 or 42 percent of the population while the number of clients in a long-term care waiver increased 9.9 percent to 9,566 (or 14 percent of the population) as shown in the following graph. This shift is indicative of more clients being directed from nursing homes (NF) to HCBS for their care. The total number of long-term care clients increased by 2.6 percent.

Another metric to measure the State's progress towards rebalancing is to look at the members identified using the hierarchy for the Global Budget Projection model. In the model, the number of nursing home clients decreased 3.1 percent, while the DACS waiver clients increased 9.9 percent for an overall system increase of 2.6 percent.

The nursing home (NF), Adult Day Health Services (MD) and Personal Care Assistance (PCA) Medicaid populations are determined based on claims activity. As a result, the SFY09 numbers may change as more claims come in. This data includes claims paid through September 2009.



As the population continues to age, clients are still able to benefit from HCBS due to rebalancing. When focusing on the adult population (excluding clients under age 21), there are similar results. The average age of nursing home (NF) Medicaid clients decreased slightly from 79.1 years to 78.8 years, while the average age of waiver clients increased 73.8 to 74.4. There was a difference with the adult population in medical day care, where the average age in SFY09 was 70.4. Including children, the average age was 67.2.



V. LONG-TERM CARE REFORM AS OF 2010

As part of rebalancing New Jersey's long-term care system, the Act also directs the Department of Health and Senior Services (DHSS) to accomplish specific mandates.

- Implement a process that rebalances the overall allocation of funding within the Department of Health and Senior Services (DHSS) for long-term care services through the expansion of home and community-based services (HCBS) for persons eligible for long-term care;
- Implement a comprehensive data system to track long-term care expenditures and services and consumer profiles and preferences;
- Implement a comprehensive consumer assessment instrument that is designed to facilitate an expedited process to authorize the provision of HCBS to a person through Fast Track eligibility prior to completion of a formal financial eligibility determination;
- 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;
- Develop HCBS long-term care models that are efficient and cost-effective alternatives to nursing home care;
- Implement a comprehensive quality management system; and
- Seek to make information available to the general public.

A. Act Mandate: Implementation of a Comprehensive Data System

A central focus of the Act is the implementation of a comprehensive data system to track long-term care expenditures and services, and consumer profiles and preferences. It is the Social Assistance Management System (SAMS) that once fully operational, will provide the information and technology (IT) infrastructure to the 700 HCBS agencies. These organizations are approved to provide information and assistance and services to older adults and younger persons with physical disabilities. Through the Aging and Disability Resource Center (ADRC), community professionals will have easy access to long-term care support services, streamlining eligibility determination and coordinating long-term care service and management.

In August 2008, the State's Office of Information and Technology (OIT) approved DACS to enter into a three-year (2008-2011), $3.8 million waiver of advertisement with Harmony Information Systems Inc. to purchase the SAMS application. As the Act was unfunded, DACS in partnership with the Department of Human Services' Division of Disability Services (DDS) and the Department of Military and Veterans Affairs are using federal monies from the System Transformation, ADRC and Community Living grants; and the Global Budget to purchase the Harmony system. As a web-based, client-tracking system, SAMS has the capacity to support multiple departments, divisions and programs. The SAMS integrated database provides intake, consumer profiles, screening for home and community-based services, clinical assessment, case management, service planning and authorization, service utilization, and the federal reports required by New Jersey under the Older Americans Act.

The approved waiver with Harmony Information Systems, Inc. included the following: (1) licenses and subscriptions to Harmony's hosting service, AgingNetwork.com for 2,000 end users; (2) support to complete the statewide deployment of the SAMS federal reporting system to the remaining 14 Area Agencies on Aging (AAAs); (3) project management to deploy SAMS to over 700 aging, disability, and veteran agencies that administer the federal Older Americans

Act, Medicaid HCBS Waiver services and State-funded programs; (4) technical assistance to support the business processes of the ADRC model; (5) an interface between the DACS' MDS-HC clinical database and SAMS; (6) the provision of technical assistance to create forms to capture additional data elements needed to fully comply with the Centers for Medicare & Medicaid Services (CMS) Quality Assurances; (7) creation of a link to export budget information to DACS' fiscal management service agencies; and (8) provision of technical assistance to develop reports, which when fully implemented will address the requirements of New Jersey's Office of Management & Budget (OMB). The OMB's issues relate to the benefit-specific tracking of clients, expenditures and per capita spending as required in the Independence, Dignity and Choice in Long-Term Care Act (Act).

The Older Americans Act federal reporting process is serving as the foundation and testing ground for the larger and more complex ADRC/SAMS implementation process. Beginning in February 2009, the DACS/Harmony Project Team conducted county-based training for the 21 AAAs and their network of 400 community agencies on these components: the federal reports required under the Older Americans Act; client and service data entry; nutrition services; care giving programs; intake/information and assistance and fiscal reporting.

As of January 2010, 1,032 associate users of the 21 AAAs and their contracted agencies were trained. By September 2009, 81,224 client records were entered into the SAMS' database. The completion of the project's first step represents the implementation plan's most expansive phase. By the end of 2010, it is anticipated that SAMS will be able to serve as the single database for Older Americans Act funded programs to collect, analyze and transfer federally required data elements to the Administration on Aging (AoA).

It is important to mention that the complexity and scope of deploying SAMS statewide to the aging and disability networks has presented many challenges. On a macro level, DACS has had to deal with issues of home rule in the 21 counties related to changing county business processes to comply with the ADRC model and integrate SAMS into their IT infrastructure. Other challenges relate to the logistics of arranging and conducting multiple training sessions in the 21 counties ─ to converting county-based computer systems to SAMS and even creating delivery routes for home delivered meal participants in one county (Bergen).

At the request of the AAA network, the DACS/Harmony Project Team slowed down and redesigned the current in-service training process on the SAMS modules for reporting Older Americans Act data, to focus on a type of provider, i.e. information and referral agencies, nutrition providers, homemaker agencies, legal service provider, rather than the general training sessions originally being conducted. This new training approach has been successfully piloted in the Bergen County Division of Senior Services (Bergen ADRC) and is currently being deployed in Gloucester, Cape May, Middlesex, and Camden counties. DACS anticipates that by the end of 2010 all 21 AAAs will be using SAMS to submit their federal reports to the AoA.

B. Act Mandate: Implement a Consumer Assessment Instrument that Expedites HCBS Care Prior to Completion of a Formal Financial Eligibility Determination

The Harmony Project Team worked with DACS to computerize the HCBS screening tool into the SAMS application. The tool is used to identify and target individuals at risk of nursing home placement and/or spend down to Medicaid eligibility. The tool consists of 20 questions focusing on the person's ability to perform Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and five financial questions to evaluate a person's income

eligiblity for public assistance (State and federal). The tool was tested in the ADRC pilot counties, recently introduced to the Bergen County ADRC, and as counties become ADRCs, staffs will be trained on how to conduct the interview for identifying individuals who need home and community-based services using the SAMS application.

The computerized screening tool uses an algorithm comprised of the five levels of service needs and provides the screener with a standardized decision-making process for evaluating the person's potential level of service needs to qualify for the public HCBS programs. The five levels of service needs are labeled as follows: (1) information and assistance; (2) homemaker; (3) intermittent personal care; (4) home care, and (5) nursing home care. The ADRC established a performance standard whereby those consumers who score from level three to five need to be offered the opportunity to have an assessor come to their home to conduct a clinical assessment and counsel them on the full range of HCBS. SAMS has automated the ADRC intake and screening processes, which are critical to support the Medicaid eligibility fast track determination (Fast Track) process identified in the Act. Between January 1, 2008 to December 31, 2009, 1,670 consumers have been screened for Fast Track, resulting in 298 consumers gaining immediate access to all Medicaid State Plan services, for up to 90 days, while their financial eligibility was determined.

The DACS and the DHS, Division of Medical Assistance and Health Services (DMAHS) have closely monitored the progress and met with the County Welfare Agency (CWA) directors and eligibility supervisors to identify and address their issues and concerns. Based on feedback, it was realized that the Medicare Part D - Low Income Database being used for Fast Track limited the pool of individuals potentially eligible for the program. Therefore the Pharmaceutical Assistance to the Aged and Disabled (PAAD) database was added because it contains a greater number of individuals potentially eligible and provides additional financial information. However, CWA feedback still indicates that a major contributor to the low number of participants being approved is the fact that the database must show that the federal financial requirements are met. Fast Track can't proceed without proof that the person's current income/assets fall within the financial guidelines at the time of application.

C. Act Mandate: Implement a System of Statewide Long-Term Care Service Coordination and Management; and Implement a Comprehensive Quality Assurance System

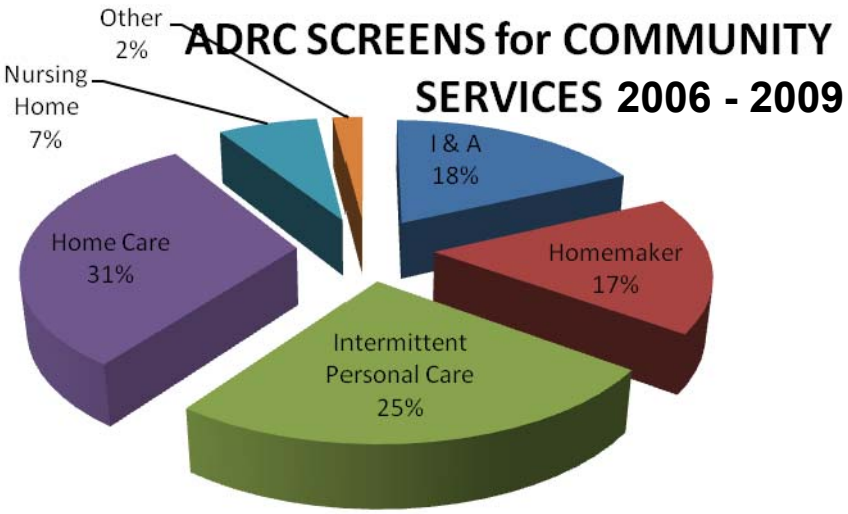
The ADRC business process serves as the foundation for rebalancing and streamlining access to long-term care supports. As mandated by the Act, the ADRC has developed a business flow process that begins with the initial intake, and if appropriate, the person is then screened to evaluate their need for home and community-based services (HCBS).

