Point of Entry Systems for Long-Term Care: State Case Studies

prepared for the New York City Department for the Aging
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Introduction

This report was prepared to inform the New York City Department for the Aging about other states' long-term care ("LTC") point of entry ("POE") systems. The analysis and case studies in this report focus on the following topics:

- system structure and integration at the state and local levels;
- common elements of successful systems; and
- special features of each POE system.

The POE and integration of the LTC system

The establishment of a POE implies some degree of integration of the overall LTC system, but establishing a POE is not the same thing as establishing a fully integrated LTC system. According to some observers, there are four aspects of a state LTC system, each of which can be more or less integrated:

1. planning and policy development;
2. system access, client assessment, and local service delivery;
3. cost containment and private sector involvement; and
4. quality assurance and consumer protection.

Establishing a POE involves integrating the second component (system access, client assessment, and local service delivery) in order to achieve equal and easier access for the greatest number. From the perspective of the consumer, integrated access is of paramount importance. From a policy perspective, however, it is useful to consider the role of integration throughout the entire LTC system.

A system that coordinates or consolidates LTC functions across various departments, agencies, or providers is "horizontally integrated". The difference between coordination and consolidation is one of degree.

State-Level Structure and Integration

At the state level, there are 3 ways in which LTC responsibilities can be structured: the cabinet model, the umbrella model, and the consolidation model.

Integration of the LTC System at the State Level

Coordination ←---------- → Consolidation

Cabinet Model **Umbrella Model** **Consolidation Model**

Cabinet model. Under the cabinet model, existing cabinet level agencies (e.g., aging, health, human services) retain their LTC responsibilities but function under an official interagency coordinating committee (Colorado). Such an interagency coordinating committee is the locus for development of any integrated LTC state policy. There is no need for departmental reorganization.

This structure requires the least amount of change, but it also lends itself least to true service integration and coordination. Its success is largely dependent upon personal effort and informal agency head consensus; support of the governor is key under this model.

Umbrella model. Under the umbrella model of state administration, all LTC services are provided under one single agency, usually a department of health and social services. Different LTC programs and functions are dispersed among various divisions and bureaus within the umbrella department (Indiana, Maine). Internal responsibilities are shifted in order to increase inter-divisional coordination. An intra-departmental coordinating structure is usually developed to integrate planning, policy development, and resource allocation among the different divisions.

Integration of services is fostered by assigning responsibility for programs to one division, using one local access and delivery system, and developing an intra-departmental planning and coordinating committee.

Consolidation model. The consolidation model entails wholesale governmental reorganization. All LTC responsibilities, both institutional and community-based, are placed within one sole-purpose agency (South Carolina (proposed); Texas). This normally requires a major reorganization of state government, including the possible creation of a new super-agency and the dismantling of existing departments. Alternatively, the sole-purpose agency could be a new division of an existing department (Alaska; Massachusetts; Oregon; Wisconsin).

Consolidating authority and responsibility in a single organizational structure substantially enhances administrative efficiency and accountability for LTC outcomes. Many states face difficulties in pooling different categorical funding streams that have contributed to the development of fragmented systems. As resource shortages limit states' capacity to fund both nursing home care and HCBS, and trade-offs become necessary, both efficiency and consumer choice are better served if decision-making is integrated within a single organizational structure that has authority over all LTC resources.

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Elements of an integrated state LTC policy. Regardless of which structural model is adopted, integration of either the POE or of the entire LTC system does not occur

automatically. The plan needs to include the following specific actions to ensure that this integration takes place:

- Agreement on common assessment tools for preadmission screening for nursing homes and for eligibility for HCBS;
- Coordination of a LTC information management system designed to produce usable information for policy development, planning, and resource allocation;
- Coordination of planning, policy development, and resource allocation to ensure that all decisions that impact the LTC system are made with the full knowledge and participation of affected programs and divisions; and
- Use of a single local client assessment and delivery system for HCBS.

Local POE Structure and System Integration

From the consumer's perspective, the state-level structure of the LTC system is far less relevant than how the system is structured locally. Regardless of the model of state government, a POE system should help reduce service fragmentation at the level of the individual consumer.

At the local level, the degree of horizontal integration depends on the degree to which access to diverse services is coordinated or consolidated across authorizing agencies and providers. A system is "vertically integrated" if all services from all sources are linked, from the time a consumer becomes aware of available services, through the provision and monitoring of those services. A POE system is, by definition, an integrated system, although the degree of horizontal and vertical integration may vary. In general, however, researchers have found that:

- POEs that **serve multiple populations** can achieve economies of scale and streamline relationships with providers;

- **combining or coordinating financial and functional eligibility determinations** expedites access to HCBS; and

- POEs that **coordinate multiple funding streams** have more flexibility to respond to various individual needs.
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There is considerable variation in the type of organizations that act as POE agencies at the local level. Moreover, some states have multiple types of organizations serving as POE agencies. Typically, different local organizations bring different strengths and face different challenges.

County Governments

Strengths:

- Have extensive expertise in administering state HCBS programs.
- Greater public accountability than private organizations.

Challenges:

- Lack experience managing the complex financial aspects of a risk-based managed care operation. Wisconsin offered counties the assistance of a financial consultant to help them design their fiscal management systems.

