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Final Report

Evaluation of Long-Term Care Options For South Dakota

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1. Executive Summary

1.1. Overview of the Study

South Dakota is committed to finding solutions to meet the needs of its elderly citizens as evidenced by overwhelming support for House Bill 1156, which passed in 2006. Through this legislation, South Dakota requested a comprehensive review of the State's long-term care system. This review comes at a time when the State faces both challenges and opportunities in designing a system of long-term care that promotes the health of its citizens, preserves independence, guards dignity and is fiscally responsible. The South Dakota Department of Social Services has been actively working with key stakeholders across the state to address and identify challenges. Among the issues facing the State are:

- An aging population;
- Geographic mismatch between the places where services exist today and the places where the elderly population is expected to grow over the next 20 years;
- Historically low utilization of home and community based services that can help seniors fulfill their desire to remain independent and in their homes;
- Aging skilled nursing facilities;
- Shortages of front-line health care workers;
- Sharply rising costs of care coupled with tightening of Federal dollars for program support and provider reimbursement; and
- Inadequate individual planning and financing of long-term care costs. Limited use of long-term care insurance.

Abt Associates was contracted by the State to assess and evaluate South Dakota's long-term care (LTC) system through the following 4 tasks:

1. **Evaluate South Dakota's long-term care system in terms of utilization, cost, quality of services and outcomes for the elderly residents of the state across the continuum of care.** Data was collected on nursing facilities, assisted living care, skilled home health services, adult day services, nutrition services, senior centers and personal care services. In-depth interviews were conducted with providers, senior organizations and tribal representatives across the state. The meetings and interviews moved beyond the numbers to identify individuals' concerns and emerging initiatives at the community-level.

2. **Project future long-term care needs, future capacity.** Abt Associates forecasted future LTC needs in the State. Projections forecasted the types of services that would be required to meet the needs of the population, using assessment tools, analytic models and expert opinion to evaluate options for skilled nursing services, assisted living, community based services, home care and family support. Analyses paid close attention to matching services with needs across urban, rural and frontier areas. The study also prepared estimates of the size of the health care workforce that would be required to deliver care across the continuum of settings.

3. **Identify policy options based on practices in other states.** Abt Associates conducted a state environmental scan to identify promising models for (1) right-sizing nursing home capacity and (2) rebalancing care to increase the use and effectiveness of assisted living and home and community based services (HCBS). Options were presented to the LTC Subcommittee for discussion.

4. **Form policy recommendations.** In collaboration with LTC Subcommittee and the State, findings and policy options were crafted into actionable recommendations.

1.2. Findings

1.2.1. Growth in the Elderly Population will Fuel a Rising Demand for Services

Demand for long-term care services is projected to grow sharply over the next two decades. By 2025, in South Dakota:

- The number of elders (over age 65) will double: increasing by 92,000-105,000 and reaching 24% of the State's population;
- Disabled elders will increase by 42,000-50,000, reaching over 10% of the State's population; and
- The number of disabled elders living in the community will rise by 20,000-40,000, depending upon the availability of home and community based care.

Growth is not evenly balanced across the State:

- Elder-population growth is greatest in the West River, and slowest in the East River regions;
- The regions that encompass the Sioux Falls metropolitan area and the Rapid City/Northwest counties will have fastest rates of growth, as well as the largest increases in the numbers of elders;
- The rapidly growing counties around Sioux Falls will witness a 250% growth in their senior populations; and
- The counties around Rapid City will see a 235% growth in the numbers of seniors, reflecting the migration of seniors from rural and frontier areas to areas affording retirement amenities and health care facilities.

1.2.2. South Dakota Needs to Rebalance and Replace Nursing Facility Capacity

In 2005, South Dakota used six nursing home beds per 100 elders compared to a national average of 4.8. This is the 10th highest rate of use in the U.S. Nursing home beds are unevenly distributed across communities in the State and available capacity is not where the elderly population is growing:

- Slow growing East River counties averaged 7.2 nursing home beds per 100 seniors in 2005;
- Rapidly growing West River counties had 3.8 nursing home beds per 100 seniors in 2005.

Abt Associates forecasted the future demand for nursing home facilities under 3 scenarios:

Scenario 1: Assumed the status quo in terms of nursing home, assisted living and HCBS use. By 2025 over 12,000 nursing home beds would be required, statewide.

Scenario 2: Assumed that nursing home utilization can be reduced to 5% of the elderly population by 2025, following national trends. By 2025, over 10,100 beds are required.

Scenario 3: Assumed that nursing home utilization can be reduced to match the national average utilization rate (4%). By 2025, over 8,300 beds are required.

Under Scenario 3, where the State is successful in rebalancing LTC to match national norms, nursing home bed requirements approximate the Moratorium cap. However, there is an acute need to shift capacity within the State.

- Western counties are expected to encounter shortages in the very near term, perhaps by 2010.
- A substantial number of the rural and frontier counties in the eastern and central parts of the state have excess capacity through 2025, and likely beyond, since elderly populations peak around the year 2025.
- The regions that include the Sioux Falls metropolitan area and the counties around Rapid City witness the greatest need for additional beds, both in percentage and absolute terms. The Sioux Falls region will require the addition of 400 beds; the region around Rapid City will require approximately 250 new beds over the next 20 years.

Nursing homes are old and in need of renovation and replacement to meet modern standards for delivering care.

- 45% of facilities were originally constructed 40 or more years ago, and exceed the depreciable life for nursing homes.
- Many of the oldest facilities are in areas with the sharpest growth in elders, many others are in sparsely populated rural areas in the east. Rather than renovating existing facilities, the State has the opportunity to consolidate and to replace aged structures with newer facilities that can offer more efficient and effective care.
- Older facilities are more likely to report operating losses, lack sprinklers and have lower quality of care scores, as reported by CMS.

1.2.3. South Dakota Needs to Target Assisted Living Capacity Towards Growing Regions

Assisted living has grown substantially in the past decade. South Dakota ranks slightly above national averages in terms of available beds. Growth in assisted living (AL) has eased the flow of elders into nursing facilities. Existing capacity, however, is scattered.

- Eighteen counties in South Dakota currently have no assisted living facilities; others show evidence of excess capacity and unfilled beds.
- At current rates of growth, many areas of the state will require increased growth in AL capacity if the State wishes to reduce reliance on nursing home care.

1.2.4. South Dakota Needs to Expand Home Health Care Services

South Dakota ranks second lowest in the U.S. in terms of utilization of skilled home health episodes, reporting only 5 Medicare and Medicaid home health episodes per 100 elders, compared to a national average of 12 episodes per 100 elders.

- In 2006, 19 counties were served by no, or at most one, home health agency.
- Moving to national norms for home health use would require doubling capacity immediately and increasing capacity 3-4 fold by 2025 to meet population growth.

1.2.5. South Dakota Needs to Expand Home and Community Based Services

Adequate home and community based services are instrumental to reducing nursing home utilization and to improving the quality of independent living for aging seniors. HCBS are limited in South Dakota, due to the difficulty of providing "community based" services in very sparsely populated areas where there are few communities and a limited workforce.

- Rural and Frontier areas face particularly low availability of HCBS;
- 34 counties have no adult day service facilities;
- 28 counties have no, or at most one, senior center per 1,000 elderly residents;
- 18 counties have no, or at most one, nutrition programs per 1,000 elderly residents
- Every county in South Dakota is served by a homemaker agency, but 40 counties have no homemaker agencies located in their borders. Service is fragile and there is a high rate of entry and exit of service providers.

1.2.6. The Labor Force is not Keeping Pace with the Growth of Elders: Shortages are Imminent

In 2000, 37% of South Dakota's population was between the ages of 18 and 44, an age bracket that represents most of the front line health care job seekers. By 2025 this share will fall to under 29%. Young folks continue to move away, leaving a growing elderly population. The decline is particularly large in frontier counties. A workforce shortage is evident today. In site visits and interviews, providers said that staffing shortages were a top operating concern.

- Survey data show that staff turnover rates are high: averaging 20% for RNs and LPNs, and over 40% for CNAs.
    - Turnover rates are highest in the West Region followed by the Southeast Region, where there has been the highest growth in the demand for health care services.
- Survey data documented a gap between budgeted and staffed positions for RNs and CNAs that followed the same geographic pattern as turnover.
    - The shortage of RNs ranged from 4% in the Central counties to 11% in the West.
    - CNA shortages averaged 4%.

Shortages will get much worse in the next 20 years. The pool of potential workers shrinks by 6% statewide, growing only modestly in the Sioux Falls and Rapid City regions. The central and northeast portions of the state will witness a 20% decline in the size of the working-age population. At the same time, the number of disabled elders in need of services doubles statewide and increases faster West River and in the Sioux Falls metropolitan statistical area.

- At today's staffing and job entry rates, there may be a 60-150% increase in the number of disabled seniors requiring care for every available worker.
- The forecasts indicate a significant and widespread shortage of both CNAs and nurses.
- Rebalancing long-term care services and reducing use of nursing home care cuts the estimated staffing shortage in half, but does not eliminate it. Similarly, increasing wage rates would attract nurses from other states and other health care services, narrowing but not eliminating the shortage.

1.3 Policy Options

The study recommends an agenda for action:

1. **First, set goals and adopt policies that reflect rebalancing. Right-size the industry**: Assure access for the population at risk by developing a "Critical Access Model" that encourages the development of smaller efficient forms of care in areas that are currently underserved, or that are served by facilities that can not remain viable in the longer run.
2. **Provide flexibility when building new capacity and develop adequate financing:** Seek exceptions to the Moratorium that permit bed trading from low growth to high growth regions, and develop financial and loan plans that will move financial capital to priority areas.
3. **Expand Home and Community Based Services across the State**: Rebalance the continuum of long-term care to provide citizens with care options that will permit them to remain independent and in their communities for as long as possible.

Eight specific policy recommendations were made:

1. Implement bed trading by an exception to the Moratorium mechanism for high-need areas.
2. Pursue means to provide Medicaid-certified nursing facilities in South Dakota with low-interest financing for capital improvements and to provide financial assistance to foster the growth of HCBS infrastructure which could include a revolving loan fund (RLF), provision of bonds, or other mechanisms.
3. Continue to evaluate and modify the Medicaid reimbursement rate setting structure to a) better fund facility depreciation and capital improvements in all Medicaid-certified nursing facilities, and b) promote the growth and expansion of HCBS, specifically adult day services.
4. Monitor and consider novel, flexible forms of nursing facility organization for nursing facility replacement to improve satisfaction among residents remaining in facilities and establish small more flexible and efficient facilities in sparsely populated areas.
5. Explore options to develop "One-Stop Shops" that provide information, assessment, and referral to appropriate services.
6. Increase programmatic integration of long-term care service management within the Department of Social Services.
7. Monitor future opportunities for federal funding that support rebalancing long-term care.
8. Continue to support expansion of LTC insurance through LTC Partnership Programs and other initiatives to improve seniors' financial planning and insurance coverage, leading the way to more independent living choices and reducing the burden on state financing of LTC.

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2. Introduction

South Dakota is committed to finding solutions to meet the needs of its elderly citizens as evidenced by overwhelming support for House Bill 1156, which passed in 2006. Through this legislation, South Dakota requested a comprehensive review of the State's long-term care system. This review comes at a time when the State faces both challenges and opportunities in designing a system of long-term care that promotes the health of its citizens, preserves independence, guards dignity and is fiscally responsible. The South Dakota Department of Social Services has been actively working with key stakeholders across the state to address and identify challenges. Among the challenges facing the State are:

- An aging population, coupled with geographic mismatch between the places where services exist today and the places where the elderly population is expected to grow over the next 20 years;
- Historically low rates of use of home- and community-based services that can help seniors fulfill their desire to remain independent and in their homes;
- Aging skilled nursing facilities;
- Shortages of front-line health care workers;
- Sharply rising costs of care coupled with tightening of Federal dollars for program support and provider reimbursement; and
- Inadequate individual planning and financing of long-term care costs, and limited use of long-term care insurance.

Concerted action is required today in order to meet these challenges.

2.1.1. The Challenge of an Aging Population

The aging of the "baby boom generation" will have a marked impact on the projected demand for long-term care services over the next half century. Nationally, the number of individuals using nursing facilities, alternative residential care, or home care services is expected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be driven by the growth in the number of elderly in need of long-term care, which is expected to more than double from approximately 8 million in 2000 to 19 million in 2050.[1]

In South Dakota, where the proportion of State residents who are currently elderly or near elderly is higher than national norms, the state's elderly population will rise at twice the speed, doubling by the year 2025. The majority of tomorrow's elders currently reside in rural and frontier areas. The relative isolation of South Dakota's aged population represents an additional challenge for the State's long-term care system.

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[1] ASPE, DHHS (May 14, 2003), "The Future Supply of Long-Term Care Workers in Relation to the Aging Baby Boom Generation," Report to Congress, May 14, 2003.

2.1.2. Elders Increasingly Want to Remain Independent and In Their Homes

With increasing numbers of aging baby boomers there has also been a growing desire among elders to remain in their own homes and independent for as long as possible. Tomorrow's "boomer seniors" along with the post-World War II generation whose members are currently entering the 65 and older age bracket will likely differ sharply from seniors of the past. New cohorts of seniors have benefited tremendously from the economic prosperity of past decades: rising home ownership, steady jobs, established pensions and substantial retirement savings. Their experiences shape expectations that their retirement years will be more comfortable and more independent than those enjoyed by their parents.

Nationally, recent studies clearly point to a growing preference among elders to seek services and accommodations that permit them to remain at home as they age. A 2002 survey conducted by AARP in South Dakota found that over half of members (53%) expressed it was "very important" to remain in their own homes and receive care there for as long as possible, even if they would have to contribute significantly to the cost of home care.[2]

Elder home care services often include meal preparation, personal care services such as grooming and dressing, household services, and transportation. Using home care providers for non-medical care can support families in their care efforts and support seniors in continuing to live independently. Utilizing home health care and personal care providers can also be more cost effective, and may slow the rate at which seniors experience functional and cognitive decline.

2.1.3. Rebalancing Efforts and the Push for Home and Community Based Care

Current initiatives for long-term care reform are centered on "rebalancing": i.e., shifting care from institutional facilities (nursing homes) to home and community based settings (HCBS), with the goal of reducing costs and increasing seniors' independence and quality of care. A large portion of the funding for HCBS comes from Medicaid 1915c waivers, the Deficit Reduction Act, and Medicaid Demonstration programs and initiatives. South Dakota has three 1915c waivers, one of which focuses on elderly care.

Compared to other states, South Dakota spends more of its Medicaid long-term care (LTC) dollars on institutional services relative to home- and community-based care. In 2005, the State ranked 43rd in the nation in terms of the share of Medicaid LTC aged and disabled spending that was directed towards HCBS relative to institutions such as nursing homes. It spent 11% on HCBS, compared to the national median of 23%. South Dakota also has no current Medicaid demonstration projects in HCBS.

New initiatives are forthcoming. The Deficit Reduction Act contains provisions for advancing rebalancing. States have the ability to offer HCBS and self-directed personal care services (cash and counseling) as part of State Plans, without a waiver. Money Follows the Person demonstrations enable states to move to individual budgets, eliminating financing "silos" that deter the transition of patients from institutional settings. A National Clearing House for long-term care information, and the "Own Your Future Program", which was rolled out in South Dakota, promotes consumer

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[2] South Dakota Long-Term Care: An AARP Survey. Mildred DePallo and Anita Stowell-Ritter, AARP 2002.

education and LTC planning. South Dakota's "Own Your Future Program" had the second highest response rate (6.63%) among the Phase III states.

2.1.4. South Dakota Nursing Homes Have an Aging Infrastructure

Over 40% of South Dakota's nursing home facilities were built over 40 years ago, and 83% are over 30 years old. Older facilities require capital improvements. The older facilities are configured in a manner that is less suited to modern modes of care. Older facilities also find it difficult to incorporate the more communal and home-like features that are encouraged under the Centers for Medicare and Medicaid Services (CMS) "culture change initiatives". Many facilities require substantial improvements and replacement to their physical plant. Only 44% of South Dakota's facilities are fully sprinklered, and 31% of the facilities are not sprinklered at all.

Replacing facilities will require an infusion of new capital into the industry. Replacement also provides an opportunity to right-size facilities, rescaling where there is excess capacity and introducing more efficient care designs.

2.1.5. A Shortage of Workers

Growth in the demand for long-term care will be coupled with growing shortages of front-line health care workers, notably registered nurses (RNs), licensed practical and vocational nurses, nurse aides (CNAs), and home health and personal care workers. Nationally, in 2000, approximately two million direct-care workers were providing long-term care to roughly 15 million people, who were in nursing, residential, and personal care facilities, or who required home health care services. The Bureau of Labor Statistics (BLS) estimates that by 2010, direct-care worker jobs in long-term care settings should grow by roughly 45%. After 2010, the demand for direct care workers in long-term care settings becomes even greater as the first wave of baby boomers reach age 85. According to estimates developed by the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, the demand for direct care workers will grow 200-242% by the year 2050.

This increase in demand will be occurring at a time when the supply of workers who have traditionally filled these jobs is expected to increase only slightly. Again, current demographic projections for South Dakota suggest the State will face an even greater imbalance between the supply and demand for direct health workers: coupled with one of the highest proportions of elderly residents in the nation, the State has a low proportion of young workers, especially in its rural areas.

Many industries will be competing for the supply of young workers, nationally and in South Dakota. In addition to raising compensation and improving working conditions, policy makers have suggested that states and localities examine policies designed to find new sources of workers, retain existing workers, and encourage the training of new direct healthcare workers at all levels of employment.

2.1.6. Who Will Pay For Long-Term Care?

The burden of paying for long-term care falls on individuals and their families, states, the federal government and communities. Current estimates suggest family resources cover approximately a third of all LTC costs; Medicaid 35%; and Medicare 15%, with long-term care insurance and other public programs covering each less than 5%. With the number of elders growing, life expectancy increasing

and the average costs of care rising, paying for tomorrow's growing elderly population will require an increased commitment of state and federal money, increased savings by individuals and innovations in the organization and delivery of care to realize efficiencies where possible.

Medicare coverage is limited largely to post-hospitalization care and home health services. Long-term care insurance remains a minor factor due to cost, lack of consumer information, and limited benefits. Research suggests that personal savings and wealth will be unable to keep pace with the rising costs of health care. If tomorrow's retirees are less able to contribute to the costs of their long-term care, a rising share of their expenses will fall to the State.

South Dakota, which currently ranks near the median in term of state spending per Medicaid beneficiary, has seen the ratio of elderly-to-working-age adults rise by 68% over the first half of this decade. Projections point to an acceleration of the "old age dependency ratio" after 2010, which translates into a growing number of elderly citizens relative to working-age adults and an increase of over 100% in the per capita cost of the State's share of Medicaid services over the next decade.[3]

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[3] Medicaid and an Aging Population, Georgetown University Long Term Financing Report, August 2004, and U.S. Bureau of the Census, "State Population Projections," Table 2. Projections of the Population, By Age and Sex: 1995 to 2025, http://www.census.gov/population Projections/state/stpjage.txt (accessed November 2006)

3. Study Methods

3.1. The Role of LTC Subcommittee of Governor's Healthcare Commission

Governor Rounds' Healthcare Commission established a Long Term Care and Medicaid Subcommittee to analyze long-term care services and reimbursement in the State. The Subcommittee was charged with evaluating the current system and infrastructure, including funding and reimbursement for LTC services provided through Medicaid and physical infrastructure of facilities, and to make recommendations to the Commission regarding health care policy.

The Subcommittee recommended two pieces of legislation. Both were passed with overwhelming support. House Bill 1156 was introduced and passed during the 2006 Legislative Session. The legislation requires this study to examine:

- Long-term care financing, including long-term care insurance;
- Costs of providing long-term care;
- Alternative approaches to providing long-term care;
- Barriers to the provision of quality long-term care services;
- Programs and techniques employed in other states for providing long term care; and
- Other issues appropriate to the study of the continuum of care.

Pursuant to this legislation, the Department must submit a final report and any recommendations to Governor Rounds and the Legislature no later than November 15, 2007.

A second Bill enabled the State to participate in the Long-term Care Partnership Program. The Partnership Program officially began on July 1, 2007, following CMS's approval of the required amendments to the South Dakota State Medicaid Plan.

3.2. Methods Used in the Study

Abt Associates was contracted by the State to assess and evaluate South Dakota's LTC system needs through the following six tasks:

Task 1: Evaluate South Dakota's long-term care system in terms of utilization, cost, quality of services, and outcomes for the elderly residents of the State across the continuum of care. Data were collected on nursing facilities, assisted living care, skilled home health services, adult day services, nutrition services, senior centers, and personal care services. Information was consolidated and analyzed from Department of Social Services databases, Department of Health facility reports, data collected by the South Dakota Department of Labor, population projections from the South Dakota Data Center, nursing home and home health data maintained by the Centers for Medicare and Medicaid, AARP research reports, and the U.S. Census, and from national health statistics surveys and databases. Analyses identified the current level of services that were provided and used across the State (by county and region), compared utilization and outcomes to national norms, and investigated how patterns of use and access were affected by geography, sociodemographic characteristics of the population, and facility locations. Exhibit 1 describes the major data sources used in the Study.

Exhibit 1

List of Major Data Sources

Data Source	Data Obtained
South Dakota DSS	Elderly Services Directory, Adult Services and Aging (ASA) Program Indicators, Nursing Facility Workforce and Financial surveys
South Dakota DOH	Medical Facilities Reports: Capacity, Utilization, and Patient Origin Data; Healthcare Workforce Report
South Dakota State Data Center	Census historical data; County Population Projections; Community Abstracts
South Dakota DOH and DSS Other Data	Nursing Facility occupancy, case-mix, construction, sprinkler data; Nutrition Services, Homemaker / In-Home Services, Adult Day Services, Caregiver data; Provider Licensure data
U.S. Census Bureau	Economic data on Healthcare & Social Assistance; Population & Disability data and county projections by age; American Community Survey
Centers for Medicare & Medicaid Services	Nursing Home Compare, Home Health Compare, and Online Survey, Certification and Reporting data
HRSA Area Resource File	Area Resource File: Utilization, Workforce, and Demographic Characteristics; Community Health Status Report:
AARP	Caregiver & Long-Term Care Survey Data
America's Health Insurance Plans	Long-Term Care Insurance Survey
Reports	Reports from the U.S. General Accountability Office, State websites, Kaiser Family Foundation, AARP

Source: Abt Associates Inc.

Task 2: Conduct in-depth interviews with providers and stakeholders across the State. Concurrent with data collection and analysis, in-depth interviews were conducted with stakeholders across the State. The meetings and interviews moved beyond the numbers to identify concerns of providers and advocates for the elderly as well as to highlight emerging initiatives and specific barriers at the community level. Overall, Abt Associates met with over 100 individuals representing over 50 groups, institutions, organizations, and tribal representatives across the State.

Exhibit 2

List of Interviews Conducted

Interviewee	Number of Different Meetings	Number of Organizations Represented	Number of Facilities Visited
Critical Access Hospitals	4	6	3
Nursing Facilities [b]	13	23	10
Assisted Living Facilities [a]	5	7	5
Home Health Agencies	2	3	*NA*
HCBS	2	7	1
Provider / Other Associations	4	4	*NA*

[a] Includes one Residential Care Facility located on an Indian Reservation.

[b] One Nursing Facility interview discussed a Facility located on an Indian Reservation.

Source: Abt Associates Inc.

Task 3: Project future long-term care needs and future capacity. Building on the description of the current LTC system, Abt Associates forecast future LTC needs in the State. Projections pay close attention to matching services and needs across urban, rural and frontier areas. There are two steps to evaluating future LTC needs. First we project the future characteristics of the South Dakota population, in terms of age, functional status, disability, illness, and geographic distribution. Second, we forecast the types of services that are required for the population, using assessment tools, analytic models, and expert opinion to evaluate options for skilled nursing services, assisted living, community based services home care, and family support.

Task 4: Formulate a list of priority policy concerns. Based on findings from Tasks 1 and 2, Abt Associates (1) identified critical areas where the existing or projected supply of services does not meet current or projected demand; (2) identified where the configuration of services does not meet the needs of the population, or offer cost-effective, high-quality care; and (3) evaluated factors that contribute to barriers including inadequate funding, inflexible financing, geographic misdistribution of resources and/or providers, state regulatory policy, and inadequate patient and caregiver information.

Task 5: Identify policy options based on practices in other states. Abt Associates conducted a state environmental scan to identify systems for financing and providing care that address South Dakota's priority concerns. In doing so, we reviewed promising models currently in use in other states, current and planned Federal programs for increasing the use and effectiveness of home- and community-based services (HCBS), and public and private initiatives to improve financing options. We presented a list of potential policy options to the State and LTC Subcommittee for discussion.

Task 6: Form policy recommendations. In collaboration with the LTC Subcommittee and the Governor's Healthcare Commission, the findings from the Study and policy options were crafted into actionable recommendations.

4. Rebalancing and Right-Sizing the System

In order to meet the needs of a growing elderly population the State must rebalance and right-size the long-term care system. Rebalancing implies moving resources to where tomorrow's seniors will reside. Rebalancing also implies updating and modernizing the mix of available services to provide care that is high quality and preserves seniors' wishes to remain independent and active in their communities.

Right-sizing implies that facilities and providers should offer the scale and scope of services that the community needs. Old facilities, excess capacity, and out-dated care modes should be replaced by facilities that offer efficient and effective forms of care. Frontier areas of the state pose special challenges since it is difficult to offer services at a scale that can be supported by the sparse population, yet at the same time the elders in these areas cannot be left without service options or isolated from care. Abt Associates supports the State's efforts to utilize data from the study to identify "Critical Access" regions to ensure that all seniors have access to care within an acceptable distance from their homes, and furthermore, to explore new forms of integrated care whereby single flexible facilities can replace the multiple, under used facilities

The State faces both long-term and short-term issues:

- In the shorter run, the State must right-size aging facilities, streamline excess capacity, and ensure critical access.
- In the longer run, the State must expand and reorganize facilities to accommodate the sharp growth in demand that the State will witness in the Western and metropolitan areas.

4.1. Demographic Trend Challenges

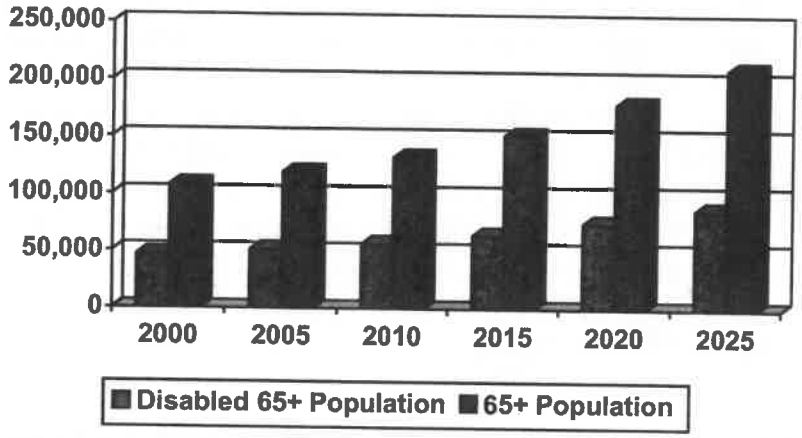
We present the key findings below, focusing on identifying trends in the growing demand for services, and in the changing configuration of providers that lead to future gaps in the availability of care, the quality of care, and the costs of care through 2025.

4.1.1. Population and Disability Rates

Demand for long-term care services is projected to grow sharply in South Dakota over the next two decades, driven by an increase in the number of individuals over age 65, in general, and specifically by an increase in the number of disabled elders, over age 65. By 2025:

- The number of elders (over age 65) will double relative to the year 2000: increasing by 92,000-105,000 and reaching 24% of the State's population.
- Disabled elders will increase by 42,000-50,000, reaching over 10% of the State's population.
- The number of disabled elders living in the community will rise by 20,000-40,000, depending upon the availability of home- and community-based care.

Exhibit 3: Projections of South Dakota's Elderly and Disabled Population: 2000-2025



Growth in the elderly population and the resulting demand for services is not evenly balanced across the State. Abt Associates used Department of Social Services (DSS) Economic Assistance Regions for analysis, since they are large enough to capture significant economic and demographic trends but small enough so that they capture the significant diversity in LTC services and utilization across the State (Exhibit 4).

Exhibits 5 through 11 show projections of the numbers of elders (over age 65) in each of the eight Department of Social Services Economic Assistance regions for the years 2000, 2005, 2010, 2015, 2020 and 2025. Projections are aggregated from county-level estimates produced by the South Dakota Data Center and the U.S. Census, and reflect projected in-migration, out-migration, and death rates for the population.[4] Local LTC services will be stressed both by growth in the numbers of seniors as well as by high rates of growth in demand for care: Exhibit 12 highlights counties where the population of seniors is expected to more than double. Exhibits 13 through 19 describe growth in the numbers of disabled elders from 2000 to 2025, again by region. Exhibits 20 and 21 summarize the numbers in tabular form.

Several points are important:

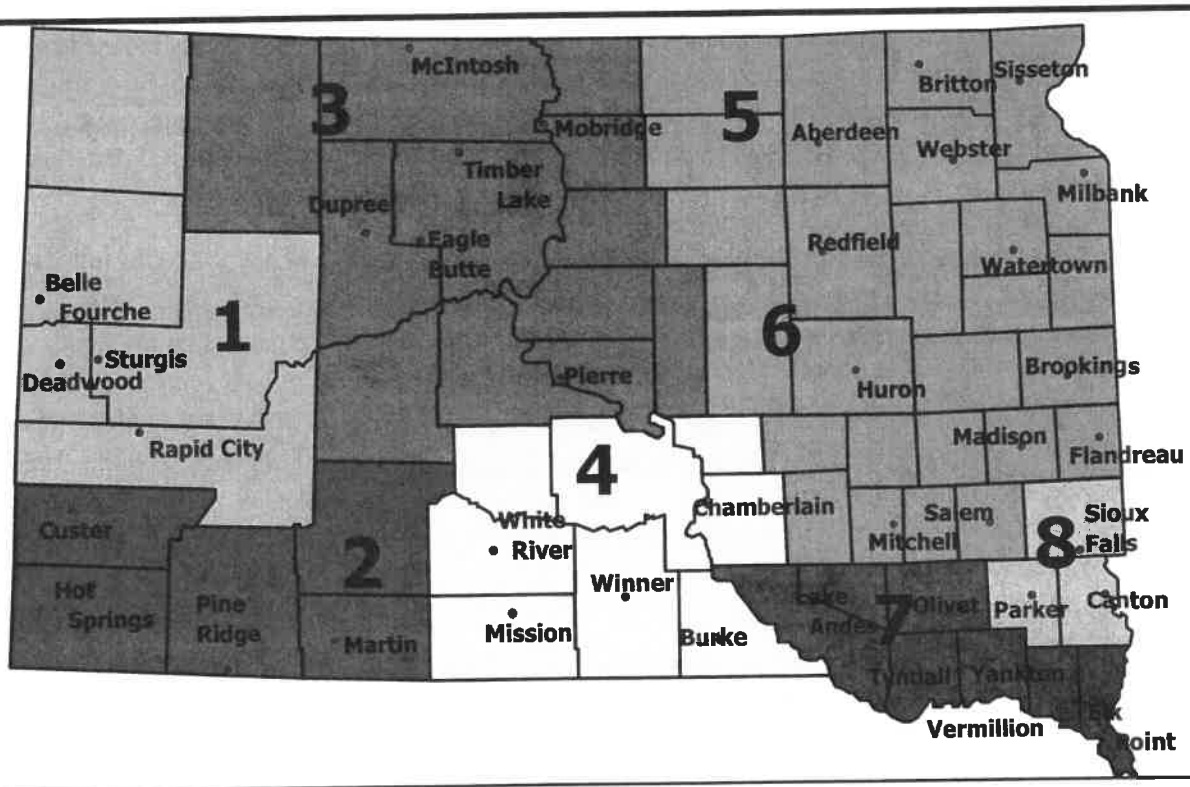
- Elder-population growth and growth in disabled elders is greatest in West River, and slowest East River.
- The regions that encompass the Sioux Falls metropolitan area and the Rapid City/Northwest counties exhibit the fastest rates of growth, as well as the largest growth in the overall numbers of elders. In Sioux Falls (Region 8, increase = 250%) the growth in the senior population accompanies an overall rapid rate of population and economic growth. In Rapid City/Northwest (Region 1, increase = 235%), growth

[4] Abt Associates Second Briefing contains the county-level projections of elder population growth and disabled elders.

in the numbers of seniors is significantly higher than growth in the overall population, reflecting the area's desirability as a retirement area.

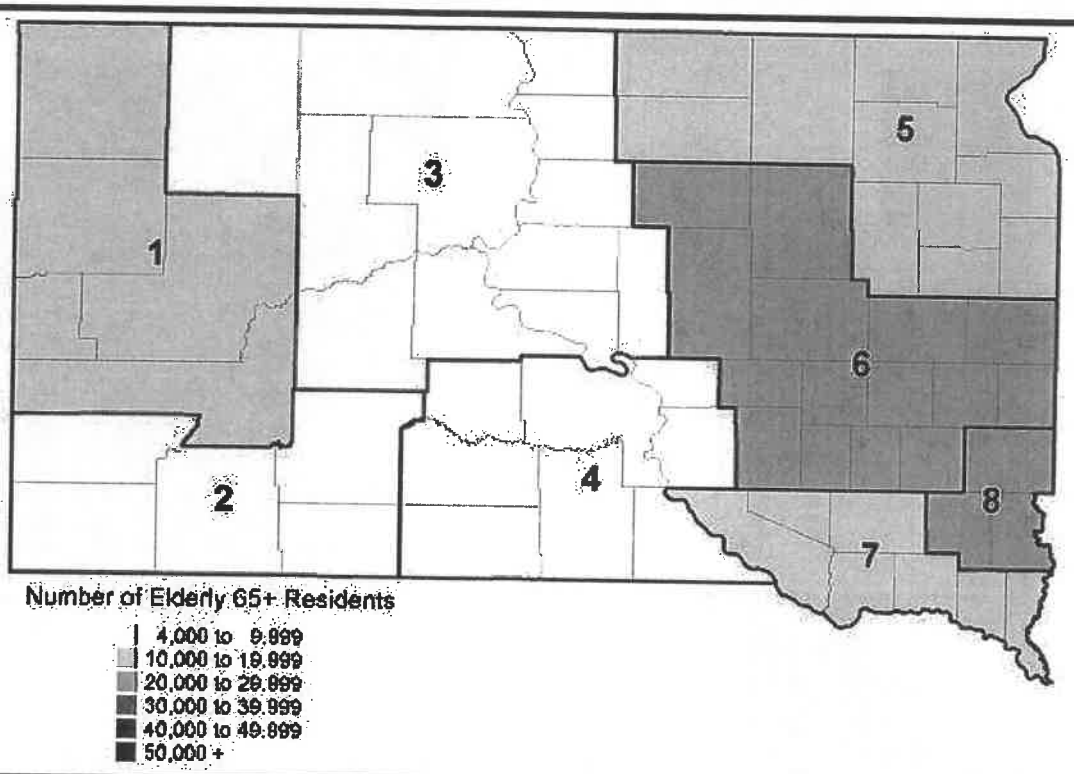
- Growth in both Region 1 and Region 8 is fueled by the migration of seniors from frontier areas towards urban areas and medical centers.
- The population of elders is expected to more than double in the Native American Counties (Shannon and Dewey), where chronic health problems contribute to higher rates of disability.
- In 2000, there were 22 counties where the elderly population exceeded 20% of total residents in the county: 18 of these counties were Frontier and four were Rural, located in the central and Northeast parts of the state.
- By 2025, in all but nine South Dakota counties elders will make up over 20% of the population. In 11 counties, elders will be over 40% of the local population. Even in the growing population centers, around Sioux Falls and Rapid City, elders will make up 20-30% of residents.

