

*D*uring its 1997 session, the New Hampshire General Court enacted legislation which recognized that long term care includes a continuum of care and that New Hampshire needs a system to help its elderly citizens maintain the maximum level of their independence. (Laws of 1997, Chapter 309) While the primary purpose of this legislation was to establish a residential care program and an oversight committee, it also imposed a requirement on the State's Department of Health and Human Services (DHHS) which will have far-reaching effects on elderly and disabled consumers of long term care services in coming years. The legislation mandated the DHHS Commissioner to submit a long term care plan to the President of the Senate, the Speaker of the House, the Governor, the Senate Clerk, the House Clerk, and the State Library. The legislature stipulated that the plan had to include provisions for equitable funding for residential care as well for other levels of long term care.

This plan, **Shaping Tomorrow's Choices**, is being submitted in compliance with the requirements of Chapter 309. A recurring theme throughout this document is that the long term care system, which provides a variety of personal care and other supportive services to the frail elderly and physically disabled or chronically ill adult populations, needs to be rebalanced. To a great extent, the current system relies on nursing facilities to provide this kind of care. While the quality of care provided in New Hampshire's nursing facilities is superior to other states, an increasing elderly and disabled population and decreasing public financial resources are causing the Department to re-evaluate how long term care services are provided. Moreover, many long term care consumers and potential consumers have expressed that they prefer to be cared for at home or in other less acute settings. Because we spend far more on nursing facility care than on home and community based care, there is an inherent dichotomy between the State's present long term care system and consumer choice. **Shaping Tomorrow's Choices** is an initial step towards rebalancing the long term care continuum by adding more resources and support to the home and community based service infrastructure to make it more responsive to increased consumer demand. This plan also supports the concept that consumers have the right to control the provision of their care, which was first put forth in the Department's **Long Term Care Policy Statement**.

Consistent with its practice of seeking input from a wide variety of sources before implementing a major policy change, the Department released a draft version of *Shaping Tomorrow's Choices* on January 21, 1998. The draft was circulated to the Governor, Executive Councilors, members of senior and adult disabled advocacy groups, providers,

legislators, family caregivers, and long term care consumers themselves. The Department conducted a series of public forums in Concord, Nashua, Portsmouth, Littleton, and Rochester at which individuals could offer comments and ask questions about the plan. Other informational sessions were given to advisory and related groups, as well as to, the news media and the Department's own staff. In addition, the Department's senior management staff were interviewed on the plan's basics by the print, radio, and television media. The text of **Shaping Tomorrow's Choices** was made available on the Department's Web Site. Throughout this process, many comments--written, oral, and electronic --were submitted.

The public review and comment process on the January 21 draft of **Shaping Tomorrow's Choices** yielded four major types of comments. Although the majority of comments supported the Department's stated goal of shifting resources to home and community based care, many commentators were concerned that DHHS was not going far enough. Limiting the scope of long term care policy changes to Medicaid nursing home eligibles only, as the plan did, was excluding the majority of those who need other services, including self-paid care. Others considered the plan's strategy of shifting funding away from nursing home care to home and community based alternatives for this group to be fundamentally flawed, given the projected increases in the population likely to need nursing home care. Some expressed the fear that there are not enough community services available for people who need them, and if nursing home care became unavailable, they would have access to no care at all.

Reviewers also faulted the draft for its lack of specificity about implementation timelines and budget, as well as for sketchy details describing the home and community based infrastructure it proposed. Some providers objected to the draft's description of a fragmented, poorly coordinated long term care system in which people experience many barriers to accessing services which may not necessarily meet their needs and which offers relatively little assistance in locating and accessing these services.

The Department acknowledges that these comments are valid. A number of changes have been made to this current version of **Shaping Tomorrow's Choices** as a result of the public review process. In response to the four broad comment areas summarized above, the following comments are offered:

1. **Shaping Tomorrow's Choices** fundamentally remains a strategy targeted to the Medicaid nursing home eligible population. Although the eligibility requirements for Medicaid nursing home care are among the

most restrictive, the federal rules governing Medicaid Waivers give the states wide flexibility in determining how long term care services can be provided to eligible persons. By amending its Home and Community Based Care Waiver for the Elderly and Chronically Ill (HCBC-ECI), the Department will be able to use Medicaid resources to fund the development of a range of home and community based services that help to create real alternatives to nursing home care and which will strengthen the home and community based service systems accessed by the non-Medicaid population. These alternatives would not exist without the infusion of additional funds, and Medicaid at present is the best possible source to accomplish the development of new services and the expansion of existing ones.

2. While New Hampshire will undoubtedly experience significant increases in its elderly population, this does not necessarily mean that all or even most elderly will need care in a nursing home.

3. DHHS will not initiate a large-scale reduction in funding for nursing home beds until an adequate level of home and community based long term care resources has been established. A gradual shifting of dollars from reductions in Medicaid nursing home beds to community based services will help to rebalance the long term care continuum as well as ensure that the appropriate level of care will still be available for a consumer, based on a needs assessment.

*4. **Shaping Tomorrow's Choices** was originally written as a concept document that sets forth a strategy for effecting change in the long term care system. It was not intended to be an implementation plan with time frames and a budget. An implementation plan will be developed at a later time by the Department after the HCBC-ECI Waiver has undergone the federal review process.*

The description of the current service infrastructure as fragmented and uncoordinated is not a criticism of service providers. The fact that many people receive the services they need in a timely manner and achieve their desire to remain at home despite funding constraints, low reimbursement rates, and inconsistent regulations, strongly suggests that service providers, including the Department's own social workers and case managers, accomplish much with relatively few resources and in spite of frustrating barriers. In reality, home and community based care is a delicate balance involving multiple funding sources, providers, and systems. More often than not, this balance is achieved thanks to the nurses, social work staff, providers, and program administrators who are deeply committed to making home based care

programs work. The fragmentation and lack of coordination evident in the current service structure ought to be interpreted as a negative reflection on State practice which currently does little to assure that coordinated services are available and delivered consistently throughout the State rather than on the performance of service providers.

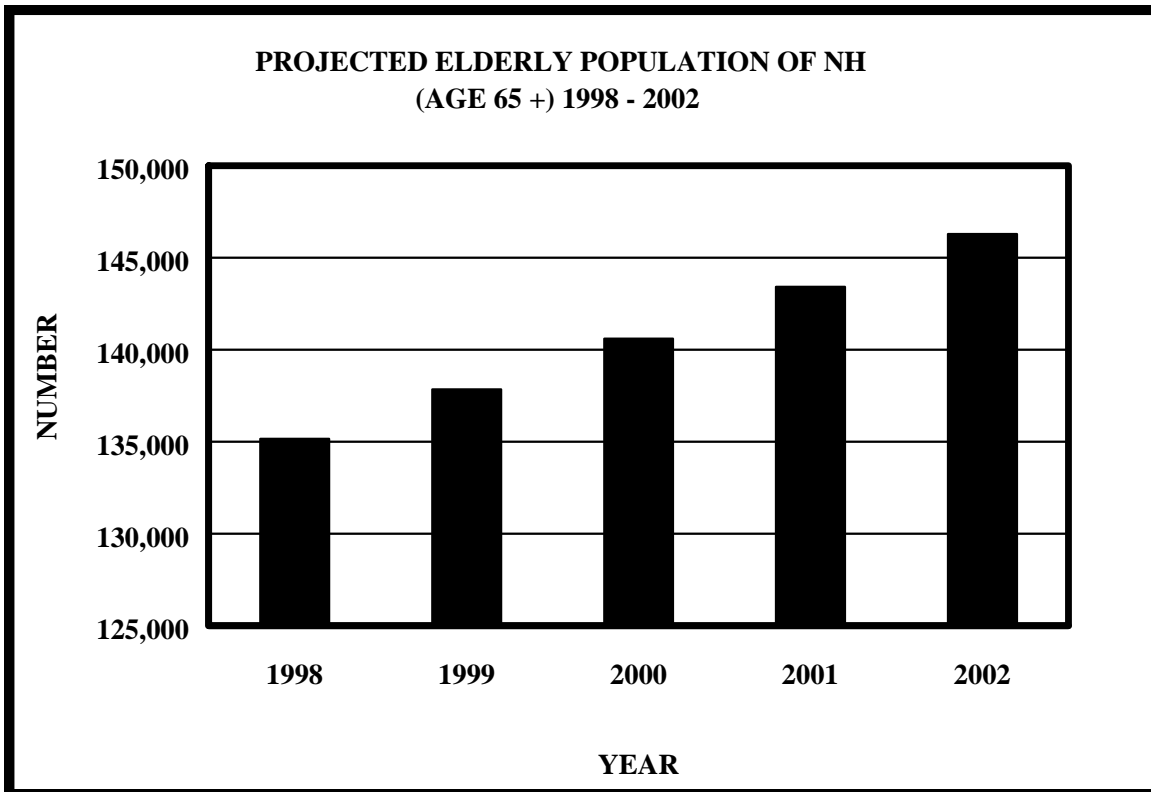
Shaping Tomorrow's Choices is targeted to serve frail elderly and the physically and mentally disabled and chronically ill population who have an array of social, physical, and emotional needs. This population has an especially high prevalence of chronic medical illnesses and can have co-occurring mental disorders resulting in higher levels of disability and an increased use of institutional long term care. A major feature of this plan is the goal of maximizing the use of home and community based alternatives to nursing homes by providing a functionally integrated approach to assessment and the delivery of services in the community that respond to the needs of the whole person. To meet this goal, **Shaping Tomorrow's Choices** aims to provide a comprehensive approach to the delivery of long term care services in the community, including the coordination and functional integration of residential support services, social supports, medical long term care and behavioral health care.

