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Money Follows the Person Site Visit: Pennsylvania Community Choice Initiative

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MFP Grantee Site Visit to Pennsylvania

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Summary

The Rutgers Center for State Health Policy/National Academy for State Health Policy Community Living Exchange Collaborative, funded by the Centers for Medicare & Medicaid Services, organized a site visit for Money Follows the Person grantees to learn about the Pennsylvania Community Choice Initiative. The initiative was designed to expedite access to home and community based services to avoid admission to a nursing home. The site visit was attended by grantees from California, Idaho, Michigan, Nevada, New Jersey and Texas.

Background

In 2003, Governor Edward Rendel issued an executive order creating the Governor's Health Care Cabinet and the Office of Health Care Reform (GOHCR) to facilitate the analysis of administrative, fiscal and regulatory policies and practices; oversee the design of operation and infrastructure and direct the creation and maintenance of a system to assure the accountability of designated agencies. The Cabinet includes seven departments with responsibility for health care and long term care. The Governor set three priorities for the cabinet: long term care, access for the uninsured and prescription drugs. Reflecting the importance of the issues, Governor Rendel changes the context of the discussions by referring to "long term living" rather than long term care. The Governor's interest in making long term living one of the administration's top priorities capped the state's 25 year effort to offer consumers more long term care service options to care in a nursing home.

Since the late 1970's, the Department of Aging has operated a home care program through area agencies on aging (AAAs) using state general revenues from the lottery. Preadmission screening of Medicaid applicants seeking admission to a nursing home began in the 1980's. Incremental progress followed a series of task force reports. An Intra-governmental Council on Long Term Care was created in 1988 to provide a public forum for discussion and debate on long term care issues; analyze and assess the current long term care system, examine options and suggest recommendations for action; develop a framework for a system of long term care services at the state and local level; seek both short and long range solutions to the problem of how to finance long term care; expand efforts to educate consumers about long term care issues and alternatives; examine and make recommendations on the organizational structure of long term care services at the state and local level; and, make recommendations on regulations, licensure and any other responsibilities relating to personal care homes.

The Council consists of cabinet officials, legislators from both parties, and stakeholders appointed by the Governor. The Council was staffed by the Department of Aging.

In March 2002, the Council issued a report that identified 22 process, informational and systemic barriers to home and community-based services. Many related to the delays in establishing Medicaid functional and financial eligibility. During the term of an interim governor, the Council prepared a transition report that was used by the incoming Rendel administration to set priorities. The priority for long term living is to achieve more balance between institutional care and community care. Based on 2003 Medicaid expenditures for adults and elders (excluding MR/DD spending), the state spends 6 percent of long term care funds on home and community-based services. However, these figures do not include expenditures for the state funded home care program for elders.

GOHCR wanted to move quickly to identify issues that could be addressed without legislation or changes in regulation. Based on the barriers identified by the Council, GOHCR created a "fast track" initiative to reduce the time needed to establish Medicaid eligibility and initiate home and community based services. Other initiatives include a statewide nursing home transition program, better information and coordination of 17 home modification programs, strategies to address the need for housing with services, and strategies to improve recruitment and retention of direct service workers.

The Community Choice initiative

Pennsylvania operates eleven Medicaid HCBS waiver programs which are administered by:

- Office of Medical Assistance Programs (AIDs/HIV, deaf and/or blind, technology dependent children);
- Office of Social Programs (attendant care services waiver, a waiver for adults with physical disabilities, a traumatic brain injury waiver and a development disabilities waiver);
- Office of Mental Retardation (operates three waivers for people with mental retardation); and
- Department on Aging (waiver for adults 60 and older).