Exhibit 4: South Dakota Economic Assistance Regions



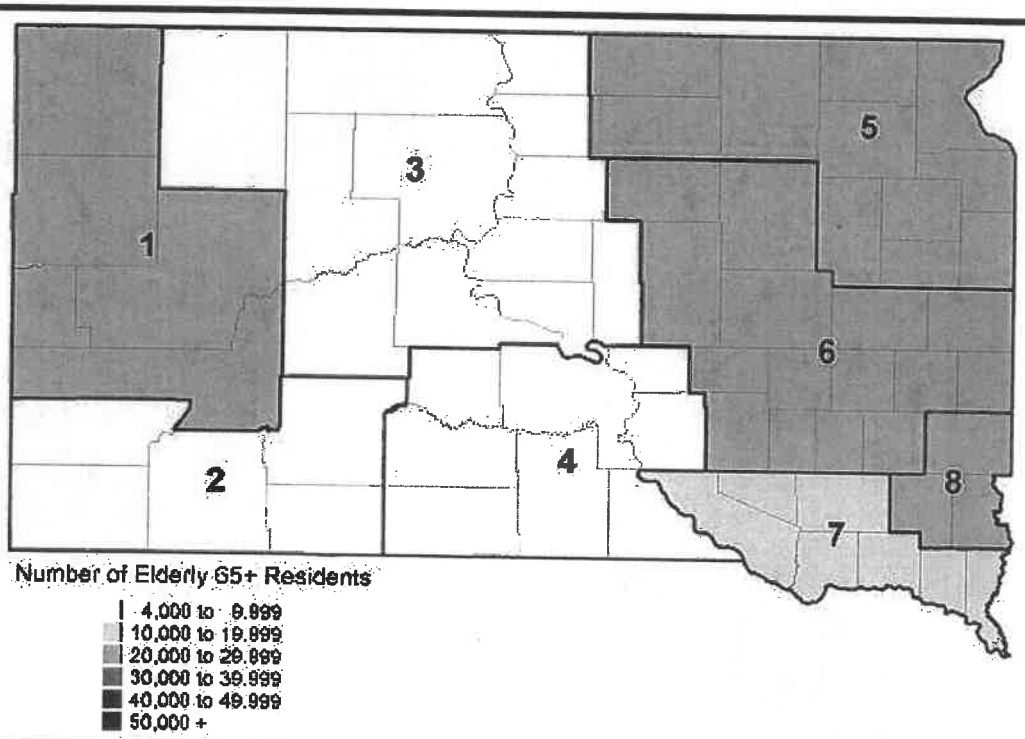
Source: South Dakota Department of Social Services

Exhibit 5: Number of Elderly 65+ Residents, 2000



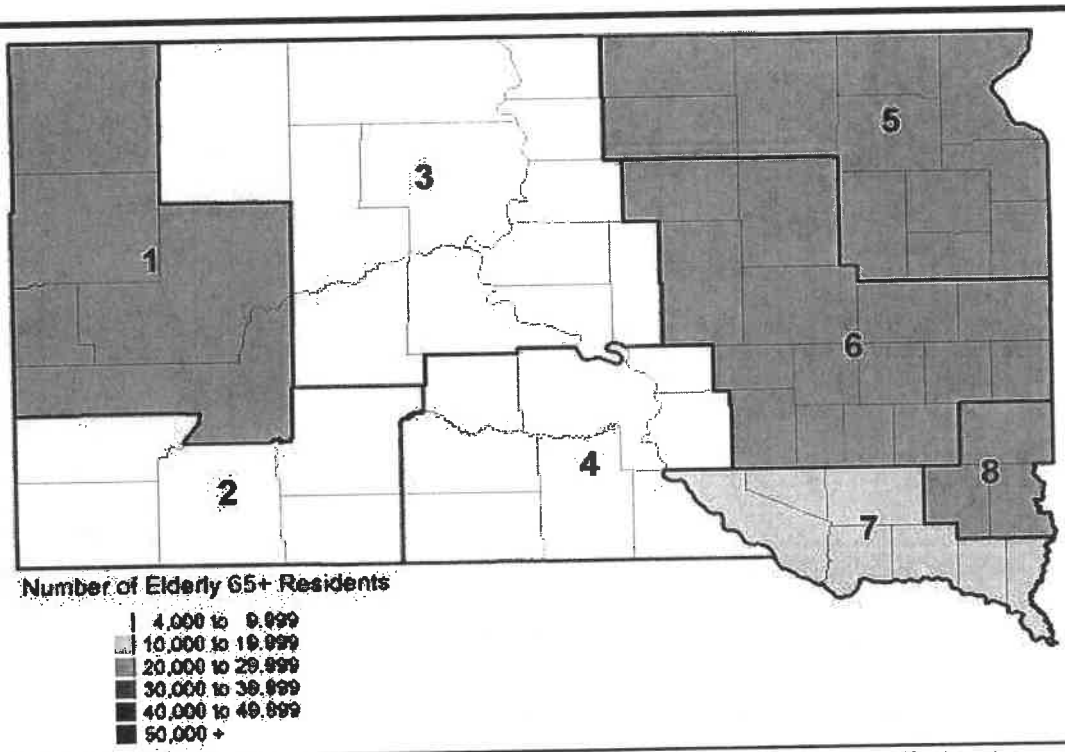
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 6: Number of Elderly 65+ Residents, 2005



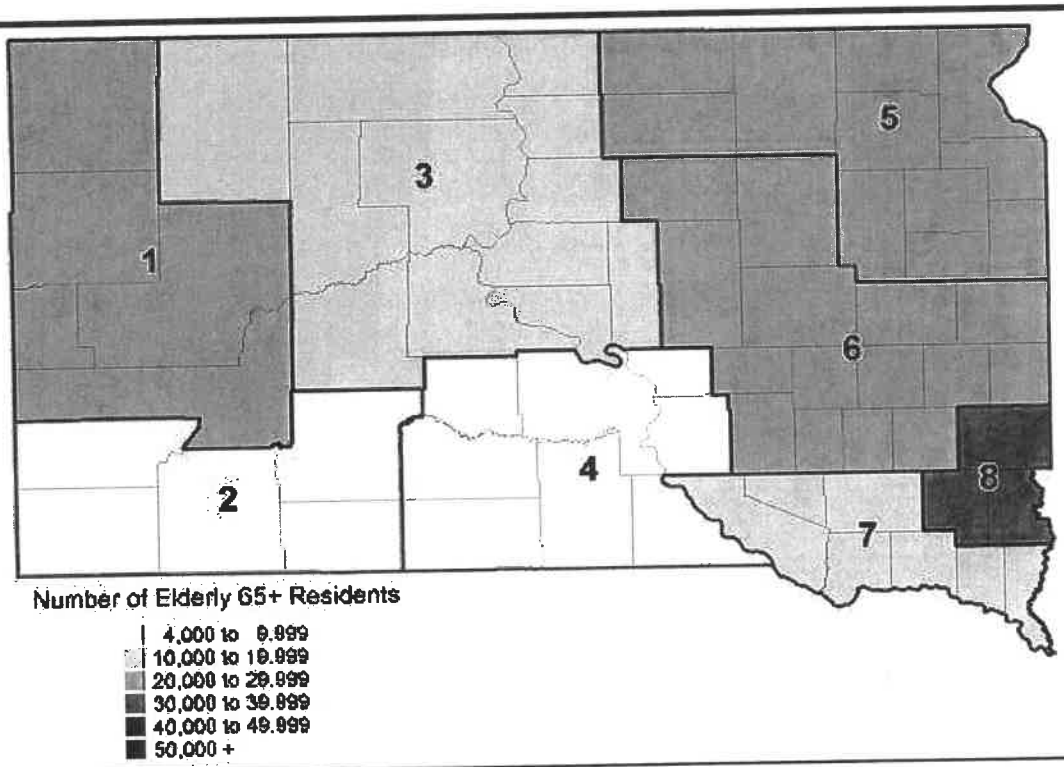
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 7: Number of Elderly 65+ Residents, 2010



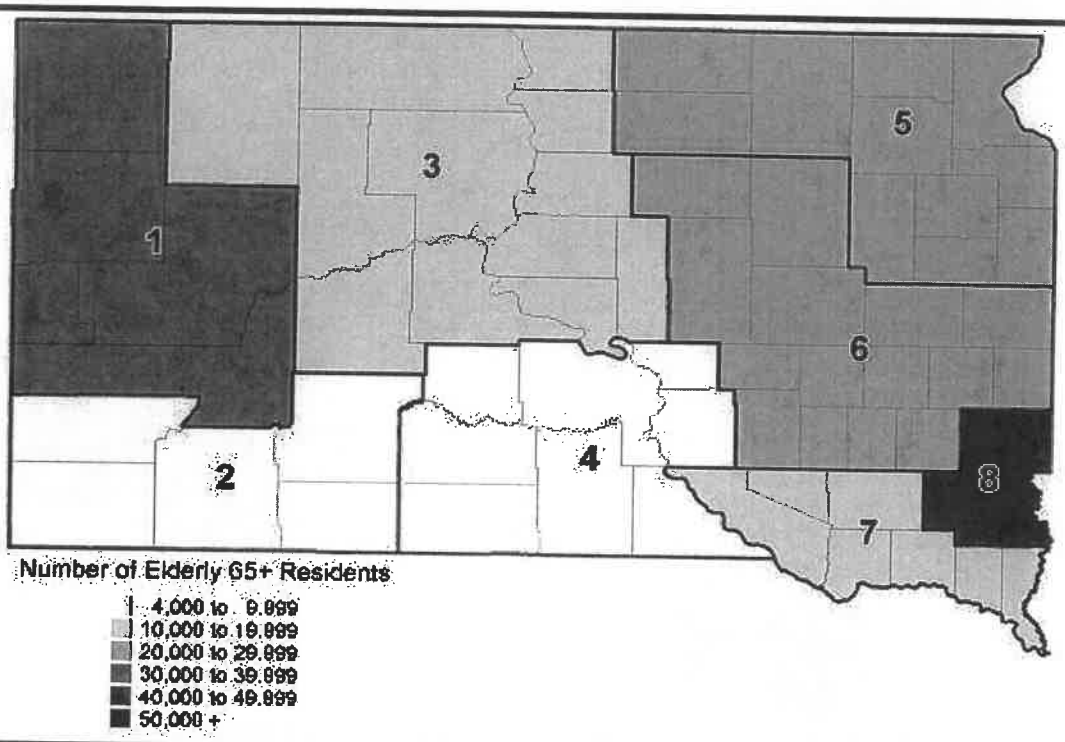
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 8: Number of Elderly 65+ Residents, 2015



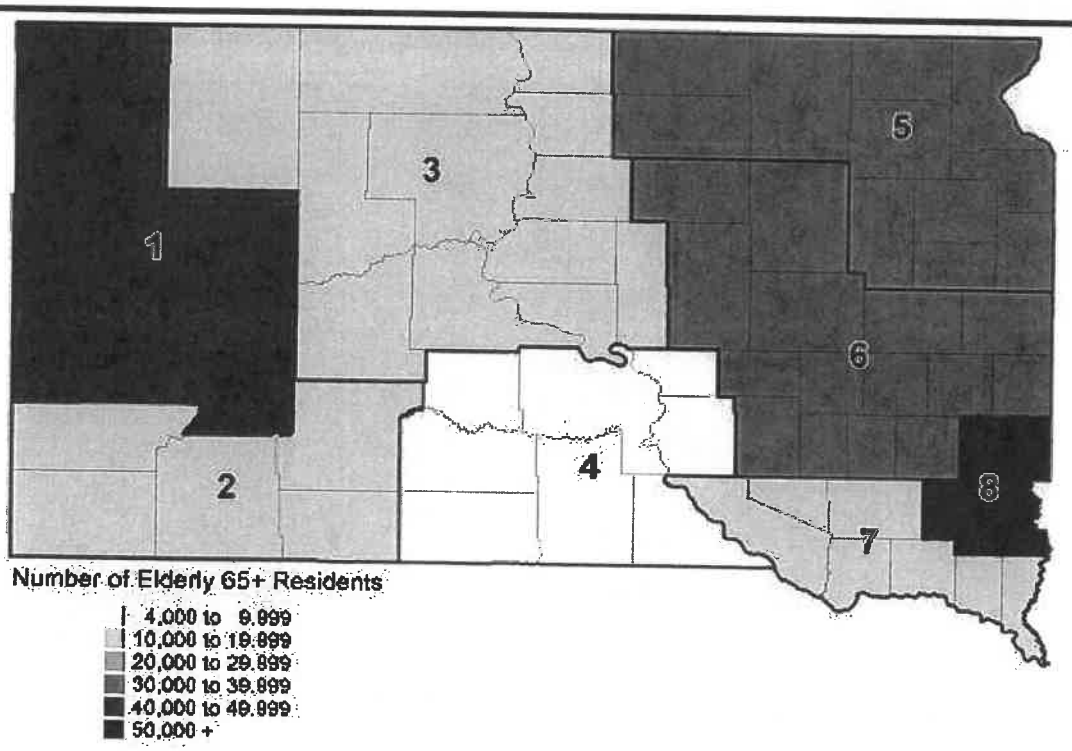
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 9: Number of Elderly 65+ Residents, 2020



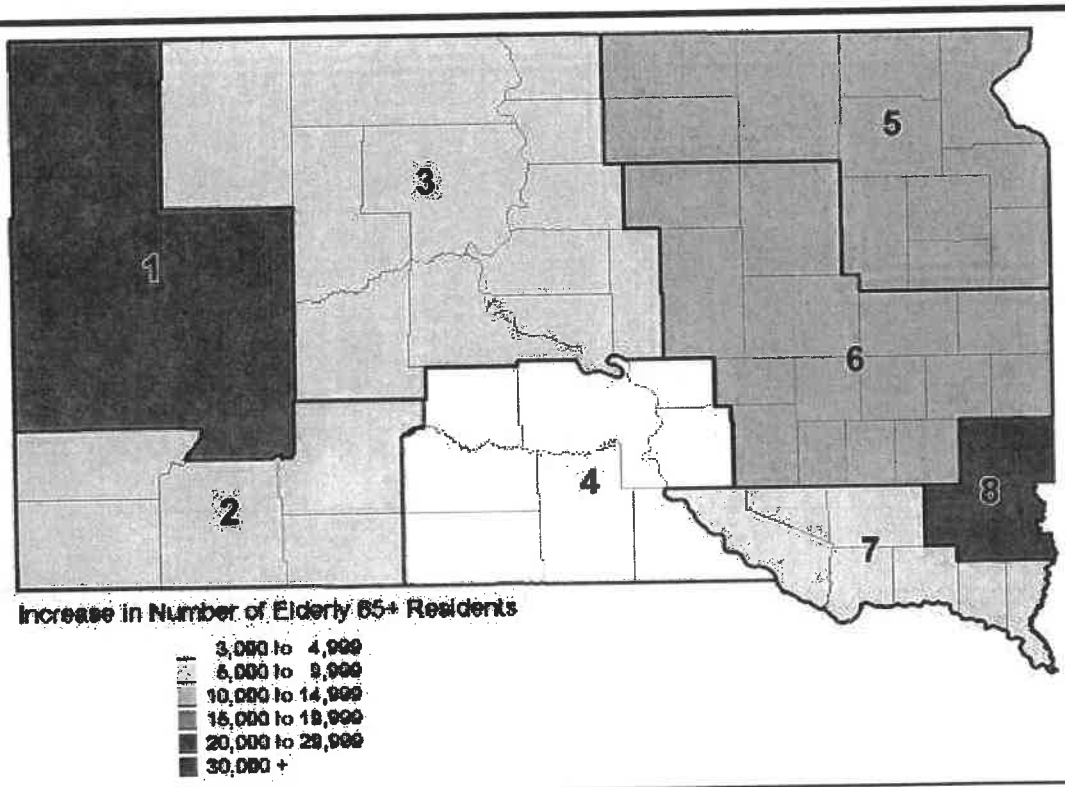
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates

Exhibit 10: Number of Elderly 65+ Residents, 2025



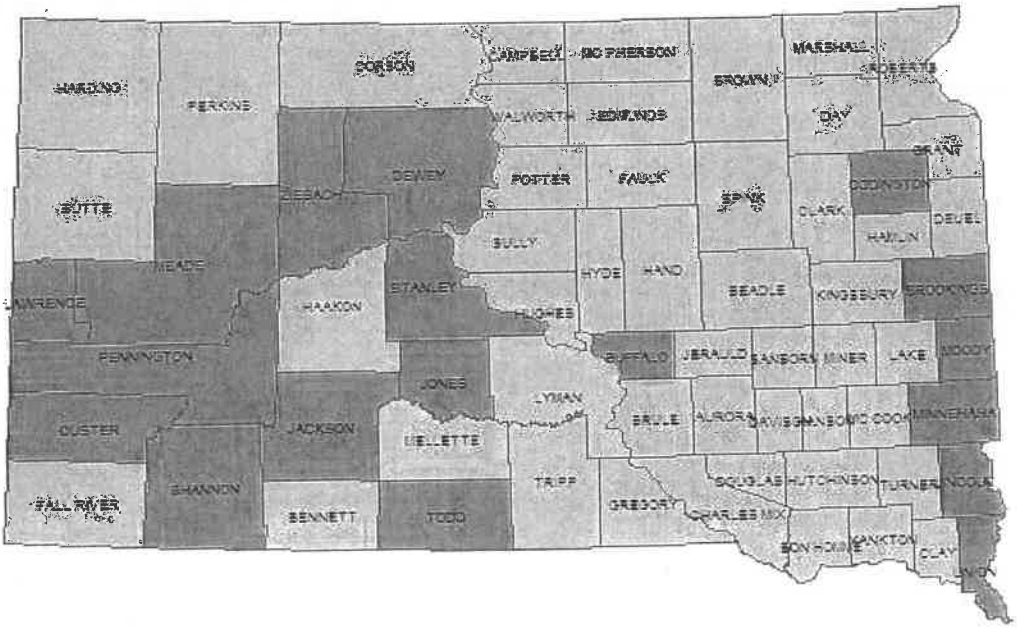
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 11: Increase in Number of Elderly 65+ Residents, 2000-2025



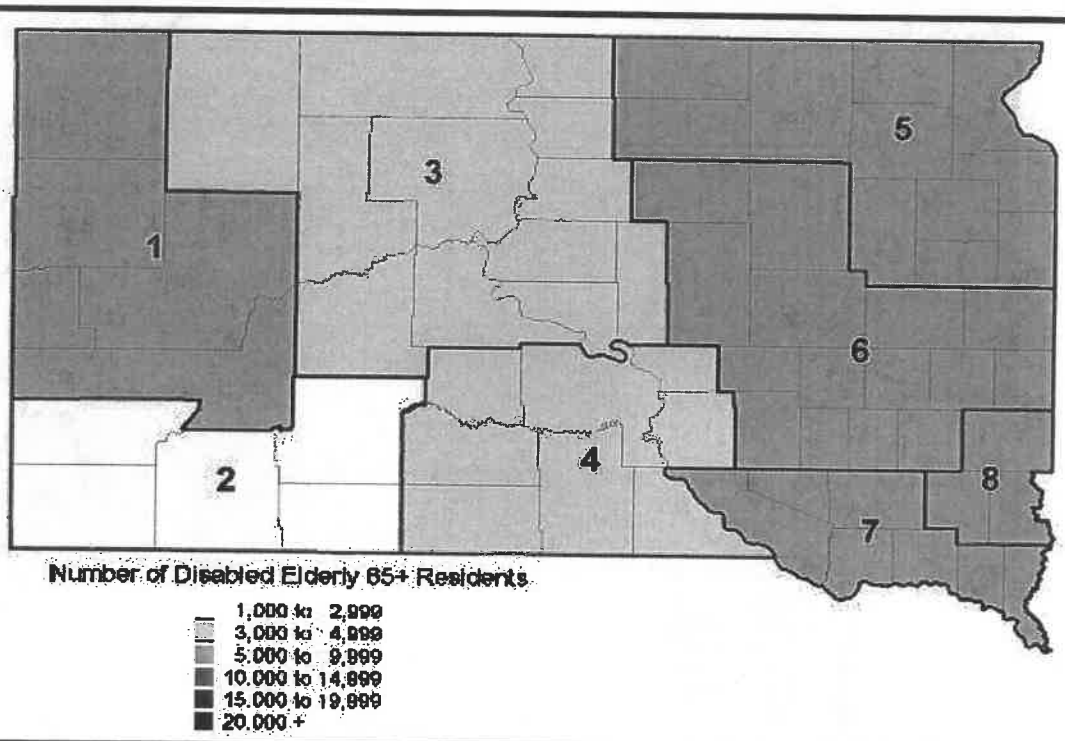
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 12: South Dakota Counties where the Elderly Population is Expected to Double by 2025 (in Dark Pink)



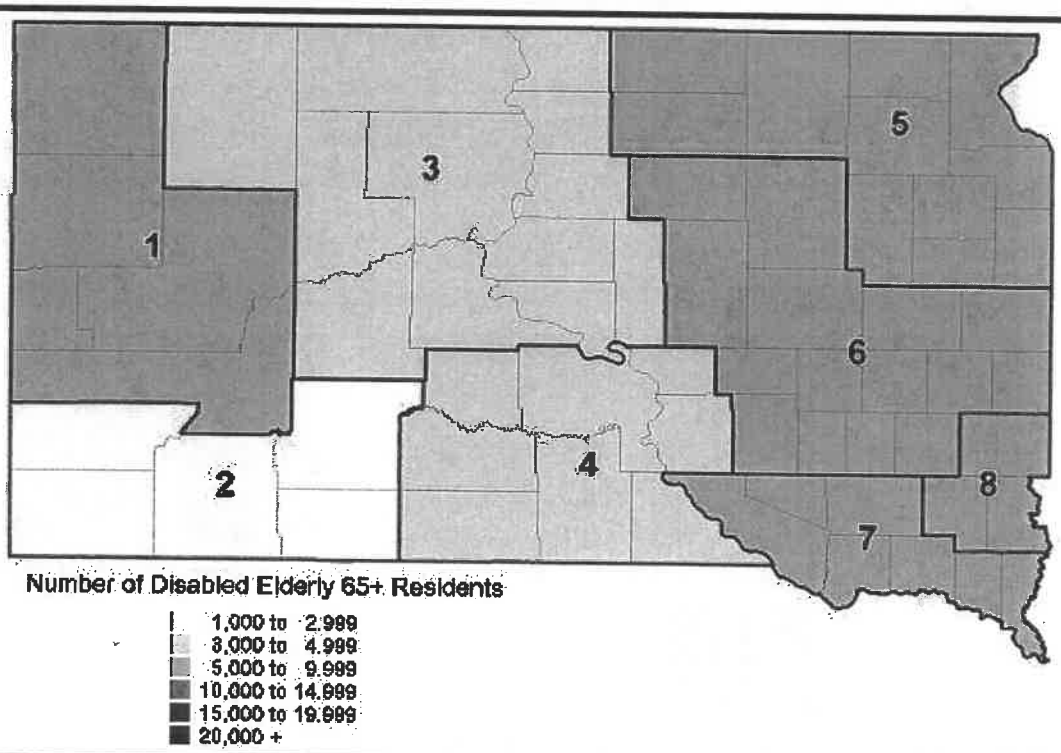
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 13: Number of Disabled Elderly 65+ Residents, 2000



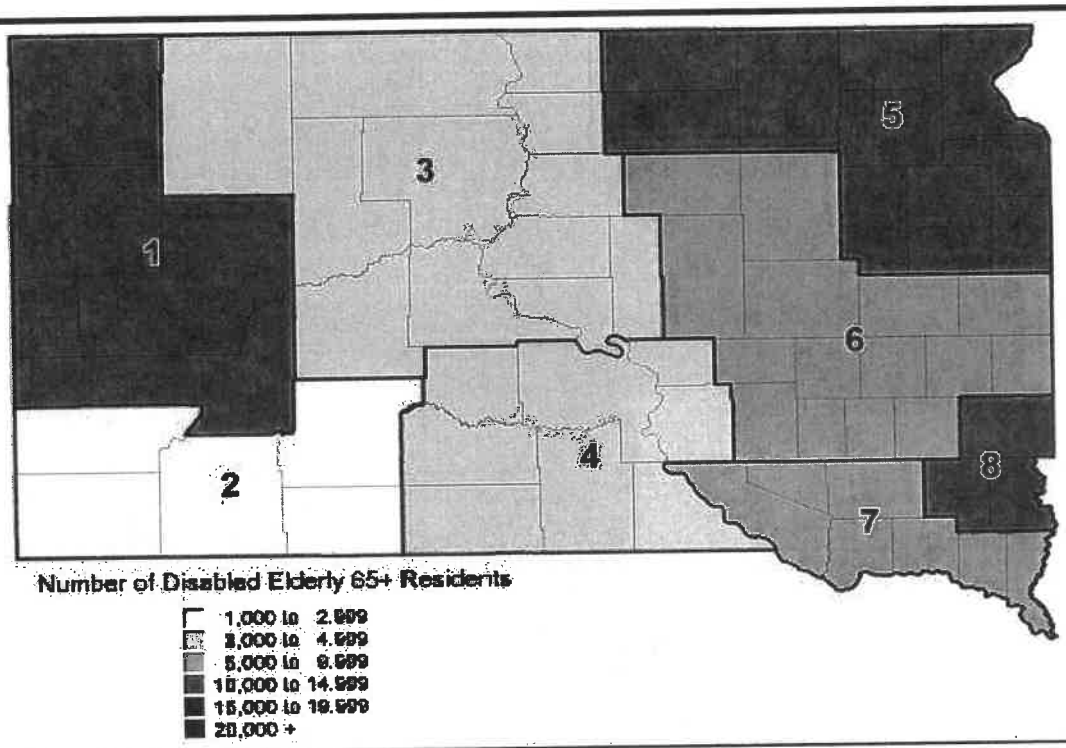
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 14: Number of Disabled Elderly 65+ Residents, 2005



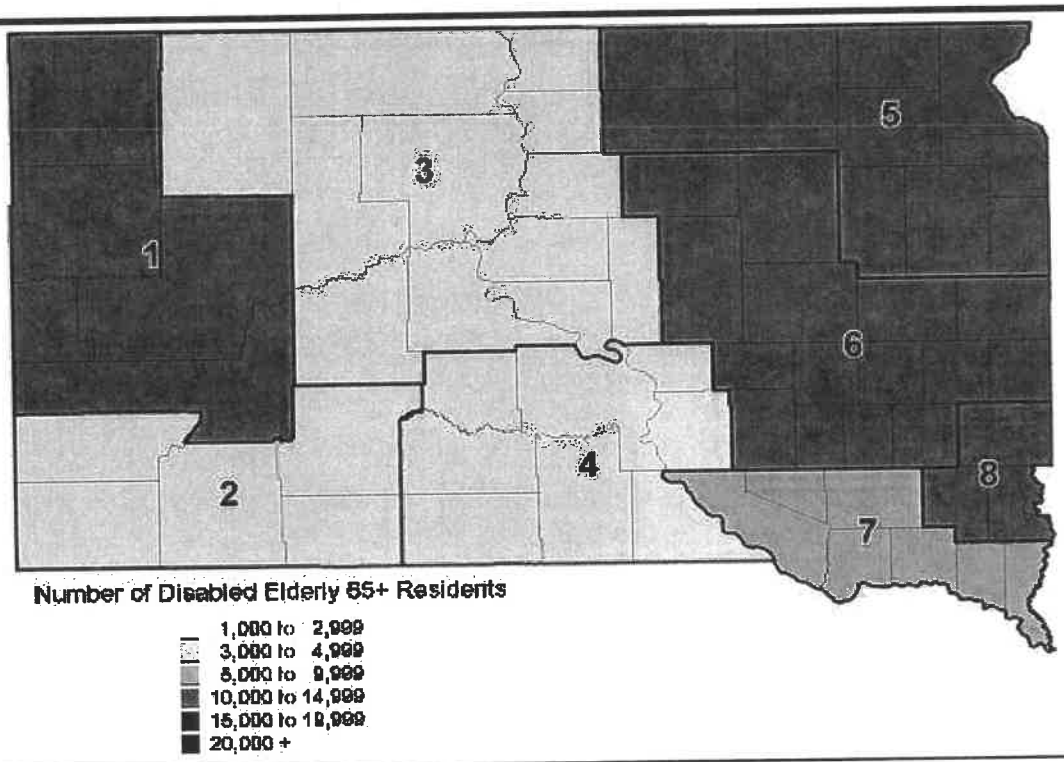
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 15: Number of Disabled Elderly 65+ Residents, 2010



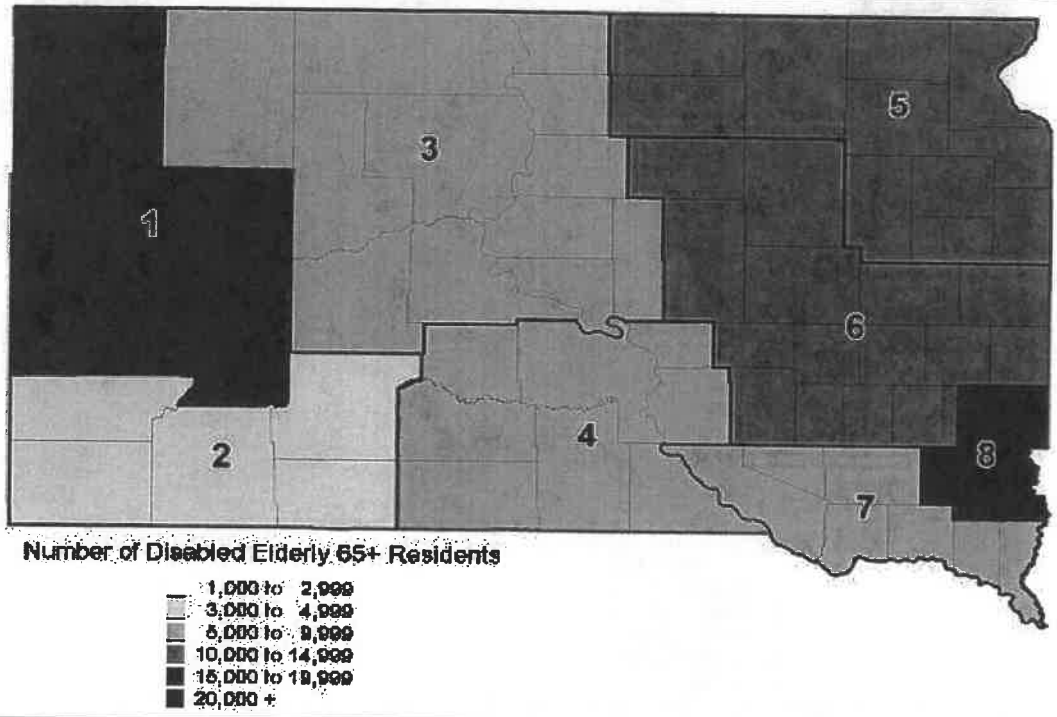
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 16: Number of Disabled Elderly 65+ Residents, 2015



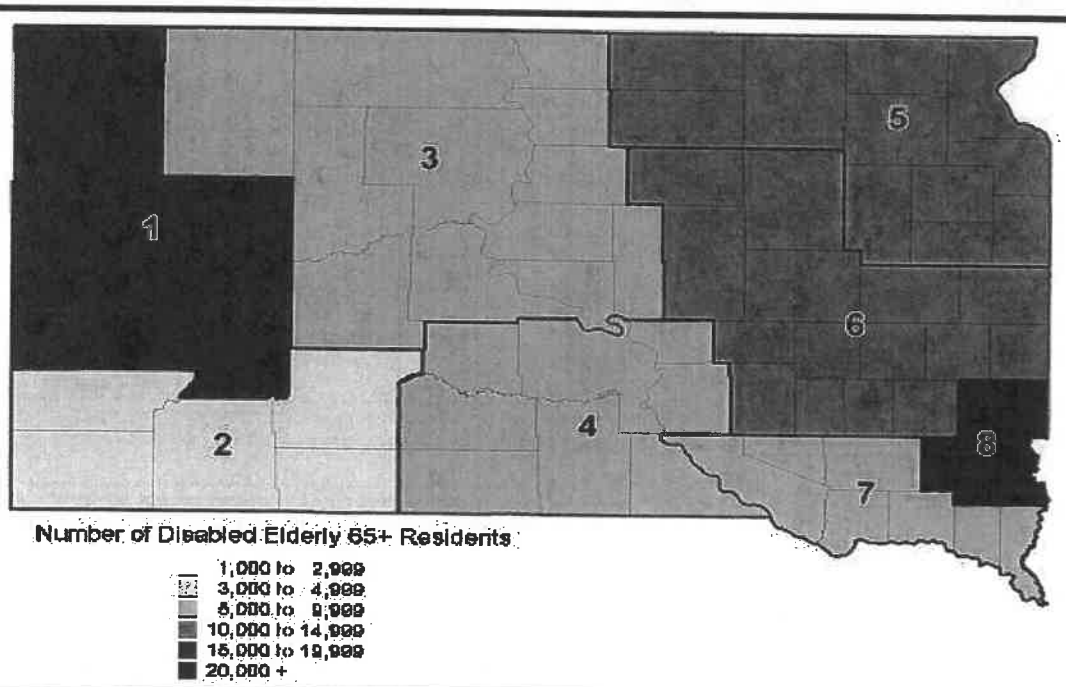
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 17: Number of Disabled Elderly 65+ Residents, 2020



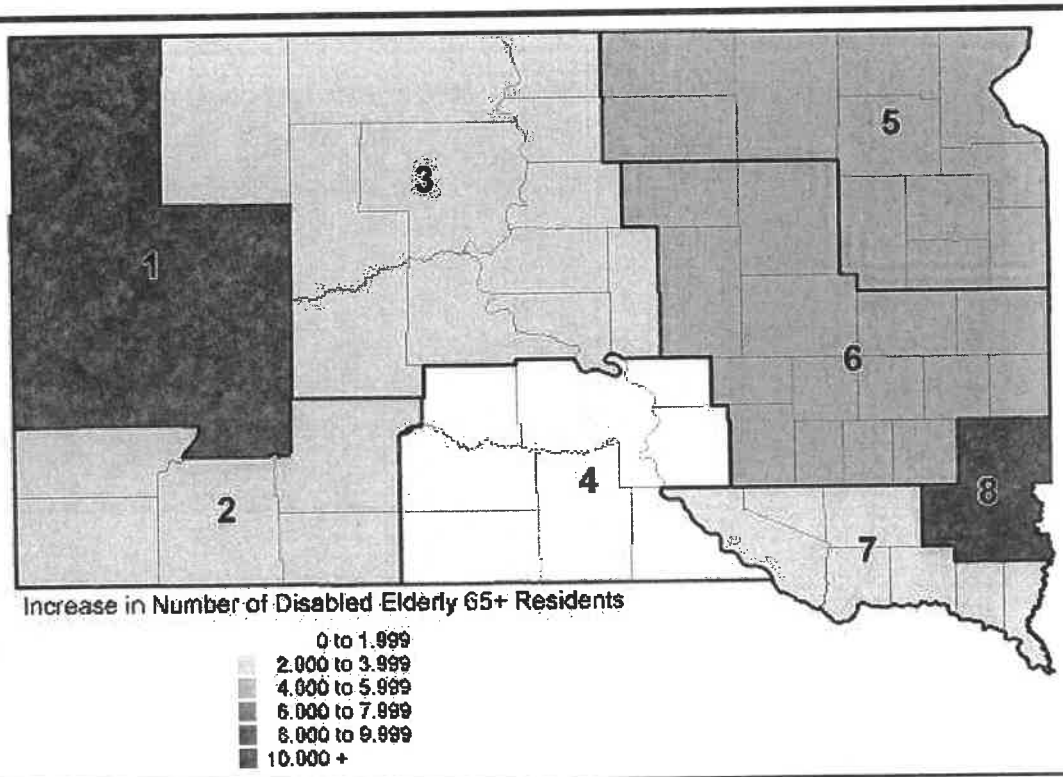
Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 18: Number of Disabled Elderly 65+ Residents, 2025



Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 19: Increase in Number of Disabled Elderly 65+ Residents, 2000-2025



Source: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 20: Projected Elderly Population from 2000 to 2025

Economic Assistance Region	Elderly Population 2000	Elderly Population 2005	Elderly Population 2010	Elderly Population 2015	Elderly Population 2020	Elderly Population 2025
1	17732	20921	24541	29678	35641	41757
2	4173	5031	6023	7487	9036	10248
3	7892	8509	9313	10361	12079	13820
4	5032	5522	6008	6699	7748	8908
5	19949	21438	23035	25099	28259	31894
6	20456	21638	22858	24642	28153	31976
7	12260	12828	13719	15065	17077	19547
8	20637	23426	27135	32847	41001	51440

Sources: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

Exhibit 21: Projected Disabled Elderly Population from 2000 to 2025

Economic Assistance Region	Disabled Elderly Population 2000	Disabled Elderly Population 2005	Disabled Elderly Population 2010	Disabled Elderly Population 2015	Disabled Elderly Population 2020	Disabled Elderly Population 2025
1	7767	9152	10724	12958	15569	18248
2	1948	2357	2812	3482	4206	4797
3	3557	3821	4176	4651	5425	6209
4	2208	2423	2637	2940	3398	3908
5	8753	9390	10081	10978	12350	13937
6	8791	9287	9794	10550	12036	13648
7	5297	5525	5885	6428	7259	8283
8	8642	9800	11340	13714	17107	21451

Sources: U.S. Census and SD State Data Center population projections. Additional calculations by Abt Associates.

4.1.2. Workforce

There is national concern that the long-term care industry faces an impending critical shortage of available front-line health care workers. Current shortages of RNs will expand to LPNs, CNAs, personal care assistants, and even entry-level non-patient care staff. Forecasts by the Bureau of Health Professions, Health Resources and Services Administration, suggest that the demand for LTC workers will double by 2030-2040, while the supply of workers is forecast to grow only modestly if at all.

Shortages are driven by the fact that the numbers of elders with needs rises faster than the supply of young people who traditionally enter nursing and long-term care (LTC) jobs. The average age of a nurse exceeds 45 and retirement will deplete the ranks of available staff. LTC is difficult work and wages in the LTC sector have not traditionally kept pace with other health care sectors that compete for front-line workers. Even if wages rise substantially, shortages will not be eliminated: doubling real (inflation-adjusted) wages could reduce the shortage of nurses by 70%, but will not eliminate a gap between available positions and available workers.

In South Dakota, the situation is potentially more critical:

- The elderly population is growing faster than national rates.
- The nursing workforce is aging. In South Dakota in 2007, the average age of LPNs was 47 years and the average age of RNs was 46 years. This is comparable to U.S. averages, where the average age of the nursing workforce has been progressively increasing. The aging workforce reflects fewer young nurses entering the population, large cohorts of the nursing profession moving into their 50's and 60's and approaching retirement, and older graduates from initial nursing education programs entering the RN population.
- The population of young workers who traditionally enter front-line health worker positions is flat or declining in South Dakota.

The South Dakota Healthcare Workforce Initiative

Workforce issues are a primary concern for the State. In recognition of current and impending shortages, the Governor established the South Dakota's Healthcare Workforce Initiative. South Dakota Healthcare Workforce Summits were held in August of 2006 and July 2007, and focused on issues related to increasing and stabilizing South Dakota's healthcare workforce. Recommendations were made in five content areas: Healthcare Educational Programming Capacity; Recruitment and Retention; Clinicals/Internships; Pipeline; and Student Perception and Awareness.

The Healthcare Workforce Initiative is undertaking an assessment of the demand for health care workers and the potential supply issues across the State. While it was hoped that their findings would be available to support the research discussed in this report, the Workforce Initiative was not yet at a point where the data or findings were available to be incorporated into this report.

Therefore, Abt Associates undertook a preliminary assessment of workforce needs and also the potential supply of workers across the State, in order to assess the extent to which shortages of front-line health care workers might pose a barrier to the implementation of right-sizing and rebalancing initiatives. The workforce analyses presented below will be expanded and updated when the Healthcare Workforce Initiative releases their more extensive report.

Abt Associates undertook the following analyses:

- Evaluated the magnitude of current staffing shortages and staff turnover at skilled nursing facilities across the state. Abt Associates analyzed the results of a staffing survey conducted by DSS and compared results to unstaffed positions and turnover rates reported for nursing positions in all healthcare sectors across the state.
- Forecasted changes in the demand for nurses and CNAs employed in the LTC sector, for the State and by DSS Economic Assistance Region.
- Forecasted changes in supply of nurses and front-line healthcare workers, based on state labor force projections and national research regarding trends in LTC and healthcare employment.
- Examined the magnitude of shortages, overall at the state level and by region. Assessed the degree to which wages would have to rise to narrow the gaps.

Nursing Facility Staffing Survey

In August 2007, the Department of Social Services sent a survey to all 110 licensed nursing facilities in the state, requesting information for the years 2004, 2005, and 2006 on: (1) Budgeted full-time equivalent (FTE) positions from RNs, LPNs, and CNAs; (2) actual filled FTE positions for RNs, LPNs, and CNAs; and (3) annual staff turnover rates for RNs, LPNs, and CNAs. The survey also asked for (4) comments on local factors that have affected their ability to fill positions. Fifty-two facilities returned the survey, representing just over 60% of licensed beds in the State. Responding facilities represented all regions of the State; however, the areas in West River were under-represented by respondents, and areas in East River were over-represented in the responses. The data reported below do not attempt to correct for any non-response bias in the data.

Exhibit 22 reports on average turnover and Exhibit 23 the average gap between budgeted positions and staffed positions and average turnover rates, by region and by RN, LPN, and CNA training. We present data for 2006, since it was reported by all 52 facilities: fewer facilities reported for the preceding years. There were, however, no significant trends in the data between 2004 and 2006.

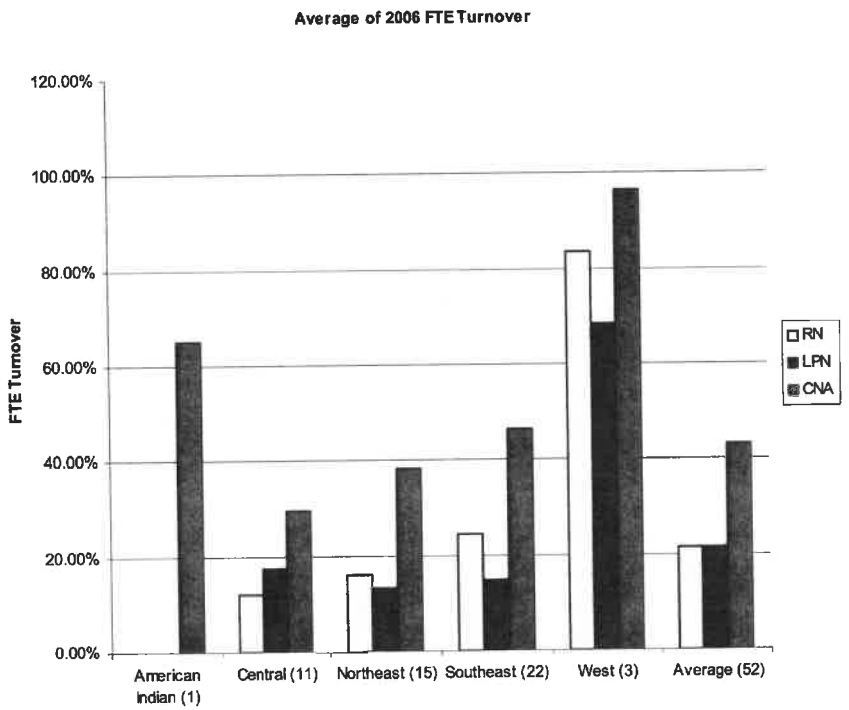
We report data using larger geographic regions: Northeast, Southeast, Central, and West.[5] The number of reporting facilities was too small in some regions to use the DSS Economic Assistance Regions.

Notably:

- Reported turnover rates are high: averaging 20% for RNs and LPNs, and over 40% for CNAs.
  - Turnover rates are highest in the West region followed by the Southeast Region, both areas where there has been very high growth in demand for long-term care and general health care services.
- The gap between budgeted and staffed positions – our measure of shortages -- is smaller and follows the same geographic pattern as turnover rates.
  - RNs demonstrate the highest gap between budgeted and staffed, ranging from 4% in the Central counties to 11% in the West.
  - There is little or no gap between budgeted and staffed LPN positions.
    - In the West counties, filled LPN positions exceeded budgeted for two-thirds of reporting facilities, potentially as a result of substituting LPNs for unavailable RNs.
  - CNA budgeted positions, on average, exceed filled positions by 4%, following the same geographic pattern as RNs.
  - Gaps between budgeted and filled positions could occur if there is a decline in a facility's patient census over the course of the year; however, this is unlikely to be driving the results presented here. Facilities with a growing or stable census reported gaps more often than those with declining census numbers.