At the same time **Shaping Tomorrow's Choices** was undergoing public review and comment, SB 409, the Department's legislative agenda for long term care, was moving in a parallel track through the legislative process. SB 409 would give the Department of Health and Human Services the authority through law to implement the changes outlined in **Shaping Tomorrow's Choices**. In June of 1998, the House Finance Committee referred SB 409 to interim study so that the issues raised during the legislative hearings about nursing home funding for Medicaid recipients could be resolved. The Department worked closely not only with the study committee but also with representatives of the Senate and the House health and human services committees, consumers, the advocacy community, and providers to resolve these issues. Rather than let these differences prevent or postpone the passage of this important legislation, the Department actively participated with other stakeholders in multiple rewrites of this bill. Consequently, the bill was passed on September 10, 1998 with the endorsement of the State Committee on Aging, AARP, the Home Care Association of New Hampshire, the New Hampshire Association of Counties, the New Hampshire Association of Residential Care Homes, as well of the Department of Health and Human Services.

*With the enactment of SB 409, the State is beginning the systems change that must occur if we are to meet an increasing need for long term care for our elderly and chronically ill population within the limits of public funding. SB 409 builds in safeguard for State and county budgets, and at the same time it promotes the highest degree of independence and personal choice for consumers as outlined in **Shaping Tomorrow's Choices**.*

CHAPTER 1 -- NEW HAMPSHIRE'S CURRENT LONG TERM CARE SYSTEM

Long term care, which involves basic living supports for frail elderly and disabled persons, is not a new issue for either the legislature or for DHHS. The past fifteen years have seen a high level of interest in long term care among New Hampshire's public policy makers, much of it being generated by the State's changing demography. Like other states, New Hampshire is experiencing remarkable increases in its elderly population.



According to U.S. Census data, approximately 12 percent of New Hampshire's population of 1.1 million are elderly. While many of them enjoy a vigorous, independent lifestyle as a benefit of an extended life expectancy, the number of older people and disabled individuals who need help with bathing, dressing, eating, getting in or out of a chair or a bed, using the toilet, and continence is increasing. These functions are called "Activities of Daily Living" (ADLs) and are part of the

standards used to determine an individual's need for long term care. Other activities which measure a person's ability to prepare meals, do laundry, do heavy housework, shop for groceries, manage money, use the telephone, take medicine, do light housework, get around outside, and travel beyond walking distance are also considered in assessing a person's need for long term care. These are referred to as the "Instrumental Activities of Daily Living" (IADLs). The need for help with both ADLs and IADLs tends to increase with age.

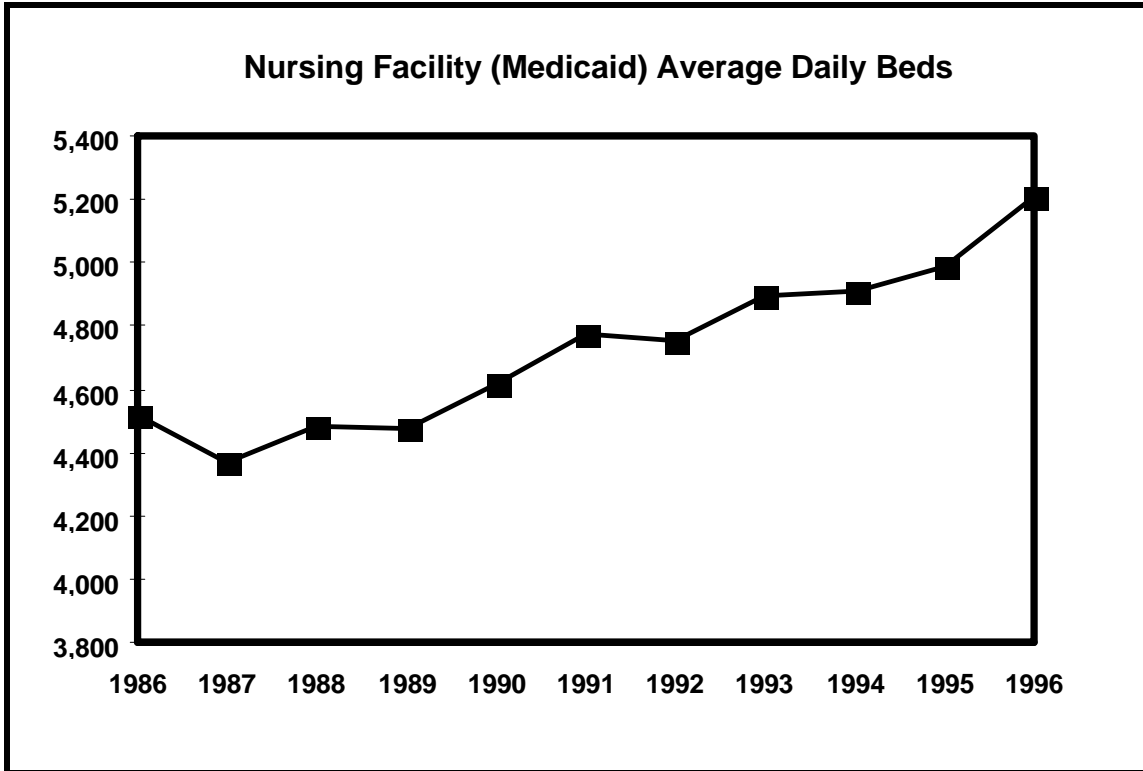
Although long term care services can be provided at home, in a nursing facility, or other community based setting, the overwhelming preference of most people is to receive these services at home. Moreover, most people want to maintain some control over the services they receive, either directly or through a representative, preferably family.¹ However, a glaring contradiction exists between consumer preferences and the State's Medicaid long term care service system. Under New Hampshire's Medicaid Plan, nursing facility care is an entitlement, that is, a service which the State is legally required to provide to individuals who are eligible, but home and community based care is optional. A state may choose to provide home and community based care to eligible people but is not required to do so.

The aging of the State's population is not occurring uniformly. The number of New Hampshire citizens over age 65 is expected to double in 20 years, while the group over age 85, which is 5 to 6 times more likely to need a nursing facility level of care than other age groups, will double between the years 1993 and 2000. Based on estimates made by the Department of Health and Human Services,² if New Hampshire maintains its current long term care utilization patterns, which

¹ A number of research studies have indicated these preferences among elderly and disabled respondents, among them being Families USA (1989), AARP (1992), and the U.S. General Accounting Office (1994).

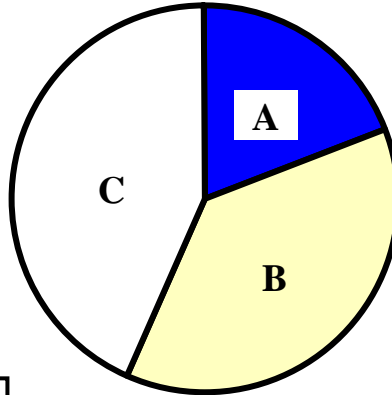
² This figure includes long term care services to the developmentally disabled, the mentally ill, and the brain-injured populations as well as to the elderly and chronically ill.

represent nearly 80 percent of the State's \$550 million Medicaid budget, its long term care costs will increase 300 to 400 percent over the next 20 years.³



³Of this amount, approximately \$200 million was spent on nursing home care and home and community based care for the elderly and the chronically ill adult population in State Fiscal Year 1998.