Aging Agencies

Strengths:

- Have experience with people of all socio-economic groups and have a broader mission than just access to public benefits, so routinely interact with people not familiar with public programs and are perceived as having a broader mission than connecting people with public benefits.
- Staff broaden their knowledge as they begin to work with other target groups, and this strengthens the agency and enhances services to older adults as well. The target groups have more in common than initially recognized.

Challenges:

- Takes time for aging agencies to change the organizational culture to incorporate other target groups.
- Aging agencies serving as POEs need to implement systems to ensure that Older Americans Act funds are used only for older adults, not other target groups served by the POE.

Human Services/Social Services Agencies

Strengths:

- Already have an intake system, including close collaboration with financial eligibility determination, that makes it easier to develop a POE for publicly-funded LTC programs.

Challenges:

- Need to avoid public perception of the POE as part of the welfare system; thus, some degree of separation between the POE and the rest of the agency may be helpful in reaching a broader group of consumers.

- Need to be careful to assign people with a broad focus to staff the POE.
- Strong interaction and collaboration with local aging programs is necessary for the POE to meet its goals.

Private Organizations

Strengths:

- May have specialized experience managing complex information systems, databases, call centers, or managed care systems.
- Have greater flexibility in managing personnel, because they are not subject to civil service rules or hiring restrictions

Challenges:

- Higher overhead, because they typically do not receive in-kind space or administrative support from local government agencies

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A POE is not necessarily a single physical location. Regardless of the model of governmental structure, a POE does not necessarily require all consumers to enter through a single, physical, geographic location. Alternatives include:

- home visits;
- toll-free telephone numbers;
- a single local or regional agency with multiple locations statewide; and
- "No Wrong Door" – multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity.

Common Elements of Successful Systems

Successful POE models share several common elements:

- **Administrative uniformity + flexible service packages.** Some aspects of community LTC systems can be tightly structured and uniform statewide without compromising states' ability to flexibly respond to individual service needs. Uniform assessment tools, explicit financial eligibility criteria, and the development of POE systems themselves have all made access to community care more predictable from a client's perspective and more standardized as viewed by program administrators. Yet the actual services provided often are very loosely defined, giving local program managers considerable latitude in tailoring service packages to individual needs.

- **Comprehensive planning + gradual implementation.** Most states studied developed their systems incrementally. Some phased in statewide implementation of POE initiatives by geographic area. Some added various program components over a period of several years. However, since the various components of LTC systems all interrelate, undertaking a comprehensive planning process before major new initiatives are underway:

  ⇒ is essential to ensure that guiding principles and goals are reflected in all aspects of the system;
  ⇒ better enables a state to manage the system as a whole, rather than its parts;
  ⇒ makes it easier to add new elements in the future.

- **Accountability for outcomes, not micromanagement.** States prefer to hold local POE systems accountable for end results rather than trying to control every detail of local administration. This approach recognizes differences among communities in local practices and traditions and avoids emphasizing process requirements.

- **Stakeholder consensus on values and goals.** Successful system changes often begin with the achievement of broad-based consensus among key stakeholders on the values, principles, and goals that a new system should reflect. Such an approach has many benefits:

  ⇒ All stakeholders have a common understanding of what the new system is expected to accomplish for participants.
  ⇒ As program design and implementation proceed, a strong values framework provides a guidepost for decision-making and for resolving conflicts about competing strategies.
  ⇒ All stakeholders have a shared investment in making the plan succeed and achieving the goals of LTC reform.
  ⇒ Stakeholders are more willing to give up their turf in order to put consumers first and work together as a team.

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San Diego, California

San Diego's LTC system features:

- POE is a county-wide toll-free Call Center based in an expanded AAA
- integrates OAA, state general funds, Medicaid waiver and state plan, social service block grants, and county funds
- investment in staff development
- strong community support

Call Center. San Diego's POE is a county-wide toll-free Call Center based in an expanded AAA. Intake workers, who are professional social workers:

- identify the caller's needs
- use the call center's electronic management tool to refer the case to another social worker associated with one of the POE's programs.

The POE contracts with more than 60 community organizations to provide services.

Financing. The Call Center integrates OAA, Medicaid, state, county, and private funds. Thus, it can address the widest possible variety of LTC needs.

Staff development. The POE credits its success, in part, to investing in staff development. It holds quarterly all-staff meetings; publishes a monthly newsletter; conducts "ride-alongs" in the community; promotes employee input and buy-in; alters work space to be efficient and effective, e.g., co-locating staff; and provides necessary tools such as cell phones and computers.

Community support. The POE promotes strong community support by convening meetings of a county collaborative group of 500+ organizations that serve or represent seniors (including, e.g., providers, educational institutions, newspapers, utility companies, social organizations, police and fire departments, and the U.S. Postal service); sponsoring trainings; and sharing resources such as vehicles, space, and materials.

Demographics. The POE serves ethnically diverse populations with urban, suburban, and rural areas equivalent in size to the state of Connecticut. In 2000, about 15% of the population was 60+.