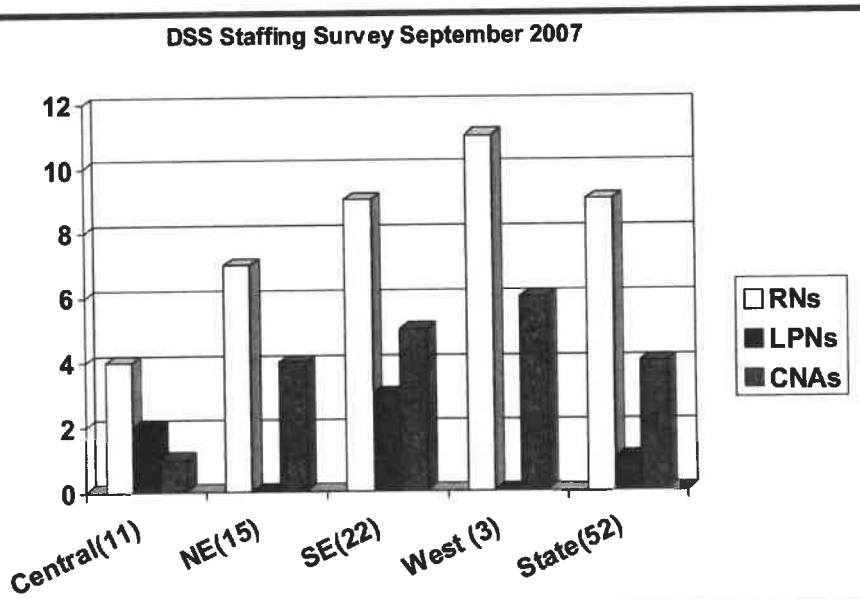
[5] County classifications are presented in Appendix 2.

Exhibit 22: Average of 2006 FTE Turnover, South Dakota Nursing Facilities



Source: DSS Nursing Facility Staffing Survey, September 2007

Exhibit 23: Nursing Facility Vacancies as a Percent of Budgeted Positions



Source: DSS Nursing Facility Staffing Survey, September 2007

While care should be taken in generalizing from the data, they suggest higher vacancy and turnover rates in the LTC sector compared to all health care settings in South Dakota, as reported by the South Dakota Department of Health (DOH).[6] The South Dakota DOH reports vacancy and turnover data collected from assisted living centers, inpatient chemical dependency, certified end-stage renal disease, home health agencies, intermediate care for mentally retarded, nursing facilities, rural health clinics, and hospitals. In 2006 they found RN vacancies were running at 3.3% statewide and turnovers averaged 9.5%. For LPNs vacancies were 3.6% of budgeted positions and turnover of staff averaged 15.3%. CNAs had the highest rate of turnover of any of the job categories for which data were collected by the DOH (36.6%) and CNA vacancies were reported to be 6.5% of budgeted positions.

The staffing surveys indicate that South Dakota currently faces significant shortages of front-line health care workers. Shortages are most significant for RNs and are largest in the growing regions of the state, where there is competition from other health care providers, and the non-health care sector as well.

The findings closely mirror what Abt Associates staff heard during extensive site visits and interviews across the state. Nursing facilities, assisted living centers, home health agencies, and organizations providing personal care services indicated that staffing shortages were among their top operating concerns. Reported shortfalls in staffing may be understated, since positions that have been unfilled for long periods of time are not budgeted. Lack of staff raised costs, as facilities were required to rely on temporary or traveling nurses. Lack of staff also threatened the quality of patient care, as nurses and CNAs were stretched to cover additional patients or work additional hours. Many facilities in the fastest-growing regions felt that when they were able to hire nurses, it was often at the expense of another facility in their region - with the supply of workers being fixed, one provider's gain was another's loss. Some facilities suggested regional hiring collaboratives might help them attract and screen potential workers more successfully, and with less duplication of effort than under the present competitive systems.

Projecting Future Workforce Gaps

Abt Associates employed the following method in order to obtain estimates of workforce adequacy for the State and by DSS Economic Assistance Regions:

- From U.S. Census data, constructed estimates of the number of direct healthcare workers living in each region; as well as estimates of the size of the labor force from which CNAs and direct service workers are drawn. (E.g. high school graduates, aged 18-44, by gender.)
- Obtained from state nursing programs estimates of the number of nurses that will be trained in future years, based on program enrollment trends and capacity.
- Obtained data on wages and employment in health care and other sectors from Occupational Employment Statistics (OES) and/or South Dakota Business Research Bureau. Combined results from national research, evaluated health care employment and wages relative to non-health care workers, by age and education, in order to assess factors that attract workers to health professions.
- Estimated retirement rates, by job category and county.

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6 See Reports "RN"and "LPN" Building South Dakota's Healthcare Workforce, South Dakota Department of Health, Office of Rural Health, July 2007.

- Estimated potential entry into the labor force, based on nursing graduates (for nursing) and the share of labor force historically attracted into healthcare (for non-nursing positions).
- Estimated labor supply, combining estimates of labor force entry, continued employment, and retirements at the State and Regional level.
- Compared potential supply of workers to forecasts of the demand for workers, adjusting for trends in nursing home utilization, home and community based service utilization, and projected changes in the intensity of staffing in LTC, again at the State and Regional levels.

Forecasts of Future Changes in the Health Care Workforce: Overview

In counties with highest job growth, new industries and growing competition from regional health care systems are pushing up wage rates. South Dakota has enjoyed a relatively low rate of unemployment (3.0% in mid 2007, compared with 4.3% nationally) and modest job growth across the State. Total non-farm employment has risen statewide at just over 3% in recent years[7]. While there has been year-to-year variation, growth in service industry employment in recent years has been strong, exceeding 3% statewide and 4% in the Sioux Falls Metropolitan Statistical Area (MSA). Forecasts must recognize that wages will have to accommodate the growing demand for skilled healthcare workers. Furthermore, wages in the LTC sector must grow at rates that maintain a competitive balance with other sectors. This is a challenge in an industry where regulated reimbursement rates can limit a facility's ability to push through increases in labor costs.

- Between 2001 and 2005, total earnings in the health care sector [8] in South Dakota grew by 33% in the state, making the sector one of the fastest growing.
    - In the Sioux Falls MSA, earnings rose by 46%, and in the Rapid City MSA total earnings rose by 55.4%, again reflecting growth in the numbers of individuals employed and a real rise in wages and salaries that averaged 3-5%.
- Earnings in the Nursing Home and Residential Care sector, the Census designation closest to employment in the LTC industry, rose more slowly overall, increasing 26.3% between 2001 and 2006, with real wages rising by 0-1%.
    - The exception in the nursing home industry occurred in the Sioux Falls metropolitan area, where the LTC industry's total earnings rose 59.3% and real wages rose by 4-5% mirroring the earnings rise in the health care sector overall.

Changes in the Potential Labor Pool Across the State

Exhibit 24 shows the changing age distribution of the State's population between 2000 and 2030. These population pyramids, constructed by the U.S. Census Bureau, show the share of the state's population according to 5-year age brackets. Demographers and state planners pay close attention to the middle population brackets— ages 25-50—since these are the prime earnings years and the ages at which individuals can most easily support those who are unable to support themselves.

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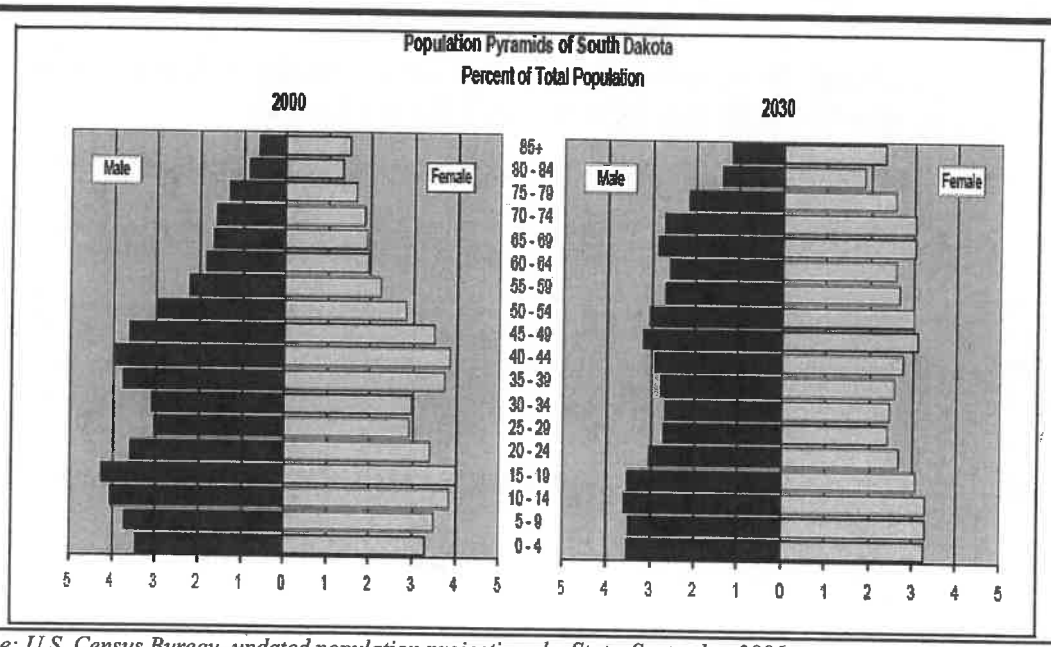
7 US Bureau of Labor Statistics, BLS.gov.

8 NAIC 62, as defined by the Department of the Census, Bureau of Economic Analysis, Data updated April 2007.

Exhibit 24: Population Projections by Age, 2000 versus 2030



Source: U.S. Census Bureau, updated population projections by State, September 2006

South Dakota faces a growing dependency crisis: Currently there are almost four "workers" aged 20 years to 60 years per retired person in the state. By 2030, that number falls to 2:1. The decline has several implications. First, the State can expect that taxes and other revenues derived from employment will rise more slowly than will required expenditures for programs that support children and the aged. Second, the workforce from which the long-term care industry draws its employees will shrink by half relative to the numbers of elders that the LTC industry will need to serve.

The patient care long-term care labor force is comprised of nurses, CNAs, personal care assistants, and other direct front-line health care workers. The pool of potential workers for this market is drawn from high school graduates who enter CNA and the non-skilled nursing positions, homemakers with school aged children who are seeking part-time employment, and college graduates, particularly females, who enter nursing or other skilled patient care training programs.

In 2000, 37% of the South Dakota population was in the age brackets of 18-44 years old. This is the age group that has traditionally supplied front-line health care workers and from which nursing program enrollees are drawn. By 2025, the share of South Dakota's population that are in this bracket will fall to under 29% of total population statewide, and will decline in absolute numbers in many regions. The drop in size of the labor pool is particularly large in frontier counties, where young people have migrated away, to the growing employment regions around Sioux Falls, or have left the State following high school or college.

Exhibit 25 shows how the size of the LTC labor pool— i.e. the population between ages 18 and 44— varies across regions in the State between 2000 and 2025, and compares the growth rate in the labor pool with the growth rate in the forecasted number of disabled elders in the region. Comparisons are striking:

- The "prime" labor pool of workers aged 20-44 shrinks by 6% statewide, growing only in the Sioux Falls (+2%) and Rapid City (+6%) regions.

- Region 3 (north central counties) and Region 5 (the northeast counties) witness a 23% and 24% decline, respectively, in their working age populations over the next 20 years.

- At the same time, the number of disabled elders in the State almost doubles (+96%), increasing by 130-150% West River and in the Sioux Falls MSA.
- Combined, the growth in the numbers of elders requiring care, coupled with the stagnant labor force, suggests that at today's staffing and job entry rates there would be a 60-150% increase in the number of disabled seniors requiring care for every available worker.

In short, if nothing changed: i.e. if workers entered the health professions as they do today, staffing ratios remained fixed at today's levels and disabled elders required care as they do today, then the number of unfilled positions in the state could equal the number of staffed positions in the State today.

Exhibit 25: Projected Size of the Population that Enters the LTC Labor Pool, 2000-2025 by Region

Region	Age 18-44 Pop 2000	Age 18-44 Pop 2005	Age 18-44 Pop 2010	Age 18-44 Pop 2015	Age 18-44 Pop 2020	Age 18-44 Pop 2025	Change in population 2000-2025
1	52031	51044	50567	51282	53399	55282	6.2
2	9691	9360	8896	8610	8600	8847	-8.7
3	15479	14411	13297	12829	12192	11854	-23.4
4	10235	9636	9090	8973	8650	8514	-16.8
5	34867	32401	29997	28809	27396	26331	-24.5
6	40528	39360	38232	37608	37028	36112	-10.9
7	25906	25054	24294	23956	23220	22422	-13.4
8	70464	71000	70249	70776	71636	72067	2.3
Grand Total	259201	252266	244622	242843	242121	241429	-6.9

Source: U.S. Census Estimates

Alternative Scenarios for Forecasting Workforce Adequacy

Assuming that labor markets and staffing ratios remain fixed is a worst-case scenario. The adequacy of the health care workforce will depend on several factors:

- The ability of employers to attract new workers into the marketplace, through higher wages, better working conditions, and improved training and job development pipelines.
- Changes in the mix of long-term care services that seniors will require.
- Changes in the intensity of services, and efficiencies in ways in which care is delivered and services are staffed.

We examine the potential role of these factors and then develop alternative scenarios for gauging workforce adequacy.

Attract new workers: Rising wages in the nursing professions have attracted non-traditional workers to the profession, including men and women who turn to nursing for a mid-life change in careers. Studies have shown that increasing wages by 10% relative to the marketplace can increase the supply of nurses and skilled health care workers in the long-term care field by 3-4%. Similarly an increase in real wages of 10% can increase the number of CNAs and entry-level front-line health care workers by 6-8%.[9] Many of these new workers come from non-traditional backgrounds and from other industries. Studies by the Bureau of Health Professions, HRSA, suggest that increasing nursing salaries by 3% annually above the market rate of increase, could increase the supply of nurses nationwide by 25%, and cut in half—but not eliminate—the workforce shortage by the year 2030.

Changing the demand for long-term care: Moving seniors from institutions to home- and community- based care reduces the overall need for front-line healthcare workers, and shifts the mix of workers away from skilled nursing positions to the use of more personal care services, where there is greater opportunity for drawing workers from other employment sectors or from part-time to full-time work. As described in the following sections, if South Dakota were able to reduce nursing home utilization to national norms (five nursing home residents per 100 elders) by 2025, the overall demand for nursing home care and nursing home staff, would rise by only 25-35%, rather than rising by 90% relative to 2005. There would be a substitution to less intensive forms of care, causing the demand for skilled home health workers, CNAs, and personal care assistants to rise more rapidly, but generating a net reduction in labor force needs vis-a-vis the status quo.

Changing care delivery and staffing: Innovations in work design and more flexible models of care may enable facilities to deliver higher-quality care with fewer workers in the future. Similarly, advances in information technology have been projected to increase the efficiency of front-line health care workers in the next decade. Research has suggested that innovations in care delivery may reduce RN and LPN nursing staffing intensity by 10-15% by 2020. The effect of technology on the workload of CNAs and direct care workers is less clear.

Workforce Scenarios

We present three (3) alternative workforce scenarios. These are not meant to exhaust the possibilities; rather, they are designed to illustrate the types of policy changes that may be required to avert large-scale shortages. Like all forecasts, they are based on research that is an estimate. We present the "most-likely" scenario, based on the expected outcomes and average forecast parameters, and discuss the likely margins of error.

Scenario 1: Status Quo: Nursing home and home health utilization rates remain at 2005 levels, with no changes in real health care wages. Nursing training slots expand by 1% per year and are filled with qualified applicants; 80% of new nurses trained in the State remain in South Dakota.

Scenario 2: Nursing home utilization rates fall to national norms by 2025 (5 beds per 100 seniors). Utilization and staffing requirements rise for assisted living utilization and home and community based services.

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[9] HRSA Bureau of Health Professions, "What is behind projections of a nursing shortage?" July 2006.

Scenario 3: Scenario 2, plus wages of LTC direct health care workers are allowed to rise by 2% per year relative to those offered by other potential employers between 2007 and 2025. By 2025, this generates a 40% wage premium relative to today's earnings.

Exhibit 26: Potential Size of LTC Labor Force Shortages

Region	Scenario 1		Scenario 2: reduce NH utilization to national norms		Scenario 3=S2 + wages rise 2%	
	RN and LPN shortage as a percent of staffed positions	CNA and other direct care worker shortage as a percent of staffed positions	RN and LPN shortage as a percent of staffed positions	CNA and other direct care worker shortage as a percent of staffed positions	RN and LPN shortage as a percent of staffed positions	CNA and other direct care worker shortage as a percent of staffed positions
Region 1	117	129	74	178	59	136
2	134	155	80	214	69	178
3	63	98	43	135	34	105
4	65	94	44	129	34	97
5	47	84	35	116	26	86
6	43	66	33	91	22	57
7	44	70	33	96	23	63
8	134	146	81	201	69	162
State wide	81	100	52	137	41	101

[a] 95% confidence interval is +/- 27 percentage points for Scenario 1, +/- 31 percentage points for Scenario 2, and +/- 33% points for Scenario 3.

Source: Abt Associates Inc.

The forecasts indicate a significant and widespread shortage of both CNAs and nurses. Rebalancing long-term care services and reducing use of nursing home care narrows the gap between available nurses and available positions, but does not close it. Similarly, increasing wage rates modestly is expected to attract nurses from other states and other health care services, narrowing but not reducing the shortage.

The scenarios do not "model" the effects of bringing non-traditional workers into health care, or significant changes in the organization of care that could reduce staffing requirements. This is largely because new models of care, and innovative job training programs, are still in their infancy. The State needs to move to the forefront in monitoring successful models and pursuing new mechanisms to attract workers into the long-term care industry, or staffing shortages will become a serious barrier to providing high-quality care to seniors across the state.

4.2. Service delivery challenges

South Dakota faces a number of challenges in the delivery of long-term care services both in the immediate future and in the longer run. Currently there are:

- Opportunities to rebalance long-term care services, moving from institutional nursing home based models of care to more contemporary care models that make greater use of home and community based services.
    - Current care patterns are far from national norms: South Dakota has one of the highest rates of nursing home use by seniors in the country, but lags in utilization of skilled health care services and home and community based services.
- Substantial patterns of geographic variation across the state in terms of where services are located as compared to where the population in need resides.
- Concerns over the adequacy, sustainability and financial condition of existing facilities. Rather than replace and patch existing structures, the State should consider opportunities to right size and modernize facilities.

Looking to the future, the sharp growth in the numbers of elders projected across the state will put new demands on the LTC system.

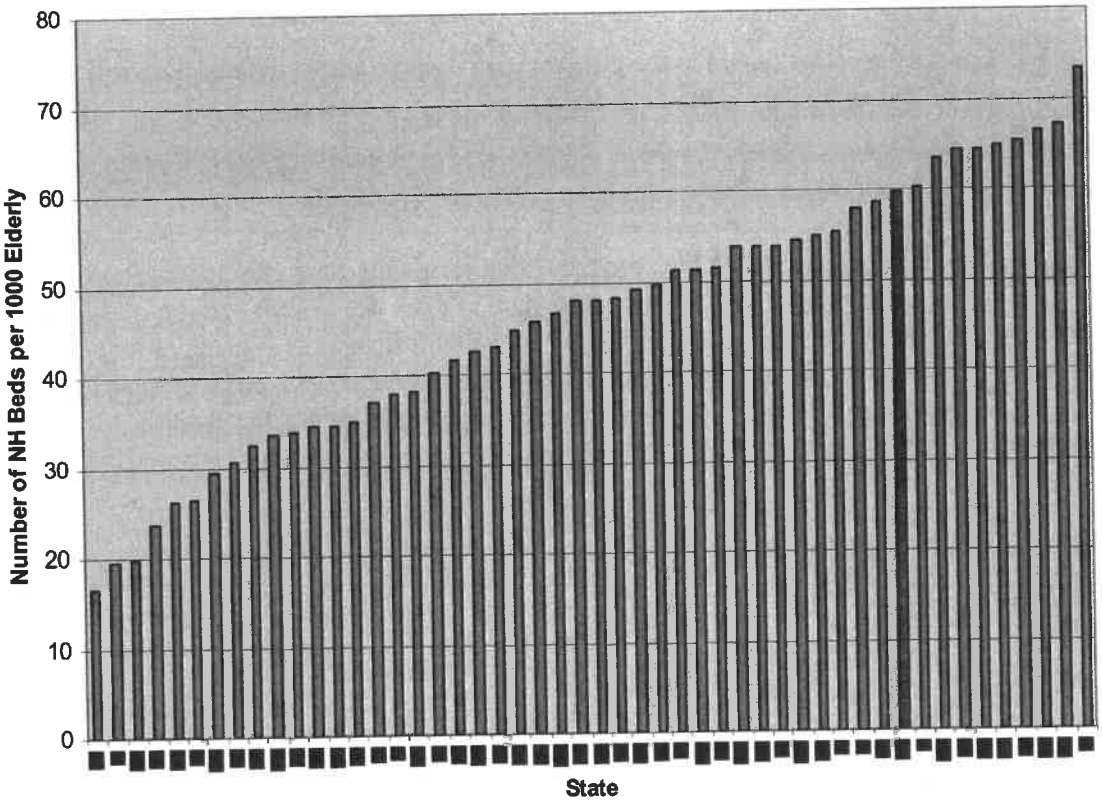
- Capacity must be shifted to the growth centers where tomorrow's seniors will reside: West River and around the Sioux Falls MSA.
- Critical Access models should be developed to assure that seniors in frontier regions and in sparsely populated communities have access to needed care.

This section reviews evidence on the adequacy of existing long-term care services and presents projections of future demands on the long-term care system. We discuss services at the state-level and also examine geographic variation, making use of the DSS Economic Assistance Regions for most analyses. We focus on variation in service availability, gaps in coverage and mismatches between where services are and where the growth in the population of elders is the greatest.

4.2.1. Nursing Homes

Currently, South Dakota has a relatively high number of nursing homes and nursing home beds licensed and in use. As of 2006, the State ranked tenth in the nation with 61 licensed beds per1000 elders (Exhibit 27). Nationally there has been a gradual decline in nursing home utilization rates over the past 3 decades, due to the improved health of seniors, coupled with the growth of assisted living and home-based services that provide an alternative to institutional care. Nursing home capacity and licensed beds have been falling in South Dakota, as well: Since 2000, NH utilization has dropped by 13% in the state. Many believe that movement away from nursing home use has been facilitated by the rapid rise of assisted living capacity in parts of the state. Beds have been taken out of use, and rooms have been converted from semi-private to private occupancy.

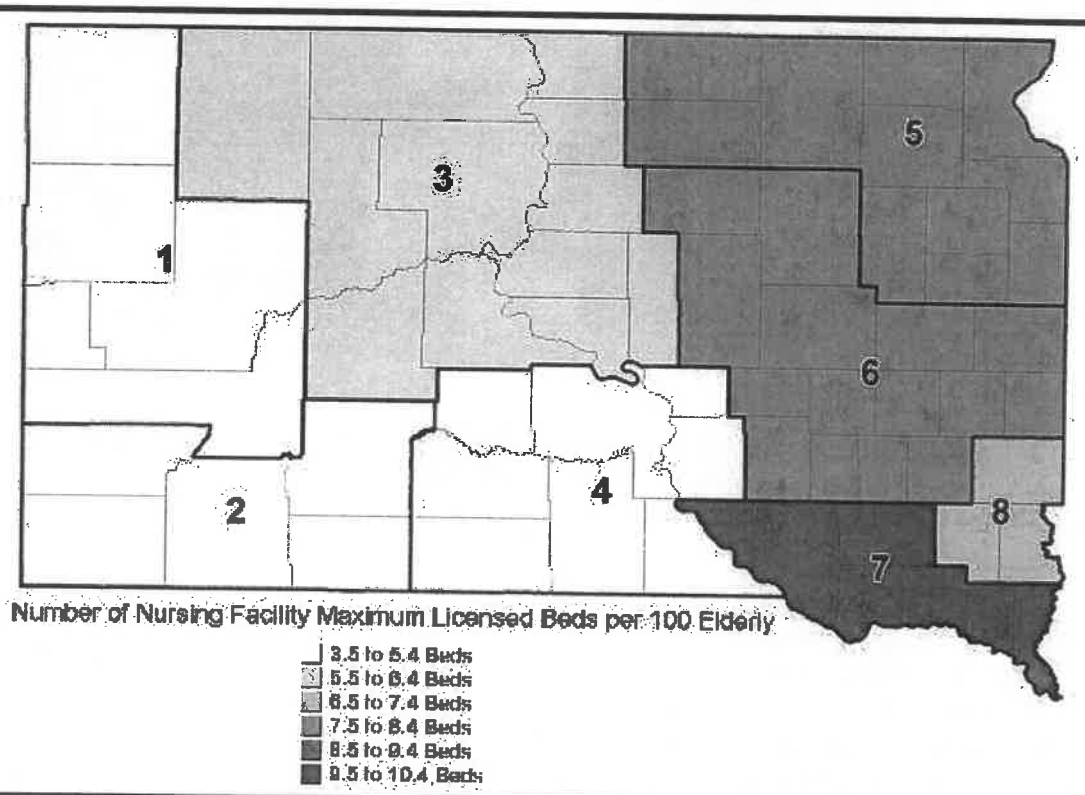
Exhibit 27: National Comparison of Nursing Home Utilization Rates



Sources: Total Number of Certified Nursing Facility Beds (source is 2005 from Kaiser Family Foundation, www.statehealthfacts.org. Original source is OSCAR data).

Current nursing home capacity is unevenly distributed across the state. Exhibit 28 shows the average number of licensed beds that were in use, by Region, over 2003-2005. The map is shaded so that counties in white are at or below national utilization rates (below 4.8 beds per 100) and those in green are above national utilization rates, with the intensity of the shading increasing with rates of utilization. Notably, the West River Regions (1 and 2) averaged only 3.8 beds per elder, while the East River Regions (5 though 8) averaged 7.2 nursing home beds per 100 elders.

Exhibit 28: Number of Licensed beds in Use, 2003-2005 average, per 100 Elderly 65+

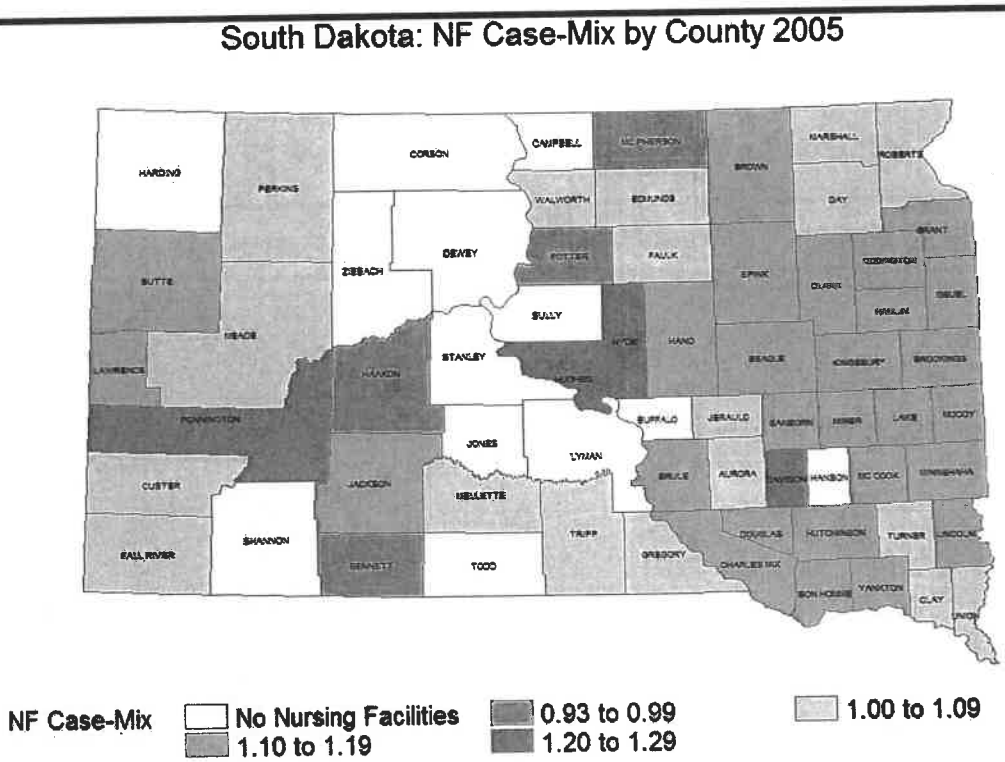


Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

Variation in Case Mix

Variation in nursing home case mix from one facility to the next reflects variation in the health of seniors. It also reflects differences in the long-term care options that are available to seniors in their communities. Medicaid case mix weights are a good indicator of the severity or complexity of a nursing home case mix: higher weights are directly associated with a larger fraction of residents who have more disabilities and more complex care needs. As Exhibit 29 shows, there is substantial variation in the Medicaid case weights across the state and these tend to mirror differences in nursing home availability. Capacity constraints push case weights up in some areas, as those with the most extensive needs take available beds. A relative abundance of nursing home beds, coupled with the lack of home and community based alternatives tends to pull case weights down, as less disabled elders enter nursing homes for care.

Exhibit 29: Nursing Facility Case Mix Variation by County, 2005



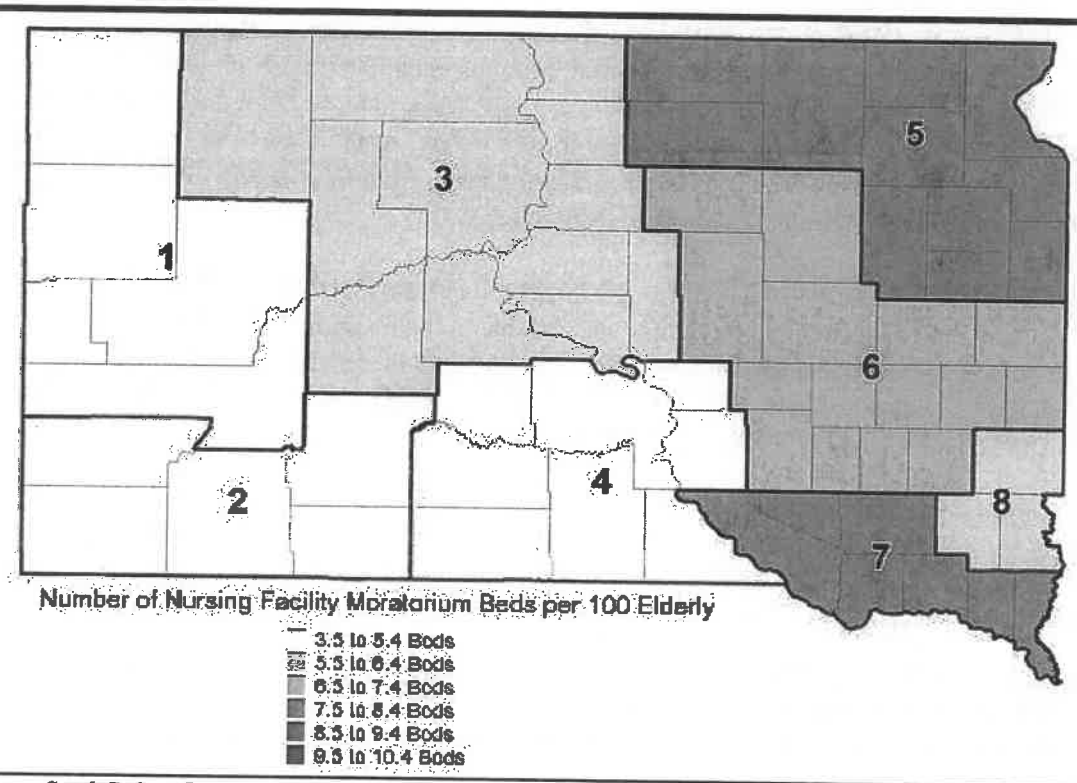
Sources: SD Department of Health, Department of Social Services

Available beds are not where population is growing.

Exhibit 30 shows nursing home capacity across the state in terms of Moratorium beds per 100 elders, while Exhibit 31 shows the difference between moratorium bed capacity and the number of licensed beds that have recently been in use. As before, moratorium bed capacity is highest in the East River regions. Furthermore unused, de-licensed capacity – i.e. the difference between the facilities' moratorium limits and the licensed beds they have had recently in use -- is also highest East River.

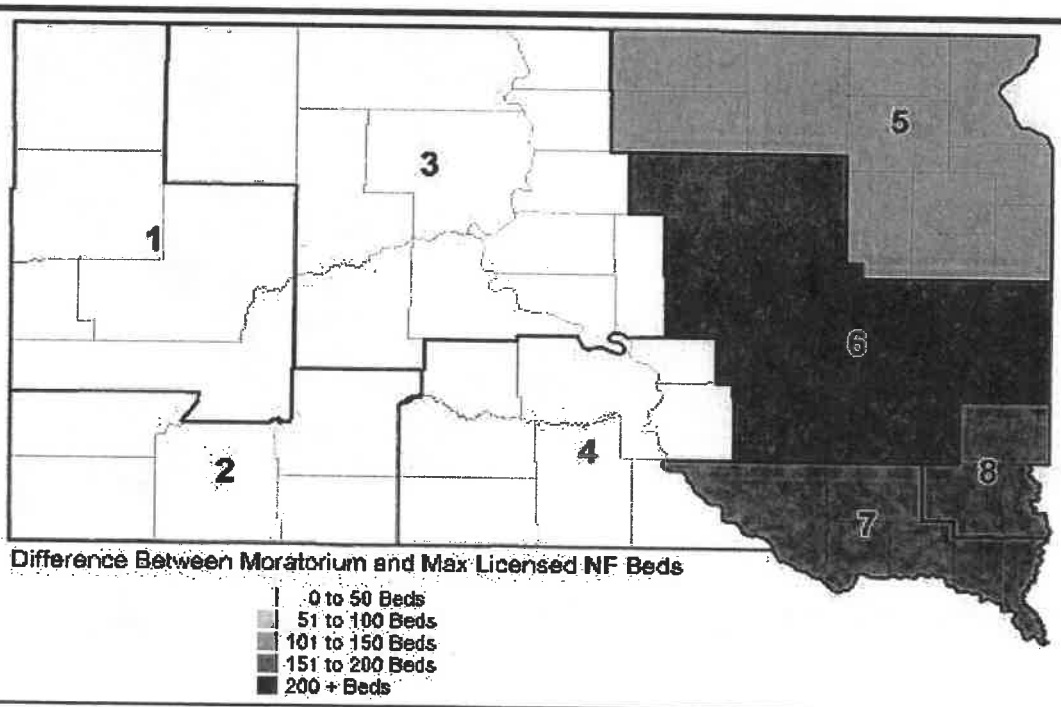
As Exhibit 30 shows, there are fewer unused moratorium beds in the West River regions. This is important since as we have seen elder population growth is projected to be highest in the western regions and around Sioux Falls. Recall Exhibit 12, where we saw that 22 counties will experience a doubling in their elderly population between 2000 and 2025, and almost all are located West River or around the Sioux Falls metropolitan area. In terms of shear numbers, Region 1 – around Rapid City – will add 10,500 seniors to its communities by 2025 and the region around Sioux Falls will add over 12,800. Accommodating the growing senior population will require redistributing capacity from the non-metropolitan areas in the east to the west and central regions.

Exhibit 30: Number of Nursing Facility Moratorium Beds per 100 Elderly, 2005



Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

Exhibit 31: Difference between Moratorium and Maximum Licensed Nursing Facility Beds, 2003 – 2005



Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

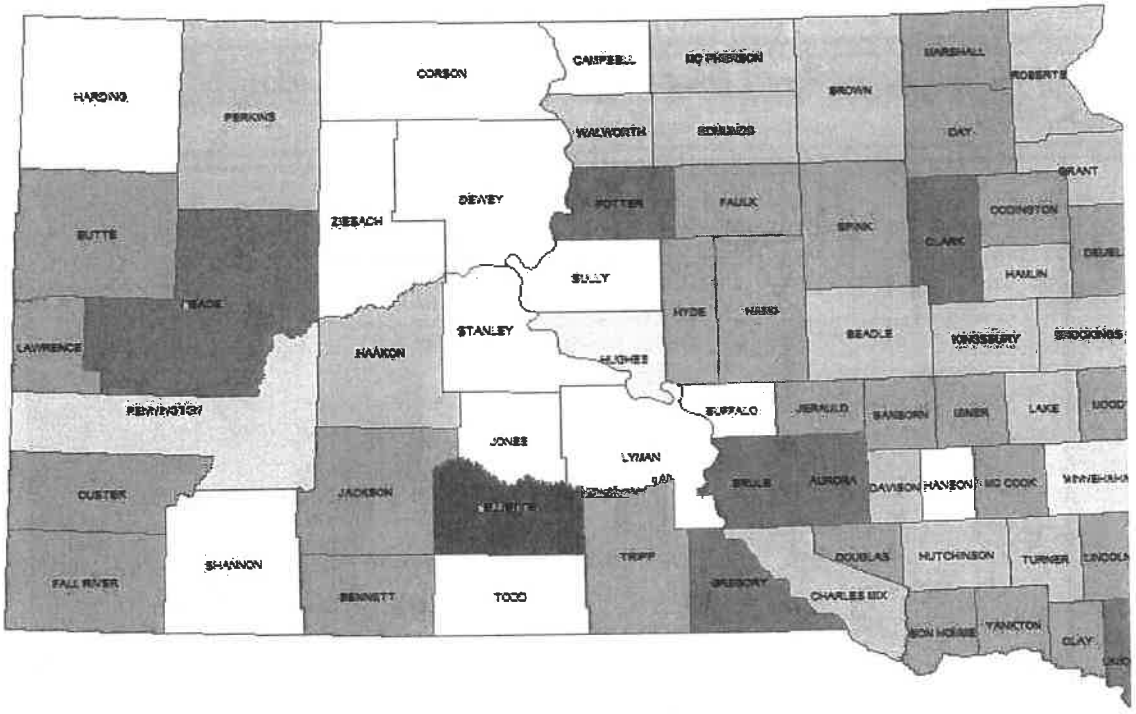
Do residents travel from their home communities to receive nursing home care?

Throughout this study, providers and stakeholder groups remarked that South Dakota seniors are attached to their home communities, and there is a reluctance to move from homes, farms and ranches, even when moving may mean access to better care. At the same time, recent population changes suggest that some seniors are indeed moving away from frontier and rural areas towards the population and medical centers in Sioux Falls and Rapid City.

There are a number of reasons why residents might travel from their home communities in order to receive long term care: services might not be available in their communities, or the quality of care might be less than available elsewhere; local facilities might be full, requiring seniors to by-pass community providers and seek care elsewhere; or seniors might move, or be moved, to be closer to adult children who themselves have relocated within the State.

Using data collected by the Department of Health, we examine the extent to which South Dakota nursing home residents have traveled to receive care. Exhibit 32 presents data on the proportion of nursing facility residents that sought care in a county other than the one where they reside. We measure travel at the county level because it captures travel patterns better than regional data.

Exhibit 32: Nursing Home Travel Patterns



Percent of Residents Leaving

- No Nursing Facilities
- 0 to 9 Percent
- 10 to 19 Perc
- 20 to 39 Percent
- 40 to 59 Percent
- 60+ Percent

Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

Looking only at the 53 South Dakota counties that have nursing facility services, on average in 2005, fewer than 35 percent of residents traveled outside the county for care. In seven counties, however, 40 to 59 percent leave, and one had 60+ percent of seniors leave. (In counties with no facilities [13], 100 percent of residents who need nursing facility services leave the county.)

To examine whether travel was motivated by lack of capacity at a local nursing home, we compared the percent of nursing facility residents leaving their home county for services to facility occupancy rates in the county. All counties with 40 percent or more of their residents who receive nursing facility services leave their home county had 85 to 89 percent occupancy (Aurora, Brule, Mellette) or 90 to 100 percent occupancy (Gregory, Potter, Clark, Union, Meade). These are mainly frontier[10] counties. Overall, residents were more likely to travel out of counties where nursing homes were older than average, potentially revealing a preference by seniors for newer facilities.