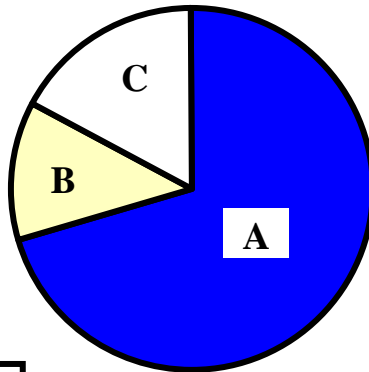
Medicaid 1998 Expenditures (Unadjusted)
\$584 Million



LEGEND

PROGRAM	AMOUNT	PERCENT
A Pregnant Women & Children	\$ 112,500,000	19.3 %
B Nursing Home	\$ 216,700,000	37.1 %
C Blind and Disabled	\$ 255,000,000	43.6 %

Medicaid 1998 Eligibles
Total Eligible: 79,316



LEGEND

PROGRAM	AMOUNT	PERCENT
A Pregnant Women & Children	55,675	70.3 %
B Nursing Home	9,875	9.1 %
C Blind and Disabled	13,766	20.6 %

Financing long term care in New Hampshire involves multiple funding sources both public and private. Public funding sources include federal, state, and county funds. Private sources come from an individual's own resources--pensions, Social Security benefits, personal savings, and in the case of home based care, the uncompensated care-related activities performed by family members and others. Community fund raising activities also supplement the financial resources of many nonprofit providers of community based care. Only a small portion of the long term care provided in New Hampshire is paid for through commercial long term care insurance.

The Medicaid Program plays a significant role in the public funding of long term care in the State. Medicaid funds both nursing facility and home based services, with nursing facility care being the single greatest expense in New Hampshire's Medicaid budget. Approximately 70 percent of the State's 7931 licensed nursing facility beds are Medicaid-funded. In 1997, the average cost of a Medicaid-funded nursing facility bed was \$32,000 per person per year. (This figure does not include the resident's contribution to the cost of care through Social Security and other pensions.) Federal taxpayers pay for one-half of this cost; the other half is shared between state and county taxpayers at the rate of 19 percent and 31 percent respectively. The average cost of a privately paid bed for the same time was \$53,000. While this figure is substantially higher than the Medicaid rate, it is significant to note that nearly half of the Medicaid-funded nursing facility beds are now filled by persons who were private pay residents upon their admission. These are the people who have "spent down" or exhausted their personal resources on nursing facility care and have then become eligible for Medicaid assistance from the State.

Over the last ten years, Medicaid long term care expenditures paid for by the State for the elderly and adult populations have increased 11.8 percent per year and the number of persons served has doubled over the period 1988 to 1994. State revenues, however, have not been keeping pace

with these increases. The New Hampshire Department of Administrative Services *Annual Report for 1995* indicates that between 1986 and 1995, General Fund revenues were increasing by only 4.5 percent per year, while appropriations, excluding Medicaid enhancement funds, were growing by 7.6 percent per year. At this rate, public resources will be inadequate to support the level of demand for long term care services being projected for the future. Unless we rethink how we deliver and fund long term care services, many of New Hampshire's most vulnerable citizens may not have access to the care they need.

When DHHS staff compared New Hampshire's nursing facility utilization patterns to those of other states, it became apparent that New Hampshire has not been using its scarce Medicaid resources as effectively as other states do. New Hampshire ranks 9th lowest among all states in the acuity level, or the severity of need, of its nursing facility residents.⁴ This means that 41 states have nursing facility residents with greater needs than New Hampshire's nursing facility residents. New Hampshire also ranks 3rd lowest among the states for the number of ADL deficiencies per nursing facility resident. Forty-seven other states serve nursing facility residents who require more assistance to meet daily living activities than New Hampshire does.⁵

A 1995 study conducted by the Department's Division of Public Health supports these findings.⁶ The study found that nearly 700 residents of nursing facilities in the State required no assistance with ADLs. Sixty-seven percent of these residents received Medicaid assistance, and 216 of these Medicaid recipients reported no difficulty in performing ADLs. Of the 143 Medicaid recipients who reported difficulty with only one ADL function, 60 percent said they did not need staff assistance. Many of these individuals lack a family and community support system. They are

⁴ *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1991-1993*. Charlene Harrington *et al.*, University of California, 1995.

⁵ *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly State Source Book*, Administration on Aging, U.S. Department of Health and Human Services, undated.

⁶ Cited in Anderson Consulting, *Draft proposed Cost Savings Plan, NH Department of Health and Human Services*, July, 1995.

unnecessarily forced into nursing facility care as the only long term care option available to them. Redesigning the long term care system would allow the State to establish the much needed local support systems which would allow such individuals to remain at home or in a setting less restrictive than a nursing facility.

A second study conducted in 1995 for the New Hampshire State Legislature reported similar findings for older adults who have mental disorders and who also reside in nursing homes. Approximately 30 percent were judged by clinical providers to be appropriate to reside in a less intensive setting in the community, but these individuals were unable to do so due to the lack of intermediate levels of home and residential care options. (*Report to the State Legislature: New Hampshire's Elderly with Mental Illness: The Challenge and the Opportunity, 1995*)

These two studies of New Hampshire's nursing home population that were conducted in 1995 are by no means conclusive. They should be considered as point-in-time studies which may or may not have allowed for other factors in the decision to use nursing home care which would be part of a rigorous research design. However, their findings are useful in understanding the important role both formal and informal supports such as socialization, personal care, home health, chore and home repair, and transportation play in keeping frail elderly and disabled adults independent in their own homes and communities.

New Hampshire has nearly twice the percentage of Medicaid eligibles using nursing facilities than the rest of the country--8.58 percent as opposed to 4.81 percent.⁷ Our nursing facility expenditures are the fifth highest in the country, exceeded only by Alaska, Hawaii, New York, and the District of Columbia.⁸ In 1992 New Hampshire's nursing facility reimbursement rate was 30 percent higher than the national average, higher than Vermont and Maine, its rural neighbors.

⁷US Department of Health and Human Services, Health Care Financing Administration HCFA PUB. NO. 10129/HCFA - 2082

⁸ US Department of Health and Human Services, Health Care Financing Administration HCFA PUB. NO. 10129/HCFA - 2082

Until recently New Hampshire had a loophole in its mechanism for controlling the number of nursing facility beds, which is essential to controlling its Medicaid expenditures. The Certificate of Need (CON) process is the mechanism which the State uses to regulate the growth of nursing facility beds. Under RSA 151-C, nursing facility providers must apply to the Health Planning and Review Board for authorization to build or establish a stated number of nursing facility beds. The Board determines if the number of approved beds the provider is requesting complies with the standard of need the Board has set for the State. Until it was changed in 1998, the standard of need was 50 nursing beds per thousand of the State's population aged 65 and older. The standard is now found in law and is 40 beds per thousand of the 65+ population (RSA 151-E:12 III (b)).

Before 1996, a facility could add additional or "leeway beds" without CON approval. In 1993 and 1994 alone, 155 leeway beds were added to the total number of approved beds, and the State is still experiencing the resulting financial impact. For every Medicaid patient who occupies a leeway bed, a cost is added to the Medicaid Program. Leeway beds, which have pushed the actual bed ratio to 58 nursing facility beds per thousand of the population age 65 and older, represent additional expenses which the State can neither afford nor control.

New Hampshire is over-bedded because it had a relatively high bed ratio to begin with and because the leeway bed provision inflated the actual bed ratio above the standard. In comparison to the national landscape, New Hampshire has a high number of nursing facility beds. The 25 states with a lower bed ratio than New Hampshire averaged only 39 beds per thousand of the elderly population.⁹

A review of national data related to home and community based care shows the extent to which the State's long term care system is misaligned. New Hampshire ranks 43 among the 50 States and the District of Columbia in nursing facility expenditures per person age 65+, a very high rating.¹⁰

⁹ Anderson Consulting, *Draft Proposed Cost Savings Plan*, July, 1995.

¹⁰U.S. Administration on Aging *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly State Source Book*, 1995

In contrast, the State spends 9.3 percent of its long term care expenditures on home and community based care, a low ranking.¹¹ This does not include other community based options such as residential care, which is not funded by the State.