Based upon the outcome of the screening, consumers may be referred to the ADRC evaluators who are responsible for conducting home visits and comprehensive assessments to identify their physical/health care needs. The ADRC assessors review the assessment outcomes; counsel consumers/caregivers on appropriate long term options; and connect them to their locally based-care management agency. It is the care manager's responsibility to arrange, coordinate and monitor services provided under the Global Options for Long-Term Care (GO) Medicaid waiver program.

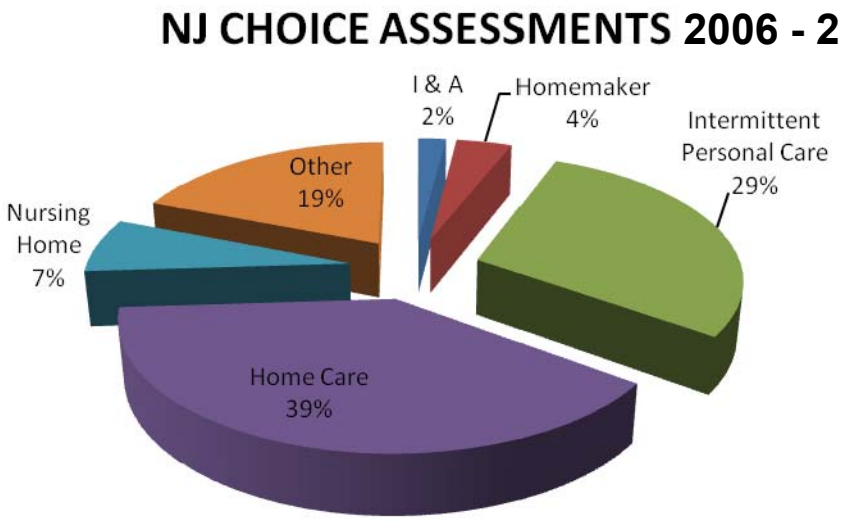
Between 2006 and 2009, the two pilot counties of Atlantic and Warren processed over 144,000 contacts. Sixty-five percent of the contacts were made to find out general information

and assistance while 23 percent of the contacts were made to get referrals to community programs. Meanwhile health insurance questions accounted for 7 percent of the contacts, 4 percent were regarding a person's potential need for HCBS and 1 percent was related to referrals for home visits, clinical assessments and options counseling on HCBS. In terms of caller profile, 42 percent of the callers were 60 years and older and 10 percent were caregivers.

As previously mentioned, the most recent data reveals 144,000 ADRC contacts in the two initial pilot counties of Atlantic and Warren. Out of the 144,000 contacts, the two counties conducted 4,129 screenings for community services. As shown in the pie chart below,18 percent of the contacts scored in need of information and assistance, 17 percent scored in need of homemaker services, 25 percent scored for intermittent personal care, 31 percent scored for home care, and 7 percent scored in need of nursing home care.



As documented by the outcomes of the clinical assessment, known as the NJ Choice, the ADRC screening tool has proven to be an effective indicator of a consumer's need for HCBS. When assessed, 94 percent of those individuals who scored at level three or above on the screening tool were clinially determined appropriate for support services as shown in the pie chart below. Not only is the tool effective in targeting the appropriate individuals for home visits and assessments, the tool is an important management tool to help allocate State and county resources more efficiently and cost-effectively.



The ADRC is now expanding statewide from its test phase in Atlantic and Warren Counties in coordination with the rollout of the SAMS application. With the ADRC model tested and partnerships now in place, New Jersey is moving forward to implement the new business processes and tools statewide. Bergen, Camden, Gloucester, Hunterdon, Mercer, Middlesex, Morris and Somerset Counties are all in various stages of development. The Department has made full implementation of the new business process a top priority in the remaining counties by 2012.

To implement the ADRC model, the State established a team to work one-on-one with each county to formalize local partnerships and integrate the ADRC client-pathway and model into their business processes. The first step that each county must undertake is to organize a local ADRC implementation team to oversee the development of a county-based single entry system. The AAA serves as the lead and is responsible for establishing the ADRC partnership. The partners must minimally include the following: county government officials and social service department heads, County Welfare Agencies (CWAs), offices on disability services, Centers for Independent Living, SHIP coordinators, State and county veteran service offices, hospital systems, senior centers/nutrition sites, home care agencies and other access points.

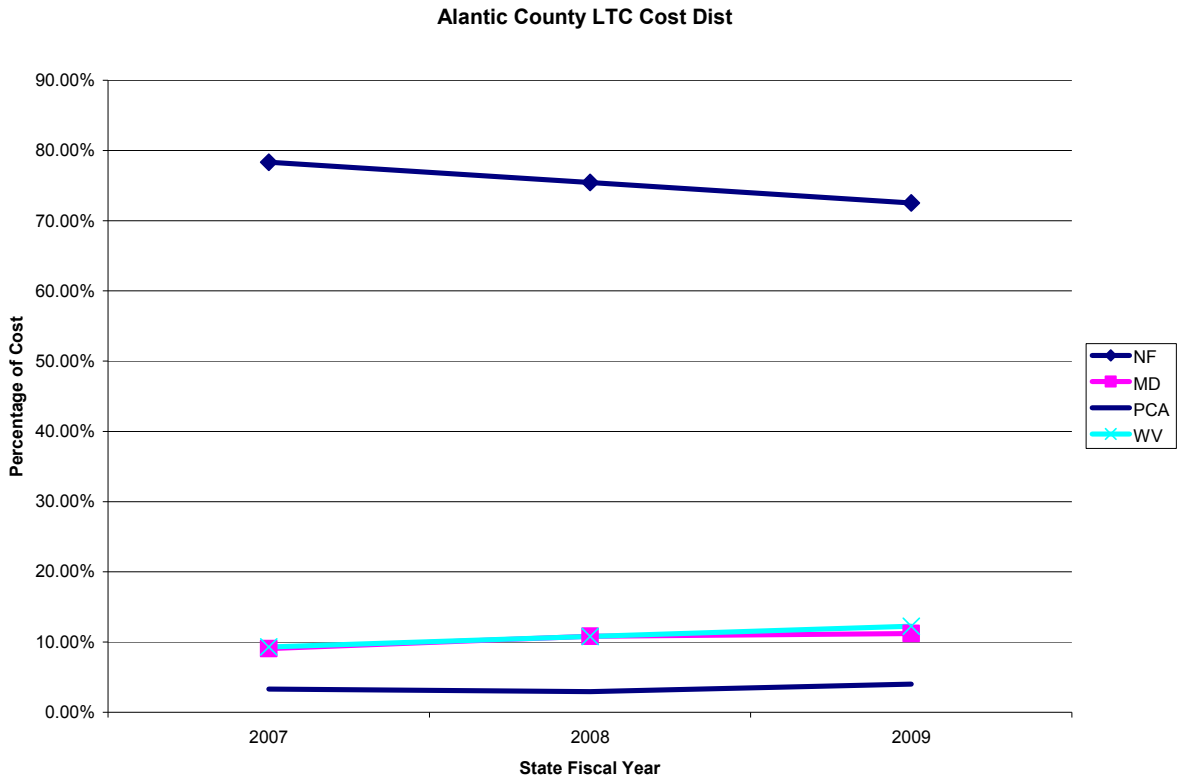
Working with the county ADRC team, the State guides the partners to identify which agencies will assume responsibilities for intake, screening, assessment/reassessment, care management, and quality assurance. The State ADRC team provides intensive training for each of the core functions, and continues to mentor the agency staff throughout the implementation phase. The State has developed performance standards for each of the core functions: for information and referral specialists, the State requires staff to complete the national AIRS certification test. The ADRC assessors are required to complete an on-line assessment training and competency test and the standards for care managers are based on the federal assurances established under the Global Options for Long-Term Care (GO) waiver program.

In 2009, the DACS/Harmony Project Team began exploring the best approach to use SAMS' functionality for care management, service planning and authorization to capture data elements that comply with the quality assurance measures established by New Jersey's ADRC and the Medicaid waiver programs. Creating a statewide system will enable care managers to

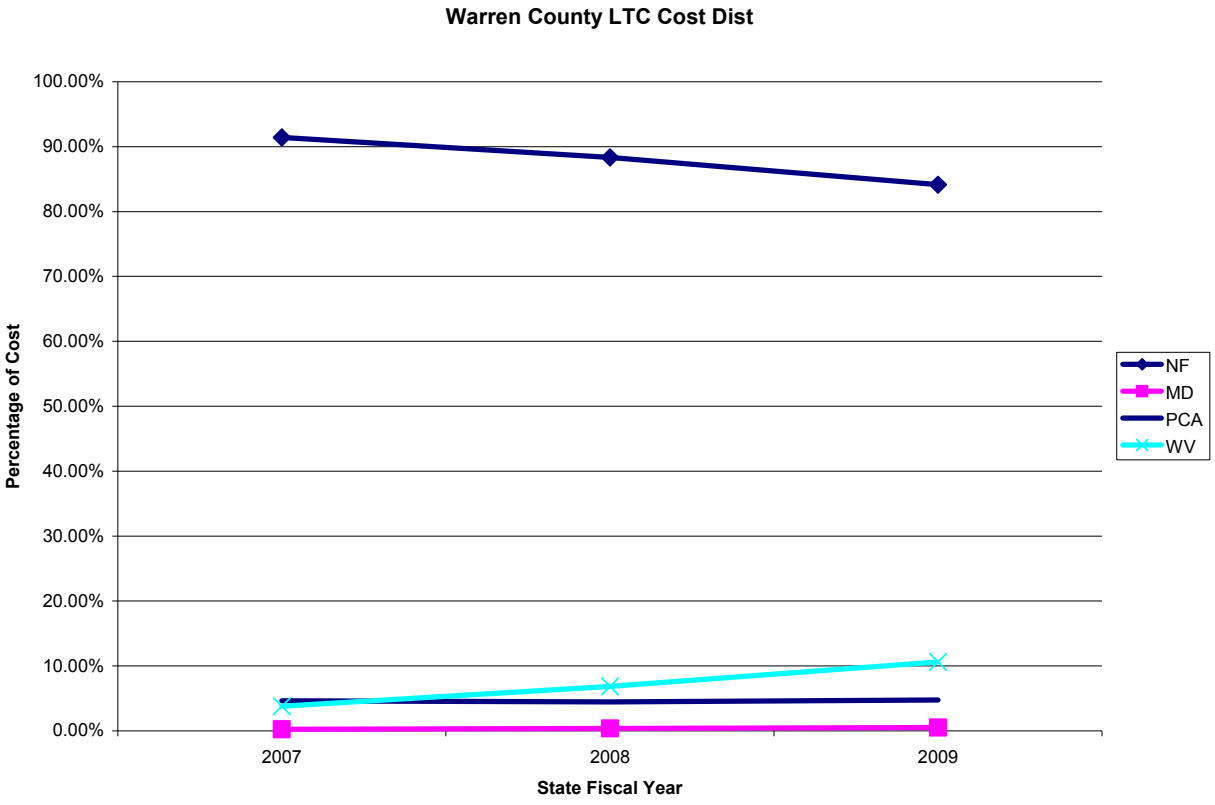
plan and coordinate services for participants through the collection of routine demographic data, the assessment of care needs as well as to plan and authorize services and providers and verify service delivery. SAMS will permit DACS, for the first time, to monitor care management practices and quality assurances through technology.