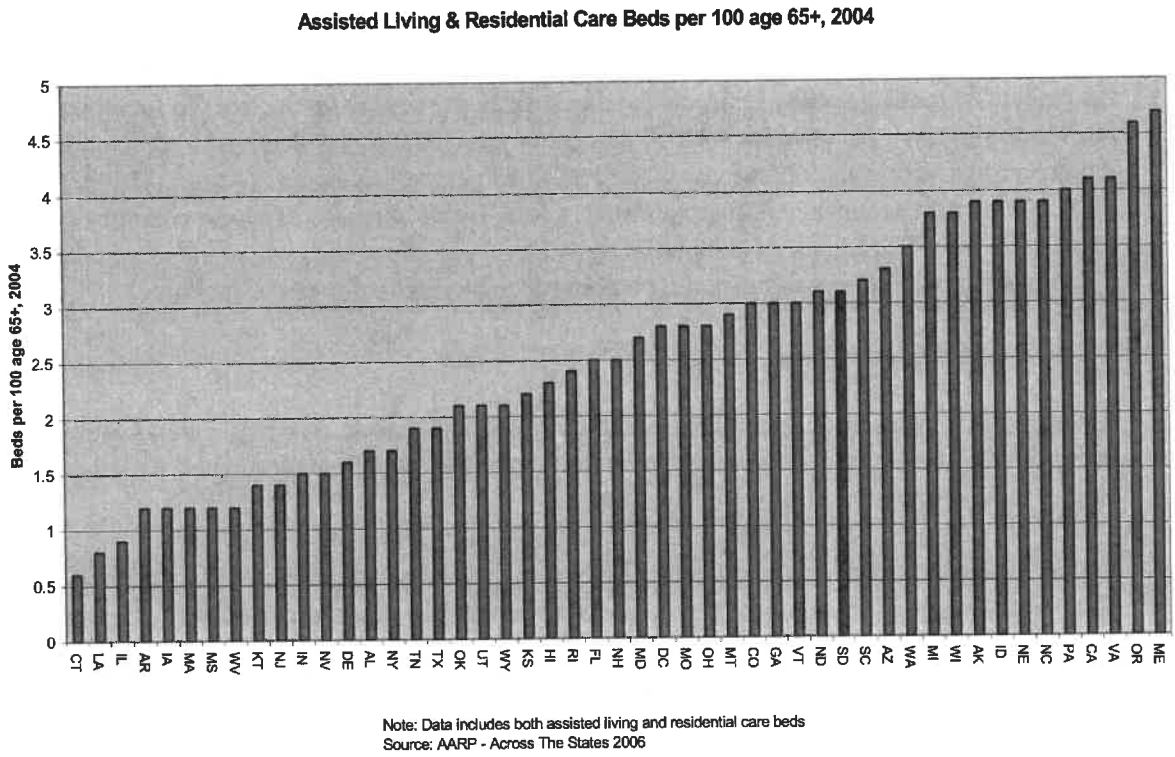
4.2.2. Assisted Living

Assisted living capacity has grown substantially in the past decade. The new options afforded by assisted living have eased the flow of elders into nursing facilities and accounted for a substantial drop in nursing facility utilization in the state.

National data on assisted living capacity are less complete than for other forms of care. However, South Dakota appears to compare favorably to other states in terms of availability of assisted living beds. As Exhibit 33 shows, based on a 2004 study, South Dakota ranked slightly above the national average in terms of "assisted living and residential care" beds available to elders: with 3.1 beds per 100 elders versus a national average of 2.7. The data potentially understate capacity in many states, since several states lacked comprehensive data on assisted living facilities. For South Dakota, the reported number of beds tracks closely to licensed beds reported to the Department of Health in 2004. Note the data reflect available beds and not utilization rates.

[10] County classifications are presented in Appendix 2.

Exhibit 33: National Comparison of Available Assisted Living Beds

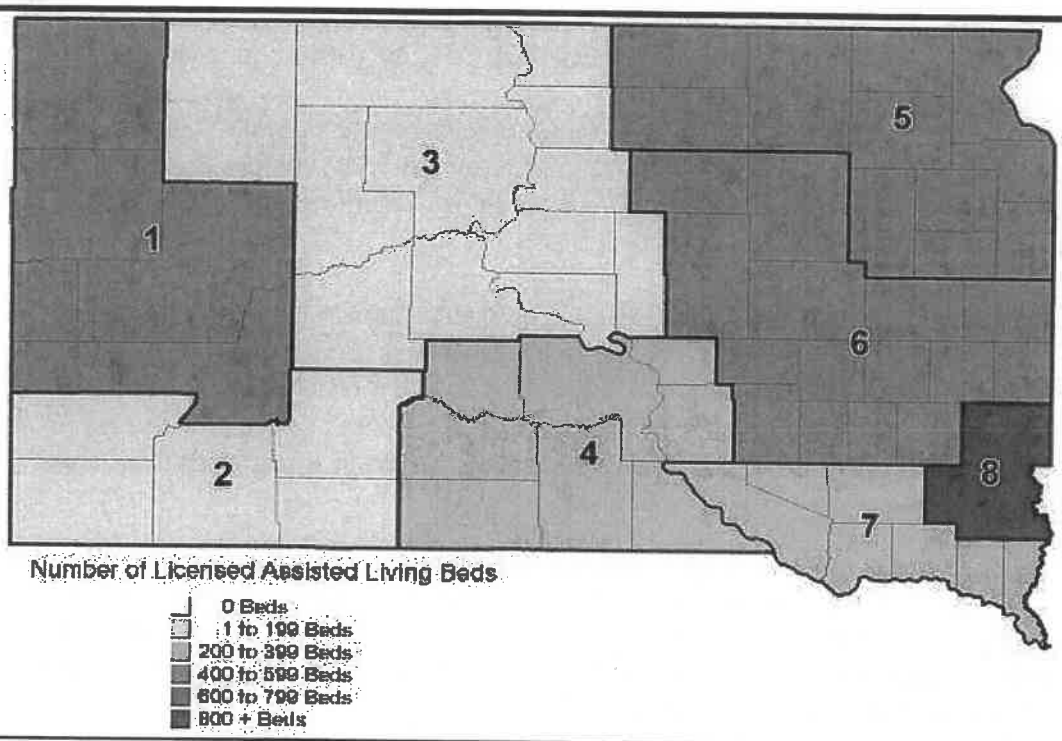


Source: AARP – Across the States 2006

Assisted living capacity is quite scattered across the state: 18 counties in South Dakota have no assisted living facilities. Eight of the counties without assisted living options have large American Indian populations in which elderly population growth has exceeded 20% since the beginning of the decade. Seven of the counties with no facilities are in the Central region where elderly population growth is also above average.

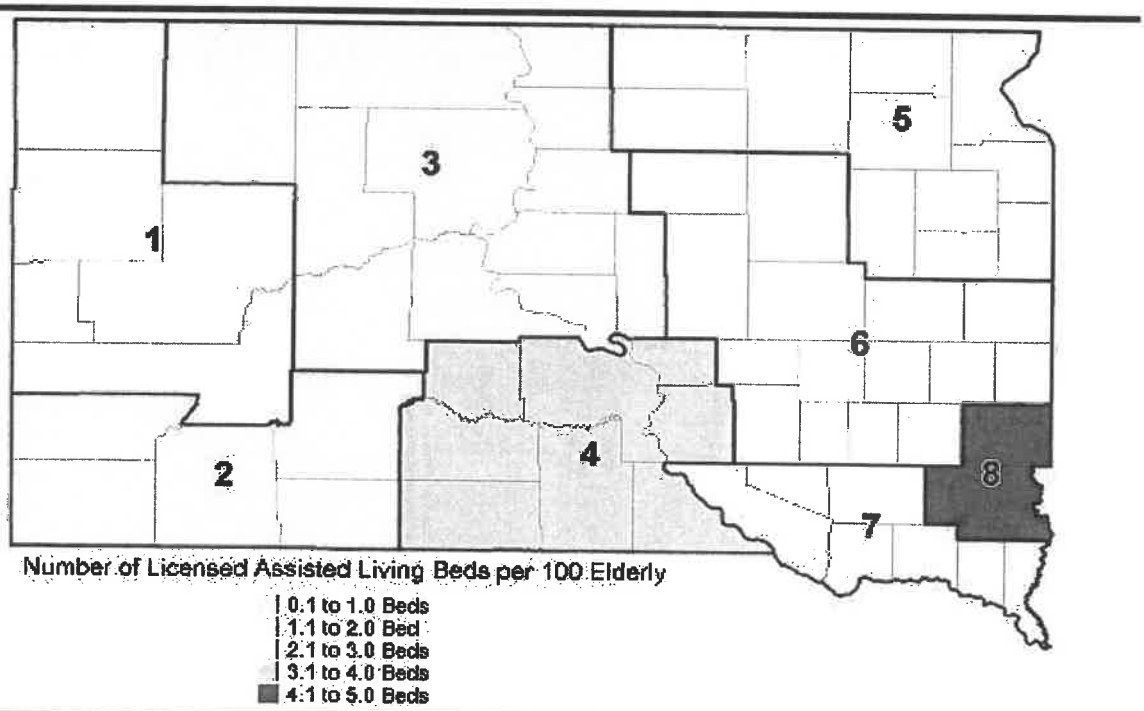
Exhibit 34 shows the number of assisted living beds by region as of 2005. Exhibit 35 shows beds available per 100 elders. The map is shaded to show how licensed bed availability compares to national average rates: regions shaded in yellow (Region 2 and Region 3, in the Central and Southwest part of the state) are below the national average; regions coded in white lie close to the national average, and regions coded in green (Region 5 and Region 8) lie above national average rates for bed availability. It is important to note that "above" and "below" do not imply better or worse: there is scant research on what might be optimal rates of assisted living use from either a cost or quality of care perspective. States that have expanded assisted living capacity, however, have been able to more readily shift care from nursing homes to less intensive settings, and individuals tend to prefer less institutional and more independent care settings.

Exhibit 34: Number of Licensed Assisted Living Beds, 2005



Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

Exhibit 35: Number of Licensed Assisted Living Beds per 100 Elderly, 2005



Source: South Dakota Department of Health Medical Facilities Report. Additional calculations by Abt Associates.

4.2.3. Home Health Care

Home health care can help seniors live independently for as long as possible, given the limits of their medical condition. It covers a wide range of services and even though it is typically episodic in nature, following acute illness or injury, it can often delay the need for long-term nursing home care.

More specifically, home health care may include occupational and physical therapy, speech therapy, and even skilled nursing. It may involve helping the elderly with activities of daily living (ADLs) such as bathing, dressing, and eating and monitoring one's daily regimen of prescription and over-the-counter medications.

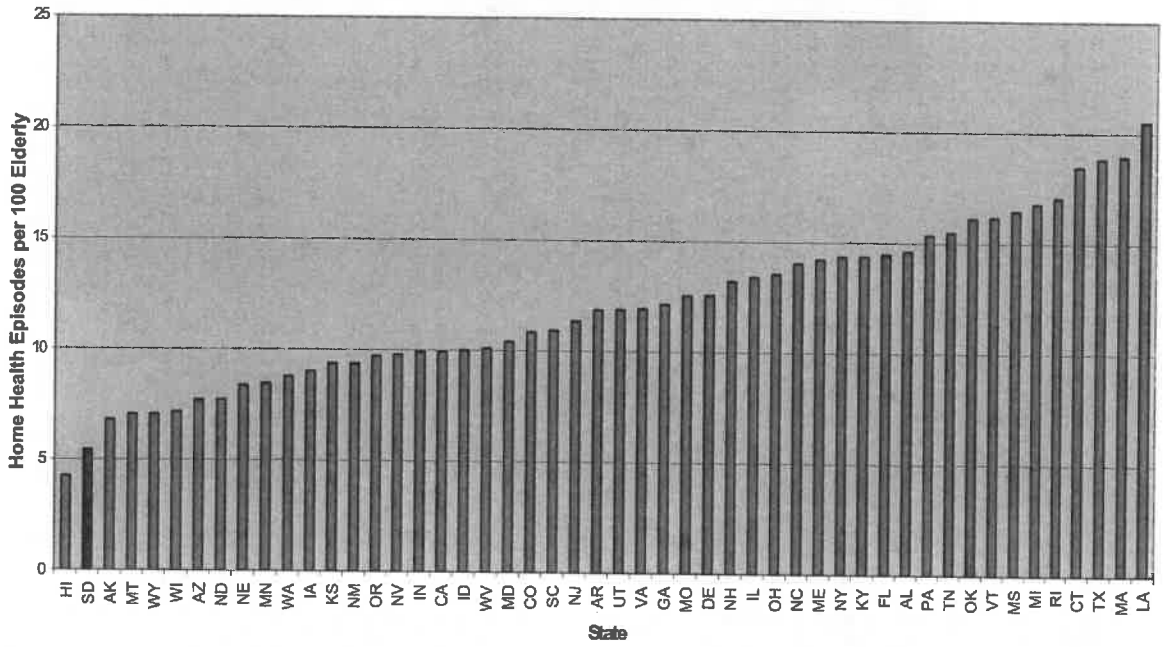
In this section we discuss the availability of home health care services, which are medical in nature and can involve skilled nursing, in contrast to homemaker or personal care services, which are in the next section. Home health services can be provided by independent agencies, or, in association with community and outpatient services, by hospitals or clinics. Since care is provided in patients' homes, travel distances pose cost and logistics problems for providers in sparsely populated areas of the State.

Medicare is a major payer for home health services, and CMS reimburses home health agencies on the basis of a prospective payment for each 60-day episode of care. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin; there are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. However, home health providers interviewed across the State indicated that most agencies took a very conservative approach to determining beneficiary eligibility for care, and this is likely reflected in lower than expected rates of use of home health services.

Home Health Utilization Rates

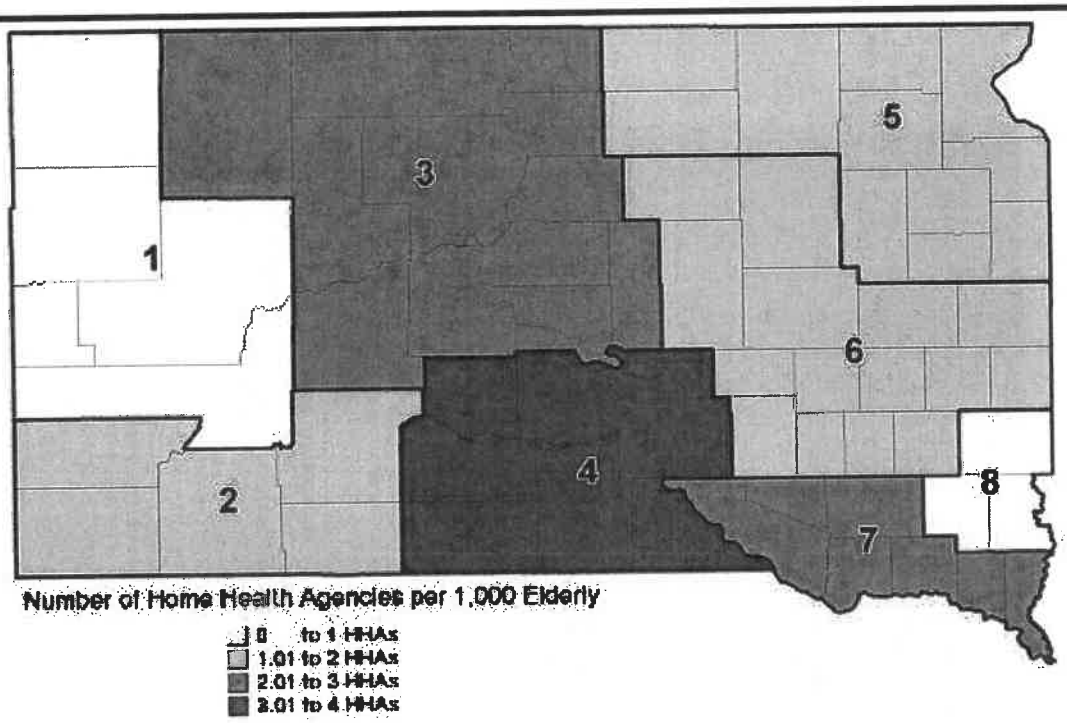
In 2005, South Dakota averaged five Medicare or Medicaid-paid home health episodes per 100 elders. This ranks the State 2nd lowest in U.S., compared to a national average of 12 episodes per year. (Exhibit 36).

Exhibit 36: Number of Home Health Episodes per 100 Elderly



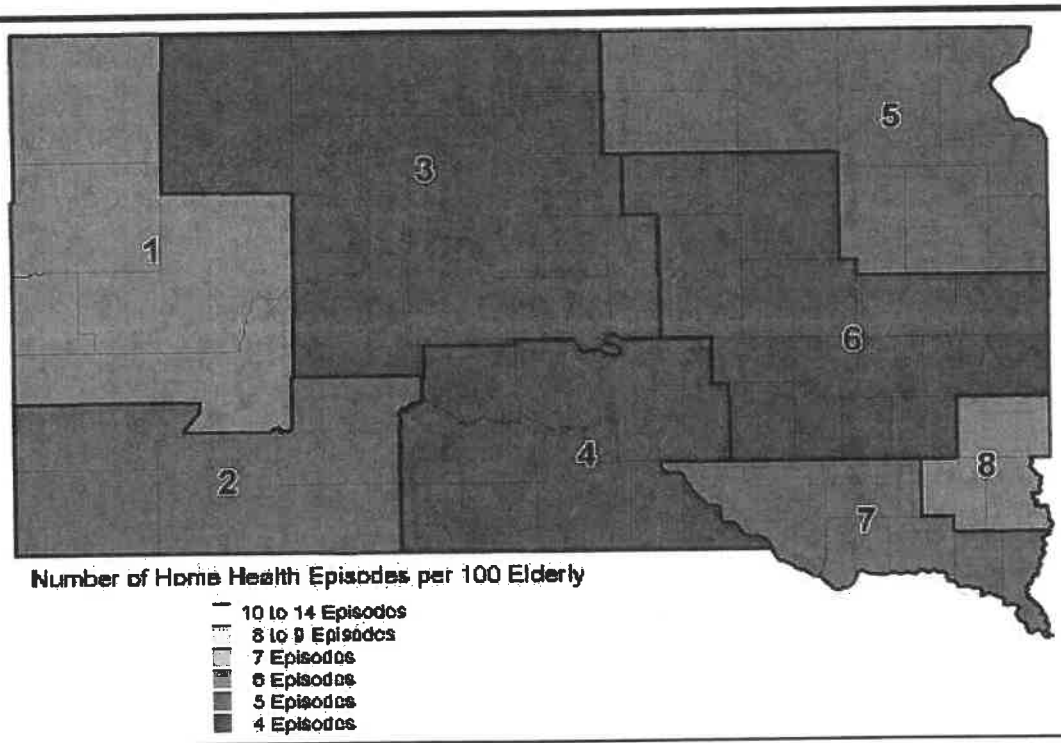
Low rates of utilization are likely due to lack of available providers, access problems and practice patterns that discourage use of services. In 2005, 19 counties in the state were served by no home health agency or only one agency. These counties were in frontier and sparsely populated areas. Similarly, 29 counties had between zero and 2.4 (very low) home health episodes in 2004. Exhibits 37 and 38 describe the locations of home health providers across regions in the state and the number of episodes of care delivered.

Exhibit 37: Number of Home Health Agencies per 1,000 Elderly, 2005



Source: Medicare Home Health Compare (09-2006). Additional calculations by Abt Associates.

Exhibit 38: Number of Home Health Episodes per 100 Elderly, 2005



Source: Medicare Home Health Compare (09-2006). Additional calculations by Abt Associates.

Moving South Dakota to national norms for home health care delivery would require doubling capacity immediately and increasing capacity 3-4 fold by 2025 simply to meet population growth.

4.2.4. Home and Community Based Services

The existence of home and community services are key to rebalancing long term care and to providing disabled seniors with the support necessary to remain independent in their communities for as long as possible. Home and community based services cover a wide spectrum of activities, including personal care assistance, cooking, transportation, meals and nutrition services, and assistance with activities of daily living. They can be provided by a wide range of organizations, businesses and charitable groups.

Across the State, and particularly in rural and frontier areas, there is limited availability of home and community based care. Clearly, a major barrier to providing community based care is the lack of a sufficiently sized community in many parts of the state to serve as the locus of services. Briefly:

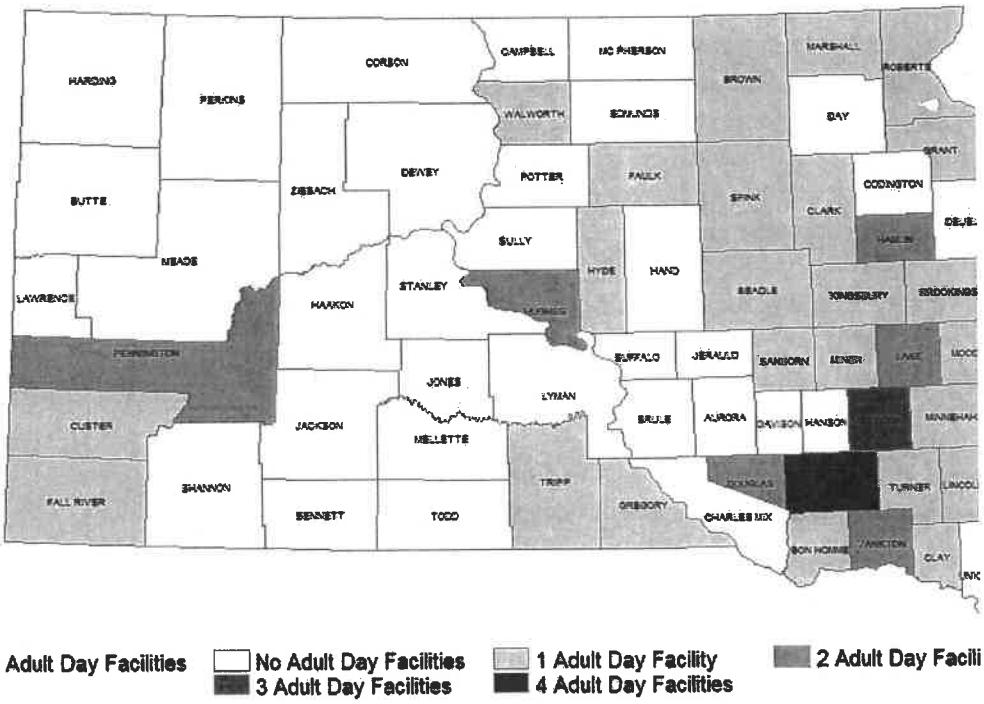
- 34 counties have no adult day facilities
- 28 counties have 0 or 1 senior centers per 1,000 elderly residents
- 18 counties have 0 or 1 nutrition programs per 1,000 elderly residents
- Although every county in South Dakota is served by a homemaker agency, 40 counties have no homemaker agencies located in their borders
    - Service is fragile; there are high rates of entry and exit of providers such that elders may not be able to depend on continuity of care

Adult Day Service Capacity

Each adult day facility is unique based on the services provided, payment source, and organization. However, data on services provided is difficult to obtain or nonexistent. Exhibit 39 presents the number of adult day facilities by county.

Exhibit 39: Number of Adult Day Facilities by County

Number of Adult Day Facilities by County



Source: Department of Social Services. Additional calculations by Abt Associates.

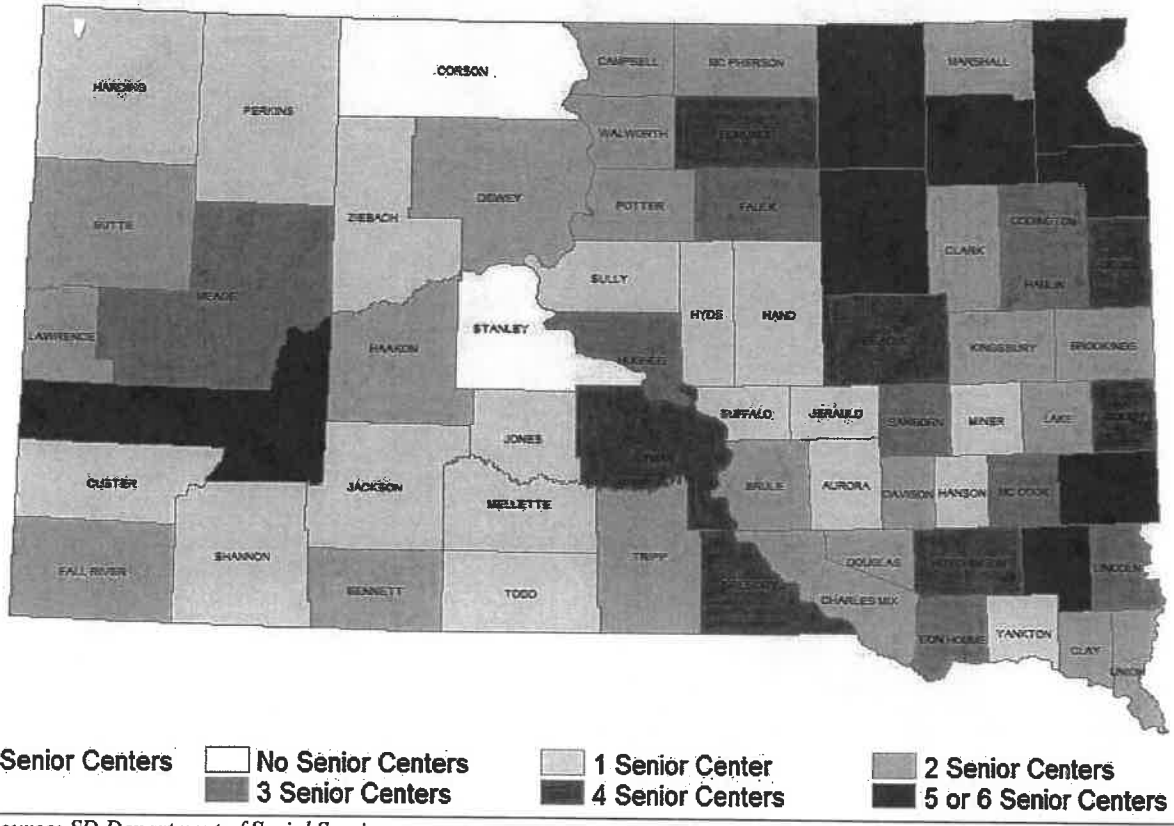
As of early 2007, 34 of South Dakota's 66 counties had no adult day facilities. Gaps in services are felt across the state. Of these 34 counties, 12 are located in the Central region, five are in the West, five are in the Northeast, three are in the Southeast, and nine are American Indian.[11] Twenty-six of the 34 counties with no adult day facilities are frontier counties, while eight are rural counties.

Senior Center Service Capacity

Each senior center provides a unique mix of the services, including recreation, transportation, nutrition and meals. There are no national data on senior center use or availability with which we can benchmark the State; however in almost all regions, existing senior centers are so few in number that they would need to serve upwards of 500-1000 seniors in their county or region. Exhibit 40 presents the number of senior centers by county. Exhibit 41 shows the number of senior centers per elderly in regions across the state.

[11] County classifications are presented in Appendix 2.

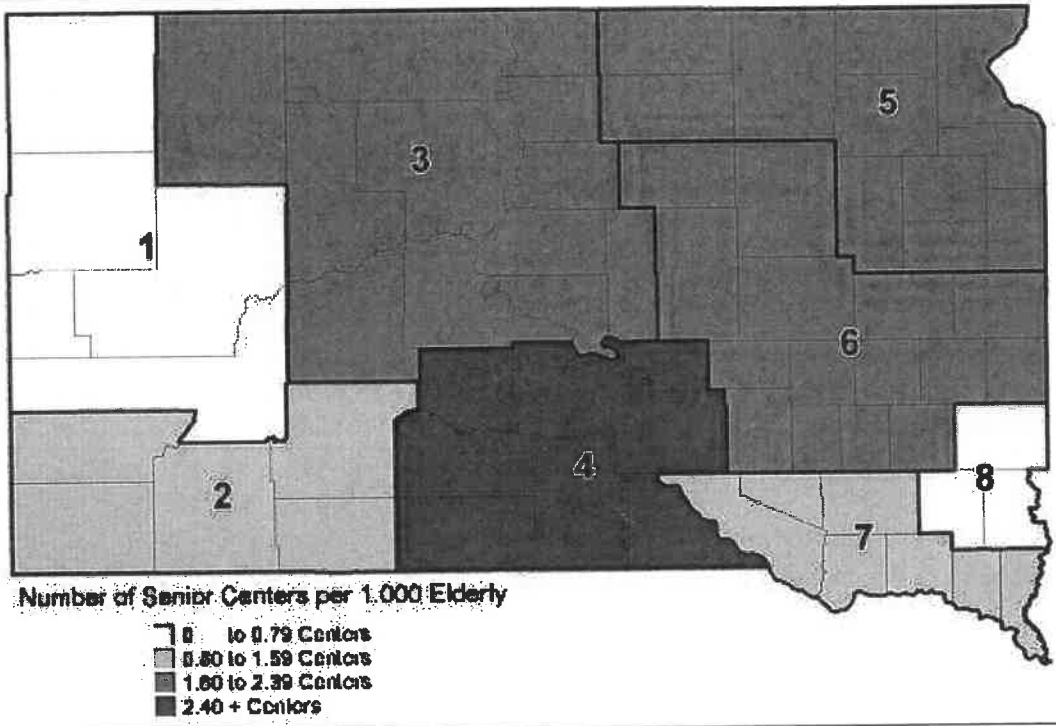
Exhibit 40: Number of Senior Centers by County



Source: SD Department of Social Services

As of early 2007, two of South Dakota's 66 counties, Corson and Stanley, had no Senior Centers. Eighteen more counties, distributed across the state, were served by only one Senior Center.

Exhibit 41: Number of Senior Centers per 1,000 Elderly, 2005



Source: Department of Social Services. Additional calculations by Abt Associates.

Nutrition Programs

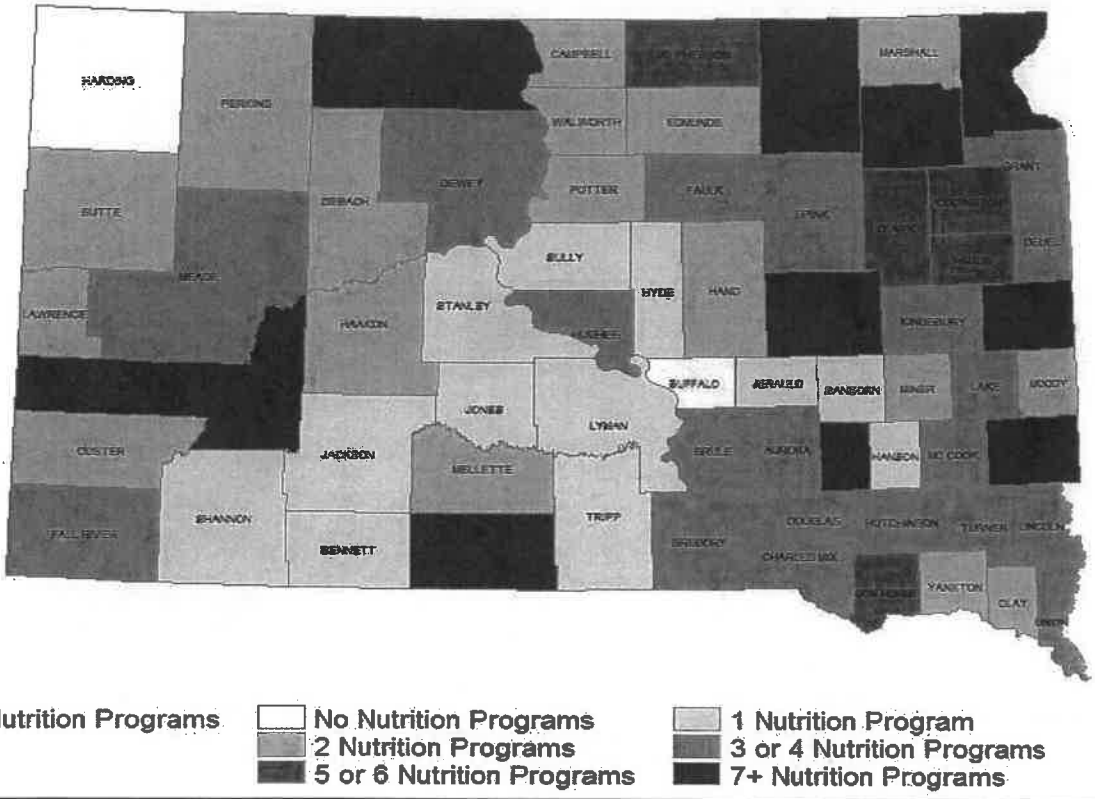
Most nutrition programs offer both delivered meals and congregate meals. Nutrition programs provide services to all counties in South Dakota, except Buffalo and Harding (Exhibit 42). Both are frontier counties[12] and have experienced higher than average rates of growth in their elderly populations in this decade.

As with other home and community based services, there are no national data with which to compare the adequacy of services. However the low numbers are telling. Of the 64 counties with available nutrition services, 12 counties were served by one nutrition program, 17 were served by two programs, 20 were served by three or four programs, five were served by five or six programs, and 10 were served by seven or more nutrition programs (although these were the most populous counties, where per capita coverage rates remained low). Particularly in rural and frontier regions, long travel distances severely limit the number of clients that can be reached by programs with home delivered meals, and seniors with mobility limitations may find it difficult to reach communities that have facilities to provide congregate meals.

In interviews, many nutrition providers reported that they were adopting novel approaches to providing meal services. Some were partnering with restaurants to provide discounted meals to eligible seniors. Others were turning to frozen meals that could be delivered several at a time, to economize on travel. Travel times and transportation costs were the largest barriers to expanding service areas.

[12] County classifications are presented in Appendix 2.

Exhibit 42: Number of Nutrition Programs Serving Each County 2006



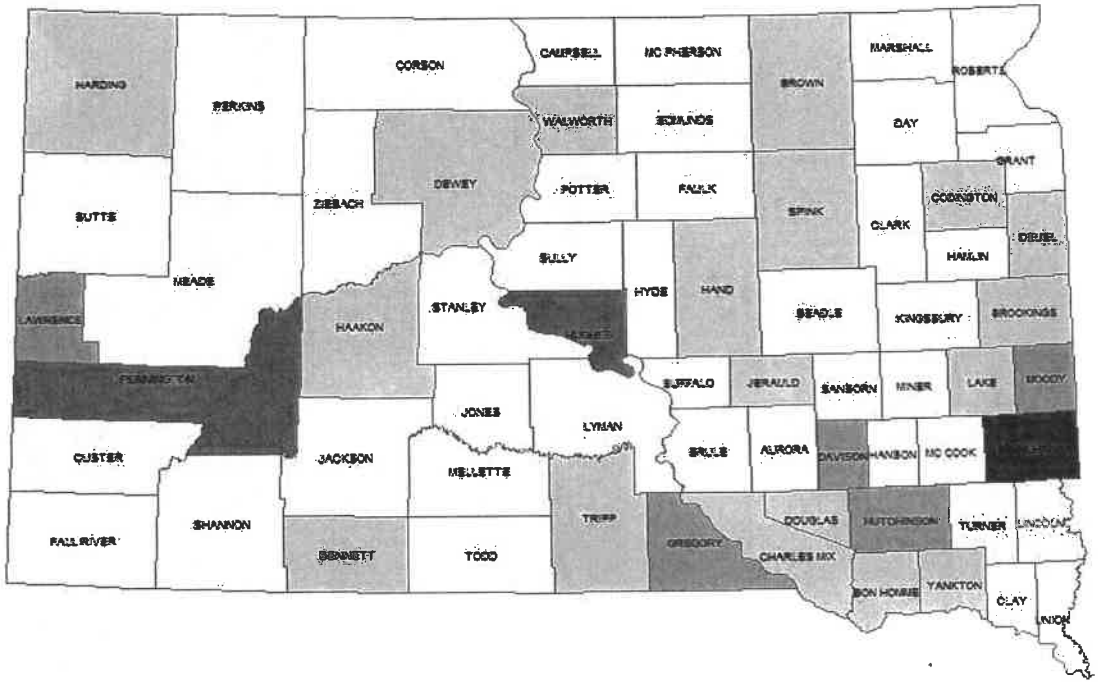
Nutrition Programs
- No Nutrition Programs
- 1 Nutrition Program
- 2 Nutrition Programs
- 3 or 4 Nutrition Programs
- 5 or 6 Nutrition Programs
- 7+ Nutrition Programs

Source: SD Department of Social Services

Homemaker / In-Home Personal Care Service Availability

Every county in South Dakota is served by a Homemaker agency. However, counties in which more Homemaker agencies are located are likely to receive more coverage than counties in which fewer agencies are located. We present the number of Homemaker agencies by county in Exhibit 43.

Exhibit 43: Number of Homemaker Agencies Located in Each County



Source: SD Department of Social Services

As of 2006, 40 of South Dakota's 66 counties had no homemaker agencies located within their borders. Of these 40 counties, five are located in the West, nine are located in the Central region, 11 are located in the Northeast, eight are located in the Southeast, and seven are American Indian[13]. Twenty-eight of the counties without county-based providers are frontier counties, and 12 counties are rural counties.

Homemaker / In-Home Service Utilization

Utilization of HCBS is difficult to assess due to differences in the unit of analysis and availability of data sources. The only utilization data available for HCBS is the number of homemaker / in-home service clients served for the years 2004, 2005, and 2006.

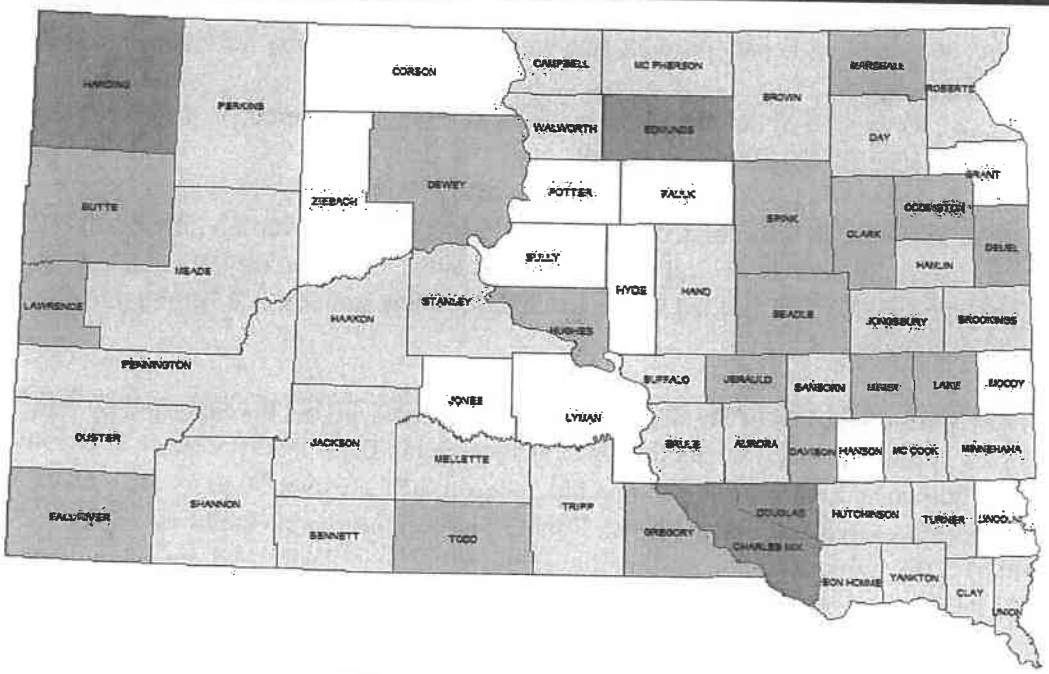
All counties had at least one client receiving in-home services during 2006. Twelve counties in South Dakota had between 15 and 29 in-home service clients, 33 counties had between 30 and 49 in-home service clients, 17 counties had between 50 and 79 in-home service clients, and four counties had between 80 and 99 in-home service clients per 1,000 elderly residents (Exhibit 44). Overall, utilization is highest in counties where there are county-based service providers.

Travel distances and costs are frequently a barrier to expanding services, according to providers, who often receive fixed reimbursements that do not reportedly cover travel expenses. The Department of

[13] County classifications are presented in Appendix 2.

Social Services (DSS) has recognized this problem and twice revamped rates to attempt to account for higher travel costs faced by rural providers. Rates were revised once in 2006 and again recently to reflect higher fuel costs. DSS has also recently modified reimbursement rates to cover the costs of health insurance for providers who offer insurance to employees. Several providers remarked that the higher reimbursement rates gave them an incentive to offer health benefits and also helped them attract better-trained and more experienced workers.

Exhibit 44: In-Home Service Clients per 1,000 Elderly by County



In Home Services Clients: 15 to 29 Clients; 30 to 49 Clients; 50 to 79 Clients; 80 to 99 Cients

Source: SD Department of Social Services

Of the 12 counties with the lowest rate of in-home service clients, eight are frontier and four are rural. Of these counties, five are located in the Central region, two are located in the Northeast, three in the Southeast, and two are American Indian.