Not surprisingly, New Hampshire is ranked below average in its progress and commitment to home and community based care¹², average in its ability to control nursing facility utilization, and below average in its ability to control nursing facility expenditures.¹³

In sum, New Hampshire has more nursing facility beds than it needs and its Medicaid nursing facility population is less disabled than the United States at-large nursing facility population. New Hampshire nursing facility residents receiving Medicaid assistance have fewer disabilities that affect their ability to clean, dress, or feed themselves. The lower acuity levels of New Hampshire's elderly suggest that these individuals can be appropriately served in a home and community based program. Compared to national statistics, the analysis of the demographics and characteristics of New Hampshire and its nursing facility population signals the need to redefine the State's dependence on institutional care for its elders and disabled persons and to offer alternative options for nursing facility care, which many consumers and their families are demanding.¹⁴

CHAPTER 2 -- A LONG TERM CARE POLICY FOR NEW HAMPSHIRE

On December 31, 1996, the Department adopted its policy statement on long term care, which was the culmination of a broad-based effort to involve consumers in developing a policy that would directly affect them. During the 1995 legislative session, the New Hampshire General Court enacted HB 32 (*RSA Chapter 310, Laws of 1995*), which required the Department of Health

¹¹ U.S. Administration on Aging *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly State Source Book*, 1995

¹² U.S. Administration on Aging *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly State Source Book*, 1995

¹³ Richard C. Ladd, Robert L. Kane et al. *State LTC Profiles Report*, November 1995 National LTC Mentoring Program, University of Minnesota.

¹⁴ American Health Care Association Background Paper *Home Care & Nursing Facility Care: Serving Separate Populations*, February 1997.

and Human Services to implement extensive changes in the State's health care system. Among them was the requirement for the Department to adopt a comprehensive long term care policy for the State. The policy, which was to be developed in consultation with long term care providers, was to address the continuum of care options for providing health care and supportive services to the elderly. In addition to providers, the Department subsequently included the views of consumers, advocates, and other interested individuals in formulating its long term care policy.

This approach was successfully tried in the Department's strategic health planning process. During a two-and-one-half year period, over one thousand New Hampshire citizens participated in seven community councils, 22 focus groups, 10 town meetings, and four symposiums related to health care, and in reviewing the reports produced in the planning process. The *New Hampshire Health Plan* is focused on the entire State population and health care delivery system rather than on a specific community, service, or age group. Thus, the health care needs of the population who will be affected by *Shaping Tomorrow's Choices* will also be addressed in the visions, values, and goals developed in the *Health Plan*.

In sum, the *Health Plan* promotes access for everyone to necessary and appropriate health and social services. Health is not defined as merely the absence of illness but as the presence or the realization of potential well-being. Health care should include those necessary and appropriate services--medical, social, or other--that promote the highest possible level of function and independence for an individual. Health care should address the whole person, and its goal should be the physical, emotional, and spiritual growth, satisfaction and fulfillment of the individual.

Within the framework of the strategic health planning process, five core values were developed:

1. Every New Hampshire citizen will have access to necessary health care services regardless of individual circumstances.
2. The health care system will be based on desired health outcomes as determined by well-defined indicators for measuring health.

3. The health care system will emphasize quality of care and focus on controlling costs.
4. Health care consumers will be empowered and assume primary responsibility for their health and for the care they receive.
5. Communities will play a role in the organization and integration of health systems and in the delivery of health care services.

The core values articulated in the long term care policy statement are similar. In brief New Hampshire's long term care policy affirms the right of elderly and of disabled citizens to receive care and services in their communities, to have a choice in the services they receive, and to direct their own care and services. New Hampshire's long term care system must be flexible enough to develop services and supports that meet a consumer's unique needs and choices rather than offer pre-determined services which may not necessarily respond to those needs and choices. The policy statement affirms the right of a competent person to make choices and to take risks that others may question, and it calls upon the State to support families and other caregivers of the elderly and disabled by offering them incentives such as respite care and affordable community services. The policy's major themes include innovative service development originating with the consumer in his or her own community and consumer choice, direction and support.¹⁵

Translating the values articulated in **The Long Term Care Policy** for New Hampshire into action will require wide-ranging, profound systems changes. Older people who will be the largest group affected by these changes and their families need to understand what these changes are and what the impact of these changes will be. The long term care system must be reconfigured if consumers are to have viable choices in the services they want and where they want to receive them. If consumers are to be truly in charge of their own care, the service environment must be transformed. Policymakers and funders must incorporate the concepts of consumer preference and consumer-directed care into the delivery of long term care services which providers can implement consistent with the **Long Term Care Policy's** values.

¹⁵ *Long Term Care Policy for New Hampshire* (adopted 12/31/96) New Hampshire Department of Health and Human Services

CHAPTER 3 -- THE STATUS QUO OF HOME AND COMMUNITY BASED CARE

As a result of the funding bias evident in public long term care programs in favor of institutional care, the current home and community care system is supported by multiple resources, which has resulted in fragmentation and an inequitable distribution of services in some areas and a strong, responsive network that is locally supported in others. Using this system as a foundation, New Hampshire has implemented a number of home and community based care programs for the elderly and disabled through Title XX of the Social Security Act (Social Services Block Grant), Title III of the Older Americans Act, the Medicaid Home and Community Based Care Waivers, and State-funded programs for congregate housing services, Alzheimer’s respite care, and adult in-home care.

These programs are provided through a locally based network consisting of the Department’s twelve District Offices, the Division of Elderly and Adult Services social workers and nurse case managers, and fifty-five nonprofit agencies under contract to the Division which provide core services such as homemaker, chore, adult in home care, meals on wheels, home health, and outreach. They also provide needed support services to family caregivers, who often supplement the care that is given by the “formal” care system and who may find it difficult to find and maintain reliable paid help. Given the nature of the current service delivery system, these providers work together, utilizing both public and private funds to deliver services. Often providers rely on the volunteer sector, which offers a variety of supports such as transportation, visiting and socialization, and chore services. It is not uncommon for providers to develop a service plan which draws from services from multiple programs. For example, a DEAS social worker may authorize Social Services Block Grant services or request the local home health agency to authorize Title III funds for homemaker services while a consumer’s eligibility status for HCBC-ECI services is pending. In situations like these, the service plan, which is operating under the goal of maintaining a consumer’s independence, can be put into place without unnecessary delays.

Although these publicly supported programs have existed for some time, funding levels have not kept pace with service demand. Waiting lists are common, and providers at times have had to scale back on both staff and the number of service units they provide to stay within the limits of available services dollars. Restrictive financial eligibility requirements also exclude many who need these services. For example, Social Services Block Grant programs may not serve individuals whose income exceeds \$749 per month.¹⁶

The rural nature of New Hampshire further complicates service access. Most service areas are rural and are impossible to serve adequately in view of funding limitations. Many small towns are without some of the home and community based services offered elsewhere. In areas where these services are available, providers have noted increases in the numbers of elderly needing services, the comprehensive nature of their service needs and the follow-up activity necessary to provide services. Other formidable barriers to service access include lack of transportation, lack of time and few resources to spend on outreach and on more complex cases, and staff reductions.¹⁷

Long term care researchers have found that the biggest gap in the current long term care system is the lack of community resources.¹⁸ In most states, including New Hampshire, multiple sources fund multiple programs which operate in parallel. There is no single coordination point, nor is there a single system capable of delivering uniform, nonduplicative care to elderly and disabled persons.

The consequences of this lack of service coordination can have a profound impact on elderly and disabled people who need long term care and on their families. Many are unaware of the existence of home and community based care or how or where to access services. To them, nursing facility care may appear to be their only choice.

For others who are already receiving home and community based services, the system is often unresponsive during health-related crises or emergencies. This is a population with chronic

¹⁶State Committee on Aging, *Chapter 193: Assessing the Future Needs of New Hampshire's Elderly*, 1991.

¹⁷State Committee on Aging.

¹⁸Walter Leutz, John Capitman *et al.* *Care For Frail Elders*. (Westport: Auburn House), 1992.

needs and medically complex conditions which can require medical services as well as long term care services across a variety of settings.

Transitions between home to hospital to nursing facility and back home again are difficult for most chronically ill persons and their families. *From a policy perspective*, the current system does relatively little to ensure that the services they need from both the acute care system and the long term care system are provided in any coordinated fashion. While professionals are available to help people make these transitions, no one has any clear and routine responsibility for monitoring a person's care plan and ensuring that the necessary services are being provided. Providers who are forceful advocates do, nevertheless, assume this responsibility in actual practice. However, the services system does not make this task easier, for barriers exist in the form of different application processes, eligibility standards, and service requirements, all of which must be adhered to if an individual in a crisis or a transition stage is to receive the services he or she needs.