With the ADRC initiative as the primary catalyst for rebalancing long-term care in New Jersey, this third and final step of the project will enable DACS to achieve the IT objectives mandated in the Act. Currently Harmony and DACS are developing a strategy to meet the Act's requirements in terms of tracking and trending expenditures by individuals, services and funding streams. It is this information that will ultimately need to be incorporated into the Budget Projection model created by Mercer to support rebalancing. This year has been spent building the IT infrastructure which will ultimately support the Global Budget Projection model.

At this time, the most complete data available to support the budget projection model is for the two original ADRC pilot counties, Atlantic and Warren. These two counties have shown marked improvement in HCBS penetration. In Atlantic County, nursing home (NF) costs decreased from 79 to 73 percent, while HCBS waiver costs increased from 9 to 13 percent as seen in the following graph.



In Warren County, the change was even more pronounced, as nursing home (NF) costs decreased from 91 to 83 percent. In addition, Waiver costs, including the Global Options (GO) waiver, increased from 4 to 11 percent.



D. Act Mandate: Develop Home and Community Based Long-Term Care Models that are Efficient and Cost-Effective Alternatives to Nursing Home Care

As part of this requirement under the Act, three successful HCBS models were advanced in New Jersey in 2009 by DACS – Nursing Home Transitions, Global Options for Long-Term Care (GO) and the Program of All-Inclusive Care for the Elderly (PACE).

Nursing Home Transitions Grow

Building upon the DHSS' successful Community Choice Counseling Program, GO-Nursing Home Transitions was developed in State Fiscal Year (SFY) 2006 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:

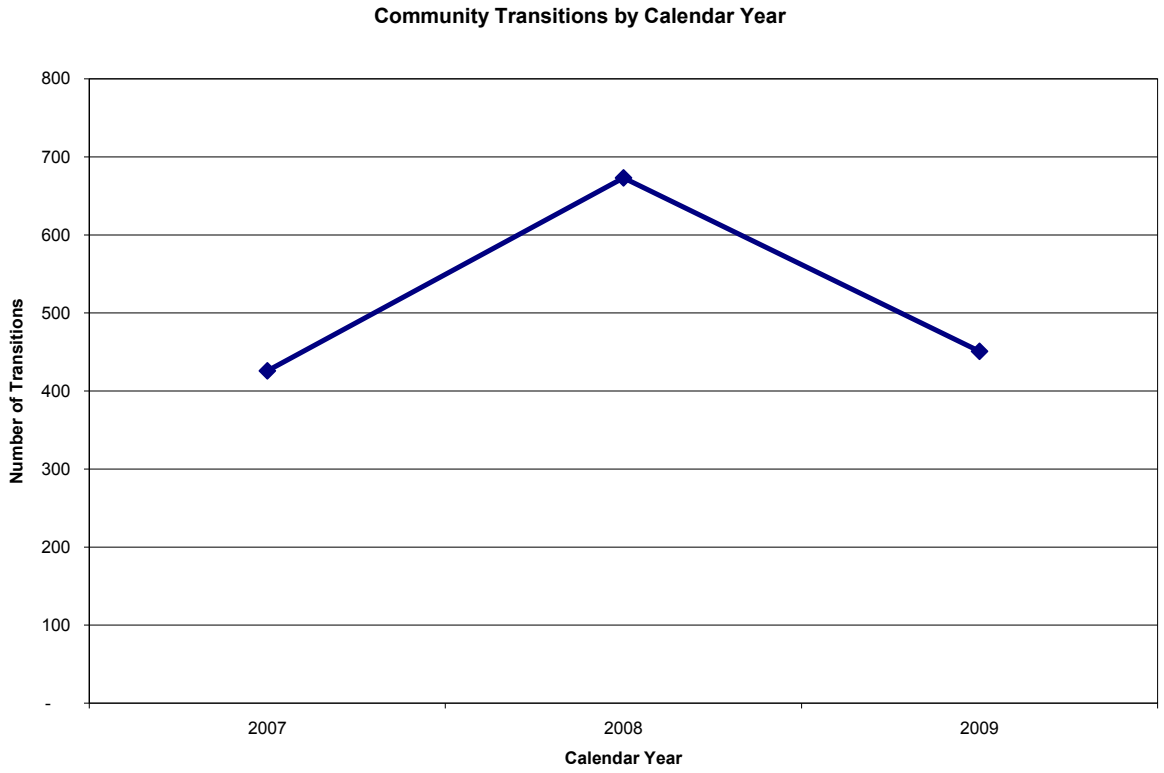
- Identifying and counseling individuals at-risk of inappropriately being placed or remaining in nursing homes, on the full range of home and community-based support services;
- Establishing an Inter-Disciplinary Team (IDT) approach that strengthens communication, collaboration and coordination among 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. Yet, it still provides the State with the necessary control of overall costs and assures budget neutrality for HCBS.

Through the Global Budget line item, the State has increased funding for Nursing Home Transitions, a component of Global Options for Long-Term Care (GO). It has expanded HCBS options and provided more flexibility for residents to control and direct their services. Since New Jersey's Community Choice Counseling Program (now known as GO-Nursing Home Transitions) began in 1998, over 5,500 individuals have been transitioned from nursing homes into HCBS.

In Calendar Years 2007, 2008 and 2009, a total of 1,550 clients were transitioned from a nursing facility to a community-based setting as shown below. Calendar Year 2007 (or State Fiscal Year 2008) is the date in the Act when the State had to begin measuring rebalancing.



Through the Independence, Dignity and Choice in Long-Term Care Act (Act), the DHSS has also been charged with rebalancing its Medicaid long-term care system to include more community care and greater consumer choice. In 2009, the DHSS made significant strides in terms of increasing its ability to provide increased support for community living.

Global Options for Long-Term Care is Launched

Effective January 1, 2009, the DHSS consolidated its three Medicaid-supported home and community-based service programs into a single program known as Global Options (GO) for Long Term Care. The Centers for Medicare & Medicaid Services (CMS) had authorized New Jersey to consolidate its three waivers into one.

Leading up to the consolidation, the Department of Health and Senior Services (DHSS) had offered Medicaid waiver services that competed against one another. They were -- the

Community Care Program for the Elderly and Disabled (CCPED), Assisting Living (AL) and Enhanced Community Options (ECO). Enormous differences existed among their service packages, which led to many inconsistencies for consumers and their caregivers. For instance:

- CCPED offered four State Plan services and four Medicaid waiver services – the others offered all State Plan services and up to 11 additional Medicaid waiver services.
- AL offered Medicaid waiver services in residential settings while the Enhanced Community Options (ECO) waiver offered services in the home.

The consolidation improved access to a wider range of in-home long-term supportive services for a greater number of seniors and adults with physical disabilities. The DHSS is now serving 9,953 participants on GO– up by 1,840 or 23 percent from January 1, 2009 to December 31, 2009.

PACE Debuts in New Jersey

PACE stands for Program of All-Inclusive Care for the Elderly. PACE is an innovative Medicare program that provides frail individuals age 55 and older comprehensive medical and social services coordinated and provided by an interdisciplinary team of professionals in a community-based center and in the individuals' homes, helping program participants delay or avoid long-term nursing home care.

Each PACE participant receives customized care that is planned and delivered by a coordinated, interdisciplinary team of professionals working at the center. The team meets regularly with each participant and his or her representative in order to assess the participant's needs. Care plans usually integrate some home care services from the team with several visits each week to the PACE center, which serves as the hub for medical care, rehabilitation, social activities and dining.

To participate in PACE, an individual must be 55 years of age or older, require nursing home level of care but be able to live safely in the community at time of enrollment with the services of PACE, and reside in the service area of a PACE organization. PACE participants may disenroll from the program and return to their former Medicare and Medicaid coverage plans at anytime and for any reason.

PACE provides its participants with all services covered by Medicare and Medicaid, without the limitations normally imposed by these programs. It also provides any other services deemed necessary by the interdisciplinary team that would allow program participants to remain in the community.

Services provided by PACE include, but are not limited to, primary care (including doctor, dental and nursing services), prescription drugs, adult day health care, home and personal care services, and hospital and nursing home care if and when needed. Transportation to and from the center and all off-site medical appointments is also provided.

In spring 2009, New Jersey opened its first PACE sites – the CMS' approved managed care model providing a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate. They

are LIFE St. Francis (Living Independently For Elders) in Trenton and LIFE at Lourdes Hospital in Pennsauken. To date, a total of over 100 participants are enrolled.

At this time, other New Jersey PACE sites are underway and are at various stages of development. PACE is an integral planned piece of the Global Budget Rebalancing initiative as it provides a sensible approach to remaining in the community with long-term care support services. As PACE expands in New Jersey in terms of its ability to serve more beneficiaries, the program will actually yield additional savings and contribute to New Jersey's rebalancing efforts.

E. Federal Grants Drive the Act's Mandates

The Independence, Dignity and Choice in Long-Term Care Act was signed into law with no funding attached to carry out the mandates discussed throughout this Report. As grant opportunities have become available to advance long-term care reform nationally and as part of the federal budget's funding cycle, the State has taken advantage of applying for these competitive grant opportunities. Indeed, New Jersey's efforts to reform its long-term care system have been recognized nationally by the federal government, namely the Administration on Aging (AoA) and the Centers for Medicare & Medicaid Services (CMS). As new opportunities become available in the long-term care arena, New Jersey needs to fully take advantage of them to support its reform agenda.