4.3. Addressing the Sustainability and Financial Condition of Existing Nursing Facilities

The prior discussion has focused on whether there are adequate numbers of providers across the state to provide a comprehensive array of services for South Dakota's growing elderly population. In this section, we examine the financial and physical factors that could affect whether existing facilities will be able to provide care for the next 25 years. Are the facilities and physical plants adequate to provide care? Are the facilities financially stable?

4.3.1. Aging Infrastructure Threatens the System

South Dakota's nursing homes, by and large, are old.

- Over forty-five percent were built more than 40 years ago and are now beyond what some experts suggest is the useful life of a skilled nursing facility.
- Many nursing facilities require major renovations and redesign so that the facility can modernize clinical practices and accommodate new care models: e.g. flexible dining, community and recreation spaces promoted by CMS culture change initiatives, private rooms.
- Many require more fundamental renovations and replacement of physical plant: boilers, heating and cooling systems, electrical work. Others face prohibitive expenses to retrofit old structures to provide patients with new medical equipment, wire information systems or install sprinklers.
    - Only 44% of nursing home facilities are fully sprinklered, 31% of the facilities in the state are not sprinklered at all.

Depreciation has not been fully funded and reimbursements do not cover the full cost of facility renovations and additions. For several years, CMS has noted a pending capital crunch in the industry, warning of high capital costs, limited access to capital funding sources, and lagging facility renovation nationwide[14].

Exhibit 45 reports on the age of South Dakota's nursing homes, across the State and by region. Age is based on the original facility construction date, as recorded in DOH facility reports[15]. Statewide, over 40% of facilities are currently over 40 years old and over 80% are over 30 years old. As we look ahead and forecast services needs for South Dakota's elders, these same facilities will be 50 and 60 years old by 2025, unless there is considerable action aimed at replacing and renewing them. Many of the oldest facilities are in West River regions where the population of elders is expected to grow significantly. Others are in Central communities where populations are expected to grow slowly if at all. Exhibit 46 shows the number of facilities by DSS Economic Assistance Regions that have no sprinklers as of 2007, as an indicator of the number of facilities that are in need of significant, short-term capital improvement or replacement.

Replacement provides the state with an opportunity to resize capacity – building more efficient structures in areas of high population growth, and consolidating outdated capacity into smaller more flexible facilities in communities where there is excess capacity and a shrinking population.

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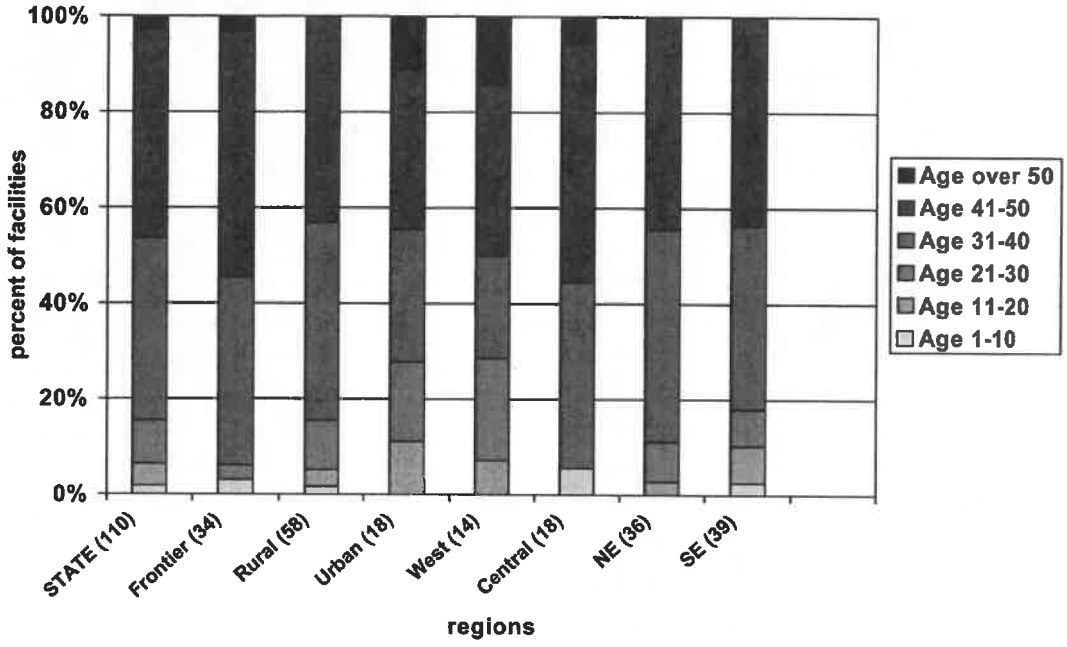
14 CMS, Health Care Industry market Update: Nursing Facilities, May 2003

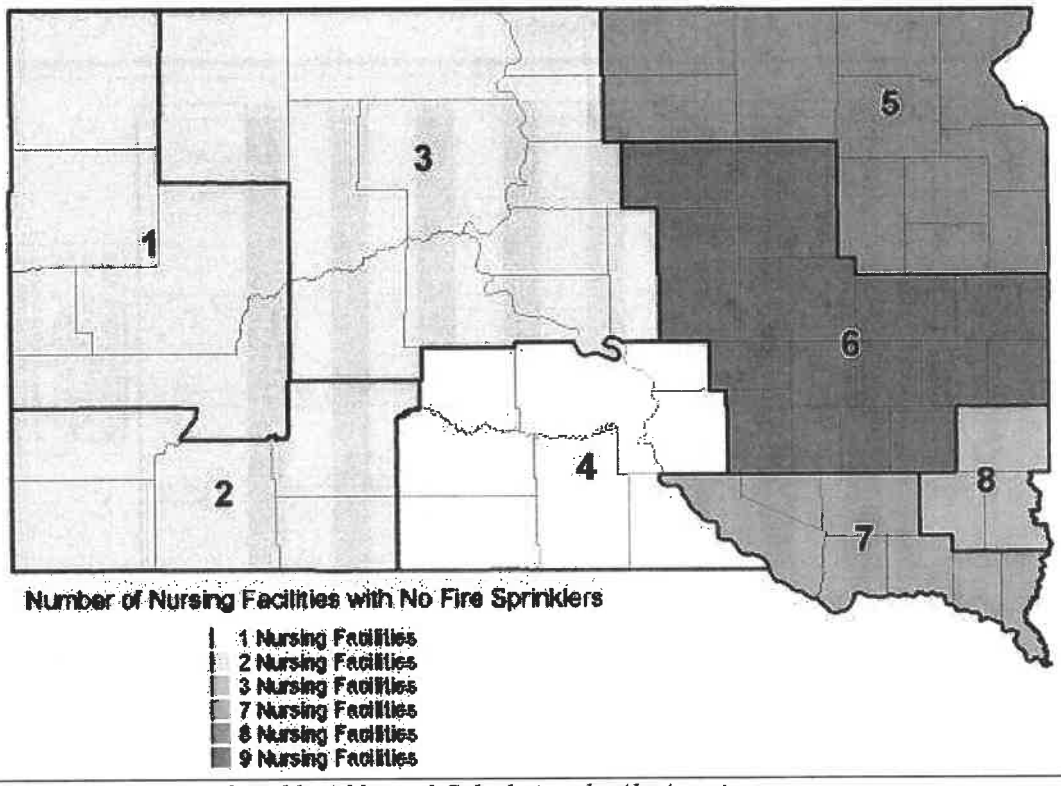
15 Approximately half of facilities have had at least one major renovation since construction, so these data overstate the average age of some of the beds in renovated facilities. Data are not available, however, to calculate the percent of licensed beds that were added after the original construction date.

Exhibit 45: Age Distribution of Nursing Home Facilities, Based on Construction Date by Region (Number of Facilities in Parentheses)



Source: SD Department of Health. Additional Calculations by Abt Associates.

Exhibit 46: Number of Nursing Home Facilities, by Region with no Sprinklers, 2007



Source: SD Department of Health. Additional Calculations by Abt Associates.

4.3.2. Assessing the Financial Condition of the Industry

As previously discussed, the nursing home industry nationwide has suffered through several recent periods of financial uncertainty and thin operating margins. Following changes to the Prospective Payment System (PPS) in the 1990s, and Balanced Budget Act (BBA) payment revisions in the early 2000s several chains filed for bankruptcy. In more recent years there has been consolidation of smaller chains and facilities, and changes in ownership among some of the larger systems. Financial volatility has made it difficult to access capital markets, even for the investor-owned chains.

Rising liability costs, renovation expenses, the need for new information systems and reporting technologies, and upward pressures on the wages of clinical nursing staff have contributed to financial pressures. Reimbursements seldom cover all operating costs: most providers rely on other sources of funding. Medicaid, the industry's dominant payer, contributes to the shortfall. Studies by BDO Seidman estimated a shortfall in Fiscal Year (FY) 2007 of $13.10 per day nationwide and gaps of $10-20 per patient day between Medicaid reimbursements and costs of care across the states[16]. For FY 2008, the Department of Social Services has estimated the gap in reimbursement compared to reported costs in South Dakota to be $8.02 / day.

[16] BDO Seidman, LLP, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care", June 2006.

Analyses of DSS Financial Ratio Surveys

Based on financial ratio data collected by DSS during the Spring-Summer 2007, Abt Associates conducted an initial analysis of the financial condition of South Dakota nursing homes. The objectives of the analysis were to assess the financial condition of the facilities across the state, and examine how financial performance relates to geography, operating characteristics, ownership, size, and facility age. The study was also interested in examining whether financial measures were linked to quality of care. Understanding factors that affect financial performance can help inform the criteria that the state may develop in deciding how to right-size industry providers.

There is considerable variation in reported financial performance across providers in the state. Some variation is due to payer mix and facility characteristics. However it is likely that a considerable amount of the variation is attributable to local operating challenges and management.

Exhibit 47: South Dakota Nursing Home Financial Ratios: 2006

Financial ratio	Non-hospital based facilities				Hospital-based facilities			
	Range	Median	Mean	25th-75th %-ile	Range	Median	Mean	25th-75th %-ile
Return on Assets	-2.21—1.70	+0.03	+0.012	-0.05 – 0.12	-0.32 – 0.13	-0.05	-0.07	-0.17 – 0.04
Operating margin ratio	-0.29 – 0.13	0.01	0.006	-0.03 – 0.06	-0.02 – 0.72	-0.045	0.032	-0.09 — 0.06
Days in Accts Receivable*	9.7 – 78.3	31.8	29.8	24.2 – 38.6				
Current ratio*	-0.20 – 7.03	2.02	2.95	1.2 – 3.3				

* Days in Accounts Receivable and Current ratio reported for only 2 hospital-based facilities. These are included in the reported data for the non-hospital-based providers.

Source: Financial ratio data, SD Department of Social Services

Key observations:

- There was considerable variation from year to year, but none of the reported ratios showed a significant trend between 2004 and 2006.
- Smaller facilities, measured in terms of number of beds, had significantly higher days in accounts receivable, potentially due to less sophisticated and extensive billing and claims processing capacity.
- The current ratio (CR) is one of the standard measures of financial strength and liquidity: examining if a business has sufficient resources to meet short-term obligations. A CR above 2.0 is generally acceptable; a CR below 1.0 is risky. Twenty-one facilities reported a current ratio (current assets relative to current liabilities) less than 1.0, and seven facilities reported a CR less than 0. The number of facilities reporting a CR less than 1.0 varied from year to year; however, over half of the facilities with a CR below 1.0 in one year also reported a low CR in another year.

Operating Margin Analyses

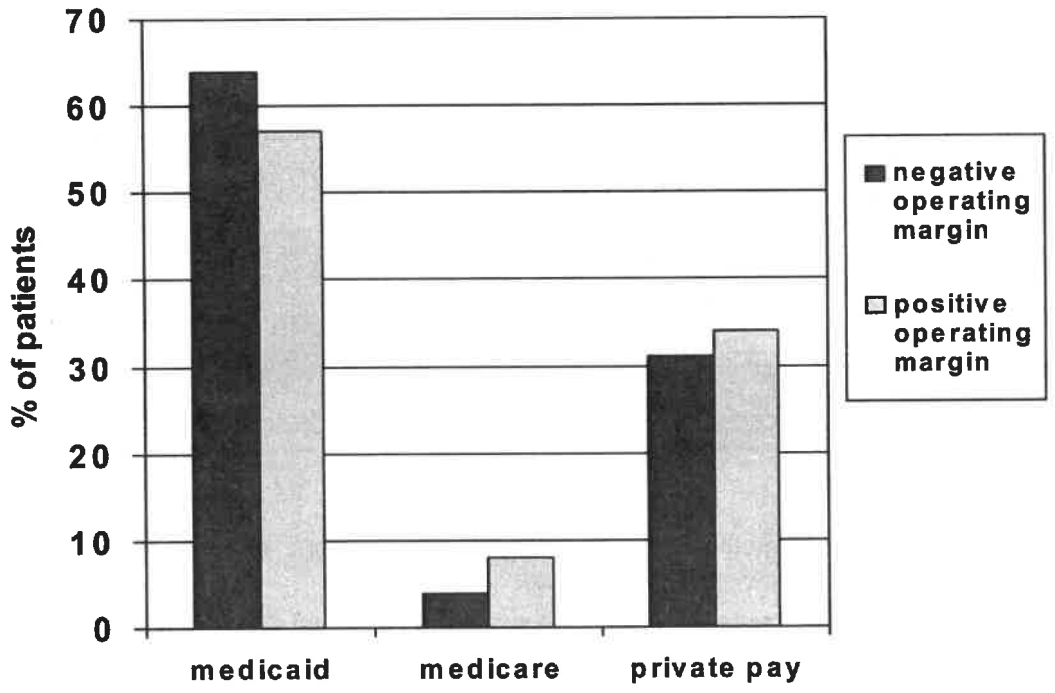
The operating margin is a standard measure of profitability. Abt Associates examined whether operating margins were related to payer mix or to case mix severity, in order to assess the role of reimbursement on margins. Providers reported widely varying operating margins: we assessed whether there were differences across regions, or according to the age of the facility. There is

considerable evidence that financial distress can lead to cost-cutting measures that impinge the quality of care. Analyses examined whether there was a relationship between poor financial condition and the quality of care delivered at the facility, as reported in CMS Nursing Home Compare quality scores.

Medicaid Caseload

Facilities that report negative operating margins are more likely to have a higher share of Medicaid patients and correspondingly lower shares of Medicare and private pay patients (Exhibit 48). There was no reported difference in the average case-mix severity weights associated with profitable versus unprofitable facilities: facilities with negative margins reported average case-mix weights equal to 1.13, while those with positive margins reported average case-mix weights equal to 1.11

Exhibit 48: Share of Patients by Payer: Facilities with Negative versus Positive Operating Margins

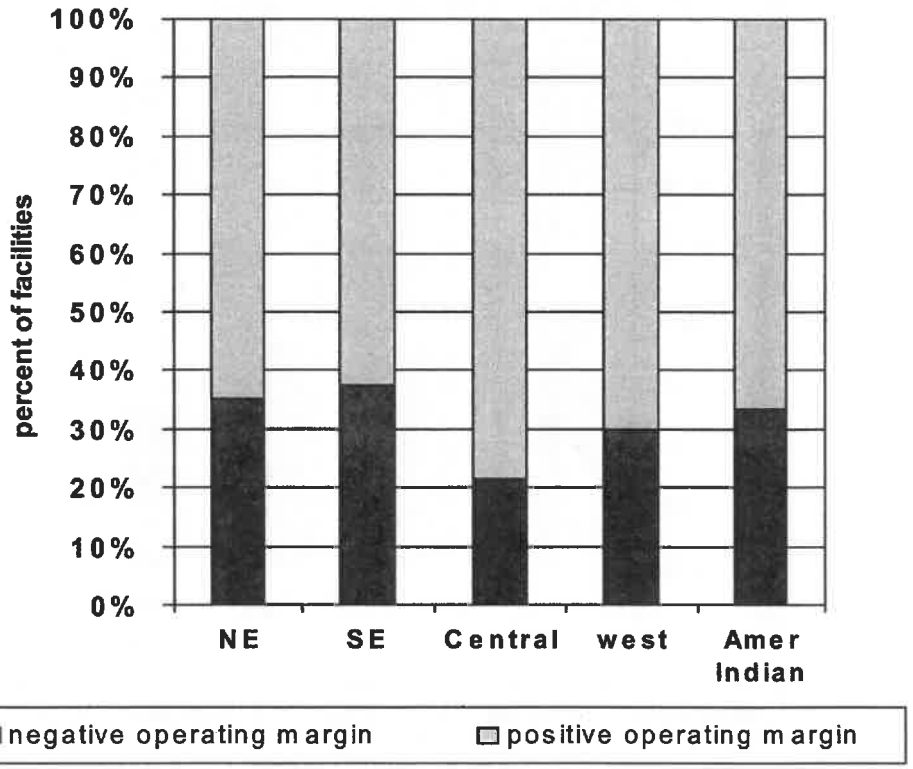


Source: Financial ratio data, SD Department of Social Services

Operating Margin, by Region

Facilities that report negative operating margins are found across the State: they are slightly more likely to be found in the Southeast or Northeast Regions, although differences are not statistically significant.

Exhibit 49: Distribution of Facilities with Positive and Negative Operating Margins by Region.

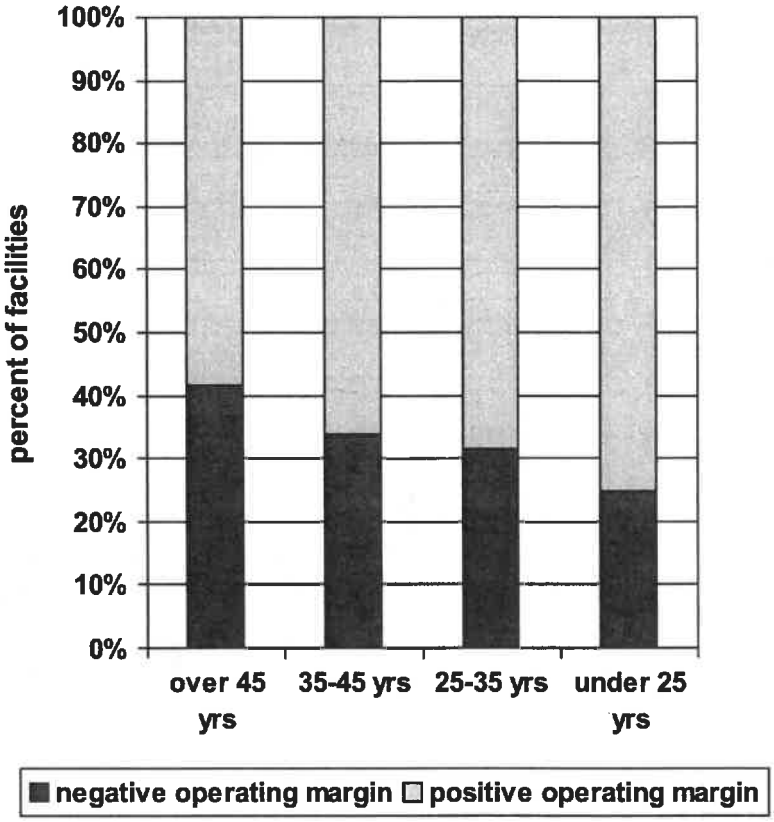


Source: Financial ratio data, SD Department of Social Services

Operating Margin, by Facility Age

Facilities that are older are more likely to report negative operating margins.

Exhibit 50: Percent of Facilities with a Negative Operating Margin, 2006 by Facility Age.

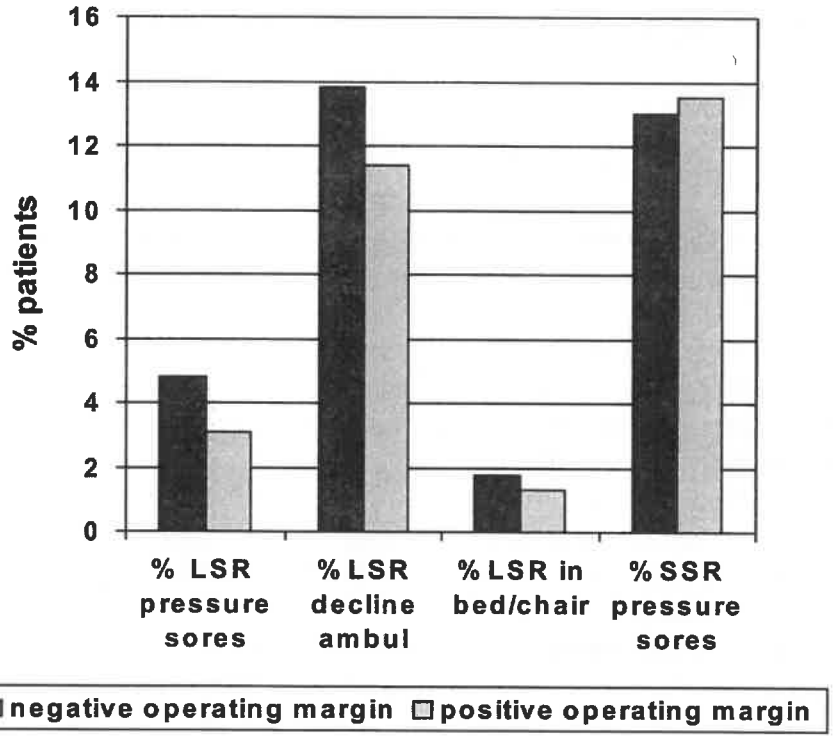


Source: Financial ratio data, SD Department of Social Services

Is Poorer Financial Condition Linked to Lower Measured Quality of Care?

While South Dakota nursing homes, overall, have above average scores on many of CMS' Nursing Home Quality Compare Measures, facilities that reported negative operating margins tended to report slightly lower scores on several measures that captured processes of care and avoidable events, relative to facilities with positive operating margins. The differences in average quality scores between profitable and unprofitable facilities are small and not generally statistically significant. There was no difference in vaccination rates between the nursing homes with positive and negative operating margins.

Exhibit 51: Scores on Major CMS Nursing Home Quality Compare Measures, 2006 Facilities with Negative Operating Margins Versus Facilities with Positive Operating Margins.



[Selected Nursing Home Compare Measures: Percent of Long-stay residents with pressure sores; percent of long-stay residents with decreased ambulation; percent of long-stay residents in a bed or chair; and percent of short-stay residents with pressure sores]

LSR: Long-stay resident

SSR: Short-stay resident

Source: Financial ratio data, SD Department of Social Services and CMS Nursing Home Compare

4.4. Projecting Future Demand For Long Term Care Services

Building on the assessment of long-term care services as they exist today, Abt Associates developed forecasts of the future demands for nursing home, assisted living and home and community based care through the year 2025. The forecast methodology involved 3 steps:

1. Develop county-level projections of the size and characteristics (gender, family structure, income) of the over-65 population, based on current demographics, death rates and population migration trends.
2. Forecast disability rates for the senior population to ascertain the level of potential care needs. Disability was defined as requiring assistance with one or more activities of daily living.
3. Translate disability rates and population characteristics into the demand for specific types of LTC services using current research and validated models. Forecasts were developed at the state, county and regional level for nursing facilities, assisted living, and HCBS.

4.4.1. Three Scenarios

We developed three primary forecast scenarios:

- **Scenario 1: Baseline/Status Quo:** Population growth as projected in the initial sections of the study[17], nursing home and assisted living utilization rates are fixed at average 2003-2005 levels
  - Nursing home utilization as % of elderly = 5.9%
  - Assisted living utilization as % of elderly = 2.1%
- **Scenario 2: Nursing home utilization declines over time at national rates,** driven by a decline in disability and substitution to assisted living and HCBS. Even though utilization declines at a rate that is equal to the national trend, historic factors keep South Dakota's overall utilization of nursing home services above national norms.
  - Nursing home utilization falls at a rate of 0.17% annually, reaching 5 beds per 100 elders (over age 65) by the year 2025.
- **Scenario 3: South Dakota will move to national rates of nursing home utilization by 2025.** Aggressive state policy encouraging substitution of assisted living and HCBS drives the utilization rate down faster than suggested by national trends and state demographics.
  - Nursing home utilization reaches 4% of the elderly population in South Dakota by the year 2025.

4.4.2. Scenarios: Background and Justifications

Scenario 1: Flat county-level nursing home utilization rates (Baseline, Status Quo)
The baseline projection scenario assumes that nursing home utilization in South Dakota will remain constant as a proportion of the elderly population in each county over time. We first aggregate

[17] We use South Dakota State Data Center projections since they are the only available county-level population forecasts for South Dakota. South Dakota State Data Center projections imply a 76% increase in the state's elderly population between 2007 and 2025. However, the US Census produces state-level population forecasts, which assume a considerably slower rate of population growth for South Dakota's elderly of approximately 56% over the same interval. Using the Census forecasts would result in lower LTC demand forecasts in all scenarios.

facility-level data from the South Dakota Department of Health Medical Facilities Reports for 2003, 2004, and 2005 to produce annual county-level estimates of the nursing home population. These estimates are divided by the total number of elderly county residents from the State Data Center population projections to produce utilization estimates as a proportion of the elderly population for each year. Though there was some variation across counties according to these estimates, statewide utilization of nursing homes as a percentage of the elderly population averaged around 5.9% over those years, or, equivalently, about 13.3% of the total disabled elderly population.

To produce our baseline forecasts, we assumed that the proportion of the elderly population in nursing facilities in each county between now and 2025 would remain unchanged from average utilization levels observed in 2003-2005. The average 2003-2005 county nursing home utilization rates are multiplied by the projected elderly population for each county to produce baseline forecasts of the total number of residents in nursing homes in the years 2010, 2015, 2020, and 2025. Under this simple assumption, the total population residing in nursing homes is expected to increase by approximately 80% between 2005 and 2025 – about the same amount as the increase in the state's elderly population over that time period. Exhibit 52 shows baseline (Scenario 1) nursing home utilization as a proportion of the elderly and disabled elderly populations.

Note that these forecasts are driven entirely by growth in the elderly population over time and do not take into account the state's current nursing home bed moratorium, or possible future changes in disability rates, family composition, income, or other factors potentially influencing utilization.

Exhibit 52: Nursing Home Utilization Rates Under Baseline Projection Scenario 1

	Elderly Population*	Elderly Disabled Population**	Nursing Home Population***	As % of Elderly Population	As % of Disabled Elderly Population
Actual Nursing Home Utilization:					
2000	108,131	46,957	6974	6.4%	14.9%
2005	119,313	51,783	6732	5.6%	13.0%
Projected Nursing Home Utilization:					
2010	132,632	57,538	7628	5.8%	13.3%
2015	151,878	65,858	8735	5.8%	13.3%
2020	178,994	77,590	10295	5.8%	13.3%
2025	209,590	90,835	12054	5.8%	13.3%

**Source: South Dakota State Data Center Projections*

***Source: Abt Associates projections*

****Source: South Dakota Department of Health Medical Facilities Reports (actuals); Abt Associates (projections)*

Key Forecast Parameters

1. County-level utilization rates: The baseline forecast assumes that county-level nursing home utilization rates as a percentage of the county elderly population hold steady at their 2003-2005 averages as reported in the South Dakota Department of Health Medical Facilities Reports. These rates range from a low of 0% in the thirteen South Dakota counties with no nursing homes to a high of 15% in Mellette County. The average utilization rate for South

Dakota as a whole from 2003-2005 was 5.8% as a percentage of the elderly population, or 13.3% of the disabled elderly population. (Total projected utilization rates for the state deviate slightly from these figures in some years due to variation in county-level contributions to the totals.)

2. Projected elderly population: Data on the projected elderly population in each county come from the South Dakota State Data Center projections. These data predict that the total elderly population will grow from 119,313 to 209,590 between 2005 and 2025, a 77% increase.

3. Projected disabled elderly population: Our projections of the future elderly disabled population assume that age-specific disability rates hold steady at their year 2000 levels. Applying year 2000 disability rates to the State Data Center projections implies that the elderly disabled population will grow from 51,783 in 2005 to 90,835 in 2025 -- a 75% increase.

Scenarios 2 & 3: Incorporating Changing Trends in Nursing Home Utilization

The baseline scenario assumes that nursing home utilization rates will remain unchanged. This is at odds with recent experience in South Dakota, where utilization rates fell sharply between the late 1990's and the early 2000's. Scenarios 2 and 3, in contrast, modify the previous simple extrapolation based on an extensive literature review and models of national and local trends.

There is some disagreement in the literature regarding future trends in nursing home utilization[18]. Spillman (2003) suggests that changes in female labor force participation and other factors are likely to reduce the future supply of informal care, driving increases in the demand for institutional care. In contrast, Alexcih (2006) predicts that increased consumer preference for home and community based care will drive continued declines in nursing home utilization rates despite population aging. Redfoot and Pandya (2002) similarly argue that the demand for institutional long-term care is likely to decline due to lower rates of disability, widowhood, and childlessness paired with increasing financial resources among the future elderly cohort. Lakdawalla et al. (2003) use the Medicare Current Beneficiary Survey to forecast future nursing home utilization as a function of disability status, marital status, and other demographic characteristics. They predict that the downward trend in nationwide utilization rates will reverse itself over the next decade as trends in age-specific disability stabilize, with the nursing home population 10-25% higher than a simple extrapolation of recent disability trends would suggest. Overall, they forecast a 1.5% decline in utilization due to reductions in disability, nationally. The impacts of demographic and geographic changes in South Dakota are anticipated to contribute to a reduction in disability that is only half the size of national figure: 0.8%.

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18 See the following studies for details of the models: Alexcih, L. (2006) "Nursing home use by "oldest old" sharply declines," Falls Church, VA: Lewin Group. Lakdawalla, D., D.P. Goldman, J. Bhattacharya, M.D. Hurd, G.F. Joyce, and C.W.A. Panis (2003) "Forecasting the nursing home population," Medical Care 41(1): 8-20. Redfoot, D.L., and S.M. Pandya (2002) "Before the boom: trends in long-term supportive services for older Americans with disabilities," Washington, DC: AARP. Spillman, B.P. (2003) "Changes in elderly disability rates and the implications for health care utilization and costs," prepared for the Office of the Assistant Secretary for Planning and Evaluation & Office of Disability, Aging, and Long-Term Care Policy, US Department of Health and Human Services.

The evidence of recent declines in nursing home utilization rates implies that the baseline scenario should be treated as an upper bound. It is unlikely that nursing home utilization rates will remain at their current relatively high levels. Over the next two decades, declining disability rates, decreases in childlessness and widowhood, increased rates of long-term care insurance coverage, and a general shift in consumer preferences towards non-institutional sources of care are all expected to contribute to a continued decline in elderly nursing home utilization rates.

Scenario 2: South Dakota utilization rates fall in line with recent national trends

This scenario assumes that the demographic and economic forces that have led to reductions in nursing home utilization continue to play a strong role. However, the various historical and institutional factors (e.g., geographic isolation, relatively low utilization of home- and community-based care) that have led to South Dakota's current high utilization rate are likely to continue to keep utilization at high levels relative to the nation as a whole. Under this assumption, we might expect trends in state utilization rates to move in line with trends in the United States as a whole; however the level of utilization in South Dakota will remain above national averages. The second forecast scenario assumes that utilization in South Dakota falls in line with national trends over the next twenty years. As Exhibit 52 shows, this implies a decline to a year 2025 utilization rate of 4.9% as a percentage of the total elderly population, or 11.1% as a proportion of the disabled elderly.

Scenario 3: South Dakota utilization rates fall to national averages by 2025

This scenario assumes South Dakota nursing home utilization declines more rapidly than national trends, reaching national norms by the year 2025. As shown in Exhibit 53, this assumption implies a 29% drop in nursing home utilization relative to the year 2005 resulting in a 9.2% nursing home utilization rate as a percentage of the disabled elderly population, or 4% of the total elderly population.

What types of policy and demographic changes might be required to hasten the decline in nursing home utilization ultimately impacting Medicaid utilization? Using published nursing home utilization models, Abt Associates examined scenarios that would produce a nursing home utilization rate of 4% in 2025. Under one such scenario utilization rates fall to 4% if the state is able to double LTC insurance coverage, expand assisted living capacity by 1.5% annually and triple available home and community based services. At the same time this scenario assumes that disability rates continue to decline according to recent trends, and that changes in family structure (widowhood, marriage) and personal income in the State match national trends.

Exhibit 53: Projected Nursing Home Utilization Rates, 2025

	Estimated Nursing Home Population*	As % of Elderly Population	As % of Disabled Elderly Population
Baseline Scenario: Flat utilization rates	12054	5.8%	13.3%
Alternative Scenario 2: NH utilization falls at a rate equal to national trends	10052	4.9%	11.1%
Alternative Scenario 3: NH utilization falls to the national average by 2025	8384	4.0%	9.2%

***Abt Associates (projections)

Summary of Nursing Home Forecasts for the State: 2000-2025

Exhibit 54 shows the nursing home utilization rates forecast under each of the three scenarios from 2000 through 2025. Exhibit 55 shows the number of beds demanded under each scenario over time, noting current levels of licensed beds and moratorium bed levels at the State.

- Under the baseline scenario, demand for nursing home beds exceeds the moratorium bed limit by 2015 and reaches 12,000 by 2025: a 75% increase relative to today.
- Under Scenario 3, bed demand rises much more slowly, as aging seniors delay entry into nursing homes and make greater use of assisted living and home and community based services.

Exhibit 54: Forecast State-level Nursing Home Utilization Rates; 3 Scenarios, 2000-2025

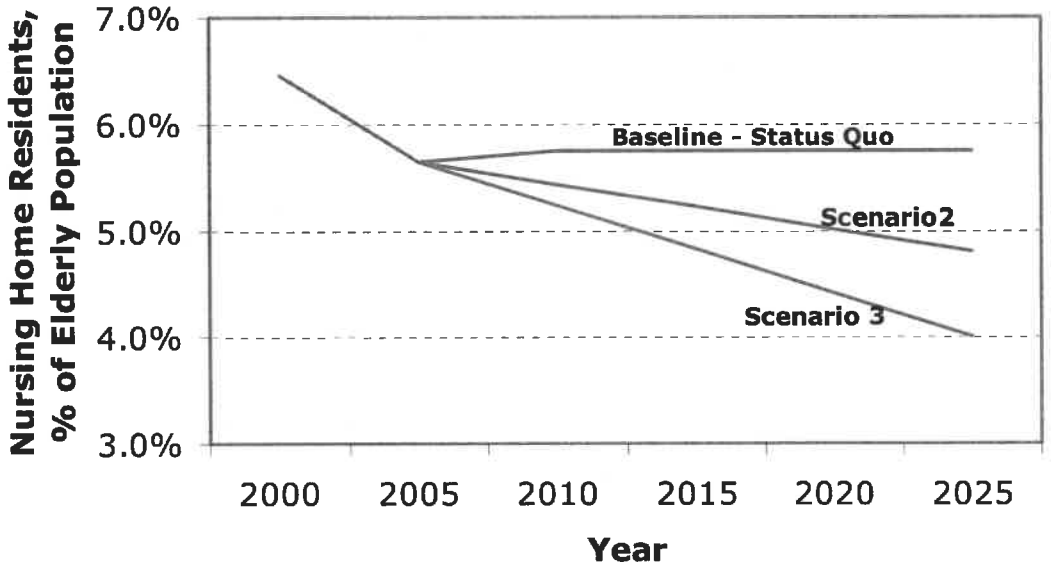
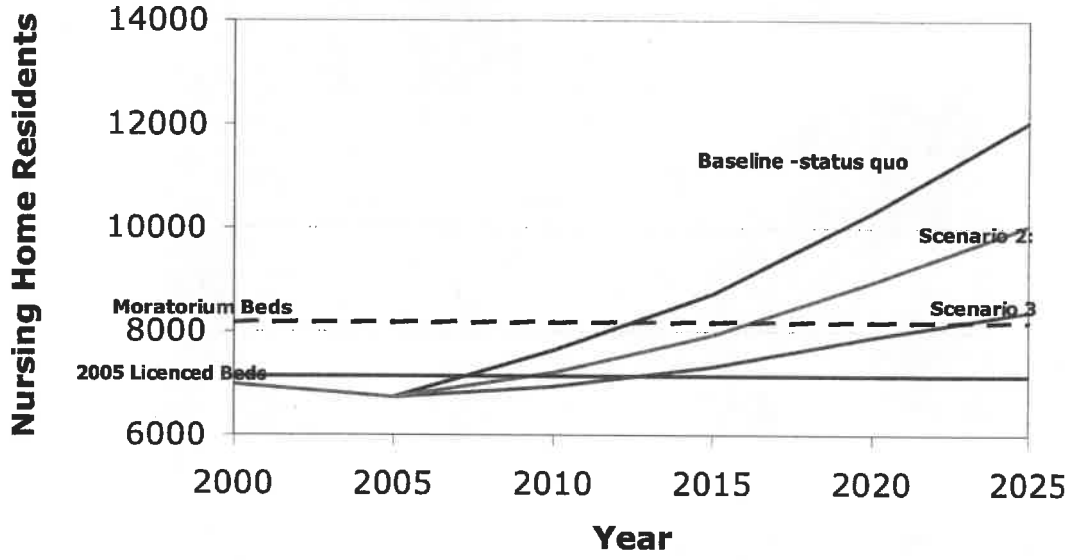


Exhibit 55: Forecast Number of Nursing Home Beds, Alternative Scenarios



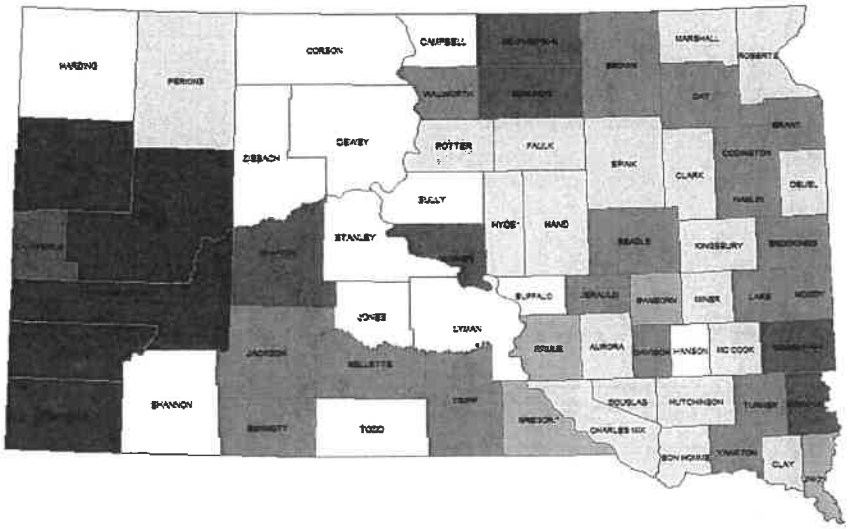
Just as there is wide variation in the population projections across the state, there is significant regional variation in projected supply and demand for future nursing home beds across the state:

- Western counties are expected to run out of nursing home beds in the very near term, perhaps before 2010.
- A substantial number of counties in the eastern and central parts of the state are not expected to become supply- constrained before 2025, or likely afterwards, since elderly populations peak in 2025-2030.

Exhibit 56 shows where county-level demand for nursing facilities will exceed moratorium bed limits before the year 2025. We present data for Scenario 3, which assumes the slowest rate of growth in nursing home demand.

In comparing demand to "moratorium" capacity we are overestimating the extent to which beds are available for use. Many facilities, operating below their moratorium limits, have converted semi-private rooms to private rooms and patient care rooms to other functions, including dining rooms, administration, rehabilitation and recreation spaces. While they could, from a statutory perspective, add new beds to accommodate demand, for many doing so would require major new construction.

Exhibit 56: Under Scenario 3 (Reduce Nursing Home Utilization to 4%) When Does County-Level Demand Exceed Supply of Moratorium Beds?



Year Capacity is Exceeded: No Nursing Facilities; 2020; After 2025; 2015; 2025; 2010

Assisted Living

As nursing home utilization rates go down, utilization rates for other types of long-term care services must go up. Built into the scenarios is an assumption that seniors who do not enter nursing homes, but who have care needs, will enter assisted living facilities or seek home and community based services.[19]

Exhibit 57 shows how use of assisted living services must rise as nursing home utilization is reduced. We present results for Scenario 2, since it is a mid-point forecast. (Under Scenario 3, nursing home utilization falls at a faster rate; so assisted living utilization necessarily rises at a faster rate, in order to take up seniors who need some form of care.)