All too frequently public long term care programs lose sight of the individuality of the people they serve. Thus, patients or consumers become "recipients" or "residents", and essential services are termed "units." Important decisions affecting a chronically ill elder or a disabled adult are often made by others, and that individual's right to make decisions about what services he or she wants may become a secondary consideration when providers work in a crisis mode to put services in place.

Absent from this discussion on long term care has been the role of the family and others known as the "informal" or natural helping networks. Families USA, a health and long term care advocacy group, has estimated that nearly 85 percent of the long term care supports provided to elderly and disabled people in this country is provided not in nursing facilities or by professional caregivers but by family members, friends, neighbors, and volunteers. Most of this care is uncompensated, and it can range from driving an elder to the doctor to 24-hour care and supervision. Only five percent of the dependent elderly receive all their care through the formal service system.¹⁹

¹⁹U.S. General Accounting Office, *Long Term Care for the Elderly: Issues of Need, Access, and Cost*. Washington, D.C. GAO/HRD-89.

Although the stresses of caregiving on family life are still being studied, the toll that unrelenting caregiving takes on the well-being of the caregiver is well known.²⁰ The fact that the average age of a female caregiving spouse is 65, that nearly one in three is over age 74, and that more than one in three caregivers of elderly persons are poor is a strong argument for caregiver support; clearly, these caregivers need as much support as the people for whom they care.²¹

²⁰ "Elderly Wives Face Stressful Demands Caring for Disabled Spouses," *Parent Care*. September-October 1991.

²¹ Vanessa Wilson, "The Consequences of Elderly Wives Caring for Disabled Husbands: Implications for Practice," *Social Work*, September 1990.

CHAPTER 4 -- PREVIOUS LONG TERM CARE SYSTEMS CHANGE EFFORTS

New Hampshire has been grappling with the public policy issues of long term care for at least fifteen years, particularly with those issues related to the institutional bias of the Medicaid Program. In 1983 Governor John H. Sununu appointed the Long Term Care Task Force and charged it with the responsibility of making recommendations for a fully developed support system for the State's elderly. The Long Term Care Task Force determined that New Hampshire needed to develop a system of care that provided a fuller range of community based support services to save the State the cost of additional and unnecessary institutionalization. The Task Force's goal was to allow people to remain in as close to normal living circumstances for as long as they desired.

In 1985 the State Legislature established the Legislative Advisory Committee on Long Term Care. In its charge to the Committee, the Legislature found that functionally impaired elderly and chronically disabled persons need assistance from a community based system of services if they are to remain independent in their own homes, with relatives, or in other community settings. The Legislature also called for the establishment of a continuum of care to prevent unnecessary institutionalization and to make community care services available to all residents of New Hampshire who are elderly or functionally impaired.

In 1986 the Legislature initiated the continuum of community based care for elders and disabled adults by establishing the Division of Elderly and Adult Services. The purpose of the new agency was to make a wide variety of home and community based services available to the frail elderly and disabled adult population to enable them to live independently and to give them alternatives to institutional long term care.

As the continuum developed, the Legislature later found that long term care programs for the State's elderly citizens lacked coordination, which caused both duplication of services and service gaps. (*RSA Chapter 22, Laws of 1988*) Several years later as the Legislature struggled with the financial aspects of providing care to an exploding elderly population, it recognized that home and community

services are a viable and necessary part of the long term care continuum and that these services enable many of New Hampshire's elderly citizens to live at home. (*RSA Chapter 193, Laws of 1990*)

In 1991 the State Committee on Aging issued the Chapter 193 report entitled *Assessing the Future Needs of New Hampshire's Elderly*. The report recommended a comprehensive restructuring of New Hampshire's long term care system. The report emphasized that New Hampshire needed to develop a long term care system that maintained the independence of elderly people in their homes with the support of community based services. It also emphasized the need for the State to rethink the allocation of Medicaid dollars that support the costly institutionalization of individuals at the expense of developing a comprehensive community support system that would assist those individuals in staying in their homes for as long as possible.

Concerned that older people requiring long term care and their families were not being given the supports they need from the service system to make informed choices about community based care, the Legislature directed the Department in 1994 to implement an in-home care pilot program to help older people receive services across a variety of settings and from multiple sources. (*RSA Chapter 401, Laws of 1994*) The Legislature "endorsed the concept that long term care services should focus on the needs of the individual and should consider the individual's desire to remain at home if appropriate."

The above efforts can be described as incremental. To date they have not been far-reaching, nor have they resulted in comprehensive system changes. As the nature of long term care evolves, and as the State's legislators and policymakers know more about the future needs and preferences of New Hampshire's long term care population, DHHS must position the State to use its scarce, publicly-funded long term care resources more efficiently. The legislative and administrative actions described in this chapter have a consistent theme: that elderly and disabled people have the right to live safely, independently, and with dignity in their communities. The State has a responsibility to encourage the development of the services and supports that allow people to remain in their

communities, especially since those community based services can provide people with the care they need and prefer at a lower cost to taxpayers than institutional care.

CHAPTER 5 -- AN AGENDA FOR SYSTEMS CHANGE

The Department's decision to redesign the long term care system for frail elderly and disabled adults to emphasize consumer choice and home and community based care was not made lightly. Its decision is supported by the work of a number of legislative study committees and independent research on system design and delivery of long term care services. This work relied on public input, which overwhelmingly affirmed the need for a variety of options to permit individuals to remain in the community with supports.²²

Nursing facilities have played and will continue to play an essential role in the long term care system. Recent utilization patterns, however, suggest that their role is changing.²³ The numbers of short-term nursing facility stays are increasing. More people are using nursing facilities for post-hospital recuperative stays or for subacute stays. These individuals return home after their recovery, and if they need additional care, they often receive it at home or in a community setting.

In addition to being a resource for individuals who may need a more intensive level of care temporarily, nursing facilities can be the locus of community based long term care services. The concept of the "service house" as developed in Sweden and other European countries is based on this premise.²⁴ In a service house model, nursing facility staff are available for day health and other on-site programs, respite, and even home care to frail elderly and disabled people in the community. The nursing facility staff represent an available pool of service resources which with retraining can be readily transferred to a home and community based care setting.

The transformation of the public long term care system from a predominantly nursing facility-based orientation to a home and community based one is fundamental to the long term care

²² See summaries of public forums *Long Term Care Policy for New Hampshire. Appendices*

²³ American Health Care Association, *Home Care & Nursing Facility Care*.

²⁴ Barbara Coleman, *European Models of Long Term Care in the Home and Community*. Public Policy Institute, American Association of Retired Persons, 1994.

systems changes proposed in *Shaping Tomorrow's Choices*. It will require a combination of regulatory modifications, legislative and policy revisions, and other administrative actions. Accordingly, the Department has implemented or proposed for implementation the following to initiate these changes:

A. Legislative Changes

During the 1998 legislative session, SB 409-FN, entitled "An Act Relative to Long-term Care and Extending the Moratorium on New Nursing Home Beds," was introduced. In sum, this proposed legislation comprised the Department's long term care legislative agenda for implementing the systems changes outlined in *Shaping Tomorrow's Choices*. Through this legislative vehicle, DHHS requested the Legislature for the authority to:

1. *Extend the nursing facility moratorium from December 31, 1998 until December 31, 2001.* HB 32 (1995), which mandated the Commissioner of Health and Human Services to develop a long term care policy, also placed a moratorium on the construction or establishment of new nursing facility beds until July 1, 1998. This legislation also eliminated the leeway bed provision in the Certificate of Need process. To allow for the rebalancing of the long term care system, which will require the development of additional home and community based resources, the Department requested the Legislature to extend the moratorium until December 31, 2001.
2. *Amend the health care facility licensing statute to permit Medicaid funding for residential and supported residential care.* By definition, services authorized under the Medicaid waiver for the elderly and chronically ill may be provided to nursing home eligible persons only. Amending RSA 151, the health care facility licensing statute, to include a provision that residential and supported residential care programs may care for Medicaid nursing home eligible persons would re-affirm the Department's authority to offer services under this waiver in a less intensive setting than a nursing facility, provided that the Medicaid recipient agreed to such an option and the facility could provide the appropriate level of care.