In 2009, New Jersey was awarded $3.6 million in new federal grant funding:

- **Aging and Disability Resource Connection (ADRC) –** Starting October 1, 2009, DACS received $445,000 as part of a new three-three grant to refine the ADRC model. Since the original ADRC grant was awarded in 2003 (prior to the Act), New Jersey has received $1.2 million to build the model unique to New Jersey and expand it statewide. Greater access to long-term care support options is at the center of the ADRC: making it easier for seniors and people with disabilities to learn about and access long-term care service options. The new funds will enable DACS to purchase from Harmony Information Systems, Inc., (1) an online resource center for consumers and professionals to learn about and link to HCBS; (2) an Agency Reporting Tool (ART) that enables end users to create unlimited data analysis and reports for quality assurance, rebalancing, trend and cost analysis, etc.; and (3) a document storage application that will enable professionals to import critical documents from other sources and link them to client records in the SAMS database.
- **Veterans Directed Home and Community Based Service Program** – The U.S. Department of Veterans Affairs awarded New Jersey $2.5 million in supplemental funding from the U.S. Department of Veterans Affairs to help New Jersey seniors and injured veterans of all ages at risk of nursing home placement to remain independent in their homes and communities. Partners include DHSS, the Department of Human Services (DHS) and Military and Veterans Affairs (DMAVA); the U.S. Department of Veterans Affairs New Jersey Healthcare System; the Morris County Division on Aging, Disabilities and Veterans; and the Somerset County Office on Aging. Through this national initiative, veterans will have a cash and counseling option that provides them with the flexibility to direct their care needs, hire their employees or agencies and purchase goods and services to meet their care needs.
- **Evidence-Based Prevention** – DACS was awarded $192,300 to continue its three-year grant, *Empowering Older People to Take More Control of their Health through Evidence-Based Prevention Programs: A Public Disease*, that ended September 30, 2009. The new funding, which began October 1, 2009 will run through September 30, 2010. In 2006, New Jersey was among 16 states selected in 2006 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 initiative builds upon the Department's existing wellness activities for older adults, specifically the HealthEASE physical activity model and health education efforts.

- **MIPPA** – The two-year grant entitled *Medicare Improvements for Patients and Providers Act (MIPPA) for Beneficiary Outreach and Assistance* was for $478,139 and began June 1, 2009. It is being used to support outreach and assistance efforts directed towards helping Medicare beneficiaries understand and apply for their Medicare benefits.

And the Act is still benefiting from these federal funding grants totaling $3.8 million:

- **Nursing Home Diversion Modernization Grant** ─ The DHSS was awarded a grant for the maximum award amount of $500,000 to develop a nursing home diversion program for individuals not Medicaid eligible. It targets individuals who are at risk of nursing home placement and spending down to Medicaid eligibility. The program uses a flexible, consumer-directed model of care; this Cash and Counseling approach will give consumers greater control over their care. The grant period is from October 2007 through March 2011.
- **Nursing Home Diversion Grant** – The DHSS was awarded another competitive federal grant – a Nursing Home Diversion grant – for $565,151 from the AoA. Other state agency partners with the DHSS include the DMAVA, DHS, Camden County Division of Senior & Disabled Services, Morris Division of Aging, Disabled and Veterans Affairs, and Somerset County Division of Aging. The grant period is from October 2008 through March 2011.
- **Real Choice Systems Change Grants for Community Living** ─ The DHSS, in partnership with the DHS, is the recipient of a five-year Systems Transformation Grant 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. The grant period is from October 2006 through September 2011.
- **Alzheimer's Disease Demonstration Grant** ─ The DHSS was one of three states awarded the *Translating Evidence-Based Alzheimer's Diseases and Related Dementia Direct Services Research into Practice* grant from AoA. With $187,500 in funding, the grant targets persons with Alzheimer's disease or related disorders and their caregivers. The grant period is from September 2010 through February 2012.
- **Sustainable Systems Grant** ─ In 2008, the DHSS was awarded a three-year grant for a total of $300,000 from the National Council on Aging to build a statewide delivery system for the Chronic Disease Self-Management Program. It complements the Division of Aging and Community Services' grant from the AoA.

New Jersey is also still able to gain from its participation in the Money Follows the Person (MFP) Rebalancing Demonstration. Under the MFP demonstration, New Jersey was awarded a grant by CMS that could total up to $30.3 million over five years, from May 1, 2007 through September 30, 2011. It represents a partnership of the DHS' DDD, DDS and DMAHS and DHSS' DACS. New Jersey's plan is assisting people who are elderly and/or physically or developmentally disabled to live and receive services in local communities rather than in an institution.

CMS awarded 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 still needs 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. To date NJ has enrolled 102 individuals in MFP.

Because of constraints for New Jersey in the federal design of this program, MFP is not as beneficial to the State as it should be. New Jersey, and other states, are trying to work with CMS to modify its requirements to include Assisted Living as a community option therefore enabling more transitions to qualify for the increased FMAP. As a result, CMS has changed the minimum stay in an institution from 6 months to 3 months. Since DACS transitions an average of 500 nursing home residents annually, it is anticipated that with the change in length of stay more nursing home residents will qualify for MFP.

VI. CONCLUSION

The State of New Jersey now has a new budgetary process for tracking its long-term care system expenditures and projecting future expenditures. It is designed to increase home and community-based care within the existing budget allocation by diverting persons from nursing home placement, allowing maximum flexibility between nursing homes (NF) and home and community based services and supports (HCBS).

The results are tracked and highlighted in the Global Budget Projection model. While there is room for improvement and more progress in rebalancing New Jersey's long-term care system, the process can already show a statewide shift in its tracking of long-term care expenditures from State Fiscal Year (SFY) 2007 to SFY2009. The percentage of nursing home (NF) spending has decreased -- from 73 to 72 percent -- with a corresponding rise in HCBS waiver spending from 7 to 8 percent all within the approved SFY10 long term care funding levels.

Based on the Global Budget Projection model, the impact of the Independence, Dignity and Choice in Long-Term Care Act (Act) has been positive on the State's fiscal situation if one considers the potential costs of long-term care without any rebalancing activities. Looking at historical and projected savings resulting from rebalancing activities, in federal and state dollars combined, New Jersey saved a total of $30,515,460 in SFY2008 and SFY2009. A savings of $40,640.095 is projected for SFY2010 and $67,206,862 is projected for SFY2011.

The long-term care system is definitely showing positive trend lines. At this point in time the State's public HCBS expenditures are increasing minimally as a percentage of the total long-term care Medicaid expenditures. The Global Budget Projection model shows definite cost containment of $138,362,417 – combined federal and state dollars – over four years.

Countless studies have reported that those individuals in need of long-term care prefer to receive it in through HCBS rather than by moving into a nursing home if feasible. They want to receive long-term care services and supports to stay in their homes and communities for as long as possible. Public policy indicates it's the right thing to do.

Addressing the imbalance in New Jersey's long-term care budget ─ which currently favors nursing home care ─ remains a large part of the solution in the context of the State's long-term care reform agenda. Today's changing demographics especially the aging of the baby boom generation necessitates cost containment. New Jersey is moving steadily and purposefully in the right direction. However, the pace will need to be expedited to achieve ongoing and future savings.

# # # #

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 long-term 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 community-based 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 long-term 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

A. Demographic Trends in New Jersey

New Jersey's senior population is growing and diverse. The state currently ranks 11th in the nation in overall population, but 9th in the number of individuals age 60 and older. According to U.S. Census data, this cohort grew 8.4 percent from 2000 to 2007 to a total of 1,565,195 individuals. The largest population growth during this period was among the youngest (people aged 60-64 years, 30 percent) and oldest (people aged 85 and over, 24 percent) age groups. This change reflects the aging of the baby boomers (those born between 1946 and 1964) and their parents.

The population over age 60 years is projected to grow substantially in the near future as the baby-boomer generation ages. By 2030, the population in this age group in New Jersey is projected to number 2.5 million. People aged 60 and over represented 18 percent of the state population in 2007: by 2030, this figure is expected to rise to 25.7 percent.

New Jersey is one of the most diverse states in the nation. Among its residents aged 60 years and over in 2007, 9.8 percent were non-Hispanic black, 8.2 percent were Hispanic and 4.8 percent were Asian and Pacific Islanders. Within each of these groups there is a tremendous diversity among ethnicities and languages spoken. In fact, more than 70 languages are currently spoken in New Jersey homes.

For income data, this plan looked to two main sources: the 2000 Census and the Elder Economic Security Standard Index, a new resource for New Jersey to measure how much income seniors need to adequately meet basic needs without public or private assistance. The New Jersey Foundation for Aging developed the Index in partnership with Wider Opportunities for Women (WOW) and the Gerontology Institute at the University of Massachusetts Boston.

The Index, released in May 2009, found that in order to reach economic security, a single senior needed an annual income ranging from $23,452 (for homeowners without a mortgage) to $33,570 (homeowners with a mortgage). For married couples, the standards ranged from $34,324 to $44,442. The standard for renters was roughly $2,500 higher than for homeowners without mortgages. With more than 25 percent of seniors relying solely on their Social Security benefit, it is clear that many cannot adequately meet their basic living expenses. The most significant barriers to economic security for seniors in New Jersey were high housing and healthcare costs. For other key findings of this report, visit the website of the NJ Foundation for Aging at http://www.njfoundationforaging.org.

Census data reveals the median income for families with the householder aged 60 years and over was $51,535 in 1999, and declined with age. The median income for families with the householder aged 85 years and over was about half that of families with the householder aged between 60 and 64 years.

In 1999, 7.7 percent of all individuals aged 60 years and over in New Jersey had incomes below the poverty level, which is lower than the proportion for the population as a whole. The poverty rates were higher for minority seniors including 16.5 percent for non-Hispanic blacks, 16.6 percent for American Indians and Alaska Natives, and 17.5 percent for Hispanics and Latinos.

Approximately 36 percent of the statewide non-institutionalized population aged 60 years and over claimed a disability in 2000. The rates did not differ much between men (34 percent) and women (37 percent). The prevalence of disability increased substantially with age. In the 60-64 age group, 27 percent of men and 26 percent of women had a disability. Within the 85+ age group, about 64 percent of men and 73 percent of women had a disability.

In 2003, 60 percent of people aged 60 to 64 years depended primarily upon employment-related health insurance and 17 percent of people within this age group did not have any health insurance. The uninsured rate was reduced to 2 percent for people aged between 65 and 74 years, for whom 92 percent had Medicare as primary insurance. For people aged 75 years and over, 98 percent had Medicare as their primary insurance.