Exhibit 58 presents demand forecasts for assisted living beds under all three scenarios and compares forecasted demand for beds to forecasted supply. In the model, assisted living bed supply was forecast to increase at 1.5% per year. This is lower than the rate at which assisted living beds expanded in South Dakota over the last decade (1.7%), but exceeds the rate at which beds have been estimated to expand nationwide (1.0-1.4% per year). Continued robust bed expansion will depend not only on the demand for care, but also on adequate reimbursement rates and continued access to capital for the largely private providers who have been responsible for the expansion of the assisted living industry.

[19] Specifically, reductions in nursing home use are driven by the assumption that seniors who have 2 or fewer ADLS can substitute care in assisted living facilities or will seek home and community based services to provide needed support.

Exhibit 57: Substitution between Assisted Living and Nursing Home Care

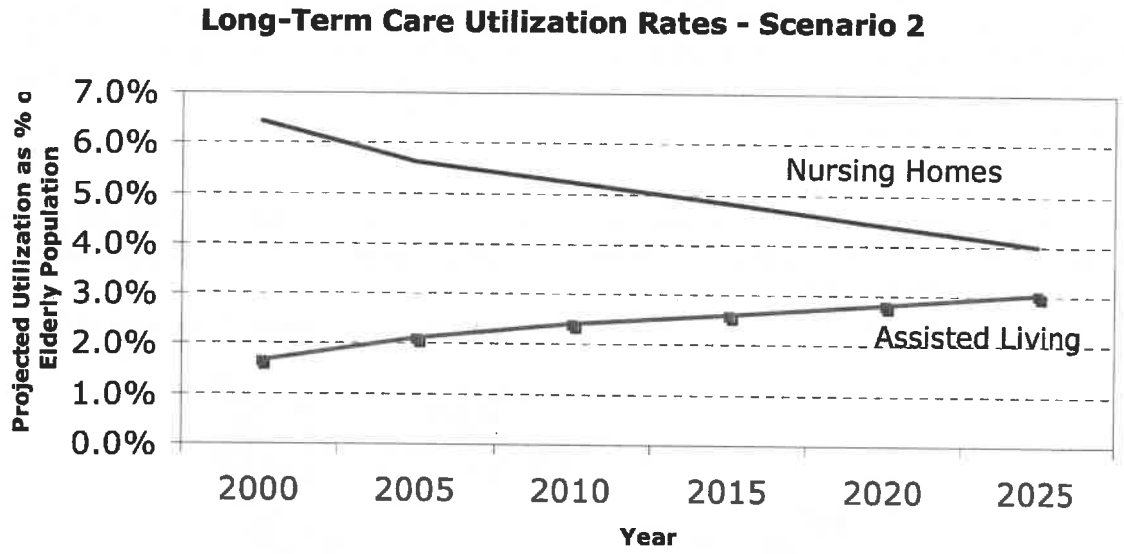
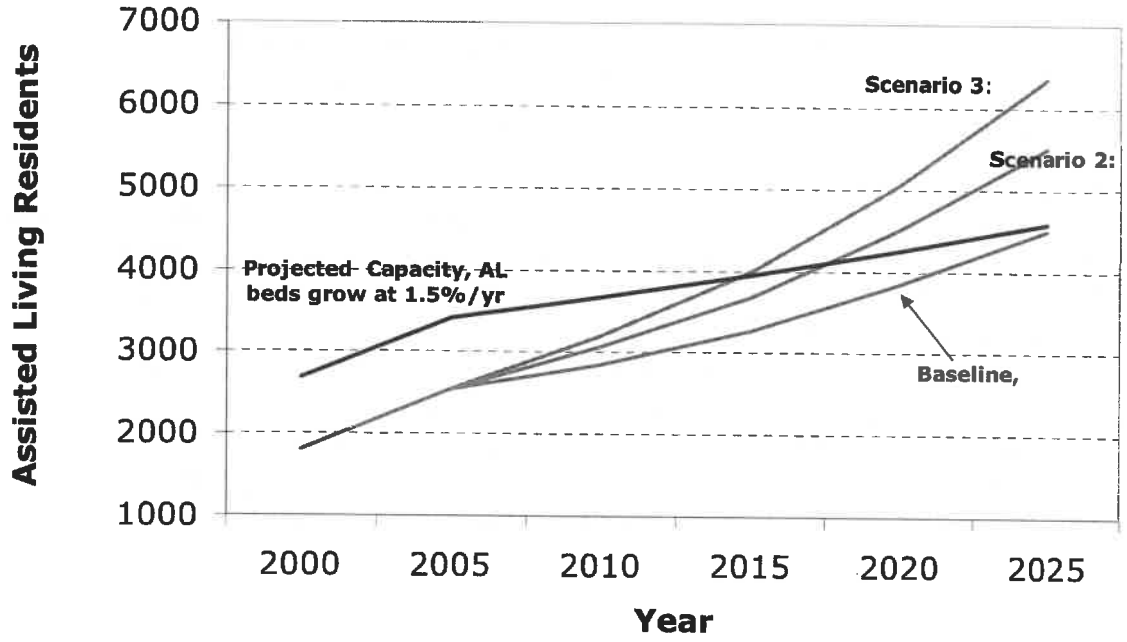
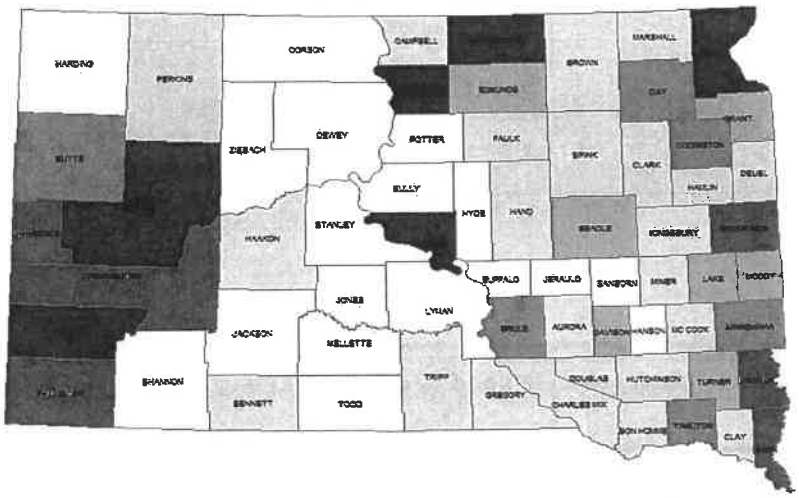


Exhibit 58: Projected Supply and Demand of Assisted Living Beds, Statewide 2000-2025, 3 Scenarios.



The supply of assisted living beds varies considerably across the state. As noted previously, in many of South Dakota's counties there are few beds and facilities available. Exhibit 59 examines the growth in demand for assisted living relative to the forecasted increases in supply at the county level. The projections are based on Scenario 3, and document the year at which projected demand exceeds projected supply. Projections assume that assisted living beds will grow at 1.5% in all counties, recognizing that this may understate bed growth in some regions while overstating it in others. The observed variation in the demand for care is caused by geographic variation in the projected numbers of disabled seniors across counties.

Exhibit 59: Projected Year at which Assisted Living Capacity May be Exceeded: Scenario 3, AL Beds Grow at 1.5% Annually.



Year Projected Capacity is Exceeded

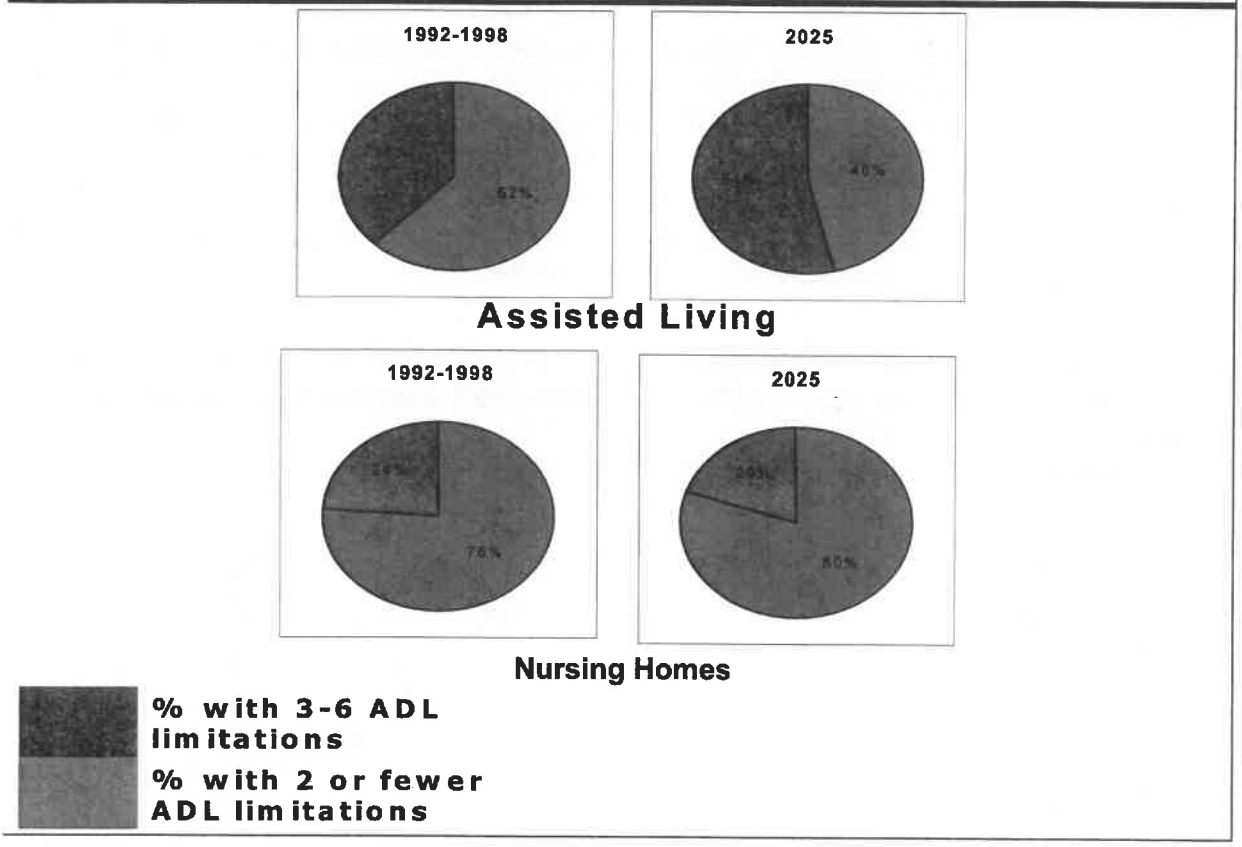
- No Assisted Living Facilities
- 2025
- 2015
- After 2025
- 2020
- 2010

Impact of Rebalancing Care on the Complexity of Nursing Home Patients

The seniors who choose assisted living are disproportionately likely to be healthier than those who move to nursing homes. This implies that future disability rates in nursing homes are likely to increase. Exhibit 60 forecasts how the complexity of the average nursing home resident, as measured by the number of ADLs will change over time.

- In the mid 1990s, 38% of nursing home residents had 3 or more ADLs. By 2025, the proportion with 3 or more ADLs is forecast to rise to 54%.
- Our forecasts assume that assisted living case mix will remain relatively unchanged, as the most complex patients continue to turn to nursing homes for care, and the least disabled will remain at home, making use of home and community based care.

Exhibit 60: Changing Complexity of Patients in Nursing Facilities and Assisted Living: 1995 – 2025, as Measured by the Number of ADLs



Home and Community Based Services

In all scenarios, the numbers of community-dwelling disabled seniors will increase, driven by population changes, higher projected wealth levels, individual preferences, or policy changes that could promote increases in home and community based care options.

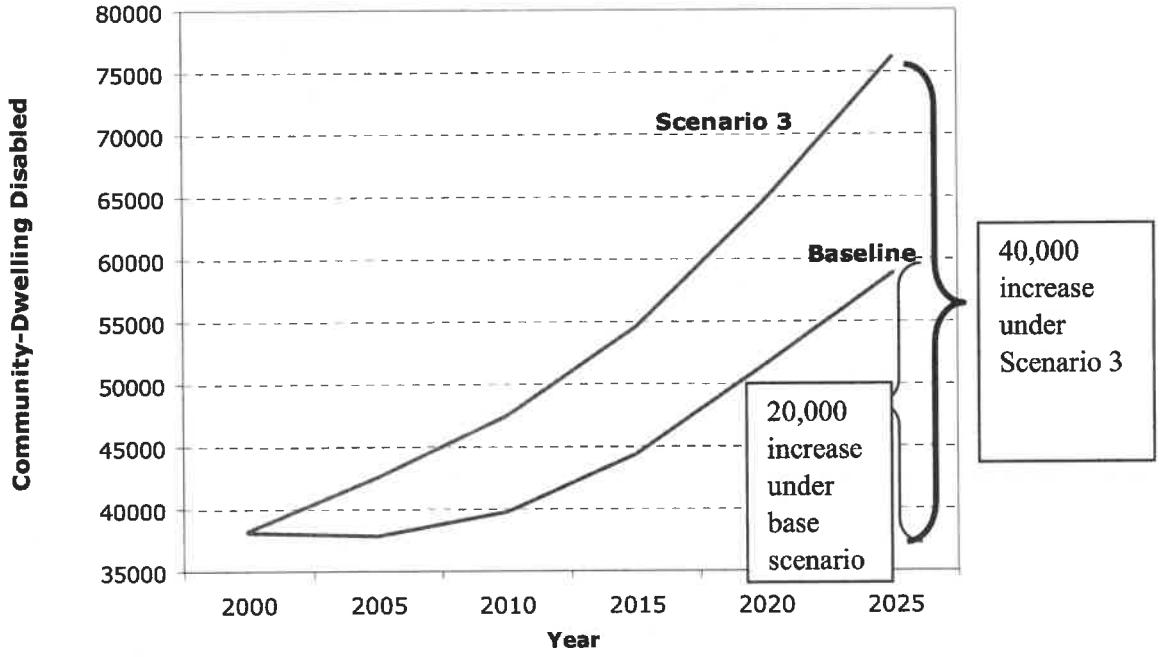
Exhibit 61 projects the increase in community-based disabled seniors under the baseline forecast and under the most optimistic rebalancing scenario, Scenario 3. Under baseline assumptions the numbers of community-dwelling disabled seniors will rise by 20,000 across the state by 2025. With greater rebalancing of care towards home and community based services, the numbers will rise by over 40,000 by 2025.

As discussed above, it is difficult to assemble current data on home and community based service utilization, and therefore it is difficult to predict future rates of demand for services. Services are provided by a wide variety of providers. Many services are privately paid and therefore do not enter state or federal accounting systems. Current utilization data, therefore, are incomplete. Furthermore the HCBS that are seen today may be far less than the care that is actually demanded by elders in the community. Workforce shortages and geographic challenges constrain suppliers today, and these problems will certainly constrain services in the future, as well.

However, all data indicate that South Dakota lags behind national norms in the use of home and community based care – ranging from homemaker services to medical home health care visits. In forecasting future needs, we make two simple assumptions: (1) HCBS will need to at least keep pace with changes in the size of the disabled elder population in the community; and (2) where possible South Dakota will attempt to move towards national utilization rates.

- Under baseline assumptions, home and community based services would have to rise by a minimum of 85% by the year 2025, simply to keep pace with growing senior populations.
    - Under Scenario 3 they will need to rise by 275%, again, keeping pace with population growth, but not improving on current rates of utilization.
    - If South Dakota moves to national utilization rates for home health services (the service for which we have the most reliable utilization data), available services would have to increase by another 300% statewide.

Exhibit 61: Under All Scenarios the Numbers of Disabled Community-Dwelling Seniors will Rise.



5. Recommended Strategies to Right-Size the System and Meet the Needs of South Dakotans in the Near and Long-Term Future

The preceding analyses set out a clear set of problems that require concerted policy action if the State is to achieve its goals of assuring high quality long term care for seniors. This section lays out a set of policy options and suggests an agenda for actions that can address the State's needs in both the near and long-term future.

1. **Set goals and adopt policies that reflect rebalancing, and right-size the industry:** Assure access for the population at risk by developing a "Critical Access Model" that encourages the development of smaller, efficient forms of care in areas that are currently underserved, or served by facilities that can not remain viable in the longer run.
2. **Provide flexibility in building capacity and develop adequate financing:** Seek exceptions to the Moratorium that permit bed-trading from low growth to high growth regions, and develop financial and loan plans that will move financial capital to priority areas.
3. **Expand Home and Community Based Services across the State:** Rebalance the continuum of long term care to provide citizens with care options that will permit them to remain independent, and in their communities for as long as possible.

Abt Associates conducted an environmental scan of potential state policy actions and selected those options that fit South Dakota's priorities, had been implemented in multiple settings and where there was concrete evidence that the policy had produced positive benefits.

We summarize key options below and discuss them in detail in the following sections.

1. ***Implement bed trading by an exception to the Moratorium mechanism for high-need areas.*** Meeting future demands for care will require flexibility and right-sizing capacity. An exception mechanism is required that would permit providers in high growth areas and designated Critical Access Areas to build efficient capacity, while at the same time not increasing the moratorium cap at the state level.

2. ***Pursue means to provide Medicaid-certified nursing facilities in South Dakota with low-interest financing for capital improvements and to provide financial assistance to foster the growth of HCBS infrastructure which could include a revolving loan fund (FLF), bonding, or other financing mechanisms.*** Tying these financing options to right-sizing priorities can provide incentives for decreasing nursing facility beds where they are not needed and increasing HCBS infrastructure where it is needed.

3. ***Continue to evaluate and modify the Medicaid reimbursement rate setting structure*** to a) better fund facility depreciation and capital improvements in all Medicaid-certified nursing facilities, and b) promote the growth and expansion of HCBS, specifically adult day services.

4. ***Monitor and consider novel, flexible forms of nursing facility organization for nursing facility replacement*** to improve satisfaction among residents remaining in facilities and establish small more flexible and efficient facilities in sparsely populated areas.

5. ***Explore options to develop "one-stop shops" that provide information, assessment, and referral to appropriate services.*** One-stop shops ensure that all LTC consumers, regardless of payer source or provider, receive the same information, screening for need and ability, assistance with developing a care plan, and long-term care service options. In conjunction with expanding the scope of one-stop shops, South Dakota should explore adopting an assessment tool for all applicants of the State Plan, HCBS, and nursing facilities to help provide more-comprehensive case management and data for planning and evaluation of LTC services.

6. ***Increase programmatic integration of long-term care service management within the Department of Social Services.*** The integration of South Dakota's DSS LTC services should support changes to the one-stop shops, assessment, and rebalancing efforts, and facilitate advances in data collection, information sharing and planning.

7. ***Monitor future opportunities for federal funding that support rebalancing long-term care.*** In the last 10 years, the Centers for Medicare & Medicaid Services (CMS) and other agencies have funded numerous programs designed to finance state efforts to remove barriers to community living and administer services in an integrated setting appropriate to the needs of elderly and disabled individuals. South Dakota should monitor future opportunities and pursue funding, particularly where grant funds can be used for establishing LTC programs that would have been undertaken with state funds.

8. ***Support Expansion of LTC insurance through LTC Partnership Programs*** and other initiatives to improve seniors' financial planning and insurance coverage, leading the way to more independent living choices and reducing the burden on state financing of LTC.

5.1. Implement Bed Trading by an Exception to the Moratorium Mechanism for High-Need Areas

Previous analyses have shown that the current configuration of nursing home capacity is not going to meet the needs of the senior citizens of the state over the next 10-20 years.

There are 4 key problems:

1. There is inadequate capacity in high growth areas;
2. There is excess capacity in low growth areas;
3. Many existing facilities are old and inefficient; and
4. There are many sparsely populated areas where care is needed, but existing providers and traditional health care organizations cannot attract enough seniors to remain viable.

The mismatch between needed capacity and available beds can be addressed by establishing a mechanism to allow bed trading by granting exceptions to the Moratorium. Under the trading program, the total number of moratorium beds would remain fixed at current levels (8193), but providers who are in "priority" areas could be granted permission to build needed new capacity.

Priority would be determined by review by state body that would operate under established criteria. Priorities would be established by the State, incorporating a number of factors, but they should necessarily include:

1. An evaluation of whether the new beds were being placed in a high growth area where, absent new construction, there was evidence that seniors faced shortages affecting access to needed nursing home care.
2. An assessment of whether the provider was in a "Critical Access" area and additional capacity was required to maintain a necessary level of care. "Critical Access" could be determined by examining distance to existing providers, similar to Critical Access Hospital (CAH) regulations, or by assuring that the number of beds in a geographic region approached national norms: e.g. a region would be designated as "Critical Access" if there were fewer than 80% of the national average NH beds per 1000 elders, and more than half of the senior population would have to travel over 50 miles to receive care. Additional priority could be granted in order to serve populations that were disadvantaged or who had special needs.
3. A requirement that new capacity be constructed in an efficient manner, replacing older facilities with more flexible and efficient operations where possible, and encouraging concurrent expansion of home and community based care. Care would be right-sized and rebalanced.

5.1.1. Evidence of the need for bed trading

Using the forecast scenarios developed in the previous section we can estimate the number of beds that might be traded under a moratorium exception program. For each DSS Economic Assistance Region, Exhibit 62 shows the maximum number of beds in use over 2003-2005, the Moratorium cap, and the projected number of beds required under alternative scenarios.

We take Scenario 3 as a starting point, since it involves the smallest expansion of nursing home capacity, and sets targets for rebalancing that would permit the state to maintain overall nursing home bed capacity at or around the current Moratorium cap. By 2025:

- Required nursing home beds in the Northwest region (Region 1), which includes the area around Rapid City and the Black Hills, would have surpassed moratorium beds by nearly 250 beds.
- Required nursing home beds in Region 8, Sioux Falls MSA, would have outstripped moratorium beds by 450 beds, with demand rising to over 2000 beds, versus the approximately 1400 that have been recently in use.
- At the same time in demand for beds in Regions 4, 5, 6 and 7, the Central and East River, non- metropolitan areas, remain well below moratorium caps.

Exhibit 62: Projected Need for Bed Trading Under Scenario 3

Economic Assistance Region	Maximum Licensed Beds 2003-2005	Moratorium Beds	Forecast Nursing Home Utilization in 2025 Under Alternative Scenarios		
			Scenario 1: Status Quo	Scenario 2: Reduce NH Utilization to 5%	Scenario 3: Reduce NH Utilization to Nat'l Avg : 4%
1: Northwest	808	841	1,522	1,329	1,090
2: Southwest	190	204	368	313	257
3: North-central	498	546	728	657	539
4: South-central	236	249	297	266	218
5: Northeast	1,647	1748	2,198	1,913	1,569
6: Mid-east	1,550	1752	2,035	1,784	1,463
7: Southeast	1,078	1258	1,464	1,288	1,056
8: Sioux Falls MSA	1,425	1595	2,930	2,502	2,052
Total	**7,432**	**8193**	**11,542**	**10,052**	**8,244**

5.2. Establish Revolving Loan Fund for Necessary Investment in Infrastructure

Policy Option: South Dakota could establish and administer a revolving loan fund (RLF) or other financing mechanisms to provide Medicaid-certified nursing facilities in South Dakota with low-interest financing for capital improvements and to provide financial assistance to foster the growth of HCBS infrastructure. Tying the RLF to right-sizing priorities can provide incentives for decreasing nursing facility beds where they are not needed and increasing HCBS infrastructure where it is needed.

South Dakota needs to invest in a variety of infrastructure in order to ensure that the continuum of long-term care can serve the needs of elders in the future. In particular, many nursing facilities will require capital improvements and many communities need to establish or strengthen home and community based services (HCBS). A revolving loan fund (RLF) or bonding option would assist providers in building or restoring infrastructure, while directing long-term care investment to areas that need it most and generate the greatest value.

5.2.1. Need to Develop Priority Criteria to Access the RLF

One of the most important aspects of these financing mechanisms is the ability to direct investment in order to achieve the greatest return on investment. An RLF or bonding option would need a set of prioritizing criteria in order to direct funds to the areas of greatest need, as well as optimize the role of the RLF to provide the greatest possible benefit to the State. Criteria necessary to establish an RLF include: facility eligibility requirements, prioritization of project types, maximum/minimum loan amounts, underwriting policies/collateral, interest rate specification, loan term, delinquency and default terms, allowed use of loan funds, etc. Other important criteria and regulations may be specified by the source capitalizing the funds.

To reiterate, the prioritizing criteria for an RLF or bonding option serve to ensure that funds are directed to projects that will provide the most value for the money, and to ensure that the RLF as a program has an optimal impact on financing projects across the State.

5.2.2. Other Steps to Implement a RLF or other financing options

A revolving loan fund (RLF) is a source of money from which loans are made for small business development projects.[20] RLFs are usually established to fill a gap in a business development project and are considered a tool of local governments or development agencies with the authority to administer the fund. Often the fund is created with monies that do not need to be repaid. The fund is "revolving" because as a loan is repaid, the money is available to make new loans to other entities. Several states have used RLF for LTC financing. Whether or not an RLF is appropriate for use in funding development projects for nursing facilities in South Dakota depends on a number of factors. The most important steps before establishing an RLF:

1. **Assess the need for an RLF or bonding mechanism:** Is there a financing gap for business development projects? Are the financing needs of nursing facilities being met by either public or private sectors?

2. **Identify criteria necessary to design a program:** These include facility eligibility requirements, prioritization of loans, maximum / minimum loan amounts, underwriting policies / collateral, interest rate specification, loan term, delinquency and default terms, allowed use of loan funds, etc. Other important criteria and regulations may be specified by the source capitalizing the fund.

3. **Assess whether an RLF program or bonding option will fill the financing need:** Is there enough money to fund development projects? Are the loan terms too restrictive, preventing borrowing? Are the collateral requirements excessive?

4. **Create an operational plan:** Who will administer the RLF (including staff capacity and responsibilities) or bonding program? Who can make changes to the program, and resolve disputes? Who will make up the loan review committee? What is the process for loan prioritization, selection, and approval? What is the source of funding for administrative costs?

5. **Implement the financing program(s):** The Fund's governing body should review and formally adopt the resolution to create the Loan Review Committee and establish positions. It should also create the necessary application forms, advertisements, etc.

The success of any financing option depends on the specifications for its use. If the fund is capitalized through federal source (such as matching funds through the Medicaid Program or the South Dakota Health Care Trust Fund) rather than a private source, there are likely to be more regulations and underwriting requirements, as is the case with USDA Rural Development Grants. However, finding a private source of funding large enough to support capital improvement projects

[20] Establishing a Revolving Loan Fund. Ohio State University Extension Fact Sheet. Accessed on 8/31/07. http://ohioline.osu.edu/cd-fact/1229.html

for nursing facilities in South Dakota may be difficult. How much money would a RLF or bonding program require to support nursing facility capital improvements? This is a difficult question that hinges mostly on exactly what type of projects would be funded, and over what period of time the projects would need to be completed. If development projects are prioritized efficiently, the RLF loans may be spread out over time to use multiple rounds of funding. For simplicity we consider just the total amount of money required for the State as if all projects were funded in one round of financing.

How Large Would a Well-Functioning or Bonding Program Need To Be in South Dakota?
In order to get the most value, it would be important to provide loans for establishing infrastructure in HCBS and nursing facility capital improvement projects that best fit the need of the facility and the community. There is a strong need for funding HCBS infrastructure; however, determining the amount of funds is difficult, as HCBS services are varied and require very different inputs. In order to roughly assess how much money would be required to fund a well-functioning RLF for nursing facility projects, we consider how many projects may be necessary based on facility age and facility fire sprinkler criteria. We use annual depreciation values of nursing facilities and estimates of the cost of installing fire sprinkler equipment for nursing facilities in South Dakota to estimate three cases:

1. Replace and resize a moderately sized nursing facility: $3.24 million
2. Remodel a moderately sized nursing facility: $885,000
3. Fully sprinkler a moderately sized nursing facility: $102,299 to $155,343

The oldest facilities would likely be the best candidates for facility replacement. In South Dakota, five facilities (four in the Northeast region and one in the West) have an estimated facility age of more than 47 years. Of the five oldest facilities three are moderately sized facilities, while one is a smaller facility and one is larger. Facilities that are older but do not need replacement would be good candidates for major facility remodeling in order to extend their useful life. Ten facilities in South Dakota have an estimated facility age of 44 to 47 years (four in the Central region, four in the Southeast, one in the Northeast, one American Indian). Of these 10 facilities, seven are moderately sized facilities and four are smaller facilities. Finally, 34 facilities in South Dakota have no fire sprinklers and 30 more facilities have some fire sprinklers, but not in the entire facility. Conversations with nursing facility administrators suggest that it would cost more to install fire sprinklers in older facilities because the original construction of the facility is more difficult to renovate. In order to install fire sprinklers in all non-fully sprinklered nursing facilities in South Dakota, the cost would be $4.44 million to $6.74 million.

Clearly, a very large RLF or bonding program could be used to fund many capital improvement projects for nursing facilities in South Dakota. However, these numbers suggest that a fund of $10 million could have an immediate and significant impact on the state of nursing facilities in South Dakota. No matter how large the fund, it is important to identify clear and appropriate criteria for prioritizing project recipients. By prioritizing candidate projects, South Dakota can optimally allocate loan funds in order to best serve the long-term nursing facility needs of the State, and can provide greater value to nursing facility improvement projects by first funding the projects that will have the most benefit.

An appropriately designed fund may have other desirable qualities for long-term planning for nursing facilities in South Dakota. One of the intrinsic benefits that a fund may provide is its ability to

provide development projects with access to financing at very low interest rates. Interest rates on RLF loans or bonds cover administration costs, but are not designed to generate profit for the lender as private debt market interest rates are designed. Access to funding for capital improvement at a very low price (interest rate) is a major source of success for development projects. Finally, an injection of a large amount of money into the State economy through improvement projects would also be a beneficial externality of an RLF.

5.2.3. Why Use a RLF or Bonding Program? What Other Capital Funding Options are Available?

As South Dakota's nursing facilities continue to age, facilities in areas of high or increasing demand for services will need major capital improvements. In general, for-profit nursing facilities can access funds privately through equity and debt markets, not-for-profit nursing facilities can access funds privately through debt markets, and all nursing facilities have access to funds through State reimbursement or other State-organized financing programs. Although State Medicaid programs reimburse facilities for capital depreciation, State programs designed specifically to fund nursing facility capital improvements are uncommon.

Some options for capital financing programs may be found in other general capital financing programs, including raising equity for publicly-traded companies, debt financing from private debt markets, mortgage insurance to encourage private loans, and modifying the nursing facility reimbursement structure. However, these options depend on the organizational structures of nursing facilities, and financing options may not be available for all organizational structures. It is also important to consider that because an option is available to a nursing facility, it still may not be a good option.

Capital Options in the Private Markets

Non-government owned nursing facility companies most often receive capital financing through private markets. Publicly held companies, such as Golden Companies, The Evangelical Lutheran Good Samaritan Society, and Manor Care, Inc., have access to capital through both equity and debt markets, while privately owned companies have access to capital through debt markets.

Publicly Held Companies—Equity: Equity financing may be limited in the near future due to industry-wide trends and uncertainty. In order to assess the financial future of for-profit nursing facility companies, the Centers for Medicare & Medicaid (CMS) considered the investor's perspective of purchasing nursing facility company equity securities (stocks) in a 2003 Market Update.[21] The analysis provides some background for the nursing facility industry nationwide. CMS found that publicly held nursing facility chains averaged 3% year-to-date return compared to 8% return on the S&P 500 Index. Uncertainty in the market is attributed to increasing labor costs due to nursing shortages, legislation allowing Medicare add-on payments to sunset in 2002, consistently below cost Medicaid reimbursement for services, and the rising cost of liability insurance. Due to these uncertainties, equity analysts do not believe that publicly held nursing facility chains could rely on the stock market as a major source of capital in the future.

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[21] Health Care Industry Market Update: Nursing Facilities. May 20, 2003. The Centers for Medicare & Medicaid Services. www.ahca.org/research/cms_market_update_030520.pdf

Debt Financing—For-Profit and Not-for-Profit Companies: The CMS Market Update explains that the nursing facility industry in the U.S. obtains most long-term capital financing from debt markets through private bonds, commercial banks, and other lenders. Commercial banks and other lenders often offer more-expensive financing options that are more often short-term and attractive for companies that are planning growth in business, rather than sustainability. Companies planning growth in business are able to accept more-expensive financing options, as their plan for increasing revenue can cover the larger expenses. Companies working to sustain current revenue levels often must find the least expensive financing available in order to work it into their budget without relying on increased revenue through expanding business. Long-term debt financing is encouraged by government-charter organizations Fannie Mae and Freddie Mac. Using the investor's perspective, debt analysts assess the likely profitability of a bond based on the company's ability to pay its debt service and related obligations. The following three statistics are a basis for assessing a bond's profitability:

1. EBITDAR – Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent. EBITDAR shows a company's cash available to pay interest, rent, and taxes after paying operational costs.

2. Rent Adjusted Leverage – Measures how much debt a company carries through leases or other obligations as a multiple of the cash flow available to pay debt service and lease payments. The rule of thumb for this statistic is that it is very difficult to raise new capital with a ratio of 5, and with a ratio of 6 it is nearly impossible.

3. Fixed Charge Coverage – Measures a company's ability to pay rent and interest based on cash available after capital expenditures. Analysts consider a fixed charge ratio of 2 to be the minimum required to raise capital.

Debt analysts have a negative outlook on investments in the nursing facility industry based on these statistics. In a state like South Dakota, a negative outlook may be easy to justify. With a moratorium on new nursing facility beds, the nursing facility business in South Dakota cannot grow and thus produce large positive returns on investments. In addition, uncertainties about revenue sources (sunsetting Medicare Add-On payments, below-cost Medicaid reimbursement) as well as increasing costs of labor and liability insurance do not make for a good rating from debt analysts. South Dakota collected data on a number of financial ratios; of the 40 nursing facilities submitting data for the Debt Service Coverage Ratio, which is similar to Fixed Charge Coverage, about half have a ratio of 2 or more and thus would meet the minimum required to raise capital in debt markets.[22]

Other Financial Assistance Options

The Department of Housing and Urban Development and the Federal Housing Administration (HUD/FHA) does not offer loans to nursing facility companies, but it does support debt financing by insuring loans from HUD-approved lenders for new construction, substantial rehabilitation, refinancing, and acquisition of nursing and other types of long-term care facilities. In addition, HUD/FHA also insures mortgages used to install fire safety equipment, including fire sprinklers. Insuring loans decreases the risk assumed by the lender and thus increases access to financing for

[22] Abt Associates analysis of State of South Dakota, Department of Social Services data collection of Selected Financial Ratios from Nursing Facilities in South Dakota.

nursing facilities through lower interest rates. However, loan insurance through HUD/FHA has additional underwriting requirements and potentially ongoing certification and regulation.

Through Section 232 of the National Housing Act, HUD insures mortgage loans to facilitate the construction or substantial rehabilitation of nursing facilities, intermediate care facilities, board and care homes, and assisted living facilities. Section 232/223(f) allows the purchase or refinancing, with or without repairs, of existing projects not requiring substantial rehabilitation.[23] In 2005, HUD insured mortgages for 22 projects totaling $1.3 billion.

Finally, CMS considered a higher cost alternative to traditional debt financing, Real Estate Investment Trusts (REITs). Instead of owning a facility outright, nursing facility operators lease facilities from REITs through a sale/leaseback contract. The major difference between REITs and traditional debt financing is that REITs do not assume the same liability risks as tenant operators. Thus, operators who lease the facilities may carry minimal insurance, forcing them to close business if faced with a lawsuit. The sunset of Medicare add-on payments has decreased the flexibility of a company to use REIT financing, but the option is still generally available.

Capital Options for Smaller and Not-for-Profit Facilities: Not-for-profit facilities, which comprise 28% of the nursing facility industry in the United States, and 64% in South Dakota (only North Dakota has a larger percentage),[24] must rely on private debt markets or philanthropy to raise capital. The not-for-profit debt market is riskier due to the greater liquidity constraints that result from operating a smaller company; however, "a strong balance sheet, adequate debt service coverage, a credible sponsor, high occupancy, decent Medicaid Reimbursement, and strong Certificate-of-Need protection" all help companies receive more favorable debt financing.[25] Analysts believe that nursing facilities can improve their financial outlook by diversifying into other types of long-term care, including assisted living and continuing care retirement communities, in order to increase payment from self-pay patients, who tend to prefer other long-term care options, and decrease dependency on Medicaid reimbursement, which generally accounts for a greater proportion of nursing facility reimbursement. So far, this strategy has been employed more often by for-profit nursing facilities, but would also similarly help not-for-profit nursing facilities.

As discussed in this section, the financing options for capital improvement are limited based on organizational structure, and limited due to a negative outlook for nursing facilities as an investment option. In short, many of these financing options are not available or not feasible for many of the nursing facilities in South Dakota.

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23 Mortgage insurance for Nursing Homes, Intermediate Care, Board & Care and Assisted-Living Facilities: Section 232 and Section 232/233(f). U.S. Department of Housing and Urban Development. Accessed on 8/31/07. www.hud.gov/offices/hsg/mfh/progdesc/nursingalcp232.cfm. The HUD Handbook " Section 232 Mortgage Insurance for Residential Care facilities" is available at www.hudclips.org

24 Distribution of Certified Nursing Facilities by Ownership Type, 2005. Kaiser State Health Facts, The Henry J. Kaiser Family Foundation. Accessed on 10/01/07.

25 Health Care Industry Market Update: Nursing Facilities. May 20, 2003. The Centers for Medicare & Medicaid Services. www.ahca.org/research/cms_market_update_030520.pdf

5.2.4. Experience of Other States that have Implemented a RLF

Minnesota Nursing Facility Conversion RLF Program: The Minnesota legislature has twice received proposals (most recently in 2007) to establish a nursing facility conversion RLF to reduce the number of licensed beds in a facility and increase the number of assisted-living beds. The proposed programs would authorize the Commissioner of the Housing Finance Agency to make loans from the nursing facility conversion RLF to nursing facilities, to cover construction and other costs related to conversion of nursing facility beds to assisted living beds.[26]

Iowa Senior Living and HCBS RLF Programs: The Iowa legislature created the *Senior Living Revolving Loan Program* to help development projects create affordable assisted living and housing for Medicaid-eligible senior citizens. The *Senior Living RLF* was initially funded by $5 million from the *Iowa Senior Living Trust Fund.* The loan amounts in the program range from $100,000 to $2 million, with interest rates set by the Iowa Finance Authority at or below the federal funds rate.[27] The first set of funded projects had loan terms of 20 years and an interest rate below 5%. The program gave priority to loans meeting the following criteria:[28]

1. Projects must be developed using low-income housing tax credits (LIHTC).
2. Assistance provided must help the project to maintain financial feasibility and affordability.
3. Applicants must satisfy all of the requirements of the application procedures described in the Qualified Allocation Plan to secure LIHTC.
4. Operating and replacement reserve funds must be adequately funded.

The Iowa legislature created the *HCBS Revolving Loan Fund* program to allow the Iowa Finance Authority to grant loans to assist in the development and expansion of facilities and infrastructure to provide adult day services, respite services, and congregate meals for low-income senior citizens. The *HCBS RLF* was initially funded by $2 million from the *Iowa Senior Living Trust Fund.*

Non-State Specific Projects: The United States Department of Agriculture (USDA) Rural Economic Development Grant Program is often a source of RLFs for utility cooperative associations.[29] For example, the Guthrie County Rural Electric Cooperative Association used a $330,000 grant to establish an RLF to assist in funding two physician clinics.[30] States and cities have also set up RLFs

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26 Minnesota State Legislature Senate Bill Name SF3252. Accessed on 9/17/07. http://www.revisor.leg.state.mn.us/revisor/pages/search_status/showtheLongD.php?b=Senate&f=SF3252&ssn=0&y=2000

27 The Federal Funds Rate is the interest rate at which private depository institutions lend balances (federal funds) at the Federal Reserve to other depository institutions overnight.