Colorado

Colorado's LTC system features:

- POE agency chosen by counties and certified by the state
- state has performance-based contracts with POE agencies
- multi-county POE districts, to achieve economies of scale
- gradual implementation of POE system, by geographic area and by function
- formal processes for stakeholder input and local resource development
- aging network and POE system are not integrated at the state level, but can be integrated locally at the option of each local POE agency.

Selection of local POE agencies. County opposition was a potential challenge to establishing the POE system, because counties had been responsible for administering HCBS. Thus, to encourage cooperation from county governments, the state gave counties an important role in selecting POE agencies:

Historically, county commissions in each POE district jointly recommend POE agencies to the state, based on an application process. The state Department of Health Care Policy and Financing ("HCPF") certifies each agency's ability to fulfill the POE requirements, contracts with the agencies, and conducts annual reviews. If the recommended agency does not meet certification standards, HCPF is able to contract with another agency. (The POE selection process may be changed in FY 2005-06, when the current POE contracts end.)

POE agencies are varied, and include county health or social service agencies, AAAs, and private non-profit agencies.

Performance-based contracts. POE agency reimbursement is determined in part by each agency's performance on specific outcome measures included in POE agency contracts.

Multi-county POE districts. Counties with fewer than 200 LTC participants were required to form multi-county districts (although they did not have to keep adding counties until the 200 threshold was reached, for fear of creating districts that were so large that they presented a geographic barrier to access). 200 was the minimum number of participants necessary for a POE agency to break even without increasing state payments for assessment and case management, as calculated by an economist hired by the state. As of 2003, the number of participants served ranged from approximately 70 in one multi-county district to more than 3,200 in the Denver district.

To provide a financial incentive for multi-county districts, the state pays each multi-county district $8,000 per year for each county it includes. In 2002, this came to $456,000 per year for the 57 counties that were members of multi-county districts. The remaining 7 counties had their own POE agencies.

Gradual implementation of POE system:

1988: planning begins in the state Department of Social Services (now the Department of Health Care Policy and Financing)
1992: legislature passes law establishing POE system
1992: county commissions are required to form POE districts
1993: state HCPF certifies first 2 POE agencies
1994: state certifies 5 more POE agencies
1995: state certifies remaining 18 POE agencies

Gradual addition of POE responsibilities:

Initially: POE agencies provided case management for Medicaid and private-pay individuals receiving HCBS
1997: 3 POE agencies piloted 2-year project to identify nursing home residents who could be relocated to less restrictive settings
2001: functional eligibility assessment for nursing facilities and HCBS piloted by 3 POE agencies; this responsibility was added statewide within 2 years
2002: prior authorization of Medicaid state plan long term home health care services added

The addition of responsibilities has increased the degree to which POE agencies can make HCBS more cost-efficient.

Stakeholder involvement. Community involvement helped build political support for the transition from a county-based LTC system to the regional POE system. In the late 1980s, the Executive Director of the state Department of Social Services (which no longer exists) appointed a Long Term Care Advisory Committee made up of providers, county staff, county elected officials, AAAs, and advocates. The group formed subcommittees and worked with Department of Social Services staff to draft an implementation plan, which became the basis for regulations governing the POE system.

The state continues to seek stakeholder input on an ongoing basis, primarily through an advisory committee of providers and consumers. Also, Colorado creates special committees of consumers, providers, and advocacy groups when considering major changes.

At the local level, each POE agency has an advisory committee that includes county commissioners, county staff, medical professionals, providers, consumers, and AAAs. This advisory committee appoints a Resource Development Committee, which, in turn:

- works with the AAA to prepare a resource development plan for increasing the local system's capacity, and
- surveys consumers and providers to identify gaps in services.

State-level organization. Responsibility for the state's many LTC programs is divided among 3 departments:

- The Department of Health Care Policy and Financing ("HCPF") administers the POE system. HCPF is a narrowly focused department that sets Medicaid policy and contracts out Medicaid funds. The state established HCPF in the early 1990s in an effort to control Medicaid expenditures.
- The Department of Public Health and Environment regulates assisted living and nursing facilities, through an inter-agency agreement with HCPF.
- The Department of Human Services administers:
    - Older Americans Act and similar state-funded services, through AAAs
    - LTC ombudsman services, through AAAs
    - Old Age Pension Health and Medical Care Program.

There does not appear to be a formal mechanism for coordinating LTC policy between HCPF and the Department of Human Services. One official said that, when HCPF establishes "working committees" around particular issues, they attempt to have representation from all three departments.

Financing. Medicaid waiver, state, county. POE agencies can accept private payment for assessment and case management, and can raise funds to subsidize a sliding fee-scale. HCPF does not control Older Americans Act funds, but local POE agencies can contract with the aging network to provide OAA-funded services.

Demographics. In 2000, Colorado had a population of 4.3 million, of whom more than 560,000 were 60+. The POE agencies serve approximately 18,200 people statewide. The Denver POE makes approximately 1,500 home visits per month.

Contacts and Resources:

Ford Allison, Director, Long Term Care Options, Denver, CO. (720) 974-2373.

Lisa Chevalier, The Medstat Group. "Promising Practices in Home and Community-Based Services: Colorado – Simplified Access to Nursing Home Alternatives. Issue: Single Entry Point Agencies." Undated.