GOHCR approached several counties interested in piloting a new approach to the eligibility process. The "fast track" initiative is not a program, but a process to expedite access to home and community-based services. The process applies to ten of the state's eleven HCBS waivers. A waiting list for MR/DD waiver services makes it impractical to expedite the eligibility process. The process was guided by two primary goals: changes must focus on consumers; the results should increase consumer choices and options. Planning began in July 2003 with the expectation that the changes would be implemented in four counties in Southwestern Pennsylvania by October 2003 and six counties in the Philadelphia area by December 2003. Planning occurred at the state and local levels. Four state agencies with responsibility for long term living functions formed a core team.

- Department of Aging manages the Medicaid and state funded home and community services programs and Older Americans Act services;
- Department of Income Maintenance is responsible Medicaid financial eligibility;

- Office of Social Programs operates four waivers and licenses nursing home, personal care homes; and
- Department of Medical Assistance manages policy development and appropriations for Medicaid long term living services.

Members of the core team met weekly to set priorities, understand the barriers, consider options for improving the process and develop and manage an implementation plan.

The state team approached local AAAs, service providers, advocates and consumers representing the 10 waivers to form a local core team. Local stakeholders recommended changing the name of the project from "fast track" to Community Choice. The initiative includes the following components:

- A reduction in the Medicaid financial application to four pages;
- Self-declaration of income and assets for applicants under the 300% special income level option;
- Presumptive financial eligibility to facilitate access within 24 hours when necessary;
- Exemption for $6,000 in assets;
- Exemption for burial plots;
- 24/7 access to assessments and eligibility determination;
- Reduction in the functional assessment form from 25 to five pages; and
- Expedited appeal process for denials.

Financial Application

The financial application was revised to expedite the process for people who are eligible under the 300% special income level option. The application forms includes demographic information; identification of unpaid medical bills; resources (checking, savings, certificate of deposit, stocks/bond, trust/annuities, prepaid funeral contract, cash, life insurance and additional resources); motor vehicles; property; income (social security, pension, VA pension, SSI, railroad retirement benefits, black lung, income from an annuity or trust, wages, dividends/interest, self-employment and other). The applicants signs the form, attests to its accuracy and the form is sent to the County Assistance Office. The form includes a statement of the applicant's rights, and information about food stamps and fuel assistance.

The individual may contact any of the organizations participating in Community Choice and complete the financial application with their assistance. The application is mailed or faxed to the County Assistance Offices which have installed a dedicated fax machine to handle Community Choice applications and notices.

Self-Declaration

Applicants sign a statement that the financial information written on the application form is true. The applicant agrees that they will be billed for the cost of services provided if they are found ineligible when the application process is completed.

Presumptive Eligibility

Financial eligibility may be presumed by the County Assistance Office based on the information supplied by the applicant. Applicants are encouraged to attach as much documentation as possible. Once an applicant is presumed eligible, County Assistance Offices verify the information supplied by the applicant. About 1 percent of the applicants presumed eligible are later determined ineligible.

Asset Exemption

Applicants with limited income and assets that exceed the $2,000 threshold are not able to receive home and community based waiver services. If they enter a nursing home, they quickly spend their assets and receive Medicaid coverage for nursing home care. To enable applicants with limited resources to remain at home and receive HCBS services, the state exempts $6,000 in resources for applicants in the 300% special income level group using Section 1902 (r)(2). Because this section applies to all beneficiaries in an eligibility group, it applies to HCBS and nursing home beneficiaries.

Burial Plot Exemption

State officials noted that tracking and verifying the ownership and value of burial plots extended the time necessary to make an eligibility determination. The value of burial plots is typically not enough to affect the decision. To remove the barrier, the Department of Medical Assistance filed a state plan amendment under Section 1902 (r)(2) to exempt that value of burial plots.

Expedited Appeals

Applicants retain the right to appeal. Since delays may place applicants at risk, a telephone appeal process was designed for applicants who were denied eligibility. The County Assistance Office sends a notice of termination with an explanation of the right to appeal. Appeals scheduled by the County Assistance Office and heard by the Bureau of Hearing and Appeals by phone every Tuesday and Thursday afternoon.