3. *Implement pre-admission assessment for individuals eligible for Medicaid applying for nursing facility services and a mandatory education program for anyone seeking to enter a nursing facility.* Such pre-admission assessment would be available on a voluntary basis to persons able to pay for their own care. Assessments would be done according to functional standards, and applicants would be advised of the level of care appropriate for their needs. All nursing facility applicants would also be educated about the range and cost of available long term care options, including home based care. Information about the range of available long term care options, which includes home and community based care, would be provided to any person applying for residential care, regardless of the payment source for the care to be provided.

SB 409 was enacted by the legislature on September 10, 1998 as RSA Chapter 388 of the Laws of 1998 and was signed by Governor Jeanne Shaheen shortly thereafter. The Department has already begun to implement the changes ordered by this new law that will lay the foundation for restructuring the long term care system.

B. Administrative Actions

a. Nursing facility initiatives

1. *The Department will explore making incentives available to nursing facilities to convert their beds to other uses.* Some nursing facilities are converting their beds to assisted living, which allows residents to maintain a private living space with a kitchen and bath but enables them access to the long term care services they need. Assisted living also contributes to an elderly or disabled individual's sense of personal security, inasmuch as help is readily available in an emergency. Some New Hampshire nursing facilities have already begun to convert their beds to assisted living. Others are considering day programming or residential care. The Department will seek the flexibility to offer incentives, administrative or financial, to facilities which convert nursing facility beds to other uses.

2. *The Department will work with the Housing Finance Authority to implement an assisted living pilot.* The New Hampshire Housing Finance Authority has made a limited number of low-cost

loans available to qualifying owners and developers of elder housing for expenses incurred in converting current facilities to other uses or for the construction of new assisted living facilities. The Department anticipates supporting this initiative by creating opportunities for Medicaid-eligible individuals to reside in these assisted living facilities.

3. *The Department will explore piloting the concept of the service house as an alternative to nursing facility care.*

4. *The Department will continue the practice of deeming licensed nursing facility beds to residential care and supported residential care.* Licensing rules allow a nursing facility to opt to provide care at a lower licensing level, i.e., licensure as a residential care or a supported residential care bed, provided that it does not exceed its licensed capacity. This practice should be continued.

5. *The Department will explore implementing an incentive rate for those nursing facility providers who voluntarily close or convert beds.* Facilities would thus be given an incentive in the short-term to improve the quality of the care they provide by having more to spend on direct care per patient. Those facilities opting to convert beds to other uses would be given incentives to participate in building resources for the home and community based infrastructure.

6. *The Department will develop and implement an acuity-based reimbursement methodology for nursing facilities.* The current nursing facility reimbursement methodology does not take into account the costs associated with the care of more severely disabled individuals, in other terms, the acuity level. As a result, facilities providing lower levels of care tend to be overpaid while those providing higher levels of care to more severely impaired individuals are frequently underpaid for the level of care they provide. Chapter 388 of the Laws of 1998 has ordered the Department to implement a system of rate-setting which will be directly correlated to the level of a patient's care and the costs of the care provided on July 1, 1999 or as soon thereafter as practicable.

b. Community Initiatives

1. *The Department will expand the access and availability of intermediate level services within the home and community based services framework included in the HCBC-ECI Waiver.* Under this Medicaid Waiver, nursing facility eligible individuals can receive home nursing, personal care, home health, homemaker, adult medical day care, respite care, and personal emergency response, as well as other Medicaid services depending on their needs. While these services are basic to the system of home and community based care, they cannot help an individual remain in the community if that individual has no home where these services can be provided or cannot afford necessary renovations which would enable a disabled person to remain at home. Lack of an intermediate level of support between home care and nursing facility care is a factor in the institutionalization of frail elderly and disabled persons. For this reason, the Department has filed an amendment to the HCBC-ECI Waiver to include Medicaid funding for this intermediate level, which will be called Community Living Services, for persons who meet nursing facility admissions standards. The amendment was submitted to the federal Health Care Financing Administration for approval on September 30, 1998. The following intermediate services have been included in the Waiver amendment:

- (a) **Shared Housing**, which will link older or disabled adults in need of supportive assistance and companionship with individuals in need of housing. Elderly people or disabled adults who want to maintain their home in the community can continue to do so by sharing their accommodations with properly screened and trained individuals who would provide minimal care and supervision in exchange for housing.
- (b) **Congregate Housing Support**, which provides meals, housekeeping assistance, personal care, and transportation to scheduled doctors' appointments to elderly and disabled residents of publicly owned housing.
- (c) **Adult Family Care**, which provides personal care, support, and supervision in a family setting.

(d) Residential Care, which provides assistance with ADLs and IADLs, supervision of medications, implementation of a care plan including therapy follow-up, transportation to non-medical activities, dietary planning, incontinence management, and other supportive activities within a community setting.

(e) Supported Residential Care, which provides Residential Care plus additional nursing, supervision, or specialized behavioral health care for more disabled residents and residents with special needs.

(f) Assisted Living, in which frail elderly and disabled people can live in an independent apartment with a separate bedroom and kitchen, but they are able to receive meals, transportation, personal care assistance and other supportive services, along with 24-hour emergency call service to on-site personnel.

The above services may also be used as an opportunity for persons living in nursing facilities to return to their communities and homes as well as options for those considering entering a nursing facility.

2. *The Department has also requested an amendment to the HCBC-ECI Waiver to include other home and community based services to enhance a nursing facility eligible-individual's ability to live at home.* These include:

(a) Personal Care Services. The Department will consider expansion of the Personal Care Services Program which was established by HB 32 and currently operates in one area of the State. Under this program, a provider who has received training in personal care activities and the supervision of an individual's self-administered medication can, under the supervision of a health care professional, provide a variety of personal care and hygiene-related activities to people who are seriously disabled. The Personal Care Services Program has enabled severely disabled individuals to remain in a community based setting while directly managing their own care. Without the program, these persons would have had to enter nursing facilities to receive this type of care.

(b) In home Mental Health Counseling for those individuals who need counseling but who are unable to leave their homes to obtain it. This encompasses integrated behavioral health care services, including integrated behavioral health assessment as a core component of determining service needs and regional coordination and integration with local behavioral health care providers in the provision of in home comprehensive long term care services. For those individuals who are assessed as having behavioral health care needs, in home psychiatric assessment, psychiatric nursing, case management and counseling services are included.

(c) Specialized Durable Medical Equipment, such as bath equipment, incontinence products, ramps, and other assistive devices.

(d) Senior Companion Program, which utilizes the services of low-income elders who receive a stipend for activities such as outreach, friendly visiting, chore, errands, etc., which they perform for socially isolated, frail elders.

(e) Environmental Modifications, which includes modifications to a family home or vehicle to make it more physically accessible, to improve the health and safety of a disabled person, and to improve a family's capacity to care for a family member with a disability. These may include ramps, widening of doorways, bathroom modifications, vehicle lifts, wheelchair tie-downs, and other needed modifications.

(f) Assistive Technology Support, which helps individuals select, obtain, and use assistive technology devices. Assistive Technology Support includes evaluation, consultation, coordination, training and technical assistance, as well as designing, fitting, and customizing devices.

(g) Socialization Components such as **Adult Social Group Day Care** and **Enhanced Transportation** to socialization-related activities for home bound individuals.

(h) Nutrition, which includes the administrative and other costs of preparing and delivering home-delivered meals to home-bound individuals. This service can also include nutritional counseling, outreach, follow up, and monitoring an individual's nutritional and functional status.

3. *The State will avail itself of the opportunity to include the PACE Program in New Hampshire's Medicaid Plan.* Called the Program of All-inclusive Care for the Elderly, PACE began as a demonstration project which used an adult day care center as the site for a variety of long term and acute care services to extremely frail elders who would otherwise be institutionalized.²⁵ Under the Balanced Budget Act of 1997, states no longer need waivers to implement PACE.

4. *The Department will establish a system of long term care focal points throughout the State.* During the public forums held by the Department on *Shaping Tomorrow's Choices*, and the legislative hearings conducted on SB 409, many consumers, families, providers, and advocates testified on the difficulty people experience in finding information about long term care services and options. As a result, the legislation was amended to include a requirement that the Department's long term care planning process include the consideration of a system of long term care focal points through which anyone could obtain information about long term care services. Working with its Long Term Care Advisory Committee, the Department has begun the process of consumer and community outreach to gather input on the design of an effective model of consumer information and assistance.