These statistics and utilization data mirror the day-to-day anecdotal experience of New Jersey's aging services network. In these figures and throughout our workday, we see an aging population that is expanding at a tremendous rate and, in too many cases, is unprepared for the medical, social and financial challenges that lay before them.

The new generation of seniors also has different expectations than previous ones. They are aging into a system that offers home and community-based services that were unavailable to their parents. Today's seniors want options, want to have a say in how, when, where and by whom their services are delivered, and are eager to use these services to maintain their independence late into life.

To meet the changing demographics, diversity and demands of its consumers, the aging network in New Jersey is changing the way is does business.

B. Economic Trends in New Jersey

The Office of Legislative Services Budget officer David Rosen in his testimony to members of the New Jersey Assembly Budget Committee on January 25, 2010 had also reported on New Jersey's shortfall for the current and future state budget. Due to continuing declines in revenues and a concurrent increase in anticipated spending needs (in part to meet pressing spending needs in a struggling economy), Rosen said that the State faces difficult spending decisions in the weeks and months ahead.

On February 11, 2010, Governor Chris Christie addressed a special joint session of the Legislature where he advised the members that he had signed an Executive Order before the speech and declared a "state of fiscal emergency" in recognition of the State's looming deficit for the balance of State Fiscal Year (SFY) 2010. The Governor put the deficit in the current budget, which ends on June 30, at $2.2 billion, while the gap in the following budget has spiked to almost $11 billion.

. For SFY 2011, Governor Christie enacted a budget that calls for spending $29.38 billion and will be making a series of spending reductions and reforms to close a budget gap that had been projected at almost $11 billion. The Governor's budget solutions include critical savings, while also maintaining funding for programs designed to protect the most vulnerable. It also provides long-term property tax reform.

New Jersey is not alone in its dire fiscal condition. States are facing one of the worst, if not the worst, fiscal periods since the Great Depression according to the National Association of State Budget Officers (NASBO) and the National Governors Association.[4] The National Association of State Units on Aging (NASUA) to which the Division of Aging and Community Services belongs as New Jersey's State Unit on Aging also reported that these are challenging times, and most states are facing declining revenues at the same time that they are facing an increasing demand for long-term care support services.[5]

And New Jersey's economic outlook made the national stage in terms of economic news headlines. A report released November 11, 2009 by the Pew Center on the States shows that some of the same pressures that have pushed California toward economic disaster are causing havoc in a number of other states, including New Jersey, with potentially damaging consequences for the entire country. New Jersey along with Arizona, Florida, Illinois, Michigan, Nevada, Oregon, Rhode Island and Wisconsin joined California as the 10 most troubled states, according to the Pew study. In the report, New Jersey was described as playing "catch-up after years of fiscal mismanagement and a daunting structural imbalance between what it collects and what it spends. The woes of nearby Wall Street—which supports approximately one third of New Jersey's economy—only made matters worse. Growing debt payments and perennially underfunded pension systems will make the Garden State's road to recovery even rougher."[6]

The grim news was backed up by predictions from various local organizations. The Rutgers Economic Advisory Services found that New Jersey's economic downturn will last longer with expansion not occurring until 2016. Meanwhile results from the New Jersey Business & Industry Association's 2010 Business Outlook Survey found that sales, profits, spending and employment dropped to record lows this year at New Jersey businesses.

C. Health Reform and New Jersey

The Patient Protection and Affordable Act was signed into law by President Obama on March 23, 2010. On March 25, both chambers passed the Health Care and Education Reconciliation Act of 2010, a package of changes to amend the newly enacted health reform law. The final health reform legislation reflects the reconciliation bill's changes and remains largely identical to the Senate's health reform bill that the President signed into law on March 25 according to the National Association of State Units on Aging (NASUA).

Here are the key health coverage provisions of the legislation as outlined in the Henry J. Kaiser Family Foundation website:

- "Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have affordable employer coverage will be able to purchase coverage through a Health Insurance Exchange with premium and cost-sharing credits available to some people to make it affordable. Small businesses will be able to buy coverage through a separate Exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the Exchange, with exceptions for small employers.

[4] Fiscal Survey of States Preliminary Data November 12, 2009, NASBO
[5] The Economic Crisis and its Impact on State Aging Programs, NASUA, 11/2009
[6] Pew Center on the States

- New regulations will be imposed on all health plans that will prevent insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133 percent of the federal poverty level ($14,404 for an individual and $29,327 for a family of four in 2009) for all individuals under age 65." [7]

The final health reform legislation also includes key provisions in the area of quality and system improvements ranging from the creation of a new Independence at Home demonstration program for high-risk Medicare beneficiaries and a new office, the Federal Coordinated Health Care Office for Dual Eligible Beneficiaries, to the closing of the Medicare Doughnut hole, the reducing of the Medicare Advantage payments and the Medicaid Disproportionate Share Hospital (DSH) payments, and the increasing of federal funding for the stare Medicaid programs. Effective October 1, 2011-September 30, 2015, selected states will receive an increased Federal Medical Assistance Percentage (FMAP) of 5 percent or 2 percent with respect to medical assistance expenditures for non-institutionally based long-term care services and supports provided under the state Medicaid program. The Money Follows the Person Rebalancing Demonstration is also extended through September 30, 2016. Its eligibility requirements are modified with a reduction of the institutional residency period to not more than 90 consecutive days.

The final legislation also provides specific long-term care provisions. The Community Living Assistance Services and Support (CLASS) program is to be a national, voluntary insurance program for purchasing community living services and supports. It includes a five-year vesting period and a three-year work requirement for eligibility of benefits. Nursing facility transparency is another provision as well as workforce training and education and elder justice. There is also $10 million annually for Federal Fiscal Year 2010-2014 to carry out the Aging and Disability Resource Center provisions of the Older Americans Act.

There are consequences of the new national health care legislation on New Jersey's long-term care system. Now that is it passed, the legislation is being studied by a Governor's Office Work Group on Health Care Reform comprised of concerned state agencies and the Office of the Governor. It will also need to be studied and taken into consideration by each member of the Medicaid Long-Term Care Funding Advisory Council with regard to their group's special interests and rebalancing long-term care in New Jersey.

[7] Henry J. Kaiser Family Foundation's Summary of Coverage Provisions in the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Appendix C

STATISTICS ON NEW JERSEY'S AGING POPULATION -- 2007 DATA FROM CENSUS

Basic Demographics in 2007

- The total population for all ages in New Jersey was 8,685,920 in 2007. Among them, 18.0% were 60 years of age and older in 2007.

- Females significantly outnumbered males at ages over 60 years. Among people aged 60 years and over in New Jersey in 2007, 42.7% were male and 57.3% were female. Among those aged 85 years and over in New Jersey, 31.1% were male and 68.9% were female.

- Among those aged 60 years and over in New Jersey in 2007, 77.0% were non-Hispanic white, 9.8% were non-Hispanic black, 8.2% were Hispanic, and 4.8% were Asian and Pacific Islanders. While population in all racial and ethnic groups increased between 2003 and 2007, Hispanic and Asian population increased at a faster rate than non-Hispanic whites and blacks.

- In 2007, people aged 60 years and over exceeded 25% of the county total population in Ocean and Cape May counties.

- More than half (56.4%) of the New Jersey population 60 years of age and older in 2007 resided in seven counties: Bergen (182,706), Ocean (143,967), Middlesex (130,560), Essex (126,434), Monmouth (118,088), Union (91,415), and Morris (90,231).

- About 58.3% of the New Jersey minority population 60 years of age and older in 2007 resided in five counties: Essex (61,618), Hudson (49,079), Bergen (35,920), Middlesex (31,919), and Union (31,062).

- Within counties, the percent of the total population 60 years of age and over that are racial and ethnic minorities ranged from 4.6% (Hunterdon) to 54.7% (Hudson). Essex (48.7%), Union (34.0%), and Passaic (33.3%) counties had the largest concentration of minorities after Hudson County.

- Nearly 35% of Essex County's population aged 60 years and over were non-Hispanic blacks. Other counties that also had a high proportion of non-Hispanic black population were: Union (16.5%), Mercer (15.0%), Camden (13.4%), and Atlantic (13.0%).

- Hudson County had the highest proportion of Hispanic among the population aged 60 years and over (36.5%), followed by Passaic (18.8%) and Union (14.0%).

- Middlesex County had the largest proportion of Asian and Pacific Islanders among their senior population (10.5%), followed by Hudson (9.1%), Bergen (8.0%), and Somerset (7.6%).

English Proficiency, 2000

- Among people aged 60 years and over in New Jersey in 2000, 4.2% did not speak English well and an additional 2.3% did not speak English at all.

- Nearly a quarter of Hudson County's population aged 60 years and over either did not speak English well (14.2%) or did not speak it (10.1%) in 2000. Passaic and Union counties also had a high proportion of people aged 60 years and over who had limited English skills. In Passaic County, 7.3% did not speak English well and 5.1% did not speak English at all. In Union County, 6.3% did not speak English well and 3.4% did not speak English at all.