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Viki Manley, Director, Long-Term Benefits Division, Colorado Department of Health Care Policy and Financing. (303) 866-2991

Colorado Department of Health Care Policy and Financing web pages:
http://www.chcpf.state.co.us/HCPF/MedicaidEligibility/mefcc.asp
http://www.chcpf.state.co.us/HCPF/Pdf_Bin/Summer_2003_LTC_Contact_List.pdf
http://www.chcpf.state.co.us/HCPF/Pdf_Bin/PCPP_Newsletter_Summer_2003.pdf

D.C.

D.C.'s LTC System Features:

- A detailed fiscal impact statement for development of a Disability and Aging Resource Center.

D.C.'s plan for its Resource Center is based on the Wisconsin model. Excerpts from D.C.'s fiscal impact statement are reproduced below:

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> The Disability and Aging Resource Center will represent a cost to the District in the immediate short-term, however the Center is expected to have cumulative savings by FY 2005. Savings will be generated by an increase in the diversion of individuals to HCBS who would otherwise be served in more costly institutional-based settings. The development of the Resource Center would reduce the District portion of Medicaid claims costs by $496,785 in FY 2002. However, operational and staffing costs will outweigh the benefits of increased diversion into HCBS for the first three years. Operational costs are expected to be $716,238 in FY 2002, for a net cost to the District of $219,453 in FY 2002. Savings are expected by FY 2003 to the extent of $41,064 and by FY 2005 there will be a cumulative benefit of $997,724. In just three years the Resource Center will be cost neutral. Note: the operational costs cited have been included in the FY 2002 budget.

Exhibit 1: Cost-Effectiveness of the Disability and Aging Resource Center

	2002	2003	2004	2005
Net Saving (Costs) in Medical Claims	$ 496,785	$ 861,996	$ 1,373,806	$ 2,050,547
Net Resource Center Operational Costs	$ 716,238	$ 820,933	$ 1,040,205	$ 1,208,034
District Saving (Costs)	$ (219,453)	$ 41,064	$ 333,601	$ 842,512
Cumulative District Savings (Costs)	$ (219,453)	$ (178,389)	$ 155,211	$ 997,724

. . .

> ***Financial Impact***
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> Based upon a review of similar Resource Center-type operations in other states and counties, MAA's current waiver experience, and a review of other states' experiences with waivers, MAA believes that development of the Disability and Aging Resource Center will further enable MAA to divert persons with a disability and the elderly from institutional care. This would result in a modest savings to the District's Medicaid program as Medicaid costs would have been higher if people received more costly

nursing home care instead of receiving care in the community (estimates are provided below).

Our fiscal impact estimate is based on a comparison of the following:

A. The average cost per Medicaid-funded nursing facility care;

B. The average cost of someone served using HCBS;

C. The likelihood that someone using HCBS would have otherwise been served in an institution, without a Resource Center operating in the District;

D. The estimated number of individuals served under the waiver without the Resource Center.

E. The likelihood that someone using HCBS would have otherwise been served in an institution, with the Resource Center operating in the District; and

F. The estimated number of individuals served under the waiver with a Resource Center in place.

We derived the first two numbers (A and B) from internal Medicaid data. We estimated the third number (C) based on the year-by-year experience of three other states [Colorado, Washington, and Oregon] that have completed such a transition from nursing home to HCBS care; this represents a conservative estimate of the true rate of diversion. We developed an assumption for the fourth number (D) based on the experience of other states that have grown the elderly/disability HCBS systems [Colorado, Washington, and Oregon]. Note that the number of individual served under the waiver is limited by the number of slots currently allocated and expected to be allocated by the Centers for Medicare and Medicaid Services (CMS). The fifth (E) and sixth (F) numbers are extrapolations of the third (C) and fourth (D) numbers and based on predictions from MAA-ODA and the impact of Resource Center-type operations in other states [Wisconsin, Indiana, New Jersey].

Based on data for 2000, we use the following assumptions:

A. The average cost per Medicaid-funded nursing facility care = $75,626

B. The average cost of someone served using HCBS = $22,385

C. The likelihood that someone using HCBS would have otherwise been served in an institution = 26%

D. The estimated number of individuals served under the waiver = 104 (by 2005)

E. The likelihood that someone using HCBS would have otherwise been served in an institution with a Resource Center in place = 31%

F. The estimated number of individuals served under the waiver with a Resource Center = 1155 (by 2005)

Additional Benefits

In addition to the tangible cost savings that the Disability and Aging Resource Center is expected to bring, there are a number of intangible and also immeasurable benefits.

Intangible Benefits:

- **Improved District LTC system analysis -** The Resource Center will be a central point of data collection, enabling improved analysis of District LTC operations and residents' LTC needs. Such analysis will be able to direct and support MAA-ODA LTC policy recommendations.

- **Streamlined process to gain HCBS eligibility –** Current District processes for gaining access to HCBS services is lengthy and confusing. The Resource Center will be able to streamline and standardize the requirements.

Immeasurable Benefits:

- **Centralized Information and Assistance services -** Consumers will experience a less confusing navigation process to gain answers to LTC inquiries, referrals to other agencies and information and materials on District LTC services. This will lead to a more informed and knowledgeable consumer base.