24/7 Access to an Assessment

Referrals are triaged based on the need for an assessment within 24 hours; 72 hours; within a timetable set by the consumer. Priority 1 applications (24 hours) respond to consumers who are at risk of nursing home placement; have lost a caregiver and do not have informal supports; are thought to be in jeopardy; or may lose or have lost their shelter arrangement. Priority 2 applications are processed within 72 hours when the applicant does not meet the priority 1 criteria and have not expressed a need to delay the process. Priority 3 applications are processed within 11 days or by a date determined by the consumer.

The availability of assessments at night or on weekends was helpful in communication the timeliness, flexibility and responsive of the process but it is rarely used. In fact, participating

agencies noted that consumers have sometimes wanted to schedule the assessment several days later than the assessor suggested so that a family member could be present.

The questions used to determine the applicant's level of care have been extracted from the comprehensive 5 page assessment tool. The assessor obtains enough information to determine level of care and initiate a temporary care plan. Information needed to devise a customized care plan is obtained after the expedited process.

Local Implementation

MFP grantees attended a meeting of the core team in Philadelphia County. The meeting was attended by the local AAA, service providers, Independent Living Centers, advocates and consumers. The meeting was chaired by the Dale Laninga Co-Director of the Long Term Care Project in the Governor's Office of Health Care Reform. The communication and marketing committee arranged meetings with area hospital CEOs and discharge planners to explain the process and the initiative. An orientation was also held for community organizations that often referred consumers for services. A brochure has been prepared and copies have been placed on each floor of the hospitals in the area. A toll free number has been set up by the Area Agency on Aging. A semi-annual newsletter will be sent to referral sources describing progress and individual examples of how the process has worked. Follow up meetings with hospital discharge planners will be scheduled to provide data on the project, obtain feedback and to orient new discharge planners.

The monthly meeting provides an opportunity to identify and resolve discrepancies that might otherwise hinder provider payment and continuity of service. The County Assistance Office sends a file each quarter to the participating agencies that lists the approved applications, pending applications, change forms and termination. The lists are reviewed and checked to make sure that approved consumers are receiving services, and consumers receiving services are included on the eligibility list.

The participating agencies have developed and maintain a data base that tracks number and sources of referral, status, and disposition. The formation of the core team has led to other activity. A subgroup was formed to conduct a survey of housing needs. Another group is meeting to examine access to transportation services. Information about emerging policies and proposals is exchanged. The core team is interested in obtaining feedback on the impact of Community Choice. A one page survey is being designed to obtain feedback from hospital discharge planners and other referral organizations.

The local core team contributed to a "story board" that describes the impact of the Community Choice and the factors that contributed to its success.

Meeting and Group Support

- Meetings were rotated among participating agencies that helped everyone feel they were in charge and contributing.
- There is a feeling of joint ownership.

- Regularly scheduled meeting created continuity.
- People who were invested in the programs were able to participate.
- Meeting notes and action items were taken to formalize the process.
- State, county and local agencies all participate.
- Operations and policy staff attended.
- Ideas were respected, discussed and implemented if possible.
- Agencies became familiar with different waivers which helped improve referrals.
- The county agency was given the flexibility and freedom to find ways to get things done.
- Larger agencies gave more staff support and resources (eg. Toll free line, manage a database).
- Each meeting had an agenda.

Consumer Satisfaction

- A standard survey was developed.
- Anecdotal feedback was considered and helped shape decisions.
- Feedback was shared with providers.
- Consumer follow up strategies are being designed to provide consistent feedback.

Data Management

- A local agency was willing to develop and maintain a data base to track activity.
- Terms were defined so they could be counted uniformly by the core team agencies.
- A manual was initiated and revised as questions arose after each meeting.
- The importance of collecting timely data and how it supports state decision making was stressed.