Table X. Limited English proficiency by age group and county for population aged 60 years and over, New Jersey, 2000

COUNTY	Population Total (60+ years)			60-64 years			65-74 years			75-84 years			85 years and over		
	Total	Speak English "not well" (%)	Speak English "not at all" (%)	Total	Speak English "not well" (%)	Speak English "not at all" (%)	Total	Speak English "not well" (%)	Speak English "not at all" (%)	Total	Speak English "not well" (%)	Speak English "not at all" (%)	Total	Speak English "not well" (%)	Speak English "not at all" (%)
New Jersey	1,443,655	4.2	2.3	330,620	5.3	2.3	577,440	4.5	2.4	402,195	3.1	2.1	133,400	3.0	2.0
Atlantic	44,600	2.5	1.1	10,515	3.3	1.6	18,320	2.8	1.1	11,965	1.5	0.9	3,795	1.3	0.8
Bergen	172,980	5.2	2.0	38,515	6.4	2.1	68,745	5.5	2.0	49,110	4.4	2.1	16,615	3.6	2.0
Burlington	70,160	1.2	0.4	16,915	1.9	0.3	29,165	1.0	0.2	18,675	1.0	0.6	5,400	1.3	0.7
Camden	82,850	2.2	1.2	19,195	3.1	1.1	33,165	2.0	1.5	23,160	1.6	0.8	7,325	2.3	1.1
Cape May	26,605	0.8	0.1	5,835	0.5	0.0	10,680	1.1	0.3	7,510	0.5	0.1	2,580	0.6	0.0
Cumberland	24,430	2.9	2.0	5,530	4.5	1.7	9,705	2.3	2.2	6,855	2.6	2.2	2,340	2.8	1.1
Essex	125,575	5.3	2.9	30,745	6.0	3.2	49,950	6.3	3.2	32,860	3.7	2.6	12,015	3.2	2.6
Gloucester	39,420	0.9	0.1	9,850	0.8	0.0	15,990	1.1	0.2	10,575	1.0	0.2	3,000	0.3	0.3
Hudson	93,125	14.2	10.1	23,155	18.2	9.2	37,300	16.0	10.8	24,575	10.1	9.6	8,095	6.7	10.4
Hunterdon	16,720	1.4	0.2	4,525	1.3	0.1	6,840	0.6	0.1	4,005	2.2	0.5	1,350	3.7	0.7
Mercer	56,860	2.4	1.1	12,960	1.9	1.0	22,085	2.5	1.2	16,270	2.5	1.0	5,550	2.9	1.4
Middlesex	119,560	4.7	2.6	27,155	5.5	2.7	48,870	5.2	2.5	34,500	3.5	2.8	9,035	3.9	2.5
Monmouth	100,570	2.4	0.8	23,320	2.0	0.6	40,845	2.7	0.9	27,160	2.4	0.8	9,245	2.5	0.8
Morris	74,285	2.7	1.4	19,825	3.2	1.4	29,135	2.6	1.5	18,705	2.4	1.6	6,620	2.3	0.9
Ocean	135,950	1.1	0.3	22,710	1.5	0.2	54,420	1.0	0.2	43,465	1.1	0.3	15,355	1.3	0.3
Passaic	77,175	7.3	5.1	18,070	9.8	5.1	30,370	8.1	6.3	21,265	5.1	3.9	7,470	5.0	3.5
Salem	11,925	0.6	0.1	2,645	0.6	0.2	4,675	0.7	0.0	3,560	0.4	0.0	1,045	1.0	0.4
Somerset	43,975	2.9	1.5	10,590	3.3	0.9	17,835	2.9	1.6	11,430	2.1	2.1	4,115	3.8	0.4
Sussex	18,315	0.9	0.3	5,290	0.6	0.2	7,070	0.9	0.2	4,190	1.3	0.2	1,770	0.6	1.4
Union	91,660	6.3	3.4	19,535	9.6	3.4	35,595	7.1	3.7	27,515	3.8	3.1	9,015	4.3	2.9
Warren	16,915	1.2	0.1	3,735	1.2	0.0	6,675	1.0	0.1	4,840	1.3	0.2	1,665	1.2	0.2

Universe: Population 60 years and over
Source: Census 2000 Special Tabulation on Aging

Table 1. Estimated population aged 60+ years by age group, gender, and race/ethnicity, New Jersey, 2007

Age group	Total	All Races		Non-Hispanic White		Non-Hispanic Black		American Indian and Alaska Native		Asian and Pacific Islander		Hispanic	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
New Jersey	1,565,195	668,122	897,073	516,622	689,199	59,940	92,677	1,123	1,448	34,848	40,708	55,589	73,041
60-64	430,559	203,148	227,411	151,974	165,058	19,155	25,939	357	400	12,599	13,652	19,063	22,362
65-69	315,598	144,768	170,830	106,438	122,913	14,746	21,086	247	274	9,533	9,770	13,804	16,787
70-74	252,956	111,281	141,675	84,696	105,183	10,869	16,483	189	277	5,877	6,947	9,650	12,785
75-79	222,304	91,359	130,945	73,950	104,262	7,409	12,311	143	197	3,456	4,888	6,401	9,287
80-84	174,592	64,987	109,605	54,745	91,740	4,436	8,732	102	134	1,900	3,015	3,804	5,984
85+	169,186	52,579	116,607	44,819	100,043	3,325	8,126	85	166	1,483	2,436	2,867	5,836
Total by Race/Ethnicity:		1,565,195		1,205,821		152,617		2,571		75,556		128,630	
Percent of Total:		100.0		77.0		9.8		0.2		4.8		8.2	

Source: National Center for Health Statistics and U.S. Census Bureau

Table 2. Estimated population aged 60 years and over by age group and county, New Jersey, 2007 (frequency and percent)

Geographic Name	Population Total	60-64		65-69		70-74		75-79		80-84		85+	
		Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
New Jersey	1,565,195	430,559	27.5	315,598	20.2	252,956	16.2	222,304	14.2	174,592	11.2	169,186	10.8
Atlantic	50,081	12,549	25.1	10,096	20.2	8,890	17.8	7,604	15.2	5,783	11.5	5,159	10.3
Bergen	182,706	50,497	27.6	36,776	20.1	29,017	15.9	25,799	14.1	20,391	11.2	20,226	11.1
Burlington	80,299	22,117	27.5	16,451	20.5	13,491	16.8	11,968	14.9	8,857	11.0	7,415	9.2
Camden	87,510	24,543	28.0	17,434	19.9	14,046	16.1	12,454	14.2	9,945	11.4	9,088	10.4
Cape May	25,548	5,676	22.2	4,874	19.1	4,398	17.2	4,238	16.6	3,194	12.5	3,168	12.4
Cumberland	26,560	7,147	26.9	5,386	20.3	4,387	16.5	3,769	14.2	3,103	11.7	2,768	10.4
Essex	126,434	35,939	28.4	26,690	21.1	20,310	16.1	16,610	13.1	13,000	10.3	13,885	11.0
Gloucester	46,348	13,427	29.0	9,750	21.0	7,627	16.5	6,636	14.3	4,939	10.7	3,969	8.6
Hudson	89,658	24,597	27.4	19,225	21.4	14,822	16.5	12,123	13.5	9,117	10.2	9,774	10.9
Hunterdon	22,383	7,924	35.4	4,865	21.7	3,302	14.8	2,667	11.9	1,926	8.6	1,699	7.6
Mercer	61,042	17,270	28.3	12,220	20.0	9,741	16.0	8,406	13.8	6,892	11.3	6,513	10.7
Middlesex	130,560	35,788	27.4	26,343	20.2	21,024	16.1	19,006	14.6	14,994	11.5	13,405	10.3
Monmouth	118,088	35,479	30.0	24,115	20.4	18,975	16.1	15,905	13.5	12,148	10.3	11,466	9.7
Morris	90,231	28,653	31.8	19,690	21.8	14,385	15.9	11,607	12.9	8,451	9.4	7,445	8.3
Ocean	143,967	26,773	18.6	22,557	15.7	24,123	16.8	25,471	17.7	21,925	15.2	23,118	16.1
Passaic	82,343	23,046	28.0	17,293	21.0	13,222	16.1	11,184	13.6	8,809	10.7	8,789	10.7
Salem	12,660	3,524	27.8	2,542	20.1	1,939	15.3	1,771	14.0	1,466	11.6	1,418	11.2
Somerset	53,673	16,034	29.9	11,522	21.5	8,708	16.2	7,301	13.6	5,172	9.6	4,936	9.2
Sussex	23,928	8,534	35.7	5,298	22.1	3,517	14.7	2,797	11.7	1,919	8.0	1,863	7.8
Union	91,415	25,550	27.9	18,638	20.4	13,876	15.2	12,164	13.3	10,353	11.3	10,834	11.9
Warren	19,761	5,492	27.8	3,833	19.4	3,156	16.0	2,824	14.3	2,208	11.2	2,248	11.4

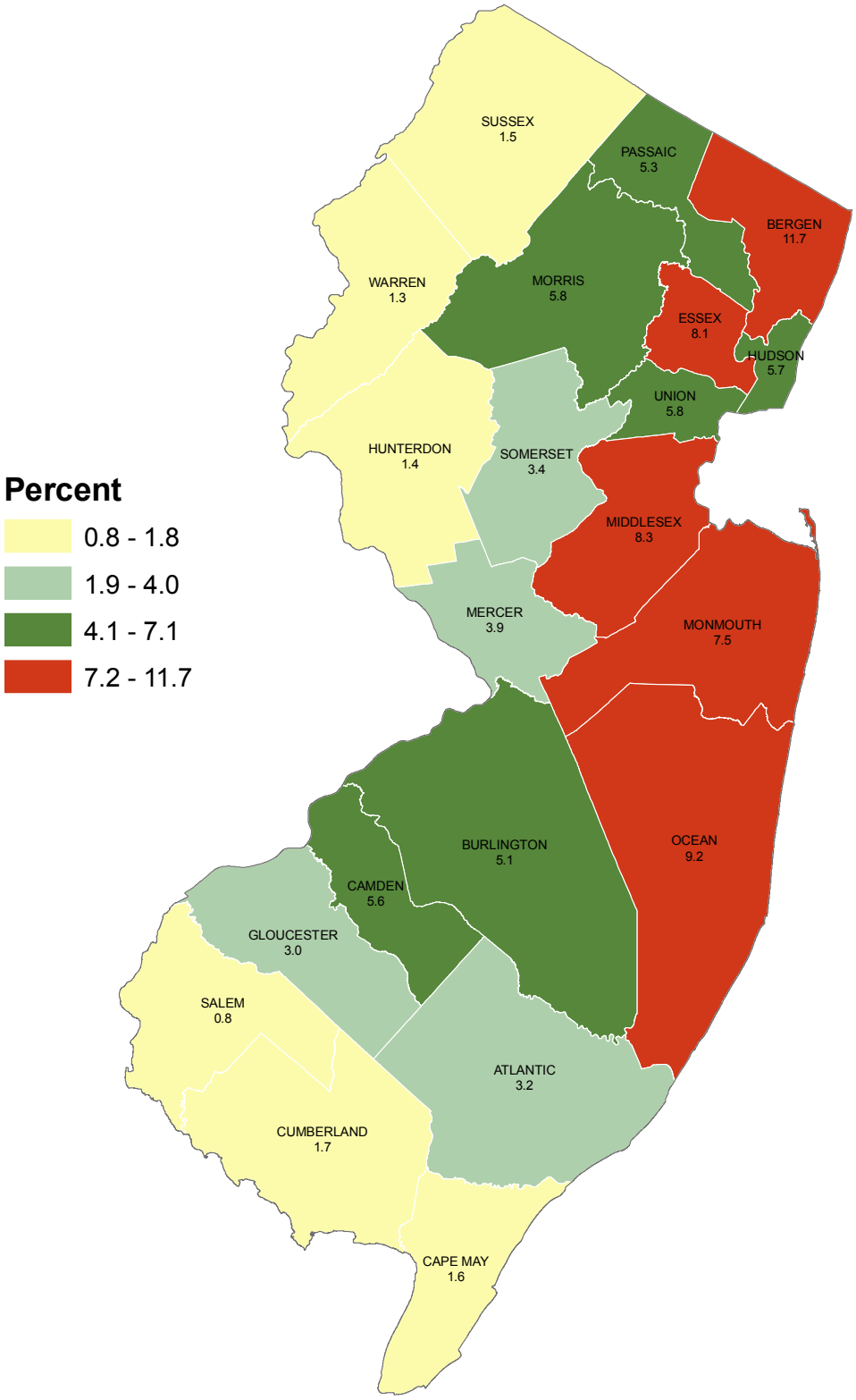
Source: National Center for Health Statistics and U.S. Census Bureau