- **More efficient use of consumer's assets** – The Resource Center will educate consumers about maximizing their current resources, which may include topics such as spend-down eligibility and the HCBS Waiver. In the long term this could prevent consumers from relying on full Medicaid support for their LTC, resulting in substantial savings to the District.

- **Improved outcomes for those in need of LTC services** – Consumers who use the Resource Center are more likely to select the LTC setting

that meets their needs and preferences, therefore receiving more appropriate care.

- **Improved Provider Accountability –** The Resource Center will be able to monitor consumer outcomes and the provision of care, ensuring that all providers are delivering top quality care.

Exhibit 2: Detailed Cost-effectiveness of the Disability and Aging Resource Center

	2002	2003	2004	2005
Average cost per NF resident	$ 79,104	$ 82,743	$ 86,549	$ 90,531
Cost per new HCBS recipients	$ 23,415	$ 24,492	$ 25,619	$ 26,796
HCBS Costs	$ 10,422	$ 10,901	$ 11,403	$ 11,927
Other	$ 12,993	$ 13,591	$ 14,216	$ 14,869
Without Resource Center				
Increase in number of HCBS recipients	100	200	300	400
Percent of HCBS recipients that are NF diversions	26%	26%	26%	26%
Number of NF Diversions	26	52	78	104
With Resource Center				
Increase in number of HCBS recipients	281	481	731	1,031
Percent of HCBS recipients that are NF diversions	31%	31%	31%	31%
Number of NF Diversions	87	149	227	320
Savings (costs) from increased diversions	$ 1,452,053	$ 2,412,476	$ 3,860,626	$ 5,857,922
Savings (costs) for increased HCBS recipients	$ (955,268)	$ (1,550,479)	$ (2,486,820)	$ (3,807,375)
District Cost of Resource Center start-up and operations	$ 716,238	$ 820,933	$ 1,040,205	$ 1,208,034
Net Savings (costs) to District	$ (219,453)	$ 41,064	$ 333,601	$ 842,512

Contacts & Resources:

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Maine

Maine's LTC system features:

- Centralized administration to control costs and streamline consumer access
  - ⇒ centralized access via telephone or referral form – not a physical location
  - ⇒ a single, independent agency to perform assessments
  - ⇒ centralized oversight and authorization of all agency-provided HCBS by one authorizing agency
- decentralized, local service provision
- laptops in the field limit back-end need for data entry
- use of program and evaluation data to analyze program costs and incorporate into planning.

Centralized Access and Assessment. Maine has a competitively bid contract with a single, independent agency to do medical assessments for LTC. Since 1998, that agency has been Goold Health Systems ("GHS"), a for-profit data management company that has one of the largest data entry facilities in the Northeast. Financial eligibility for Medicaid services is determined separately by the state Department of Human Services, Bureau of Family Independence.

To access LTC services, consumers must go through GHS (exceptions: those who want *only* adult day care or homemaker services). Consumers do not actually go to GHS offices, however. Rather, they can

- call GHS;
- be referred to GHS by hospital discharge planners, nursing facilities, and other providers; or
- contact their local Department of Human Services office, which will conduct the financial eligibility assessment, then forward the medical eligibility request to GHS.

Requiring all consumers to go through a single agency helps to ensure equitable access to LTC services statewide, on a first-come, first-served basis. Prior to the establishment of this system, the state apportioned LTC funding to local AAAs, some of which would run out of funds too quickly, while others would have surpluses. There are currently no waiting lists for any of Maine's LTC programs.

GHS has a team of more than 60 nurse assessors across the state who conduct assessments in hospitals, nursing facilities, individuals' homes, etc. Each nurse carries a laptop computer which they use to complete the uniform assessment instrument. At the assessment, the nurses:

- meet with the consumer and the caregiver;
- determine medical eligibility of all LTC clients for nursing facility and community-based services, regardless of payer;

- inform the consumer which programs and services he or she is eligible for;
- authorize a service plan;
- assign HCBS consumers to one of 4 levels of need; and
- refer HCBS consumers to the statewide home care coordination agency (see below).

After each assessment, the information collected is directly relayed to GHS and to Maine's Bureau of Elder and Adult Services, via a statewide network of secure dial-in locations.

GHS also staffs a toll-free help desk to receive referrals from medical providers and answer questions about existing or past cases. Currently GHS processes 300 calls, 100 referrals, and 60 face-to-face assessments every day.

Centralized HCBS Case Management. Maine has competitively bid contracts with two agencies, Alpha One and Elder Independence of Maine ("EIM"), to manage publicly-funded HCBS statewide. Alpha One manages consumer-directed programs, and EIM manages HCBS purchased through agencies.

EIM is a division of one for state's AAAs, and is co-located with it. There is no significant conflict-of-interest issue, because the AAA does not provide much in the way of LTC services. EIM receives a monthly, per person payment from the Bureau of Elder and Adult Services to:

- arrange services;
- coordinate and monitor care;
- collect consumer co-payments;
- administer contracts with service providers;
- pay claims;
- audit provider agencies; and
- participate in quality improvement activities.