Access

- Toll free phone line.
- Flyers are available in different languages.
- Providers make more effective referrals through a “no wrong door” approach.
- Self-declaration, resource disregard and presumptive eligibility have expedited access.
- Triage and 24/7 response capacity.
- The physician review form has been shortened and expedited.
- A flow chart helped clarify the process and organization responsibilities.
- Transitions between waivers are more seamless.

Forms and Tools

- Universal cover sheet.
- Boiler plate script.

- Shorter assessment tool for decisions about level of care.
- New consent form.
- Reviewed training needed by staff affected by the program.
- Summary of the waivers helped agency staff understand the differences.
- Instructions for completing forms were simplified.

Results

During the first year in operation, the Community Choice pilot sites received 8,810 applications. Eighty nine percent of the applicants were 60 years of age or older. Twelve percent of all applications were processed within 72 hours and 5 percent within 24 hours. About 30 percent of the referrals were made by family members. Hospitals accounted for 19 percent of the referrals. AAA network agencies, nursing facilities, and other service providers accounted for just over 11 percent of the referrals. Seventy four percent were found eligible. About 10 percent were either financially or functionally ineligible. Another 10 percent of the applications are pending at the end of each reporting period. The data indicated that 27 percent of the applicants were diverted from nursing home placement, relocated from a nursing or were referred by a nursing home. The remaining 67 percent accessed services more quickly. State agencies are adapting existing information systems to determine the impact on nursing home admissions and Medicaid bed days in the demonstration counties.

On the local level, Community Choice helps to monitor the pieces of the long term living system, and to identify glitches and strategies to improve operations.

The State core team prepared a list of best practices based on the results from both demonstration areas. The findings include:

Establish a local stakeholder team to provide the foundation for local processes, policies and procedures. The team serves as a forum for feedback among stakeholders and problem solving with state agencies. The teams created a common vision and principles:

- Promote a “team attitude,” foster communication, cooperation and flexibility;
- Encourage, value consumer choice;
- Agree there is no wrong door for assisting consumers;
- Obtain HCBS as quickly as possible to avoid nursing home admission;
- Develop a flow chart to ensure clarity of process and timelines.

Organize Participants

The local team should include any person or agency involved in the process from referral to service delivery.

Pre-implementation

- Review and adjust reporting and data systems to accommodate changes in the process;
- Meet well in advance with local program staff to discuss referral, feedback and reporting expectations;
- Allow two month start up to develop and implement protocols and procedures;
- Consider the application pipeline and handle as many as possible to avoid parallel processes;
- Test triage times with consumers to estimate volume and capacity;
- Review and evaluate scheduling functions, assessment time frame methods and staffing capacity use to meet triage times.

Training Integrated program of cross-system training was developed for staff in all participating agencies.

- Ongoing discussion with the local implementation team provides a mechanism to identify training needs;
- Include Medicaid financial eligibility staff as part of the training;
- Develop training on the assessment tool and the application process;
- Fully train all intake and assessment staff in advance on all waivers included in the program;

Implementation

- Initially use the most experienced and knowledgeable assessors and train all assessors over time;
- One pilot used benefits counselors to explain financial and estate recovery information;
- Develop an on-call system to ensure timely response to level of care determinations during non-working hours;
- Designate the local Area Agency on Aging as the central contact and repository for all information;
- Evaluate the need to distribute the workload within the nursing home/waiver unit;
- Develop clear procedures with County Assistance Office (Medicaid financial application) regarding timely submission of information and completeness of applications.

Care/Service Plans

- The initial care/service plan must follow the time frames determined by the triage procedures;
- A comprehensive service plan must be developed with the consumer within 14 days;

- Experienced case managers/service coordinators should be used to complete the preliminary care plan;
- Once the preliminary plan is developed, the case might be transferred to another care manager or enrollment specialist to complete the comprehensive plan;
- Increased number of cases and the shorter time frame led to the creation of three lead case manager positions and one additional supervisor within the elderly waiver program.