Table 3. Estimated population aged 60 years and over by race/ethnicity and county, New Jersey, 2007 (frequency and percent)

Geographic Name	Population Total	Non- Hispanic White		Non-Hispanic Black		American Indian and Alaska Native		Asian and Pacific Islander		Hispanic	
		Total	%	Total	%	Total	%	Total	%	Total	%
New Jersey	1,565,195	1,205,821	77.0	152,617	9.8	2,571	0.2	75,556	4.8	128,630	8.2
Atlantic	50,081	38,305	76.5	6,534	13.0	104	0.2	2,303	4.6	2,835	5.7
Bergen	182,706	146,786	80.3	7,852	4.3	201	0.1	14,606	8	13,261	7.3
Burlington	80,299	66,099	82.3	9,883	12.3	171	0.2	2,327	2.9	1,819	2.3
Camden	87,510	67,926	77.6	11,724	13.4	201	0.2	3,331	3.8	4,328	4.9
Cape May	25,548	24,260	95.0	821	3.2	29	0.1	156	0.6	282	1.1
Cumberland	26,560	20,071	75.6	3,120	11.7	215	0.8	310	1.2	2,844	10.7
Essex	126,434	64,816	51.3	43,407	34.3	290	0.2	4,659	3.7	13,262	10.5
Gloucester	46,348	40,741	87.9	4,027	8.7	95	0.2	776	1.7	709	1.5
Hudson	89,658	40,579	45.3	7,987	8.9	205	0.2	8,186	9.1	32,701	36.5
Hunterdon	22,383	21,349	95.4	200	0.9	17	0.1	498	2.2	319	1.4
Mercer	61,042	45,984	75.3	9,139	15.0	93	0.2	3,070	5	2,756	4.5
Middlesex	130,560	98,641	75.6	7,918	6.1	176	0.1	13,657	10.5	10,168	7.8
Monmouth	118,088	102,158	86.5	7,709	6.5	142	0.1	4,177	3.5	3,902	3.3
Morris	90,231	79,086	87.6	2,007	2.2	84	0.1	5,120	5.7	3,934	4.4
Ocean	143,967	136,385	94.7	2,377	1.7	112	0.1	1,485	1	3,608	2.5
Passaic	82,343	55,787	67.7	7,711	9.4	162	0.2	3,164	3.8	15,519	18.8
Salem	12,660	10,788	85.2	1,554	12.3	52	0.4	81	0.6	185	1.5
Somerset	53,673	44,222	82.4	3,048	5.7	51	0.1	4,063	7.6	2,289	4.3
Sussex	23,928	22,721	95.0	209	0.9	23	0.1	278	1.2	697	2.9
Union	91,415	60,353	66.0	15,112	16.5	136	0.1	3,046	3.3	12,768	14.0
Warren	19,761	18,764	95.0	278	1.4	12	0.1	263	1.3	444	2.2

Source: National Center for Health Statistics and U.S. Census Bureau

Map 2. Distribution of New Jersey's population aged 60 years and over, by county of residence, New Jersey, 2007



Source: National Center for Health Statistics and U.S. Census Bureau

Marital Status

Table 4a. Population aged 60+ years by age group, gender, and marital status, New Jersey, 2006-2008

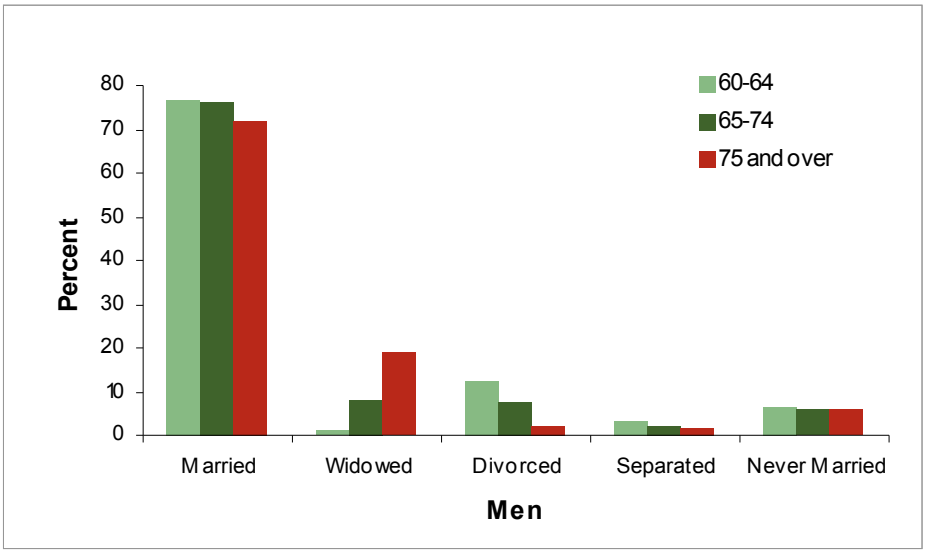
			Marital Status				
	Gender	Population Total	Married	Widowed	Divorced	Separated	Never Married
New Jersey	Male	634,488	475,793	60,984	44,618	14,770	38,322
	Female	853,739	394,213	320,896	72,318	21,019	45,293
60-64	Male	172,781	132,853	1,611	21,468	5,800	11,048
	Female	219,905	132,909	23,021	33,053	6,609	24,313
65-74	Male	257,859	196,161	21,225	18,976	5,839	15,657
	Female	302,463	165,097	98,074	22,850	9,439	7,002
75 and over	Male	203,849	146,779	38,148	4,174	3,131	11,617
	Female	331,371	96,207	199,800	16,415	4,971	13,977

Note: Married includes married, spouse present; married, spouse absent.
Universe: Population 60 years and over
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2008

Table 4a. Population aged 60+ years by age group, gender, and marital status, New Jersey, 2006-2008 (Percent)

			Marital Status				
	Gender	Percent Total	Married	Widowed	Divorced	Separated	Never Married
New Jersey	Male	100	75.0	9.6	7.0	2.3	6.0
	Female	100	46.2	37.6	8.5	2.5	5.3
60-64	Male	100	76.9	0.9	12.4	3.4	6.4
	Female	100	60.4	10.5	15.0	3.0	11.1
65-74	Male	100	76.1	8.2	7.4	2.3	6.1
	Female	100	54.6	32.4	7.6	3.1	2.3
75 and over	Male	100	72.0	18.7	2.0	1.5	5.7
	Female	100	29.0	60.3	5.0	1.5	4.2

Figure 2. Marital status of people aged 60 years and over, by age group and gender, New Jersey, 2006-2008



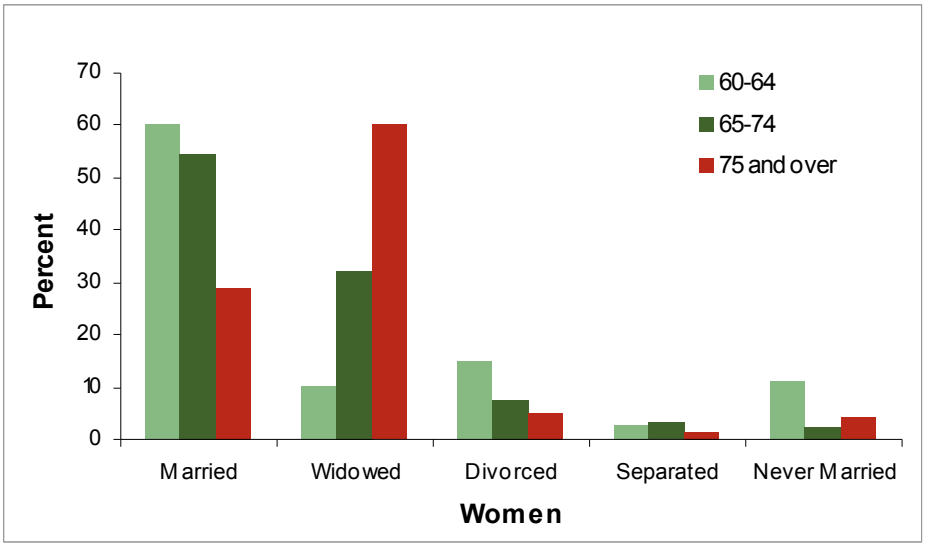
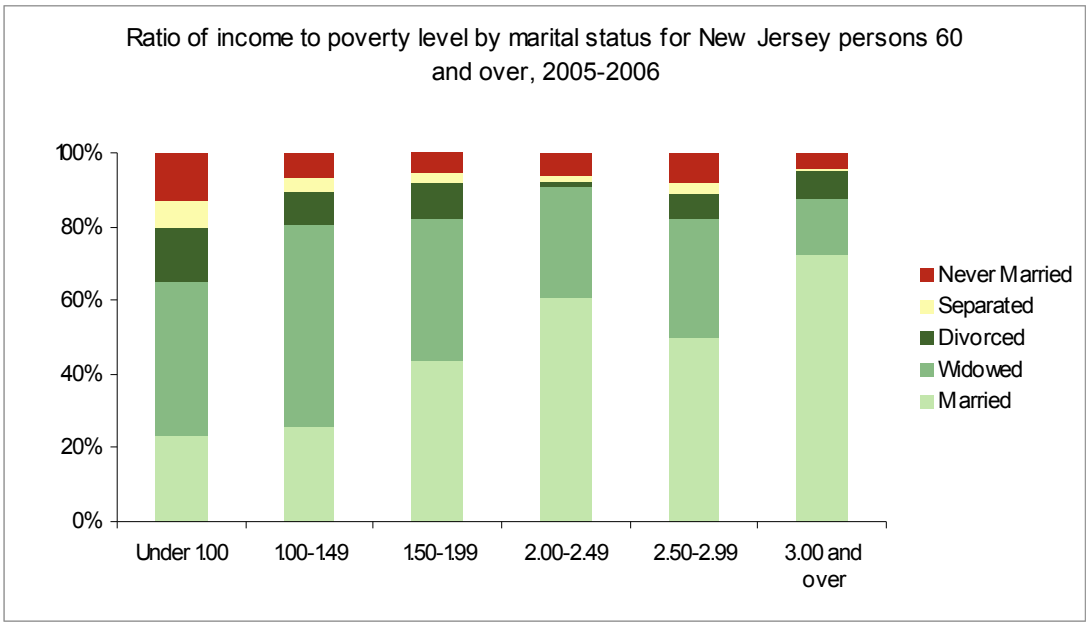