EIM has a staff of over 80 and manages more than 3800 cases daily. HCBS are delivered through a network of more than 250 local home health agencies, adult day services, personal care agencies, and independent nurse contractors. Services can be provided in homes, residential settings, assisted living facilities, and adult family care homes.

State-level organization. Maine's LTC program is carried out by 2 divisions of the State Department of Human Services. (1) The Bureau of Elder and Adult Services is responsible for the planning, policy development, coordination, and evaluation of all services relating to older adults and people with disabilities, and their families. (2) The Bureau of Family Independence is responsible for determining financial eligibility for Medicaid LTC services.

Financing:

- State general funds
- Medicaid state plan
- Medicaid HCBS waivers

Non-waiver services have case mix adjusted payments that set varying monthly coverage caps based on acuity.

Consolidating the administration of HCBS has saved approximately $800,000 annually since 1996.

Use of data. Maine has a long history of using program data to analyze costs and monitor "cost drivers". The computerized LTC assessments provide a rich store of information on the characteristics of LTC consumers, which State administrators, legislators, and advocates all use as the basis for analyzing the impact of proposed policy changes. In addition, State universities conduct useful analyses of Medicaid costs, utilization, provider certification, etc.

Demographics. Maine is a large, rural state with a population or 1.3 million, of whom 238,000 (18%) were aged 60 and above. Maine's population is 99.4% white.

Resources & Contacts

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U.S. Dep't of Health and Human Services, Administration on Aging. Creating More Balanced Long Term Care Systems: Preview of Case Studies on the Role of the National Aging Services Network. Sept. 2003.

Alpha One website, www.alpha-one.org

Elder Independence of Maine website, www.elderindependence.org

Goold Health Systems website, www.ghsinc.com

Maine Department of Human Services, Bureau of Elder and Adult Services website, www.state.me.us/dhs/beas/ltc/2000/ltc_2000.htm

Massachusetts

Massachusetts' LTC system features:

- Centralized access, medical eligibility determination, service authorization, and case management, via a network of 27 regional Aging Services Access Points (ASAPs);
- a uniform assessment instrument and uniform case management standards;
- collaboration among ASAPs and with other community partners;
- consolidation of LTC administration in a single state agency; and
- support from the state legislature, the state aging office, and a strong trade association.

Centralized access. The Executive Office of Elder Affairs contracts with 27 regional ASAPs, most of which are local AAAs, to provide:

- information and referral;
- comprehensive needs assessments, pre-admission screening, medical eligibility determinations, and service authorization for elders seeking institutional and community care services from Medicaid or the home care program;
- case management.

Consumers enter the system through a statewide "Age Info" 800 number and website, calls to the local ASAPs, referrals from a range of community partners and providers, and other local outreach activities.

In addition to providing some services, each ASAP contracts with multiple providers. They also maintain close ties with city-based councils on again, often directing OAA funds to these organizations to serve a broader range of elders with nutrition services, health promotion programs, and social activities.

Based on input from the Massachusetts Home Care Association, ASAPs statewide have adopted uniform case management and eligibility determination standards and training level guidelines.

State-level organization. Under the final FY 2004 budget approved by the General Court, $1.5 billion in Medicaid senior care plans is to be transferred to the Department of Elder Affairs as of January 1, 2004. This means for the first time, Medicaid-funded elderly services, including home health, personal care, and nursing home care, will be under the same agency as state funded home care.

The budget plan moves the former independent Executive Office of Elder Affairs into Executive Office of Health and Human Services—but it places more services under DEA's administration. The DEA is still headed by a Secretary at the cabinet level, but the EOHHS oversees all of its activities. The new budget gives DEA administrative authority over Medicaid long term care services for people age 65 and over. "Overall management,

administration and oversight activities related to the screening and authorization of community long term care services and related case management services shall be the responsibility of" DEA, the budget says, but it also requires that this authority in many cases be carried out "in consultation with" EOHHS.

Financing. The ASAPs administer OAA, Medicaid state plan and waiver, state, foundation, and private funds.

- For the basic home care program, ASAPs receive $232 per active home care client per month. There is no per person service cap, but the ASAPs have to manage within an overall budget.
- ASAPs receive $812 per month for case management and services in the Enhanced Community Options Program.
- A new initiative for high-risk HCBS waiver clients is funded on a cost-reimbursement basis and allows ASAP to provide the service level needed to keep clinets in the community.

Demographics. ASAPs serve about 39,000 frail elders in need of community-based care and their families, as well as providing information and referral to many who do not qualify for publicly funded home care services. Particularly in urban areas, ASAPs serve diverse populations and provide case management and assistance in multiple languages.

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New Jersey

New Jersey's LTC system features:

- POE agency chosen by counties
- Information systems upgrade plans required
- Toll-free number for information and services
- Gradual implementation of POE system

Selection of local POE agencies. The county authority designates a county agency to take the lead in designing and operating the POE system, as well as a lead agency for the toll-free number. The lead POE agency identifies other agencies that can help the county provide a full range of core services.

For example, as of 1998, Atlantic County was using the Division of Intergenerational Services as the lead agency. The division, in turn, had contracted with 2 nonprofit agencies and a municipal office to provide outreach and care management services for older people in 2 municipalities and one rural area in the county.