5. *Through a series of carefully planned pilot projects throughout the State, the Department will field test key elements of its redesigned model for home and community based care.* The following sections broadly describe the range of pilot projects under consideration by the Department, subject to the availability of funding, the recommendations of the Long Term Care Advisory

²⁵ *Care for the Elderly (PACE) and Social Health Maintenance Organization (S/HMO) Projects*, Statement of Bruce C. Vladek, Administrator, Health Care Financing Administration before the Subcommittee on Health, House Committee on Ways and Means, April 18, 1996.

Committee, and policy considerations. Regardless of whatever projects are selected for implementation, each will be thoroughly evaluated upon conclusion to determine what impact it has had on the development of the community based service system and its cost-effectiveness.

(a) Consumer Voucher Demonstration. The Department is considering field testing the concept of consumer direction in long term care through a voucher pilot in several sites throughout the State. Individuals who have been assessed to be in need of long term care services would be given a voucher for a given dollar amount to spend on services of their own choosing. Consumers or their authorized representatives would be able to hire providers, train them, pay them, and even fire them, with or without the assistance of a fiscal intermediary. Research on voucher programs implemented in Europe has found that the incidence of fraud and abuse of the voucher program is relatively rare. Most individuals are fairly frugal with their vouchers. Evaluation of a voucher program in Germany found that the average long term care consumer spent only 60 percent of what a comparable consumer would in a traditionally financed nursing facility.²⁶ As an additional safeguard to the integrity of the program, the design of the voucher pilot would include a screening protocol to identify consumers who would be appropriate for participation. It would also ensure that consumers will receive information, advice, and training about the issues and practicalities of accessing and managing their own services, as well as assistance in managing the delivery of their services.

(b) At Risk Targeting/Service Bundling Pilot. Another project being considered by the Department is related to the ability of a State to claim Medicaid funding for services and activities directed to preventing nursing facility placement for those individuals

²⁶ Kathleen A. Cameron, United Seniors Health Coop, *International and Domestic Programs Using "Cash and Counseling" Strategies to Pay for Long Term Care* (1993).

whose frailty or disabilities will put them at risk of entering institutional care. Through “bundling” or grouping of similar or related services, for example, personal care, homemaker services, chore, and companion services, a state can improve the efficiency of service delivery. A provider does not have to bill separately for each element of a bundled service, nor does a state have to report expenditures and service utilization on a disaggregated basis, thus reducing administrative costs. Service bundling can be another vehicle for offering consumers a greater range of choices and more control over their services. It can also be a means of funding preventive long term care services which the State’s current Medicaid Plan does not support.

(c) Respite Care. The Department plans to strengthen the family care network by putting into place a series of pilots related to respite care development. Despite the enormous personal costs associated with caregiving for an elderly or disabled family member, research suggests that most people caring for elderly relatives do so willingly, and their willingness has been identified as a major reason for relatively low rates of institutionalization on a national level²⁷ Were it not for the family members and others who provide care to many of the 1385 elderly and disabled people receiving services through New Hampshire’s Home and Community Based Care Waiver for the Elderly and Chronically Ill (HCBC-ECI), a substantial number would be in nursing facilities. Because of financial constraints, the HCBC-ECI Program does not provide 24-hour care. Families and others provide care during off-hours or as a back-up to professional home care providers.

However, some caregivers, overwhelmed physically, emotionally and sometimes financially by caregiving demands, reach a point of “burn out” and are unable to

²⁷Wilson.

continue. Caregiver burnout has been identified as a prime reason why people enter nursing facilities.²⁸

A practical, low-cost way in which family caregivers can be supported, thereby preventing or delaying institutional care, is through respite care. Offered in a variety of settings, respite care allows caregivers a temporary relief from their responsibilities while knowing that their family member is well cared for. The positive effects of quality respite care on the physical and emotional well-being of caregivers have been well documented.²⁹

The Department of Health and Human Services spends approximately \$250,000 for respite care for frail elderly and disabled adults. Most of these funds are General Revenue dollars appropriated for families of persons with Alzheimer's Disease and other irreversibly dementing illnesses. Medicaid funds are available only for respite care that is provided in a licensed nursing facility. Compared to the \$169 million the Department spent on nursing facility care in State Fiscal Year 1996, the cost of respite care is a small investment with the potential to realize significant returns in Medicaid savings. Expanding this service to the long term care service population at large and to a variety of settings would achieve this goal.

(d) Shared Housing Pilot. The Department will implement a demonstration project which will link older or disabled adults in need of supportive assistance and companionship with individuals in need of housing. Elderly people or disabled adults who want to maintain their home in the community can continue to do so by sharing

²⁸ Alzheimer's Association, *Alzheimer Care Program Guide--In-home Respite Care*. ACTION Grant 136-H008/01 and 136-H009/01, 1990.

²⁹ Elaine M. Brody *et al.* "Work Status and Parent Care: A Comparison of Four Groups of Women," *The Gerontologist*, vol. 27, no. 2, pp. 201-208. Vernon L. Greene and Deborah J. Monahan, "The Effect of a Support and Education Program on Stress Among Family Caregivers," *The Gerontologist*, vol. 29, no. 4, pp. 472-477. M. Powell Lawton *et al.*, "A Controlled Study of Respite Service for Caregivers of Alzheimer's Patients," *The Gerontologist*, vol. 29, no. 1, pp. 8-17.

their accommodations with properly screened and trained individuals who would provide minimal care and supervision in exchange for housing.

(e) Congregate Housing Services Initiative. Along with the Department’s intent to modify the HCBC-ECI Waiver to include Medicaid funding for Congregate Housing Services, the Department will also expand the number of Congregate Housing Services slots throughout the State. At present, Congregate Housing Services sites are located only in Manchester, Nashua, Keene, Sommersworth, and Laconia. Expanding the program will give more individuals who would otherwise enter nursing facilities more options for community based care, as well as enable persons currently residing in nursing facilities to return to a community setting with the necessary supports in place.

(f) Volunteer Development Pilot. The Department will stimulate the development of volunteer resources by implementing pilot projects which will enable volunteers to claim service credits for the work they perform in the home and community based service system. Volunteers are then able to utilize the services of volunteers when they themselves need long term care supports. Often referred to as the “Time Dollar Program” or the “Service Credit Program,” this initiative has been successfully implemented in other states. The Department will also consider enhancing other types of volunteer programs such as the Caregivers Program and similar groups.

(g) Adult Medical Day Care Expansion. Currently offered in only certain areas of the State, this service can be instrumental in helping working families care for a frail elderly or disabled member while maintaining employment. Adult Medical Day Care can also be used as a form of respite care for a caregiving family. The service offers a supervised setting where an individual’s health-related needs can be met, as well as serving as an opportunity for people who would ordinarily not be able to socialize to have this stimulation.

(h) Integrated Behavioral Health Long Term Care Pilots: The Department will implement a series of demonstration pilots coordinated by the Division of Behavioral Health that will integrate behavioral health providers into the core assessment and long term care community services provider panels. These regional assessment and provider networks will conduct comprehensive assessments of individuals seeking nursing home placement; develop service plans with consumers that are comprehensive; and provide coordinated and integrated services by residential, social, medical, and behavioral health care providers.

CHAPTER 6 -- REBALANCING THE CONTINUUM

Making the recommendations presented in this plan work demands that New Hampshire's home and community based long term care be completely redesigned. If New Hampshire's elder and disabled citizens are to have realistic choices for long term care and the opportunity to manage their care themselves, and policy makers genuinely accept that most people prefer home and community based care, then the current service infrastructure must be changed.