Table 6. Ratio of income to poverty level in 2005 to 2006 by marital status for population aged 60+ years, New Jersey

Ratio of income to poverty level	Population/ Percent Total	Marital Status				
		Married	Widowed	Divorced	Separated	Never Married
Totals	1,467,841	867,631	374,726	114,989	26,660	83,834
Percent	100	59.1	25.5	7.8	1.8	5.7
Under 1.00	112,759	26,420	46,813	16,969	8,265	14,292
Percent	100	23.4	41.5	15.0	7.3	12.7
1.00-1.49	128,402	33,029	69,680	12,359	4,932	8,401
Percent	100	25.7	54.3	9.6	3.8	6.5
1.50-1.99	126,970	55,466	48,716	12,524	3,187	7,077
Percent	100	43.7	38.4	9.9	2.5	5.6
2.00-2.49	163,961	100,124	49,141	2,145	2,403	10,148
Percent	100	61.1	30.0	1.3	1.5	6.2
2.50-2.99	106,541	53,061	34,498	7,076	3,225	8,682
Percent	100	49.8	32.4	6.6	3.0	8.1
3.00 and over	829,209	599,531	125,879	63,917	4,648	35,234
Percent	100	72.3	15.2	7.7	0.6	4.2

Note: Married includes married, spouse present; married, spouse absent.
Universe: Population 60 years and over for whom poverty status is determined
Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006 through 2007



Marital Status

- The majority of New Jersey adults aged 60 years and over were either married or widowed between 2006 and 2008. Older men were more likely to be married than older women.
- The gender difference became larger as age increased. Among those aged between 60 and 64 years, 77% of men compared with 60% of women were married. Among those aged 75 years and over, however, 72% of men were married, compared with only 29% of women.
- The percent of women widowed (38%) was nearly four times of the percent of men widowed (10%) for New Jerseyans aged 60 years and over between 2006 and 2008.
- As shown in Table 6, lower income older New Jerseyans were more likely to be widowed and much less likely to be married than people of other income levels.

Appendix D
Global Budget Projection Methodology

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

1. If a client was in a waiver, then the eligibility is listed as waiver (DACS or DDS)
2. If a client was not in a waiver but had a nursing home (NF) claim, then the eligibility is listed as nursing home (NF)
3. If a client was not in waiver or nursing home (NF) but had an Adult Day Health Services (MD) claim, then the eligibility is listed as Adult Day Health Services (MD)
4. If a client was not in waiver, nursing home (NF) or had an Adult Day Health Services (MD) claim, then the eligibility is listed as PCA

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

The Driver workbook is where the user makes selections and launches the model. This workbook has the most user interaction. The user has several options (i.e. trends, Incurred but Not Reported[7] , specific adjustments and the projection period) from which to choose before running a projection. The user can also choose other adjustments to be applied to the projection. If there are any program changes that occurred after the base data period (i.e., fee schedule change or removal/addition of covered services), the user can enter a factor which will be applied to the projection. The user can also adjust the age band mix by county to account for demographic shifts or can use the historical distribution. Additionally, the user can update the Federal Medical Assistance Percentage (FMAP) percentage, should it change, which will provide an accurate split between State and federal dollars.

The Calculation and Projection workbooks automatically open during the projection process but then close when the projection has completed running. Both these workbooks can be opened after the projection process. The Calculation workbook develops the trend and completion factors based on historical data in the model and using the choices made in the Driver workbook. The Projection workbook then applies the factors from the Calculation workbook to the historical data to calculate the projected values. The projected values are then used in both the Budget Outputs and Rebalancing workbooks.

The Budget Outputs workbook automatically opens when the projection has completed running. This workbook includes summarized graphical and tabular representations of the projected data from the model. Most budget output reports will also include historical data, including the most recent 24 months of data. There are charts and

[7] . “On an incurred basis” refers to the point in time when the service takes place. The user chooses from different methods that are more or less sensitive to outlier months.

tables that show total dollars, per member per month cost, utilization and enrollment by month, category of service and category of aid.

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

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

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

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

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

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

Appendix E

Home and Community Based Waiver Services (HCBS) Programs

WAIVER	ACCAP	CRPD	TBI	GO	
TITLE	AIDS Community Care Alternatives Program	Community Resources for People with Disabilities	Persons with Acquired Traumatic Brain Injuries	Global Options for Long Term Care	Medicaid State Plan Services
ADMINISTRATIVE OFFICE OF SINGLE STATE AGENCY	Department of Human Services (DHS) Division of Disability Services (DDS) Home and Community Services (HCS) 609-292-4800	DHS DDS ⇦	DHS DDS ⇦	Department of Health & Senior Services (DHSS) Division of Aging & Community Services (DACS) 609-292-4027	Department of Human Services (DHS)
TARGET POPULATION	• Adults and children over the age of 13 with a diagnosis of AIDS and in, or at risk of, NF placement. • Children under the age of 13 with a diagnosis of AIDS or HIV positive and in, or at risk of, NF placement.	• Blind or disabled children and adults who are only eligible if in, or at risk of, NF • Blind or disabled eligible in, or at risk of, NF and in need of private duty nursing to remain at home	Individuals with acquired, non-degenerative, structural brain damage who are at least 21 but no more than 64 years of age at enrollment who are in, or at risk of, NF. The TBI must have occurred after the 21st birthday.	• Age 65 or older • Age 21-64 physically disabled • NF Level of Care or at risk for NF placement	• Medicaid eligible participants
MEDICAID STATE PLAN SERVICES	All, except: • Nursing Facility • Personal Care Assistant (PCA)* in excess of 40 hrs. per week.	All, except: Nursing Facility	All, except: Nursing Facility	All, except: • Nursing Facility	**MEDICAID STATE PLAN SERVICES** **Eight (8) Mandatory services provided for all New Jersey Medicaid clients:**
WAIVER SERVICES	• Case Management • Private Duty Nursing (PDN) • Personal Care Assistant (PCA) **(In excess of 40 hours per week).** *PCA services of 40 hours or less per week is a Medicaid State Plan Service available to ACCAP waiver participants.	• Case Management • Private Duty Nursing (PDN) • Environmental/ Vehicular Modifications • Personal Emergency Response System (PERS) • Community Transitional Services (CTS)	• Case Management • Counseling (behavior & drug) • Community Residential Services (CRS) • Therapies through a CRS or Day Program - OT, PT, Speech or Cognitive Rehabilitative Therapy • Behavioral Programs • Environmental/ Vehicular Modifications (non-CRS residential enrollees) • Structured Day program • Supported Day program • Respite Care (non-CRS residential enrollees and is provided in-home or at a CRS) • Adult Companion Service (non-CRS residential enrollees)	▪ Care Management ▪ Respite ▪ Environmental Accessibility Adaptations ▪ Special Medical Equipment & Supplies ▪ Chore ▪ PERS ▪ Attendant Care ▪ Home Delivered Meals ▪ Caregiver/ Participant Training ▪ Social Adult Day Care ▪ Home-Based Supportive Care ▪ Transportation ▪ Transitional Care Management ▪ Community Transition Services ▪ AL, ALP, and AFC	• Inpatient/outpatient hospital treatment • Laboratory tests and X-rays • Early and Periodic Screening, Diagnostic and Treatment services • Home health care • Physician services • Nurse-midwife services • Assistance with family planning and necessary supplies • Nursing facilities for people over 21 **Twenty-one Optional Services provided to New Jersey Medicaid clients enrolled in specific programs including, but not limited to:** **Personal care assistant whereby** services are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services or as a Self-Directed Personal Assistance Services, and (C) furnished in a home. **Adult Day Health Services** (MDC) – offers medical, nursing, social, personal care and rehabilitative services, as well as a nutritious midday meal, activities and transportation to and from the center.
FUNDED SLOTS	750	300	350	11,669 (as of 01-01-09)	

Appendix F

Abbreviations and Acronyms

Activities of Daily Living	ADLs
Administration on Aging	AoA
Adult Day Health Services	ADHS
Adult Family Care	AFC
Aid to Families with Dependent Children	AFDC
AIDS Community Care Alternatives Program	ACCAP
Aging and Disability Resource Connection	ADRC
Alternate/Comprehensive Personal Care Homes	CPCH
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
Community Resources for People with Disabilities	CRPD
DACS Category of Aid	DCOA
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 Financial Participation	FFP
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
Instrumental Activities of Daily Living	IADLs
Inter-Disciplinary Team	IDT
Jersey Assistance for Community Caregiving	JACC
Long-Term Care	LTC
Living Independently for Elders	LIFE
Low Income Subsidy	LIS
Medical Day Care	MD
Medicaid Eligibility Fast Track Determination	Fast Track
Medicaid Long-Term Care Funding Advisory Council	Council
Medicaid Management Information System	MMIS
Medically Needy Income Level	MNIL
Mercer Government Human Services Consulting	Mercer
Money Follows the Person	MFP
New Freedom Initiatives	NFI
Nursing Facility	NF
Nursing Facility Level of Care	NF-LOC
Office of Community Choice Options	OCCO
Office of Information Technology	OIT
Office of Management and Budget	OMB
Personal Care Attendant	PCA
Programs 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
Traumatic Brain Injury	TBI
Waiver	WV