Counties are required to submit plans for upgrading their computer systems to manage the information necessary to provide quick information and assistance. State staff work closely with the counties to provide training and assistance in overcoming various obstacles to implementation and standardization.

Toll-free number. New Jersey has established a nationwide toll-free number to enable people to learn about and obtain services. Within New Jersey, the telephone system automatically recognizes the county from which the incoming call is being made, and transfers the caller to the POE agency for that county. Calls received during regular business hours are answered by a live person; at other times, calls are answered by a recording that gives an emergency number. Start-up costs for the system were approximately $100,000.

Through the NJ EASE toll-free number, a person can:

- obtain information on a wide range of services;
- receive counseling about available public benefits;
- arrange for assistance;
- receive assistance in completing applications for services; and
- make adjustments to services currently being provided.

If a telephone counselor is unable to answer a caller's question, the caller is referred to an appropriate agency. The counselor can place a 3-way call to the agency if necessary.

For people who need more intensive assistance, in-home comprehensive assessments can be arranged to determine the need for LTC support services.

A standard form is completed for each caller that receives assistance; to prevent people from unnecessarily repeating paperwork, this form comprises the beginning of the NJ EASE Comprehensive Assessment Instrument used to perform the in-home assessments.

Gradual implementation.

1994: New Jersey received Robert Wood Johnson Foundation grant.
1996: Implementation of NJ EASE began in 7 of the state's 21 counties, with more counties added over 5 years.
1999: Toll-free number piloted in NJ EASE counties. The mechanics of the toll-free number system were able to be put into place in just three months, due to very strong backing from the Governor.
2001: Statewide implementation of NJ EASE and toll-free number substantially completed. Quality standards pilot-tested.

Financing. Counties must use existing funds from OAA, Medicaid, and state and county programs to cover the costs of the POE system.

Resources:

Barbara Coleman, AARP Public Policy Institute. New Directions for State Long-Term Care Systems (2nd Edition). http://research.aarp.org/health/9809_stateltc.pdf

Medstat. "Promising Practices in Home and Community-Based Services: New Jersey – Single Access Point for Information on All Services for Older People." Undated, c. 2001. http://www.cms.hhs.gov/promisingpractices/

Oregon

Oregon's LTC system features:

- AAAs have the option to serve as POE agencies
- Case managers use laptop computers to complete an automated assessment instrument
- POE determines financial eligibility for Medicaid
- Priority level system facilitates planning and resource allocation
- Recognized as a leading model for LTC reform

Local POE agencies. Oregon allows AAAs to be designated as POE entities if they wish. In the few regions where they have declined, local offices of the state Senior and Disabled Services Division serve as the POE agency for Medicaid LTC, while AAAs continue to manage OAA funds.

POE agencies provide:

- information on a wide range of topics
- benefits counseling
- crisis intervention, adult protective services, and after-hours on-call support
- needs assessment and eligibility determinations for Medicaid, food stamps, HCBS, and institutional care
- case management and service plan authorization
- pre-admission screening

The state has invested significant resources in the development of a new automated assessment tool. Case managers use laptop computers to directly record a consumer's responses during the assessment, while being guided to collect additional information by triggers built into the system.

Financial eligibility. Oregon is the only state in which the federal government has permitted the POE agency to determine financial eligibility for Medicaid.

Priority level system. Based on the needs assessment, the automated system calculates a consumer's priority for receiving services according to a 17-level scale. Whether people in specific priority levels are eligible for publicly-funded supports depends on the size of the program budget. Because the state compiles data weekly on the number of people receiving services, the cost of their authorized service plans, and their priority level, the state is able to accurately project the amount of funds required to cover all people in each level of need. Because of the state's current budget crisis, the legislature has, for the first time, eliminated LTC eligibility for priority levels 12-17.

State-level organization. Legislation passed in 1981 reorganized the agencies that provided LTC to the elderly. The Senior and Disabled Services Division of the

Department of Human Resources oversees all senior LTC programs financed with federal and state dollars.

Consolidating responsibility for community and institutional services into a single, sole-purpose agency enabled Oregon to develop coordinated state policies that promote common goals across all service settings.

Resources:

Diane Justice and Alexandra Heestand, Medstat Research and Policy Division. Promising Practices in Long Term Care Systems Reform: Oregon's Home and Community Based Services System. June 18, 2003. http://www.cms.hhs.gov/promisingpractices/

South Carolina

Local POE agencies. Pre-existing County Councils on Aging serve as the county-level SEP agencies.