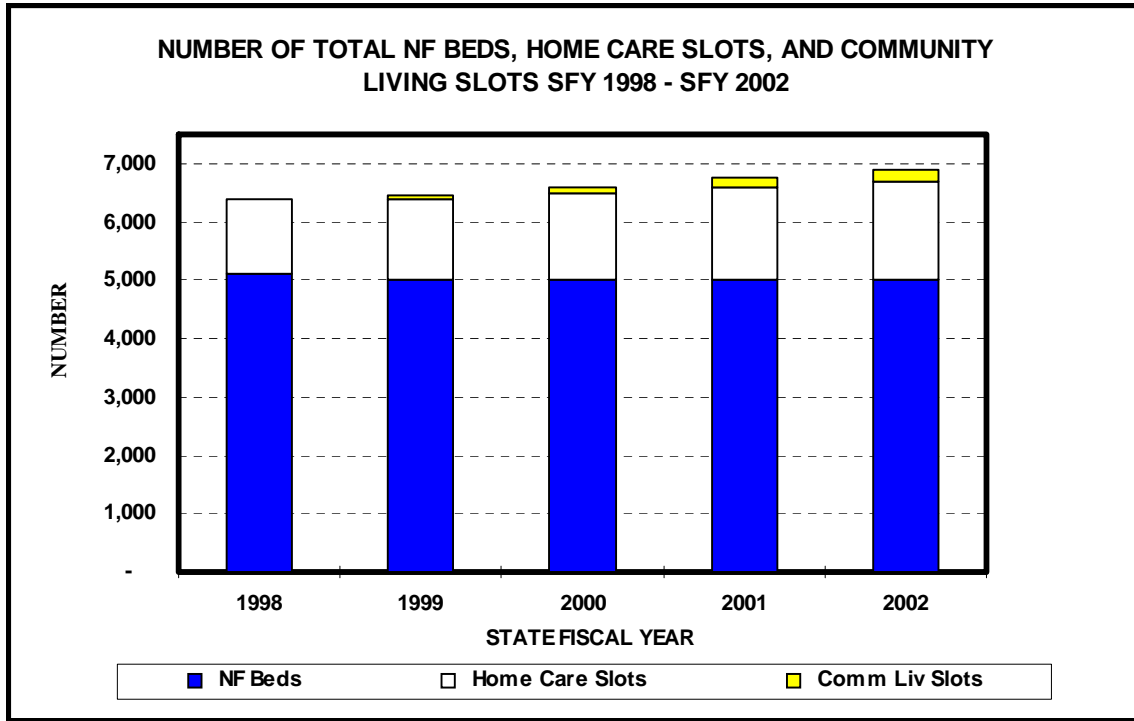
Shaping Tomorrow's Choices is about reforming the current long term care system to make it more responsive to New Hampshire's elderly and disabled citizens and their families. The New Hampshire Department of Health and Human Services believes that offering alternatives to institutional care supports independent functions and improves the quality of life for consumers. At the same time, implementing alternatives promotes the cost efficient and appropriate use of scarce resources.

The budgetary changes which the Department will implement to bring about the changes described in the preceding sections of this plan were determined on the basis of a formula whereby a portion of the funds originally budgeted for nursing facility care will be earmarked for home care, mid-level care, and potentially for the pilot demonstration projects previously

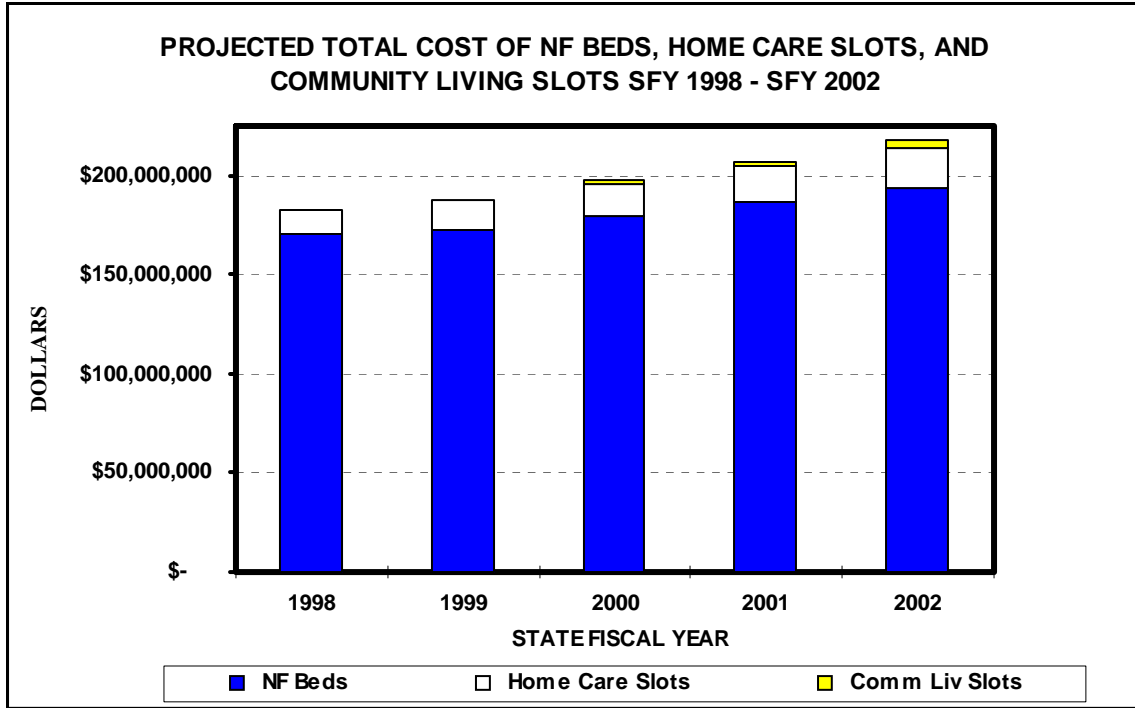
described. Beginning with State Fiscal Year 1999, the Department will gradually increase home and community-related expenditures over a five-year period. SB 409 builds in program management and cost controls, both at the level of the individual long term care consumer as well as in the aggregate. The legislation directs DHHS to designate specific class lines in its budget for nursing facility, mid-level, and home based care and to include the estimated number of persons to receive services in each of these three settings. Both the approved budgeted expenditures for long term care and the number of persons the Department plans to serve may not be increased without the authorization of the Legislative Fiscal Committee.

According to the requirements of SB 409, the average annual cost for the provision of services to persons in the mid-level care may not exceed 50 percent of the average annual cost for the provision of services in a nursing facility, beginning on July 1, 1999, and each fiscal year thereafter. The average annual cost for home-based services may not exceed 33 percent of the average annual cost for the provision of services to persons in a nursing facility. The home and community based options available under SB 409 have controlled growth projections that increase if there is a corresponding reduction in nursing home care.

The following two charts project the total number of nursing facility beds, home care slots, and community living or mid-level slots over a five year period beginning in 1998. The first assumes a gradual decrease in the number of nursing facility beds accompanied by a corresponding increase in home care and community living settings while the second keeps the number of nursing home beds constant over the same period. However, the second chart shows the same gradual increase in the number of home and community based options as in the first chart.



TYPE	1998	1999	2000	2001	2002
NF Beds	5,100	5,000	5,000	5,000	5,000
Home Care Slots	1,300	1,400	1,500	1,600	1,700
Comm Liv Slots	-	50	100	150	200
Total	6,400	6,450	6,600	6,750	6,900



Projected Total Cost Of NF Beds, Home Care Slots, and Community Living Slots SFY 1998 - SFY 2002					
TYPE	1998	1999	2000	2001	2002
NF Beds	\$ 170,270,191	\$ 172,500,000	\$ 179,400,000	\$ 186,576,000	\$ 194,039,040
Home Care Slots	\$ 12,660,387	\$ 14,700,000	\$ 16,380,000	\$ 18,170,880	\$ 20,078,822
Comm Liv Slots	\$ -	\$ 750,000	\$ 1,560,000	\$ 2,433,600	\$ 3,374,592
Total	\$ 182,930,578	\$ 187,200,000	\$ 195,780,000	\$ 204,746,880	\$ 214,117,862

The Department has also considered the budgetary impact that the need for funding for the pilot demonstration projects proposed in this plan that are intended to strengthen the home and community based service infrastructure on existing programs and resources. These proposed pilots include the voucher program, the Pace Program, the caregiver respite projects, volunteer development, at risk targeting/service bundling, Shared Housing, and Congregate Housing Services Program expansion. In addition, funds will also be needed for nursing facility initiatives including the service house model and the Medicare Bed Bonus Program. Funding for technical assistance from national long term care experts that staff and providers may require to implement these changes will also be necessary, as well as for evaluations of the pilot programs. The level of funding needed is dependent upon what projects are selected, what resources are

available within the Department's budget, and the recommendations of the legislature as well as those of the Long Term Care Advisory Committee.

The approach outlined in *Shaping Tomorrow's Choices* is deliberately incremental. The Department intends to carry out its agenda for long term care reform with a minimum of disruption to the people in need of long term care services, their families, and those who assist them. Long term care is essentially about choices--individuals deciding where to live, what services they want to receive, who will provide them, and ultimately, where they will die. The current long term care system has not always given consumers these choices, nor has it always respected their choices. Long term care services can be invasive inasmuch as these services involve assistance with personal and private activities. By investing frail elderly and disabled consumers with the ability to control this aspect of their lives, which is the fundamental value on which *Shaping Tomorrow's Choices* is based, policymakers can honor consumers' choices, and in so doing enhance the quality of their lives.