28 Morris, M. (2007). Reducing Nursing Home Utilization and Expenditures and Expanding Community Based Options. Community Living Exchange, funded by the Centers for Medicare & Medicaid Services. Rutgers Center for State Health Policy, February 2007. http://www.hcbs.org/files/107/5339/NursingHomeAlternatives_FEB2007_--FINAL.pdf

29 USDA Rural Economic Development Loan was used to help build the White River Health Care Center Assisted Living Facility in Mellette County. Accessed on 9/10/07. http://www.rurdev.usda.gov/RD/NEWSROOM/1999/redg99.htm

30 USDA Rural Economic Development Loan and Grant Program. Accessed on 9/10/07. http://www.rurdev.usda.gov/RD/NEWSROOM/1999/redg99.htm

through government offices or agencies. The Rhode Island Department of Public Health Office of Drinking Water Quality RLF has completed a number of development projects related to improving drinking water access and quality. This RLF has a working priority list of development projects generated by assigning points to six different categories to give each project a total point value, and thus a rank. The priority list and an established set of rules and regulations for the RLF are available online.[31] Although RLFs are often used for utility or small rural town capital improvements, the tool may be generalized for any purpose. The success of the program is largely dependent on how well the program specifications meet the need.

5.2.5. Establishing a RLF: Action Steps

- Determine where there is need for HCBS and nursing facility capital improvement financing in South Dakota.

- Specify Program Criteria: Eligibility requirements, prioritization of loans, maximum/minimum loan amounts, underwriting policies/collateral, interest rate specification, loan term, delinquency and default terms, allowed use of loan funds, etc. Other important criteria and regulations may be specified by the source capitalizing the fund.

- Assess whether a RLF program will fill the financing need: How large should the fund be? Will those requiring funds meet the loan specifications?

- Determine program administration: Who will administer the RLF and what are the responsibilities? Who can make changes to the RLF Program and resolve disputes? Who will make up the loan review committee? What is the process for loan prioritization, selection, and approval? What is the source of funding for administrative costs?

- Implement the RLF program: The Fund's governing body should review and formally adopt the resolution to create the Loan Review Committee and establish positions. It should also create the necessary application forms, advertisements, etc.

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[31] Rhode Island Department of Health Office of Drinking Water Quality. http://www.health.state.ri.us/environment/dwq/projcomplete.php

5.3. Continue to Evaluate and Modify Reimbursement Rates Paid by Medicaid and the State

Policy Option: South Dakota could modify the Medicaid reimbursement rate setting structure to 1) better fund facility depreciation and capital improvements in all Medicaid-certified nursing facilities, and 2) promote the growth and expansion of HCBS, specifically adult day services.

Evaluating reimbursement rates for nursing facility services and HCBS would allow the State to address certain long-term care issues through regular financing options. In particular, nursing facilities need to better finance depreciation of facilities in order to ensure that they are able to support good quality care for the longest possible life. Also, reimbursement rates for HCBS need to be structured to provide incentives for program growth and operation in more areas of the State.

5.3.1. Adopt LTC Subcommittee's Recommendation for Revising Nursing Facility Rates

The current nursing facility reimbursement policy in South Dakota separates costs into direct care and non-direct care costs. Direct care costs per day are adjusted for inflation, case-mix, and professional therapy. Then recognized direct care costs per day are limited by ceilings to 115% and 125% of the median cost of all non-waivered nursing facilities with a case-mix greater than or equal to 1.00. Non-direct care costs are then separated into three groups: 1) health and subsistence, plant/operational, and other operating, 2) administration, 3) capital costs, adjusted for inflation. Then recognized non-direct care costs for the three groups are limited to defined ceilings and combined into the non-direct care rate.[32] The non-direct care rate per day and direct care rate per day are added to determine a facility's *per diem* reimbursement rate.

Finally, the *per diem* reimbursement rate for a nursing facility is subject to a maximum 8% increase from the previous year. If a nursing facility has a reimbursement rate increase larger than 8% based on the methodology described, the non-direct care rate is decreased so that the full reimbursement rate for the facility is equal to an 8% increase from the previous year. Thus, the 8% *per diem* maximum increase imposes an additional limit on reimbursement for non-direct care. A rate increase cap is not a common method of controlling costs. In a 2003 report, the Government Accountability Office (GAO) noted only two instances of rate increase caps in the nursing facility reimbursement structures of 19 states. The only other rate increase cap noted was a 6% cap on recognized administrative costs in Colorado.[33] Discussions with nursing facility administrators, association representatives, and the Reimbursement Subcommittee suggest that the maximum 8% *per diem* increase more heavily impacts capital financing compared to other non-direct care costs. In the last fiscal year, 24 facilities hit the 8% maximum increase ceiling, while 17 hit the ceiling for capital reimbursement. In addition, Medicaid does not recognize capital depreciation as reimbursable cost for facilities that are older than their depreciable life: 25 – 40 years, depending on the facility

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32 South Dakota Legislature Administrative Rules: Chapter 67:16:04:51 Nursing Facility Rate Setting: Ceilings.

33 United States General Accounting Office (2003). Medicaid Nursing Home Payments: States' Payment Rates Largely Unaffected by Recent Fiscal Pressures, GAO-04-143. October 2003. Accessed on 10/02/07. http://www.gao.gov/new.items/d04143.pdf

construction type.[34] Thus, capital available to finance improvement projects has been limited under this reimbursement structure.

The Reimbursement Subcommittee has made the recommendation to remove the direct care recognized cost ceilings that are currently imposed, and increase the maximum *per diem* reimbursement rate annual increase from 8% to 10%. These steps will ease liquidity constraints on facilities planning capital improvements, and are important for facilities to more completely fund facility depreciation. Conversations with industry associations and nursing facility administrators suggest that these changes in reimbursement rate setting structure are important, and provide an appropriate start for modifying the reimbursement rate to finance future capital investment that will be needed in nursing facilities.

5.3.2. Continue to Evaluate and Revise HCBS Reimbursement Rates to Promote Expansion and Growth

Adult day services, in particular, are reimbursed by rates that do not promote the expansion and growth of adult day programs, and may hinder expansion of these services. Currently South Dakota reimburses adult day programs $4.77 for each hour of care. Costs for providing adult day services vary across the country, but average approximately $56 per day.[35] One provider in South Dakota had costs that averaged $8 per hour across all patients for one year. Many adult day programs are associated with other provider types: home health, nursing facility, medical centers, or multi-purpose senior centers. Therefore, it seems likely that with appropriate reimbursement rates, more existing providers of other long-term care services would expand into adult day service provision.

In addition to the LTC Subcommittee, beginning in 2005, DSS formulated a number of stakeholder financial workgroups to include nutrition, homemaker, and assisted living. These groups are analyzing reimbursement rates for a number of HCBS services to assess whether adequate reimbursement for services exists.

5.3.3. Medicaid / State Reimbursement Rate Action Steps

- Adopt the Long-Term Care / Reimbursement Subcommittee's recommendation to revise nursing facility reimbursement rates.
- Evaluate and restructure adult day service rates to promote the expansion and growth of adult day services.
- Continue to work with existing stakeholder workgroups to analyze reimbursement for other HCBS.

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[34] 25 years for masonry wood frame facility, 30 years for masonry steel frame non-fire protected facility, 40 years for masonry steel frame fire protected facility, and 40 years for masonry concrete enforced facility. Source: South Dakota Legislature Administrative Rules: Chapter 67:16:04:46 Nursing Facility Rate Setting: Depreciation.

[35] National Adult Day Services Association: Trends in ADS. Accessed on 10/30/07. http://www.nadsa.org/adsfacts/trends/default.asp

5.4. Pursue Innovative Care Models, Such As Green House Concept

Policy Option: South Dakota should monitor and consider novel forms of nursing facility organization for nursing facility replacement to improve satisfaction among residents remaining in facilities.

5.4.1. Description of Green House Facilities

A new model of decentralized nursing facility care, the Green House concept, is now emerging. This model involves the construction of "small, self-contained houses for 10 or fewer elders, each with private rooms and full bathrooms and sharing family-style communal space, including hearth, dining area, and full kitchen." The facilities are staffed with certified nursing assistants who are "universal workers," cooking meals, doing laundry, providing personal care, assisting with habilitation, and promoting the elders' quality of life. Nurses, doctors, and other professionals comprise a visiting clinical support team for the residents.[36] South Dakotans may benefit from a Green House model that provides a more homelike setting than transitional nursing facilities, and also operates at a smaller scale that may be feasible in frontier regions where there are few seniors and varied care needs.

Currently Green House concept homes are operating, or are planning to open in 2007, in 21 states. In 2005, the Green House effort received a five-year $9.5 million grant from the Robert Wood Johnson Foundation to diffuse the Green House model. The grant offers prospective developers training, start-up funding, and financing, and has spurred the growth of new models in 12 states in the past year. This alternative is most viable when providers are considering replacement facilities, since they generally require new construction. In a February 2007 letter, Leslie Norwalk, Acting Administrator of CMS, found "no barriers" that would prevent Green House homes adhering to the model's principles from being "qualified as nursing facilities under Federal regulations."[37]

5.4.2. Results associated with the model

The prototype was developed in Mississippi. Multiple Green Houses (four on a single campus in the case of Tupelo, Mississippi) comprise a nursing facility, meeting all nursing facility regulations and working within state-reimbursement levels. An initial evaluation of the model Green House project has demonstrated that the model is feasible, and documented positive experiences for residents, family, and staff. Researchers found:[38]

- Green House residents reported significantly higher satisfaction with their facility as a place to live than did residents of the other two traditional nursing facilities, and better scores on many dimensions of self-reported quality of life.

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36 Rabig, J, W Thomas, RA Kane, LJ Cutler, S McAlilly. (2006). "Radical Redesign of Nursing Homes: Applying the Green House Concept in Tupelo, Mississippi" The Gerontologist 46:533-539.

37 http://www.ncbcapitalimpact.org/default.aspx?id=414

38 Kane, RA, TY Lum, LJ Cutler et al., (2007) Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program, Journal of the American Geriatrics Society, 55(6):832–39.

- In terms of care and health outcomes, Green House residents experienced lower rates of depression, bed rest, reduced activity, and decline in functional abilities, but did have higher rates of incontinence than did one of the comparison settings.
- Green House residents reported significantly higher scores on emotional well-being indicators.
- Evidence is mixed for residents with more-substantial care needs and for residents who required short-term rehabilitation care.

The Green House model has not been extensively evaluated. South Dakota should monitor the future rollout of this model and its variants to assess whether this model would be viable in counties with moderate requirements or constrained skilled labor markets.

5.4.3. Expansion and Development Opportunities

NCB Capital Impact, with support from the Robert Wood Johnson Foundation, "is pursuing the rapid replication of The Green House model" on a national level, offering technical assistance and pre-development loans to organizations that want to establish a partnership with The Green House Project. Over the next five years, NCB Capital Impact plans to develop Green House homes with 50 or more organizations throughout the country.

The Green House Replication Initiative (GHRI) offers eight-hour orientation workshops to answer questions that organizations may have about the Green House model. These workshops are conducted at a Green House training center and include a visit to a Green House home. Workshops are scheduled once per month throughout 2008 in Nebraska, Montana, and Michigan[39].

The pre-development loan program (up to $125,000) is to assist qualified organizations assess project feasibility, obtain control of a site, and fund architect, engineering, and other third-party expenses. The borrower must match 25% of the loan amount. The loan is for up to 24 months with a fixed 6% interest rate. If a funded project is deemed by NCB Capital Impact to be infeasible, NCB Capital Impact, in its sole discretion, may forgive all or a portion of the pre-development loan.

Selected Green House Facilities in operation or under development are summarized in Appendix 3.[40]

5.4.4. Action Steps: Green House Models for Care

- Review experience of recent projects to understand how the concept could be scaled to rural South Dakota.

- Participate in training and workshop programs.

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[39] Workshop dates for 2008 are: Jan. 15-16 - Lincoln, NE (deadline: Jan. 4);Feb. 13-14 - Billings MT (deadline: Feb. 1); Mar. 11-12 - Redford, MI (deadline: Feb. 29); Apr. 8-9 - Lincoln, NE (deadline: Mar. 28); May 7-8 - Billings, MT (deadline: Apr. 25); Jun. 17-18 -Redford, MI (deadline: Jun. 6); Jul. 15-16 - Lincoln, NE (deadline: Jul. 3); Aug. 13-14 - Billings, MT (deadline: Aug. 1); Sep. 16-17 - Redford, MI (deadline: Sep. 5);Nov. 5-6 - Lincoln, NE (deadline: Oct. 24) Dec. 10-11 - Billings, MT (deadline: Nov. 26).

[40] This material is summarized from www.ncbcapitalimpact.org.

- Explore feasibility of obtaining start-up funding from the Foundation.

- Identify pilot communities in the State where there are opportunities to replace out-dated nursing home facilities with Green House homes.

5.5. Develop "One-Stop Shops" that Provide Information, Assessment and Referral to Appropriate Services

Policy Option: South Dakota should explore options to develop "one-stop shops" that provide information, assessment, and referral to appropriate services. One-stop shops ensure that all LTC consumers, regardless of payer source or provider, receive the same information, screening for need and ability, assistance with developing a care plan, and long-term care service options. In conjunction with expanding the scope of one-stop shops, South Dakota should explore adopting an assessment tool for all applicants of State Plan, HCBS, and nursing facilities to help provide more comprehensive case management and data for planning and evaluation of LTC services.

South Dakota has an entry system for individuals that request services provided by ASA to assist them to stay in their home, increase their ability to live independently, and improve their quality of life at home. With an increase in individuals entering the LTC system and an increase in HCBS options, South Dakotans could benefit from an expansion of the current system to all individuals entering the long-term care system (e.g., nursing facilities, State Plan home care, and HCBS), and a uniform assessment tool to provide more-comprehensive data on LTC needs for better service planning and coordination.

One-Stop Shops

One-stop shops are developed to help the LTC population navigate the LTC system. One-stop shops provide information, referral, and assistance regarding an array of services available at the local level. A one-stop shop for State Plan home care, HCBS, and nursing facility care ensures that all long-term care applicants receive the same information, screening for need and ability, assistance with developing a care plan, and service options. A uniform process can help ensure that all LTC applicants obtain their care in the most appropriate, efficient, and preferred setting.

States use these one-stop shops to serve a variety of populations, which may include elderly, people with physical disabilities, people with mental retardation or developmental disabilities, traumatic brain injury clients, children with special needs, HIV/AIDS clients, and mental health clients.[41] One-stop shops may be local, state, or county offices, community-based non-profits, Area Agencies on Aging, or private subcontractors, and may use telephone and Internet services.

Assessment Instruments

Some one-stop shops use a single assessment instrument (AI) for admission to nursing facilities and home and community based services, to help promote individuals staying in their home with appropriate community based services, and to prevent individuals who prefer to live in community

[41] Single Point of Entry for Long Term Care & Olmstead. Long Term Care Community Coalition. 2005.

based settings from entering nursing facilities. An AI can also evaluate Medicaid eligibility; streamline the assessment, referral and care planning process; and permit the tracking of consumer outcomes and quality of care provided across the LTC continuum. CMS and other stakeholders, including funders, are very interested in LTC outcomes and will likely push states towards better quality monitoring of HCBS and other LTC services in the future.

AIs that determine financial and functional eligibility of Medicaid long-term care services can simplify a complex application process. States may use assessments to determine Medicaid functional eligibility and financial eligibility, and to develop care plans for older adults, people with physical disabilities, and/or people with developmental disabilities.[42] The level of automation and integration with other systems also varies. Some states complete paper instruments and enter data into a database, while others complete assessments online linked to other information systems such as care plan, case management or Medicaid billing systems.[43] Assessment tools and procedures vary among states, but states are moving toward standardized tools and assessment processes.[44] Without uniform state-assessment tools, eligibility is often made by different entities within the state government and not well coordinated.[45]

South Dakota counties have relatively high nursing facility acuity case-mixes, indicating that current nursing facility residents receive care in the appropriate care setting and should not be transitioned from nursing facilities to HCBS (See Exhibit 29). Enhanced one-stop shops and uniform assessment tools can help meet the information and assessment needs of the growing elderly population and care options and provide South Dakota with the data for ongoing planning and evaluation of services.

5.5.1. Benefits of Enhanced One-Stop Shop Efforts in South Dakota

An expanded one-stop shop system and uniform assessment tool could benefit South Dakota by establishing:

1. **Comprehensive case management for a broad range of LTC services.** Currently ASA local offices provide case management services for individuals who receive services from the Division of Adult Services and Aging. In the recent past, individuals entering nursing facilities were assessed and referred to the appropriate level of care, but case management services did not continue once the individual entered the nursing facility. Case management services, including information and referral, for all LTC services, including those referred to nursing facilities, could help ensure that all individuals know about their care setting options. As HCBS capacity increases, a comprehensive case management system can help support LTC consumers navigate the LTC system.

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42 Gillespie J. Assessment Instruments in 12 States. State Policy in Practice, NASHP. January 2005.

43 Gillespie J. Assessment Instruments in 12 States. State Policy in Practice, NASHP. January 2005.

44 Summer L. Community-based long-term services financed by Medicaid: managing resources to provide appropriate Medicaid Services. Long-Term Care Financing Project, Georgetown University. June 2007.

45 National Health Policy Forum. Trading Places: Real Choice Systems Change Grants and the Movement to Community-Based Long-Term Care Supports. Issue Brief No. 822, May 20, 2007.

2. **A central location for LTC consumers to obtain information and referral.** A one-stop shop can ensure that all LTC consumers know where to obtain information and referral to services. The one-stop shops can provide expert information on all the available options for services. Currently ASA local offices provide information and referral for ASA services and other community resources.

3. **A uniform assessment instrument for individuals entering LTC services.** ASA currently uses an assessment instrument for individuals accessing ASA services. Prior South Dakota efforts have also included assessment of individuals entering nursing facilities. A uniform assessment tool, along with case management services, can ensure that individuals are introduced to the appropriate options for LTC services, regardless of the level of care. A broader assessment instrument will also provide South Dakota with more-comprehensive data to support ongoing planning for LTC services. These data will help identify the needs of the LTC community and help improve coordination of services.

5.5.2. Current One-Stop Shop Efforts in South Dakota

South Dakota has Adult Services and Aging (ASA) local offices, which serve as points of entry to resources and services for individuals (older adults and adults with physical disabilities) who receive services from the Division of Adult Services and Aging (Medicaid-funded and other). ASA Specialists assist clients with accessing a wide range of services including home-delivered meals, homemaker services, personal care, adult day services, caregiver services, and transportation, and determine functional eligibility for Medicaid State Plan and HCBS waiver services. Twenty-six local offices and a State office have ASA Specialists who work with individuals to evaluate and assess situations, plan and identify situations, arrange and implement services, and follow up and monitor cases with the goals of increasing the client's independent living, developing support systems in the community, and improving quality of life.[46]

When an individual requests services, an ASA Specialist collects basic information through an Intake Assessment to help prioritize client referrals and determine whether assistance (above and beyond providing information or referral to another agency) is required. After intake, the ASA Specialist collects information about the client's problem and condition and may conduct a formal "SD Assessment." The SD Assessment includes:

- General information items (demographics, Medicare and Medicaid information, living arrangements).
- Current health status (conditions/diagnoses, medications, nutritional health, emotional health, behavior, cognition).
- Functioning (activities of daily living [ADLs], instrumental activities of daily living [IADLs], assistive devices, medical equipment/supplies, emergency response).
- Home environment (physical environment problems).
- Social supports (community supports, caregiver supports, legal supports).

[46] ASA In-Home Services Program Case Management. Provided by South Dakota DSS. August 2007.

The SD Assessment does not include Medicaid eligibility, but refers individuals to obtain eligibility if appropriate. Although case management is provided to help individuals living in their own or a family member's home, SD Assessments can be completed for individuals who are living in a nursing facility but would like to return home.

Based on the assessment, an ASA Specialist makes a determination of whether the individual is eligible for and would benefit from ASA services, and begins the care planning process. Care planning includes documenting specific client goals and plans for formal and informal services. The resulting Individual Care Plan is accepted and signed by all parties. Implementation of the Care Plan is monitored through regular contact between the ASA Specialist, client, caregivers, and service providers. Many ASA services require formal review of the care plan at least every six months.

5.5.3. Implementation of Expanded One-Stop Shop

One-stop shop services, including screening or assessment, can be financed through combinations of Medicaid, state general revenue, Older Americans Act, Social Services Block Grant, county funds, foundation support, private funds, and fees charged to consumers.[47,48] For example, Colorado uses Medicaid waiver and state and county funding, accepts private payment for assessment and case management, and can raise funds to subsidize services on a sliding fee-scale. Because South Dakota's current infrastructure is not county based, options for implementation include either private organizations or State operated One Stop Shops. South Dakota's Medicaid eligibility staff utilize a regional approach to covering the large geographic area of the state and this concept could be replicated.

Successful one-stop shops have developed through comprehensive planning, gradual implementation, and involvement of stakeholders. One-stop shops that have the ability to determine financial eligibility for Medicaid may increase the number of individuals that use the entry point. Many states have developed their systems incrementally by geographic region, function, and/or program components. Successful implementations have also achieved consensus among key stakeholders on the values, principles, and goals that a system should reflect. Stakeholders should have a common understanding of what the one-stop shop and/or assessment tool will accomplish for consumers. They may be less resistant to change if they are included in the entire process.[49]

Resistance from stakeholders may be further reduced through implementation of other initiatives beneficial to the stakeholders. For example, a state could partner with the nursing home industry on quality initiatives and provide nursing facilities with information and/or training on quality issues. An expanded one-stop shop system and assessment tool could be introduced in collaboration with right-sizing incentives.

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47 Single Entry Point Systems: State Survey Results. NASHP. August 2003.

48 Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

49 Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

Examples of innovative models in other states are presented in Appendix 4.

5.5.4. Action Steps for Implementing Enhanced One-Stop Shop and Assessment Instruments

- Evaluate options and determine scope of one-stop shops. Discuss options for one-stop shops with stakeholders and determine the scope of work.
- Evaluate options and determine organizations to serve as one-stop shops.
- Determine funding and budget for one-stop shops and assessments.
- Develop implementation plan and timeline for one-stop shops. Consider gradual implementation of one-stop shops by regions and/or service.
- Evaluate options for adopting a uniform assessment tool or revisions to the current assessment tool. Consider data collection necessary for future LTC service planning needs.
- Conduct outreach to LTC community about implementation of one-stop shops.

5.6. Integrate LTC Management by DSS

Policy Option: In combination with any changes to its one-stop shop, assessment tool, and rebalancing efforts, South Dakota should consider increasing programmatic integration of long-term care service management within the Department of Social Services. *The degree of integration of South Dakota's DSS LTC services should support changes to the one-stop shops, assessment tool, and rebalancing efforts.*

Based on the policy options that South Dakota implements, the Department of Social Services should consider establishing internal management that supports those initiatives. Integration of functions and responsibilities within the Department of Social Services may help streamline processes for consumers to obtain information about services (institutional and HCBS), eligibility for services, and access to services.

Adoption of rebalancing efforts, one-stop shops, and uniform assessment tools will integrate services for LTC consumers and expand data collection activities. The Department of Social Services organization of long term care services should provide the building block to:

- Support coordinated systems of care and streamline processes for consumers to obtain information about institutional and HCBS services, eligibility for services, and access to services;
- Facilitate improved coordination across service areas; and
- Facilitate data sharing, collection, and identification of new data needs.

Integration is a key organizational and structural element for state rebalancing of long-term care services and support programs.[50] The level of integration of a state's long-term care system is a building block for rebalancing initiatives of long-term care; the organization of functions and responsibilities affect how institutional and community care budgets, program administration, licensing, and supply of services are aligned. Some states have integrated LTC functions and responsibilities into a single department while others have separate agencies for functions or populations.[51]

5.6.1. Specific Options for South Dakota DSS Organization

South Dakota's Department of Social Services, Division of Adult Services and Aging provides assistance and services for older and disabled adults, including in-home and community based services. The Division of Economic Assistance determines Medicaid eligibility, and the Division of Medical Services provides health insurance and pays for services for individuals who qualify for Medicaid. South Dakota could consider incorporating Medicaid eligibility staff for long-term care into the Division of Medical Services or the Division of Adult Services and Aging.

5.6.2. Action Steps for LTC Management Integration by DSS

- Consider integration of LTC management within DSS to support adoption of policy options, including rebalancing efforts, one-stop shops, and uniform assessment.

- Organize LTC management within DSS to make use of data collection by one-stop shops and assessments in planning and evaluation of service needs statewide.

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[50] State Long-Term Care Systems: Organizing for Rebalancing. University of Minnesota. December 2006.

[51] State Long-Term Care Systems: Organizing for Rebalancing. University of Minnesota. December 2006.

5.7. Monitor and Pursue Federal Funding Options for Rebalancing LTC

Policy Option: South Dakota should monitor future opportunities for federal funding that support rebalancing long-term care. In the last 10 years, The Centers for Medicare & Medicaid Services (CMS) and other agencies have funded numerous programs designed to finance state efforts to remove barriers to community living and administer services in an integrated setting appropriate to the needs of elderly and disabled individuals. The majority of states have received grants to support rebalancing initiatives. South Dakota should monitor future opportunities, including new grant announcements for *Real Choice Systems Change Grants; Money Follows the Person Grants*, and *Administration on Aging Grants*.

CMS and other agencies have funded several programs designed to finance state efforts to eliminate barriers to community living and manage LTC services in an integrated setting appropriate to the needs of elderly and disabled individuals. These programs have taken the form of demonstration programs and grants targeted towards revising state infrastructure, building tools, and developing and revising state processes. Most recently, the Administration on Aging (AoA) announced $5.7 million in awards to 12 states for the *Nursing Home Diversion Modernization Grants Program*. Other major funding initiatives include *Money Follows the Person, Real Choice Systems Change Grant Programs*, and initial *Nursing Home Transition Demonstration Grants*. Although we cannot predict future funding opportunities, Medicaid reform continues to be a funding priority for the federal government.

The application processes for federal funding opportunities can be labor-intensive and require cost-sharing by the states/grantees. In the most recent *Real Choice Grant Awards* (2007), grantees submitted a non-binding Notice of Intent to Apply, standard forms including disclosure and budget information, letters of endorsement from the lead agency that will manage the grant, a one-page abstract of the proposed project, a cover letter, a detailed budget, and resumes. Grantees were required to make a non-financial contribution of 5% of the total project cost.

Despite the effort required to apply for federal grants, many states have taken advantage of federal funding options for LTC systems change and rebalancing initiatives. Twelve states have recently been awarded up to $500,000 each in federal funding for the *Nursing Home Diversion Program*, 31 states have been awarded *Money Follows the Person* grants (2007), all 50 states, the District of Columbia, and two US territories have received *Real Choice Grant Awards*, and 12 states participated in the *Nursing Home Transition Demonstration Grants*. South Dakota has not participated in these opportunities for federal funding.

Each of these funding opportunities is described further below.

OAA New Nursing Home Diversion Program Grants

Twelve states have been awarded a total of $5.7 million in federal funding for grants to assist individuals to avoid unnecessary nursing facility placement, impoverishment, and spend-down to Medicaid. These grants "enable states to use existing Older Americans Act (OAA) and state revenue

funds in a more flexible manner so that a greater range of support options can be made available to individuals who are high risk of nursing facility placement."[52]

Money Follows the Person (MFP) Demonstration Grants

The CMS Money Follows the Person (MFP) Rebalancing Demonstration is intended to assist states to change their long-term care support systems.

MFP program objectives include:

- Rebalancing: Increase the use of home- and community-based services while decreasing the use of institutional LTC services.
- Money Follows the Person: Eliminate barriers or mechanisms that prevent or restrict flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTC services in setting of choice.
- Continuity of Service: Increase ability of State Medicaid program to assure continued provision of HCBS to eligible individuals who choose to transition from an institution.
- Quality Assurance and Quality Improvement: Ensure procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS.

To date, CMS has awarded $1.4 billion in grants to 31 states to transition individuals out of institutional settings over a five-year demonstration period. On January 11, 2007, CMS awarded $888,625,631 in MFP grants to 17 states and awarded $547,083,848 to 14 additional states in May. See Appendix 5 for state-specific information on MFP grants.

Real Choice Systems Change Grants

Since 2001, CMS has awarded approximately $256.5 million in Systems Change Grants for Community Living to 50 States, the District of Columbia, and two U.S. territories. In July 2007, states submitted proposals for assessing a State's Long-term Care System and developing and implementing a Person-Centered Planning model. Between 2001 and 2006, the awarded grants include:[53]

- **Real Choice Systems Change (RCSC)**: to help states design and implement improvements in community long-term support systems to enable people with disabilities or long-term illnesses to live in the community.

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52 HHS News Release September 24, 2007. http://www.hhs.gov/news/press/2007pres/09/pr20070924a.html

53 These grants apply to rebalancing as it is discussed in this report. Other grants include the **National Technical Assistance Exchange for Community Living** to provide technical assistance, training, and information to states, consumers, families, and other agencies and organizations, **Respite for Children** to conduct feasibility studies and explore the development for Medicaid respite projects specifically targeted for caregivers of children, **Community-Based Treatment Alternatives for Children to** assist states in developing a comprehensive community-based mental health service delivery system, through Medicaid, for children with serious emotional disturbances. **National State-to-State Technical Assistance Program for Community Living**: a national technical assistance grant to support all of the Real Choice Systems Change Grants for Community Living efforts, **Technical Assistance for Consumer Task Forces** to provide expanded technical assistance to the consumer task forces involved with the Real Choice Systems Change Grant Program, **Family-to-Family Health Care Information and Education Centers** to provide information and education centers to provide education and training opportunities for families with children with special health care needs and disseminate health care information to families and providers.

- **Community-Integrated Personal Assistance Services and Supports**: to assist states to improve personal assistance services that are consumer-directed or offer maximum individual control.
- **Nursing Facility Transition**: to help states transition eligible individuals from nursing facilities to the community.
- **Respite for Adults**: to enable states to conduct studies assessing the feasibility of developing respite projects for caregivers of adults through Medicaid or other funding streams.
- **Quality Assurance and Quality Improvement in Home and Community Based Services**: to assist states in ensuring the health and welfare of individuals who participate in the state's home- and community-based waivers under section 19159(c) of the Social Security Act.
- **Independence Plus Initiative**: to assist states in meeting the federal expectations for self-directed program waivers and demonstration projects.
- **Money Follows the Person Rebalancing Initiative**: to reform the financing and service designs of state long-term support systems in a manner that permits funding to "follow the person" to the most appropriate and preferred setting, and financing arrangements that enable transition services for individuals who transition between institution and community settings.
- **Systems Transformation Grants:** to develop comprehensive and integrated long-term support systems, including better coordination of services, more services directed by the consumer, better funding for community-based living, and quality control in community settings.

RCSC grants are "intended to help states and others build the infrastructure that will result in effective and enduring improvements in community-integrated services and long-term support systems that enable individuals of all ages to live in the most integrated community setting suited to their needs, to have meaningful choices about their living arrangements, and to exercise more control over the services they receive."[54] With these grants, states address personal assistance services, direct service worker shortages, transition from institutions to the community, respite service for caregivers and family members, better transportation options, resource centers to obtain information on available services, and housing linked with support services and systems transformation.[55]

Nursing Home Transition Demonstration Grants

CMS and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) sponsored the Nursing Home Transition Demonstration Grants to assist states in providing transition options to nursing facility residents who wish to move back to the community. Twelve states were awarded $160,000 - $500,000 between 1998 and 2000.[56]

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54 http://www.cms.hhs.gov/RealChoice/

55 http://www.cms.hhs.gov/RealChoice/

56 Arkansas, Colorado, Florida, Michigan, Nebraska, New Hampshire, New Jersey, Pennsylvania, Rhode Island, Texas, Vermont, Wisconsin.

5.7.1. Mechanisms for Payment of HCBS Services

Policy Option: South Dakota should monitor other state Medicaid plan amendments related to elderly services and outcomes related to those amendments. The *Deficit Reduction Act of 2005* introduces opportunities to allow states to provide all HCBS waiver services without needing to get a waiver to seniors and people with disabilities up to 150% of the federal poverty level, and permits states to allow for self-direction of personal assistance services without a waiver.

The *Deficit Reduction Act of 2005* (DRA) has created new incentives and opportunities for states to re-focus their Medicaid long-term services delivery systems away from nursing facilities and toward a greater community orientation. South Dakotans may benefit from an expansion of Medicaid waiver services and greater access to care in community settings.

President Bush signed the DRA in February 2006. A major program change is that, subject to certain limitations, states are now permitted to offer different Medicaid benefits in different areas and tailor benefit packages for different populations.[57] So far there has not been a rush to amend State Medicaid plans. Seven states have successfully applied to amend their State Medicaid plans—four in 2006 and four so far in 2007. The first four states to apply were West Virginia, Kentucky, Idaho, and Kansas. Iowa, Virginia, South Carolina, and Washington were granted amendments in 2007. As the plan descriptions below highlight, only Idaho, Iowa and Kentucky have addressed the elderly and disabled. The other amendments have focused on disease management (Virginia and Washington), the non-elderly (West Virginia and Kansas), and an HSA option.

Key provisions of the DRA include:[58]

State Plan HCBS Option (Section 6086)

Section 6086 creates a state plan option for home and community based services (HCBS) where states can create a package of services similar to packages available under Section 1915(c) waivers, but make them available through the state plan. States do not have to prove cost neutrality of HCBS compared to institutional care. States can create state plan HCBS programs that serve only certain areas in the state, cap the number of individuals served, and create a waiting list. They may also choose to provide either agency-based or self-directed programs. States do not have to periodically renew their state plan HCBS programs with CMS, as they do with waivers. State plan HCBS must have needs-based functional eligibility criteria that are less stringent than those the state applies to institutional care, and states must institute an independent assessment process and pay special attention to quality assurance. They can modify the eligibility criteria if they exceed their enrollment cap, but must give CMS and the public at least 60 days notice. Programs under this section cannot

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[57] Groups exempt from mandatory changes to their Medicaid benefits package include: dual eligibles (individuals eligible for both Medicare and Medicaid), hospice patients, people living in institutions, pregnant women, medically frail and special needs populations, people eligible for long-term care, the blind, people with disabilities, foster children, women in the breast or cervical cancer eligibility category, and parents eligible for cash assistance under state rules as of July 16, 1996. CMS has determined that people who are part of these populations may be assigned to a new benefit package but must be given the opportunity to opt out.

[58] This summary is based on http://www.nchsd.org/AccessDocument.cfm?document=DRA_NCHSDBackgroundBrief.pdf viewed September 12, 2007.

serve individuals with income above 150% of the Federal Poverty Level, a restriction that limits the option's usefulness for many Medicaid Buy-In enrollees.

Self-Directed Personal Assistance Services (PAS) Option (Cash & Counseling) (Section 6087)
Section 6087 provides an option for self-directed personal assistance services based on the Cash and Counseling model implemented through either state plan or waiver services, and states can limit enrollment in these programs.[59] Participants in PAS programs develop an individual budget and written care plan. States can permit participants to hire family members to provide services, including "legally responsible relatives," and to use their budget to purchase items to increase their independence or substitute for personal assistance, such as an accessibility ramp. There are provisions to ensure participants are trained and supported to hire and manage their services and the programs' fiscal accountability. This new option is more flexible than the home and community based waivers (HCBW), as States wishing to adopt Self-Directed Personal Assistance Services need only amend their State Medicaid plans, rather than apply for a waiver. States still must seek federal approval to offer this State Plan option, but once a state plan amendment (SPA) has been approved by HHS, no further permission is required. The program has reporting and evaluation obligations. Alabama has been approved under the DRA to allow self-directed personal assistance services as a feature of its Medicaid plan.

Benchmark Benefits Packages (Section 6044)
Section 6044 provides a mechanism for states to create "benchmark" or "benchmark-equivalent" benefits packages tailored to meet the needs of specific Medicaid enrollee groups. The benefits packages can be offered as an alternative to the state's regular Medicaid state plan services for designated groups of Medicaid enrollees. Benchmark plans can be a state employee health plan, federal employee Blue Cross/Blue Shield coverage, the state's largest commercial HMO plan, or an HHS Secretary-approved package that meets the needs of a specific population. Alternative benefits cannot be mandated for all Medicaid eligibility groups. Services that may be affected by these new scaled-back benefit packages include all optional services, such as dental care, vision care, mental health services, and certain therapies. However, a state may offer an optional alternative benefits package to any eligibility group. States must inform "opt-in" groups that the package is voluntary.

State Plan Amendments with programs applicable to South Dakota include:[60] [61]
Idaho received federal approval for its plan to provide benchmark benefits in 2006. Idaho is offering an enhanced package for individuals with disabilities and elderly people that covers all the traditional Medicaid benefits, including long-term or institutional care. Persons enrolled in the basic plan that

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59 The original Cash & Counseling Demonstration was a three-state demonstration in Arkansas, New Jersey, and Florida beginning in 1998, and Cash & Counseling is now a national program sponsored by the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation in the United States Department of Health and Human Services, and the Administration on Aging. The program operates in Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia. Illinois has been funded by the Retirement Research Foundation to implement its own Cash and Counseling program.

60 These summaries rely on http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp

61 West Virginia directs amendments toward the non-elderly and non-disabled to provide children with an enhanced level of health coverage. South Carolina's amendments focus on one county and allow individuals/families to establish a Health Savings Account for their Medicaid coverage.

need benefits not covered there will be transferred to the enhanced plan. A coordinated benchmark plan will include all the benefits of the state's traditional Medicaid program, and will serve Medicaid enrollees who are also eligible for the Medicare program—the so-called "dual eligibles." This group is required to enroll in the Medicare outpatient coverage plan, or Part B, as well as the new prescription drug benefit, Medicare Part D. The new plans all feature new benefits, including preventive and nutrition services and "preventive health assistance." Idaho will also institute a program allowing the working disabled to purchase a basic benefit Medicaid package.

Iowa received federal approval for its plan to add HCBS as a permanent feature of its Medicaid plan. This approval eliminates the need for Iowa to make repeated requests for time-limited waivers. These waivers generally require renewal every three to five years. Iowa's benefit will provide statewide HCBS case management services and rehabilitation services for individuals in their home or day treatment programs.[62]

Kansas received approval from CMS in 2006 to establish a benchmark benefit for its Working Healthy Ticket to Work Medicaid Buy-In program—a program directed to individuals with a developmental or physical disability or traumatic brain injury, who are working, between the ages of 15 and 65 years old and who, except for their income and resource levels, are eligible to receive SSI. Working Healthy provides working individuals with disabilities who have incomes below 300% federal poverty level (FPL) the State Plan Medicaid coverage, in addition to the following benefits: personal assistance services, which can be self-directed or agency directed, including a "Cash and Counseling" model; assessment to determine personal assistance and related service needs; independent living counseling; and assistive services.

Kentucky received federal approval to offer two new programs, "Optimum Choices" and "Comprehensive Choices," alongside its current Medicaid benefit package, "Global Choices." The two new programs are designed for elderly and disabled persons who are exempt from mandatory enrollment in benchmark programs but who need long-term services. While the list of acute care benefits under the new programs is largely the same as those under existing Medicaid, one major difference is how long-term care services are provided. Under regular Medicaid, these beneficiaries would be guaranteed home health care or care in a nursing facility if they need it. Under the benchmark package, beneficiaries will get long-term care services, or home and community based services that would not be available under regular Medicaid, based on an assessment of their needs. The only service that benchmark package beneficiaries are guaranteed is care management.[63] "Under both Optimum and Comprehensive Choices, beneficiaries would be eligible for minor home adaptations in order to remain in their homes and Kentucky has plans, which would require an 1115 waiver, to expand self-direction options and alternative community living options." [64]

Virginia received approval in March 2007 for its request to offer a benchmark plan incorporating disease management and directed to individuals with asthma, congestive heart failure, coronary artery disease, and/or diabetes. This is an opt-out program that excludes individuals in managed care, dual

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[62] CMS News Release. HHS Approves Iowa as First to Add Home and Community-based Services to Medicaid State Plan. April 5, 2007.

[63] http://www.cbpp.org/9-14-06health.htm

[64] Kaiser, July 2006

eligibles, the institutionalized, and those with third-party insurance. The plan is expected to cover 20,000 to 25,000 participants.

Washington targets Medicaid beneficiaries with certain chronic medical conditions, including: diabetes, heart failure, coronary artery disease, cerebrovascular disease, renal failure, and chronic pain associated with musculoskeletal conditions and other chronic illness, and offers them "regular Medicaid State plan services plus disease management (DM) services."[65] Individuals enrolled in this program also receive a condition-specific education; access to a nurse call line; regularly scheduled telephonic health care management and support; and care coordination including feedback to the primary care physician.[66]

5.8. Continue to Support Expansion of LTC Insurance Through LTC Partnership Program

The Long-term Care Partnership grew out of a growing public and private recognition that increasing insurance coverage for long-term care services was a win-win proposition for state and federal Medicaid programs as well as for senior citizens. Under the Partnership, individuals who purchase long-term care insurance policies are insured for long-term care up to a pre-set dollar level through a private insurer. Once the private insurance is exhausted, they can continue their long-term care under Medicaid without spending-down their assets, as is usually required to meet Medicaid eligibility criteria. Under the dollar-for-dollar model, for every dollar of long-term-care coverage that the consumer purchases from a private insurer participating in the partnership, a dollar of assets is protected from the spend-down requirements for Medicaid eligibility.