The South Carolina Bureau of Senior Services will pilot a Resource Center program by establishing centers in two counties

State-level organization. In January 2003, the SC Legislative Audit Council proposed consolidating all senior and LTC programs (which are currently in 3 different departments) into a newly created, freestanding agency specializing in senior and LTC services.

http://www.cms.hhs.gov/promisingpractices/

Legislative Audit Council, South Carolina Health and Human Services Agencies: A Review of Non-Medicaid Issues, Report to the General Assembly (Jan. 2003). http://www.state.sc.us/sclac/Reports/2003/Health_Agencies.pdf

Wisconsin

Wisconsin's LTC system features:

- managed care pilot
- "no waiting list" guarantee
- Web-based functional screening tool
- gradual implementation
- localities have the option to include Older Americans Act funds
- has been extensively studied and written about

POE agencies and services. Wisconsin's Aging and Disability Resource Center ("ADRC") are part of Family Care, a major redesign of the state's LTC system. A consumer enters the system by calling or visiting the ADRC, or visiting an ADRC website; home visits can also be arranged. An ADRC can be a AAA, a county human service/social service agency, or a collaboration between agencies. ADRCs are required by contract to provide the following services:

- Information and assistance
- LTC counseling and advice
- Benefit specialist services
- Crisis assistance and advice
- Elder abuse and adult protective services need identification
- Transition assistance
- Prevention and early intervention
- Eligibility determination for Family Care – The ADRCs determine functional eligibility for Family Care; Economic Support Units determine financial eligibility, in collaboration with ADRCs; and Independent Enrollment Consultants help consumers understand their options
- Pre-admission counseling

Managed care. In some counties, Wisconsin is piloting the Family Care managed care program. If an ADRC consumer wishes, he or she may enroll in Family Care, which offers a blend of Medicaid waiver and state plan services. The county-operated Care Management Organizations ("CMOs")must develop a provider network sufficient to provide services to the target populations enrolled in Family Care in their respective counties.

- CMOs provide interdisciplinary care management by an RN and a social worker, and arrange or provide an extremely wide range of LTC services designed to meet individual consumers' needs and desires.
- Consumers who are not Medicaid-eligible may enroll in Family Care, but have cost-sharing requirements based on income.
- Family Care clients are guaranteed not to be put on a waiting list.

- Family Care is voluntary. Qualifying individuals who do not enroll in Family Care still receive Medicaid fee-for-service benefits, but are not eligible for waiver services.

Web-based functional screening tool:

- The Web-based functional screen to determine functional eligibility for all target populations is one of the few standardizations the state required of the pilot counties.
- The screen offers the beginning of a more comprehensive assessment that can be used to develop an initial plan of care and to determine level of care for Medicaid.
- The Web-based screen increases screener reliability by subjecting the information to cross-edits and other checks as it is entered.
- The system generates reports that identify questionable screening practices, such as numerous screens recorded on one person during a short time period; this makes it more difficult to use the screen to manipulate eligibility determinations.

Gradual implementation:

1996: The Department of Health and Family Services established a Center for Delivery Systems Development to lead system redesign, with input from stakeholders via committees, focus groups, and public forums.
1999: Wisconsin enacted Family Care into law and began been piloting ADRCs in 8 counties, of which 5 have Care Management Organizations.
2000: A 9th county began piloting an ADRC.
2001: Web-based functional screen replaces PC-based, dial-in upload screen
2003: Functional screen adopted statewide.

Numbers served. During the last six months of 2000, ADRCs answered 34,000 phone calls. From October 2001 through September 2002, ADRCs made more than 69,000 information and assistance contacts (an exchange between a person seeking assistance or information and an ARDC staff member).

Financing. Medicaid waiver, state general funds, participant co-payments. Many counties provide in-kind space and information technology support. Individual counties have the option of integrating aging network funds.

Care management organizations receive one monthly, capitated rate for all Family Care clients. The rate is based on the state's historical costs and the enrollees' functional needs as reported on the state LTC functional assessment. This integrated payment rate requires the publicly funded programs to have standard eligibility criteria and offer one service package for all enrolled members, regardless of funding levels. Consumers who are not eligible for publicly funded programs pay up to 100% of the rate for Family Care services.

Wisconsin spent approximately $10 million on ADRCs during the 2-year start-up phase, 1999-2001. An estimated 1/3 of this amount represents the cost of assessments and

eligibility determinations that would have been conducted in any case. ADRCs were slated to receive $8.3 million in FY 2003.

State-level organization. In February 2003, the Wisconsin Department of Health and Family Services announced the consolidation of 2 divisions and the agency that oversees Family Care, to improve the management of LTC. The new Division of Disability and Elder Services will manage the full continuum of community support and institutional care for the elderly and people with disabilities.

Contacts and Resources:

Diane Justice, Medstat Research and Policy Division. Promising Practices in Long Term Care Systems Reform: Wisconsin Family Care. March 3, 2003. http://www.cms.hhs.gov/promisingpractices/

The Lewin Group, Aging & Disability Resource Centers Technical Assistance Exchange. An Annotated History of Wisconsin's Aging and Disability Resource Centers. October 24, 2003. http://www.adrc-tae.org/tiki-list_file_gallery.php?galleryId=2

Medstat. "Promising Practices in Home and Community-Based Services: Wisconsin – Resource Centers Offering Access to Services and Comprehensive Information." Updated February 18, 2003. http://www.cms.hhs.gov/promisingpractices/

U.S. Dep't of Health and Human Services, Administration on Aging. Creating More Balanced Long Term Care Systems: Preview of Case Studies on the Role of the National Aging Services Network. Sept. 2003.

Wisconsin's Aging and Disability Resource Center website, http://www.dhfs.state.wi.us/ltcare/Generalinfo/RCs.htm