The Deficit Reduction Act (DRA) of 2005 lifted a moratorium that Congress had imposed on expanding a limited pilot test the program. As a result, states and private insurers have seized on new opportunities to expand coverage.

While it is too soon to know the full effects of partnership programs, early evaluations have suggested the following positive changes:

- Delaying the time at which patients qualify for Medicaid — which occurs when patients exhaust, or spend down, their assets— can help long-term-care patients and their families avoid financial distress.
- Delaying Medicaid eligibility can save public funds. The Government Accountability Office reports that, "More policyholders have died while receiving long-term-care insurance than have exhausted their long-term-care insurance benefits which could suggest that the Partnership for Long-Term Care program may be succeeding in eliminating some participants' need to access Medicaid." The original four states estimated savings of $8-10 million over the initial 5 years of the programs.[67]

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65 http://www.nccbh.org/TemporaryFiles/AnAvoidableTragedy.pdf

66 http://www.cms.hhs.gov/DeficitReductionAct/03_SPA.asp

67 Government Accountability Office. GAO-05-1021R. Washington: GAO, September 9, 2005.

- Insurance coverage allows seniors and their families to play a more direct role in their choice of care providers and settings, often keeping seniors in their homes and communities longer, and improving health status and quality of life.

Prior to Partnership initiatives, South Dakota was among the leading states in terms of private LTC policy coverage, indicating a high level of acceptance and existing knowledge in the population. According to American Association of Health Plans (AHIP) survey data, in 2002 over ten percent of South Dakota adults had purchased some type of LTC policy.

South Dakota launched its LTC Partnership Program on July 1, 2007, following approval of its State Plan Amendments by CMS. As part of the launch the State has initiated wide spread education and training programs aimed at the general public, the insurance industry and state social support agencies.

The success of Partnership programs depends on whether individuals with moderate incomes, who would otherwise rely on Medicaid for potential LTC needs, choose to purchase private insurance. Evaluations of early programs are mixed. Some research has shown that they generally succeeded in attracting individuals who would have not otherwise purchased policies, although the take-up of policies was slower than expected.[68] However the GAO in a new study, cautions that a review of the evidence suggests programs are unlikely to save Medicaid money since "80 percent of individuals who purchase Partnership LTC policies would have likely purchased private policies" and the DRA requires asset protection and inflation protection benefits that will result in increased costs to Medicaid programs in the future.[69]

Information is key in expanding coverage. A large fraction of middle-aged and near-elderly individuals are unaware of the financial burden of long-term care costs, or mistakenly believe that Medicare will pay for long-term care.[70] States can play a central role in informing their citizens, and in partnering with insurance companies to educate and train agents in the complexity of the long-term-care insurance choices and the added intricacy of Partnership programs' relationship to State Medicaid provisions.[71] South Dakota should continue to promote education and training programs as a central part of the State's LTC Partnership initiatives.

A 2007 Study by the AHIP Center for Policy and Research found that there were great opportunities to improve individuals' knowledge about long-term care costs and planning[72].

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68 Long-Term Care Partnership Expansion: A New Opportunity for States", Issue Brief, Center for Health Care Strategies, May 2007

69 Government Accountability Office: GAO-07-231, "Partnership Programs Include Benefits That Protect Policyholders and Are Unlikely to Result in Medicaid Savings", May 2007.

70 Long-Term Care Insurance Partnership Programs: Important Issues for State Implementation. AARP Public Policy Institute, December 2006. ".

71 Ahlstrom A, Clements E, Tumlinson A, et al. The Long Term Care Partnership Program: Issues and Options. Washington: The Brookings Institution and The George Washington University, December 2004.

72 Who Buys Long-Term Care Insurance? A 15-year Study. AHIP Research and Policy Center, May 2007

- Individuals who forgo purchase of LTC coverage are more likely than buyers to underestimate the cost of nursing homes in their areas. While only 14 percent of those who purchase LTC underestimate the cost of nursing home care, 70 percent of non-buyers significantly underestimated nursing home costs.
- LTC policy buyers typically perceive the risk of needing nursing home services more accurately than do non-buyers, who underestimate their eventual likelihood of needing any LTC services.
- Only 30 percent of non-buyers stated that they do not plan to buy LTC insurance at all, while 56 percent remain undecided about whether to buy. This would seem to point to a large potential market for LTC insurance and an opportunity to provide information about the value of LTC protection.
- The primary reason cited in 2005 for purchasing insurance was for protection of assets.
- Most individuals relied primarily on a private insurance agent's recommendations in deciding to purchase a policy and in selecting terms of coverage.

5.8.1. Action Steps

- Continue to partner with senior organizations and employers to promote education about LTC insurance options and financial planning, in general. Target middle-income working adults in their 50s and 60s who are focusing on financial planning for retirement and protecting their assets.

- Partner with private insurance companies to assure agents are well informed and engaged in offering policies to existing clients.

- Monitor evaluation efforts by the Center for Health Care Strategies, the Robert Wood Johnson Foundation, and government agencies to identify best practices across the states for promoting coverage. Monitor actuarial research that will provide better estimates of potential cost-savings to the State and provide guidance on how benefit design affects policy take-up rates.

5.9. Involve Stakeholders and Evaluate Progress

Applicable to all policy options, South Dakota should consider two essential steps in implementation:

- **Include stakeholder involvement during all phases of rebalancing and right-sizing efforts**. South Dakota acknowledges the value of stakeholder involvement and has included many stakeholders in Abt Associates' study of the LTC system. Research and practice has shown time and again that policy implementation is more successful when key stakeholders are kept well informed and are consulted on operational steps that affect their interests.

- **Evaluate progress and outcomes.** South Dakota should develop objective criteria and evaluate progress against these criteria for all rebalancing efforts. Evaluation of accomplishments will provide South Dakota with the data required to determine success of policies and programs, and will enhance the transparency of policies and the credibility of initiatives.

Appendix 1:
List of Acronyms/Abbreviations

Table A2.1

List of Acronyms

AAA	Area Agencies of Aging
AARP	American Association of Retired Persons
AAS	Division of Aging and Adult Services (Colorado)
ADL	Activities of Daily Living
ADRC	Aging and Disability Resource Center
AI	Assessment Instrument
AL	Assisted Living
AoA	Administration on Aging
AR	Accounts Receivable
ASA	Adult Services and Aging
ASPE	Office of the Assistant Secretary for Planning and Evaluation
BBA	Balanced Budget Act
BLS	Bureau of Labor Statistics
CA/PS	Client Assessment and Planning System
CAH	Critical Access Hospital
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nursing Assistant
CR	Current Ratio
DHHS	Department of Health and Human Services
DM	Disease Management
DOH	Department of Health
DRA	Deficit Reduction Act
DSS	Department of Social Services
EBITDAR	Earnings Before Interest, Taxes, Depreciation and Rent
FHA	Federal Housing Administration
FPL	Federal Poverty Level
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
GHRI	Green House Replication Initiative
GHS	Goold Health Systems
HCBS	Home and Community Based Services
HCBW	Home and Community Based Waiver
HCPF	Department of Health Care Policy and Financing (Colorado)
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
HS	High School
HSA	Health Saving Account
HUD	Housing and Urban Development
IT	Information Technology
LIHTC	Low-Income Housing Tax Credit
LPN	Licensed Practical Nurse

Table A2.1

List of Acronyms

LTC	Long-Term Care
MFP	Money Follows the Person
MSA	Metropolitan Statistical Area
NA	Nurse Aide
NF	Nursing Facility
NH	Nursing Home
OAA	Older American's Act
OES	Occupational Employment Statistics
OSCAR	Online Survey Certification and Reporting System
PAS	Personal Assistance Services
PDL	Pre-Development Loan Fund
PPS	Prospective Payment System
RCSC	Real Choice Systems Change
REIT	Real Estate Investment Trust
RLF	Revolving Loan Fund
RN	Registered Nurse
SD	South Dakota
SEP	Single Entry Point
SPA	State Plan Amendment
SSI	Supplemental Security Income
USDA	US Department of Agriculture

Appendix 2:
Urban/Rural/Frontier and Geographic County Classifications and Definitions

Exhibit A3.1

Urban, Rural, and Frontier Classification Areas

Sources: 2005 South Dakota Health Care Professional Workforce Report.

Definition of Urban, Rural and Frontier Counties

Urban

An Urban county is a county having a population center of 50,000 or more.

Rural

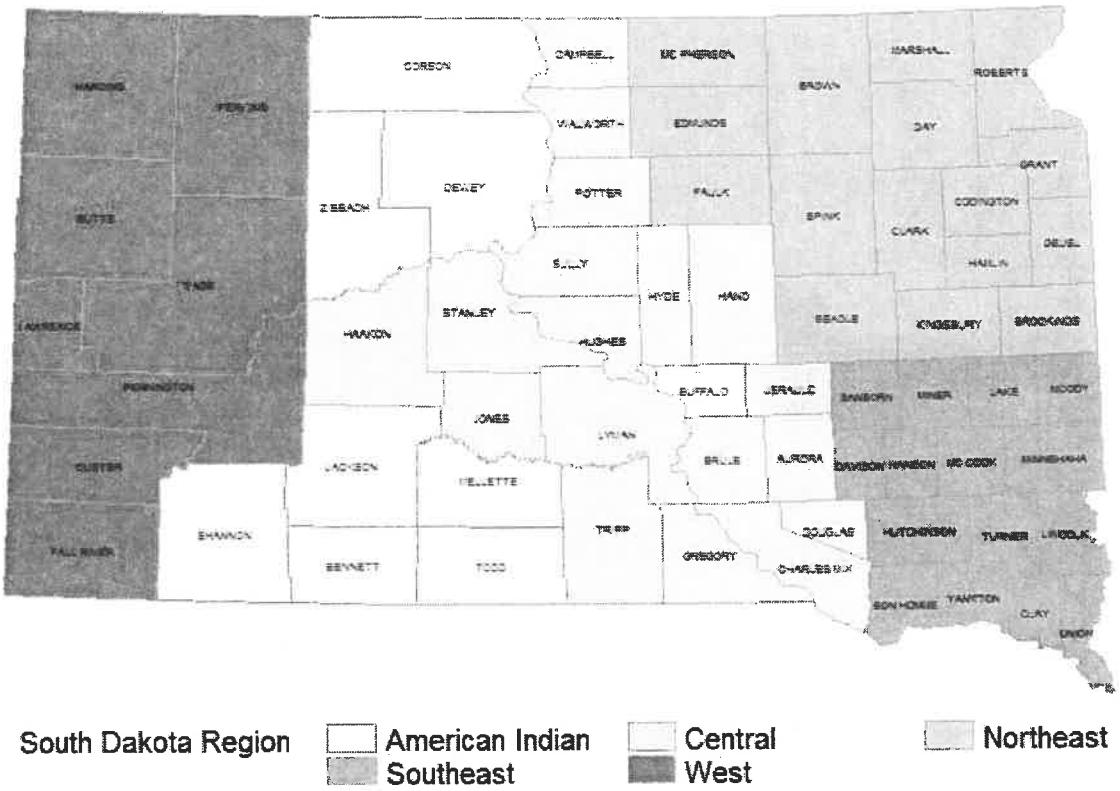
A Rural county is a county with population density of more than six persons per square mile but no population centers of 50,000 or more.

Frontier

A Frontier county is a county with population density of six or less persons per square mile.

Exhibit A3.2

South Dakota Geographic Regions



Sources: South Dakota Medical Facilities Report, 2005.

Appendix 3:
Summary of Green House Facilities

Summary of selected Green House Facilities in operation or under development:

Arizona Baptist Retirement Centers - Youngtown, Arizona (3 GREEN HOUSE® homes - operating). One of the largest independent, non-profits in Arizona, Arizona Baptist Retirement Centers, Inc. (ABRC) has been providing care to elders for nearly thirty years, and currently serves over 600 residents in four communities in the Phoenix metropolitan area. Baptist Village communities offer residential living, assisted living, skilled nursing, and memory care. ABRC is currently operating three assisted living Green House® homes at its Baptist Village, Youngtown campus. The Youngtown campus includes 160 independent living units, 44 assisted living units, and a 128-bed skilled nursing facility. The Green House® residences will replace the current assisted living facility. In addition, ABRC plans to construct three additional assisted living Green House® homes on its Northeast Phoenix campus. Currently, this campus consists of 77 independent living garden apartments. www.abrc.org/

Asbury Park - Newton, Kansas (6 GREEN HOUSE® homes - operating). Asbury Park is a continuing care retirement community in Newton, Kansas. Its 30-acre campus is home to over 200 residents, with 67 independent living cottages, 56 assisted living units and 89 nursing care beds, including an 11-bed memory support program for individuals with Alzheimer's and other dementia disorders. Asbury Park has been selected by the Kansas Department on Aging to partner with the state agency in bringing The Green House® Project to the state of Kansas. Asbury Park's master plan includes a total of six Green House® homes. www.asbury-park.org

Baptist Memorials Ministries - San Angelo, Texas (2 GREEN HOUSE® homes - in development). Baptist Memorials Ministries (BMM) is a full-service retirement organization with a total of approximately 650 residents residing in homes, duplexes and apartments located in San Angelo and Burnet, Texas. The initial phase of The Green House® development project involves adding two houses adjacent to its 52-bed Alzheimer's facility. BMM plans to license these as nursing facilities. A second phase of development will replace two existing nursing facilities wings with six additional Green House® homes. www.bapmem.com

Buckner Retirement Services, Inc. (BRS) - Longview, Texas (2 GREEN HOUSE® homes - opening in 2007). BRS will be opening two GREEN HOUSE® homes at Buckner Westminster Place in Longview, Texas, in the fall of 2007.

Calvary Baptist - Columbus, Georgia (1 GREEN HOUSE® home - operating) The Gardens at Calvary begin with one Green House® residence center and expand to meet the needs of the community. The first Green House® development will include a total of 8-10 houses. www.calvary-ministries.com

Chelsea's Leonard Florence Center for Living (LFC) will be America's first urban Green House® homes, providing skilled nursing care for 100 elders in a warm, residential environment. www.cjnh.org

Hillcrest HealthCare Communities - Knoxville, Tennessee (12 GREEN HOUSE® homes - in development). The Hillcrest HealthCare organization, with over 600 licensed beds, serves four locations within Knox County, Tennessee. Hillcrest is unique in that over 90% of its funding

comes from the Medicaid program, and it is not currently financially supported by any trusts or religious affiliations. In 2004, Hillcrest launched the Beverly Park Foundation to enhance the care of residents by providing services and programs not available through Medicaid. Hillcrest operates 580 long-term care and 30 assisted living beds. Hillcrest HealthCare Communities Incorporated will be adding 12 Green House® homes to their portfolio of eldercare housing options. www.hillcresthc.com

Lebanon Valley Brethren Home - Palmyra, Pennsylvania (4 GREEN HOUSE® homes - opening in 2007). Located in Palmyra, PA, a central Pennsylvania town about 10 minutes from Hershey, Lebanon Valley Brethren Home (LVBH) is a freestanding Continuing Care Retirement Community founded in 1979. LVBH is home to 575 residents, of whom 70% are in independent living apartments and cottages. The campus is currently built out on approximately 80 acres, with another 70 acres available for expansion. Construction began in the Fall of 2006 on Green House® homes to replace two older skilled nursing units. www.lvbh.org

Lutheran Senior Services at Lenoir Woods - Columbia, Missouri (12 GREEN HOUSE® homes - pre-development). Lutheran Senior Services (LSS) at Lenoir Woods, a continuing care retirement community located in Columbia, Missouri, is part of one of the nation's largest not-for-profit providers of senior care and services. The 110-acre campus at Lenoir Woods is home to approximately 370 residents who reside in its independent living apartments, village homes, center for assisted living, skilled nursing facility, and unit for special care. The LSS Green House® project involves replacing 122 beds in the skilled nursing facility as 9-12 houses are developed and built in a series of phases. www.lssmo.org/LSSatResources.html

Mennonite Manor, Inc - South Hutchinson, Kansas (2 GREEN HOUSE® homes - operating). Mennonite Manor was founded in 1973 and is affiliated with nine area Mennonite Congregations. Located in South Hutchinson, Kansas, its 170-acre campus offers the convenience of city living with the serenity of the country. Mennonite Manor is home to over 270 elders in a variety of living options. This is the first Eden Alternative facility in Kansas. Mennonite Manor plans to replace the current 116-bed Medicare/Medicaid Certified Healthcare Facilities with Green House® homes over the next several years. The first phase is complete, creating 2 operating Green House® homes. www.mennonitemanor.org

Mennonite Memorial Home - Bluffton, Ohio (2 GREEN HOUSE® homes - in development). Mennonite Memorial Home is a fully integrated retirement community comprising two campuses that house 250 seniors in cottages, duplexes, independent apartments, assisted living, and nursing home facilities. The original campus is made up of 16 acres, surrounded by residential housing. The second campus, Maple Crest Senior Living Village, sits on 18 acres adjoining a residential community. Mennonite Memorial Home is presently building two Green House® homes on its main campus for residents who require dementia care and skilled nursing. Mennonite Memorial is planning on replacing its existing nursing facilities with Green House® residences. www.mmhliving.org

Mississippi Methodist Senior Services - Tupelo, Mississippi (10 GREEN HOUSE® homes - operating). Mississippi Methodist Senior Services is the proud developer of the first Green House® residences in the United States. Mississippi Methodist Senior Services serves over 1,600

residents on eleven different campuses. The Traceway campus has independent living cottages and assisted living, in addition to 10 operating Green House® homes. www.mississippimethodist.org/ The Riggs Manor Retirement Community offers independent living apartments and personal care studio apartments. The Raymond campus has four assisted living Green House® homes in operation. www.mississippimethodist.org/riggs.html

Pinecrest Medical Care Facility - Powers, Michigan (3 GREEN HOUSE® homes - under construction). Pinecrest is a 174-bed facility owned by Delta, Dickinson and Menominee Counties. Pinecrest Medical Care Facility has embraced the Eden Alternative, which complements its mission. Pinecrest is currently building one Green House® home, but is planning on building a total of five, each housing 10 residents. Pinecrest is licensed and certified with the Consumer and Industry Services of the State of Michigan. Pinecrest is a registered Eden Alternative Home. www.pinecrestmcf.org

Porter Hills Presbyterian Village- Grand Rapids, Michigan (2 GREEN HOUSE® homes - in development). Porter Hills provides retirement communities for nearly 800 older adults—at all income levels—on eight different campuses located throughout the greater Grand Rapids area. Two Green House® homes are currently in development in Porter Hills' Presbyterian Village. www.porterhills.org

Presbyterian Villages of Michigan - The Village of Redford - Redford, Michigan (2 GREEN HOUSE® homes - operating). Presbyterian Villages of Michigan (PVM) sponsors a growing number of retirement communities, senior housing facilities, and programs for older persons. PVM's Redford campus operates two Green House® homes. www.pvm.org/redford/skilled.asp

Providence Seward Medical and Care Center - Seward, Alaska (4 GREEN HOUSE® homes - in development). Providence Seward Medical and Care Center is a 40-bed, long-term care facility that provides skilled care and rehabilitation services. The center's staff includes registered nurses, licensed practical nurses, certified nursing assistants, physical, occupational, and speech therapists, and activity and dietary staff who work together to develop individual plans of care, staff the center. Providence Seward Medical and Care Center is building four Green House® homes with room for 40 additional residents. www.providence.org/alaska/seward

Resthaven Care Community - Holland, Michigan (1 GREEN HOUSE® home - operating). Resthaven Care Community's Green House®, will construct its first Green House® home on property near the campus of its existing skilled nursing facility, the Resthaven Care Center, on the south side of Holland. The Vern & Lois Boersma Cottage will house 10 elders (scheduled to be completed in June of 2007). www.resthaven.org

St. John's Home - Honeoye Falls, New York (14 GREEN HOUSE® homes - in development). St. John's Home is a progressive long-term care community located in Rochester, New York. St. John's services include: skilled nursing care, Alzheimer's/dementia care, transitional care, rehabilitation, adult day service, and hospice care. St. John's Home also embraces the Eden Alternative philosophy in caring for elders. St. John's Home will build on 14 new Green House® homes. www.stjohnshome.com

St. John's Lutheran Ministries - Billings, Montana (5 GREEN HOUSE® homes - operating). Started as the first HUD-financed senior retirement community in Montana, St. John's has grown to become the largest senior campus in the state, consisting of 109 low-income retirement apartments, 186 skilled nursing beds, an adult day care center, and a rehabilitation center. In partnership with St. Vincent Healthcare, the largest hospital system in Montana, St. John's also operates the first full service Continuing Care Retirement Community in Montana, consisting of 122 independent living and 59 assisted living apartments. In addition to services for elders, St. John's also provides on-site childcare through the Center for Generations. The assisted living Cottages at St. John's, modeled after The Green House® approach, opened in August 2005. St. John's has begun moving elders into skilled-nursing-level Green House® homes on their campus (ongoing - five homes are planned in 2007). A future phase of five additional skilled nursing Green House® homes is envisioned. www.sjlm.org

St. Martin's in the Pines - Birmingham, Alabama (14 GREEN HOUSE® homes - in development). St. Martin's in the Pines is a Continuing Care Retirement Community providing residential care to approximately 350 elders. St. Martin's consists of a 138-bed skilled nursing facility, a 71-bed assisted living facility, a 35-bed dementia care facility, and a 100-unit independent living apartment building. As part of a long-range plan, the leadership has identified the need to replace the skilled nursing facility with a care model that will lead to better care, and better quality of life, for the elders living there, as well as increased elder and employee satisfaction. St. Martin's is determining the feasibility of constructing on the current campus 14 GREEN HOUSE® homes to replace their 138-bed skilled nursing facility.

Tabitha Health Care Services- Lincoln, Nebraska (1 GREEN HOUSE® home - operating). Tabitha Health Care Services has successfully pioneered such essential community programs as Home Health, Hospice, Meals on Wheels, and intergenerational day services. The organization's continuum also includes HUD housing for independent living, specialized Alzheimer's programs, rehabilitation, and long-term care. Tabitha operates one Green House® home. www.tabitha.org

Appendix 4:
One-Stop Shops and Assessment Instruments: Examples of Innovative Models in other States

One-Stop Shops and Assessment Instruments: Examples of Innovative Models in other States

Colorado

Colorado Single Entry Point (SEP) systems are a statewide network of case management agencies, with each contracting with the State to perform level-of -care assessments, care planning, and case management for older adults and people with disabilities in one or more counties. The agency is chosen by the counties and certified by the state. Colorado agencies include county social service departments, county health departments, and private non-profit organizations. The Colorado Division of Aging & Adult Services (AAS) oversees their system, sets statewide rules, and coordinates activities of the 25 local agencies.

Colorado's SEP system enables streamlined access to long-term supports via one agency instead of several. Colorado's SEPs assess functional eligibility for Medicaid nursing facility services and Medicaid and state-funded services to help people live in the community. SEPs also provide case management for the HCBS options and state-funded programs.[1] Prior to SEP implementation, several agencies provided case management and functional eligibility assessments for HCBS; this system required consumers to go to different agencies to learn about different programs.[2]

Common referral sources to SEP agencies are hospital discharge planners, family members, county workers, and consumers. SEP case managers coordinate with families, physicians, hospital discharge planners, nursing facility staff, and consumers. Upon referral, a SEP intake case manager uses a basic screening tool to determine functional capacity and financial information. Once the consumer is determined to be Medicaid-eligible, the case manager conducts an in-person assessment to inform service planning. Colorado uses the same assessment tool for nursing facility services, State Plan long-term home health care, Medicaid HCBS, and the Adult Foster Care program. A licensed health professional determines functional eligibility based on the assessment information. In cases where the consumer is eligible for HCBS, the case manager works to develop the care plan and establish services. Since 1995, the number of people using nursing facilities has remained relatively constant while HCBS participation has grown from 5,368 to 17,173 people per year.[3] Participant satisfaction surveys indicate that the majority of participants are pleased with services and with SEP agency staff.

Colorado has performance-based contracts with each agency. This contractual arrangement allows quality control of case managers and providers and gives the state authority to fire or fine those providing service. Based on prior utilization, the Department of Health Care Policy and Financing (HCPF) limits payment to SEP agencies to inhibit manipulation of the payment

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[1] Thomson Medstat. Promising Practices in Longer Term Care Systems Reform: Colorado's Single Entry Point System. December 18, 2003.

[2] Promising Practices in Home and Community-Based Services. Colorado – Simplified Access to Nursing Home Alternatives. 12/3/2004. Medstat.

[3] Promising Practices in Home and Community-Based Services. Colorado – Simplified Access to Nursing Home Alternatives. 12/3/2004. Medstat.

system.[4] The state pays each multi-county district $8,000 per year for each county it includes to provide an incentive for multi-county districts.

Colorado uses Medicaid waiver, state and county funding, accepts private payment for assessment and case management, and can raise funds to subsidize services on a sliding fee-scale.

Colorado implemented their SEP gradually by geographic region and function. Gradual implementation included:[5]

1. Planning in state Department of Social Services (1988)
2. Legislature passes law establishing SEP (1992)
3. County commissions form SEP districts (1992)
4. SEP agencies are certified (1993 – 1995)

The function and responsibilities of SEP also gradually increased. The SEP function began as case management for Medicaid and private pay individuals receiving HCBS. Between the introduction of SEPs in 1993 and 2002, the addition of responsibilities included a pilot project to identify nursing home residents who could be relocated to less restrictive settings, functional eligibility for nursing facilities and HCBS, and prior authorization of Medicaid state plan long-term home health services.[6]

Colorado involved stakeholders and community in the planning and implementation process through a Long Term Care Advisory Committee made up of providers, county staff, county elected officials, AAAs, and advocates. The group formed subcommittees and worked with the Department of Social Services staff to draft an implementation plan. Stakeholder input continued throughout the process via an advisory committee of providers and consumers.

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[4] Point of Entry Systems for Long-Term Care. Prepared for the NYC Department for the Aging. April 30, 2004.

[5] Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

[6] Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

Maine

Maine uses a centralized administration to control costs and streamline consumer access and decentralized service. Maine contracts with a single independent agency, Goold Health Systems (GHS), to conduct LTC medical assessments. The Department of Human Services, Bureau of Family Independence determines financial eligibility. GHS also has a toll-free help desk for referrals and answer questions.

LTC consumers access LTC services through GHS by calling GHS, referral from discharge planners, nursing facilities or other providers, or referral from the local Department of Human Services office.[7]

Maine uses the same eligibility criteria, tools, and needs assessment process for all clients, aged and disabled, regardless of the payment source and for all long-term care services. Automated databases aid in coordination of screening and needs assessment. Assessment is conducted by a GHS and administered by nurses. The tool is used to determine Medicaid functional eligibility, but not financial eligibility. Consumers provide their preferences for type of care during their assessment.[8]

During assessment, nurses meet with the consumer and caregiver, determine medical eligibility, authorize a service plan, and assign HCBS consumers to level of need.

In 2002, 15,849 individuals were assessed and 6% of nursing facility applicants were determined not to require nursing facility care. Maine's assessment process has been a central component in decreasing the number of Medicaid nursing facility residents (an 18% decrease between 1995 and 2002) and increasing Medicaid HCBS services (a 78% increase between 1995 and 2002).[9]

Oregon

Oregon uses Area Agencies on Aging (AAA) and local offices of the state Senior and Disabled Services Division as points of entry. Case managers use laptop computers to conduct and record comprehensive assessments (Client Assessment and Planning System - CA/PS) to determine eligibility for long-term supports programs. The CA/PS calculates each consumer's priority for services based on a 17 level scale. The same eligibility criteria are applied to Medicaid HCBS wavier services and Medicaid financed nursing facility services. All nursing facility applicants are required to have a face-to-face assessment, including Medicaid eligible and private pay individuals; however, pre-admission screening for non-Medicaid services is less comprehensive than for Medicaid-funded services. Assessments are conducted via single entry points, which

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[7] Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

[8] Gillespie J. Assessment Instruments in 12 States. State Policy in Practice, NASHP. January 2005.

[9] Diversion and Transition Services in the U.S. Promising Practices and Options for the Future. UMass Medical School, Center for Health Policy and Research. February 15, 2006.

have the authority to authorize supports in a consumer's home, residential facilities, and institutions.[10]

Wisconsin

Wisconsin has developed an extensive system, using Aging and Disability Resource Centers (ADRCs) to provide in-person case management and a 24-hour hotline. Wisconsin's ADRCs provide information and counseling for older adults and individuals with disabilities; pre-admissions counseling to individuals entering nursing facilities, community-based residential facilities, and adult family homes; transition assistance; and counseling on available HCBS options; the ADRCs also determine eligibility for waiver programs. When a consumer is expected to have long-term care needs of 90 days or more, the ADRC is notified by the hospital, nursing facility, or residential facility so pre-admission counseling on care options can be provided.

Wisconsin ADRCs use a web-based functional screening tool to determine functional eligibility for all target populations. This screening tool includes the beginning of the more comprehensive assessment that can help develop the initial plan of care and determine level of care for Medicaid. Cross-edits and other checks increase screening reliability, and reports check for questionable screening practices.

The Wisconsin ADRC system is financed through Medicaid waiver, state general funds, and participant co-payments. Wisconsin spent $10 million on the ADRCs during the two-year start-up phase. One-third of this cost would have been spent on assessments and eligibility determinations.[11]

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[10] Justice D, Heestand A. Promising Practices in Long Term Care Systems Reform: Oregon's Home and Community Based Services System. Medstat. June 18, 2003.

[11] Point of Entry Systems for Long-Term Care: State Case Studies. Prepared for NYC Department for the Aging. April 30, 2004.

Appendix 5:
Money Follows the Person Demonstration Grants

Money Follows the Person Demonstration Grants

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
AR	305	$20,923,775	$139,519	Transition 305 individuals who have resided in institutions six months or longer into qualified home and community-based programs via a new waiver (ARHome) or three existing waivers. The following populations residing in nursing homes and ICF-MRs will be served: Individuals with developmental disabilities/mental retardation; individuals with mental illness; individuals 19 to 64 with physical disabilities; and individuals age 65+.
CA	2000	$130,387,500	$90,000	Develop culturally competent and self-directed community-based living options for persons who have been institutionalized longer than six months, achieved via local transition models that are implemented by Community Transition Teams.
CT	700	$24,207,383	$1,313,823	Use Department of Social Services to address service gaps and provide broader choices for persons who would like to receive long-term care in the community. Quality evaluated through consumer satisfaction surveys.
DC	1110	$26,377,620	$2,546,569	Develop a Community Development Plan that refines government and community roles, coordinate government and community health services delivery and housing demand across four disability populations (elderly, individuals with physical disabilities, individuals with mental illness, and individuals with mental retardation/developmental disabilities) and redesign government infrastructure to facilitate access to HCBS, reducing institutionalization.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
DE	100	$5,372,007	$132,537	Three-part approach: 1) outreach and transition program to coordinate and standardize existing transition efforts, fill in transition and community-based service gaps that exist, and efficiently use existing resources and program structures. 2) Expand current self-direction efforts to allow for full consumer self-direction and with choices for individual control over service dollars. 3) Budgeting/financing strategies to allow money to move between agencies and "follow the person," maximizing LTC rebalancing, and capture savings that may result from rebalancing efforts.
GA	1,347	$34,091,671	$480,193	Five-year demonstration to transition 1,435 people, focusing on three specific populations: aging persons, persons with developmental disabilities, and persons with physical disabilities and traumatic brain injury. Also address the needs of those within these populations who have mental illnesses and other thought disorders. Use Transition Coordinator sand Peer Counselors to guide consumers.
HI	415	$10,263,736	$231,250	Collaborative effort among various state institutions, hospitals, and physicians to discharge individuals from Medicaid institutions. An estimated 200 individuals will be discharged from nursing facilities, 40 from hospital waitlists, and 50 from ICF-MR.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
IA	528	$50,965,815	$307,933	Builds on the work done through a 2005 Real Choice Systems Transformation grant to enhance access to HCBS. Goals are to rebalance expenditures in LTC to provide improved access to HCBS, provide transition services necessary to assure consumers can successfully move from ICF-MRs to the least restrictive living environment of their choice, and strengthen the HCBS system with an array of services provided under Iowa's traditional MR waiver to assure that supports in place are sufficient to sustain all eligible individuals in the community of their choice.
IL	3,357	$55,703,078	$6,879,166	Transition 3,500 individuals through services administered by the Medicaid and partner agencies over the course of the demonstration. Will address affordable housing needs across disability groups and needs of individuals with mental illness for LTC support systems.
IN	1039	$21,047,402	$860,514	Support a strengthened stakeholder input process, help develop and improve transition team training materials and processes, develop options counseling materials and processes to increase personal choice, implement an improved assessment process for home care, and develop and implement person centered planning.
KS	934	$36,787,453	$102,483	Five percentage point shift of HCBS spending over institutional costs. Target population is elderly, physically disabled, persons with traumatic brain injury and individuals in ICF-MR setting both private and State Mental Retardation Hospital.
KY	431	$49,831,580	$4,973,118	Address barriers and gaps and collaborate with all stakeholders, government and private agencies, consumers, advocates and family members to facilitate a successful transition for individuals choosing to leave the institutional settings using existing waiver and supplemental demonstration services.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
LA	760	$30,963,664	$524,000	Goals are to address political resistance to rebalancing, fill gaps in access to HCBS, increase community capacity by focusing on enhancement of infrastructure, and assist the state in accomplishing rebalancing of the long-term care system. Targets are 760 people with developmental disabilities living in ICFs/DD, children with developmental disabilities living in nursing facilities, and adults with disabilities and elders living in nursing facilities.
MD	3091	$67,155,856	$1,000,000	The state is committed to transitioning 5,832 individuals during the demonstration period, and is estimating that half of these individuals will be eligible demonstration participants. The state plans to implement an aggressive identification and transition assistance program through the state from day one of implementation, using transition teams of professionals as well as peer counselors who have experienced institutionalization themselves to canvass facilities and identify potential individuals for transition to the community.
MI	2500	$67,834,348	$2,034,732	The grant will produce an operational protocol for transition services. The goals are to assist at least 3,100 individuals in transitioning from nursing facilities or hospitals to their homes or qualified community residences, develop and provide housing coordination services to individuals transitioning to the community, and develop within the MI Choice waiver for the elderly and disabled the option of receiving services in licensed settings, allowing for the transition of 600 of the 3,100 individuals to qualified residential settings.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
MO	250	$17,692,006	$3,398,225	Objectives are to transition a minimum of 250 individuals who have disabilities and those who are aging who choose to move from state Habilitation Centers and Nursing Facilities to the Community, eliminate barriers that prevent individuals currently residing in state institutions from accessing needed long-term community support services, improve the ability of the MO Medicaid program to continue provision of HCB LTC services to individuals who choose to transition from institutional to community settings following this demonstration, and ensure that procedures are in place to provide for continuous quality improvement in LTC services.
NC	552	$16,897,391	$16,055	Target individuals in nursing facilities, state psychiatric institutions, and state centers and intermediate care facilities for the developmentally disabled by developing an array of services and supports that enhance HCBS waiver programs, developing additional waiver programs and state optional services, and developing regional case management teams that will identify and effectively utilize a broad range of services and supports provided by both public and private agencies and organizations.
ND	110	$8,945,209	$18,089	Goals are to increase use of HCBS, eliminate barriers that restrict the use of Medicaid to enable people to receive support for LTC services in a setting of their choice, increase the Medicaid program's ability to support HCBS, and ensure quality assurance procedures are in place for individuals receiving Medicaid HCBS. Target population is people with developmental disabilities and individuals residing in skilled nursing facilities.
NE	900	$27,538,984	$202,500	Goal is to support the choice of 900 people (aged, physically disabled, developmentally disabled, traumatic brain injury) to move from nursing homes and ICFs/MR to community settings, which is about 10% of people in those institutions.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
NH	370	$11,406,499	$297,671	Goals are to rebalance the LTC support system to provide individuals with greater choice of where they live and receive services, transition eligible individuals from institutions to appropriate community settings, and further NH's strategic approach to implementing a system that provides person centered, appropriate, needs based, quality services and supports that ensures a high level of access and quality in both home and community based settings and institutions.
NJ	590	$30,300,000	$230,000	Goals are to pilot an innovative support coordination model to assist elderly and/or disabled individuals and families to choose and self-direct services, explore ways to eliminate barriers due to service definitions, eligible criteria or rules the state can change, improve access for individuals from all cultural and disability groups, expanding transition services to aid in finding housing and service to improve quality of life and use consumer/family feedback and quality data to continuously improve quality in HCBS.
NY	2800	$82,636,864	$192,981	NY will service individuals with disabilities, ages 18+ and seniors, individuals who have resided in a nursing facility for at least six months, including individuals with mental retardation and developmental disabilities and individuals with mental health disabilities. Projected 2,800 individuals will be transitioned in the demonstration period.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
OH	2231	$100,645,125	$2,079,488	OH will build on existing Medicaid HCBS waivers, state plan services and delivery systems, adding capacity and a coordinating "hub" for MFP participants. Proposes to add HCB Demonstration and Supplemental Demonstration Services to facilitate a successful transition, including independent living skills, peer support, benefits coordination, housing locator, service animals and home computers.
OK	2100	$41,805,358	$3,526,428	Expand ongoing projects and improve community integrated services by bringing agencies and organizations into a continuous collaborative framework to: increase the use of HCBS rather than institutions, eliminate barriers that prevent or restrict the flexible use of Medicaid funds, increase choice and control for the Self Directed Service Delivery System, assure continued provision of HCB LTC services to eligible individuals who choose to transition, provide for continuous quality assurance and Quality Indicators of services for those receiving Medicaid HCBS LTC services, and establish long-term supports coordinated with affordable and accessible housing.
OR	780	$114,727,864	$80,785	Transition 40 children with developmental disabilities in pediatric nursing facilities, 300 seniors with end-stage dementia in nursing facilities, 300 adults with physical disabilities in nursing facilities, and 140 adults with developmental disabilities in nursing and intermediate care facilities, a total of 16.5% of the institutionalized Medicaid population.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
PA	2600	$98,196,439	$130,609	Pursue stateside, cross-age, cross-disability strategy with a goal of transitioning 2,600 consumers over the demonstration period, including consumers in nursing facilities, state MR Centers and state hospitals, via MFP Director, Statewide Housing Coordinator, Housing Coordinators, Transition Consultants, Restructuring and Investing in Community Based Programs, and an education/information strategy.
SC	192	$5,768,496	$34,789	Utilize services found in the Community Choices waiver as its base of support in the home and community setting. Additionally, two more demonstration programs, adult foster care and transition nursing services, will be added, as well as Adaptive Devices, a one-time service to help individuals modify their environment so that they are able to make a smooth transition to HCB care.
TX	2616	$142,700,353	$143,401	For individuals in nursing facilities: build upon current MFP initiative and use the enhanced match to finance HCBS and improve outreach efforts, and target for transition individuals with complex support needs in general and through a new pilot focused on individuals with co-occurring behavioral health conditions. For individuals in institutions serving persons with intellectual and developmental disabilities: build upon current initiative and use the enhanced match to transition individuals out of 14-plus bed community-operated intermediate care facilities and State Mental Retardation facilities, and implement a new initiative to close 9+ community-operated intermediate care facilities and transition residents to other settings of their choice, including community waiver programs.

State	Total Transitions	Five Year Commitment	FY 2007 Award Amount	Program Overview/ Goals
VA	1041	$28,626,136	$13,793	Goals are to rebalance LTC system, giving individuals more informed choices and options about where they live and receive services, transition individuals from institutions (ICF/MR, nursing facilities, and long stay hospitals) who want to live in the community, and promote quality care through long-term support services that are person centered, appropriate, and needs based, ensuring continual improvement is made through a quality management strategy for HCBS settings and institutions.
WA	660	$19,626,869	$108,500	Demonstration program to transition 660 high-acuity individuals whose needs exceed services and supports offered under current programs. Support individuals who choose to move from institutional settings to achieve their goal of independence. Target groups are older adults, individuals with developmental disabilities, individuals with physical disabilities, and individuals with mental illness.
WI	1322	$56,282,998	$8,020,388	Managed LTC strategy that ensures money responds to the needs of the individual in a comprehensive system rather than money having to be made to follow the individual in a fragmented system.