Consumers about LTC options

In addition to the new home- and community-based services, NJDHSS created two new programs to help older adults and their families understand and choose among the long-term care options it was creating. As mentioned above, New Jersey Easy Access, Single Entry (NJEASE), planned with a grant from the Robert Wood Johnson Foundation, helps people find information by phoning a single number that leads them to aid at the local level. The Community Choice Counseling Program helps people in nursing homes to get information about other options and to return to their homes and communities when possible.

NJEASE

NJEASE was developed in two phases. In Phase I, protocols and arrangements were established at the local level to make sure that older adults and their families could call one number and get a trained professional who would ask consistent questions and know how and where to direct that caller for more help. These tasks are consistent with the responsibilities of the area agencies on aging. However, the counties needed more training, more protocols, and better information systems in order to provide consistent information and referrals. Phase I focused on these tasks.

In 1996, Phase I of NJEASE was launched in four counties—Ocean, Union, Morris, and Atlantic. By 2000, all 21 counties had started Phase I, and the state had set up a national toll-free number (Reinhard and Scala 2001). There was no state legislation to create NJEASE, no mandate to choose a particular county agency to serve as the NJEASE office, and little money for this phase. Each county selected its county office on aging (also the designated federal area agency on aging) to serve as the lead NJEASE agency. There were some other early contenders, such as home health care agencies and county boards of social services, but the area agencies on aging succeeded in gathering support at the local level.

Phase II of NJEASE involves more complex organizational capacity and development. Phase II tasks move from information referral to more sophisticated forms of assistance and case management, including the responsibility to manage budgets for home- and community-based services using all funding streams from Medicaid, the Older Americans Act, the Social Security Block Grant, state casino revenues, and elsewhere.

New Jersey's 21 counties have a long history of local control. Their agencies differ in their infrastructure and their capacity to provide case management. Developing a sophisticated "single point of entry" system in Phase II has therefore proved challenging. The NJEASE mission is to ensure that older adults and their families can get the full range of services they need by calling the toll-free number that is directed to the local NJEASE office. Some callers merely need information. Others may need a thorough assessment of their needs and resources. Each county's NJEASE office should have

(From Rebalancing LTC in NJ by Susan Reinhard)

care or case managers with authority to enroll consumers in home- and community-based programs, including Medicaid waiver programs, and the managers should be well-trained and accountable. Accomplishing this requires major shifts in policy and budgeting, a process that is continuing.

Community Choice Counseling

Because many older adults enter nursing homes directly from hospitals, without understanding their other options, NJDHSS created a Community Choice Counseling pilot program in March 1998 (Reinhard, Howell-White, and Quinn 2001). Now a statewide program, Community Choice Counseling helps nursing home residents explore community-based alternatives. It provides information about in-home services, housing alternatives, and community programs. At first the state tried to assign counselors to hospitals for the purpose but found that there was not enough time to counsel older adults and their families in an acute care setting. After a hospital-based pilot program in 2000, the Community Choice Counseling staff recommended that they concentrate on nursing home residents, including those who are newly admitted on Medicare but are likely to remain for longer stays unless they receive the information and support they need to return to their homes and communities. Most counseling now occurs in nursing homes.

Since its inception, Community Choice counselors have helped more than 4,000 people move from nursing homes to private homes, senior housing, or assisted living residences. Although the counselors devote most of their attention to people who have lived in a nursing home for less than a year, they have also helped transfer people who have lived in one for as long as nine years (Reinhard, Howell-White, and Quinn 2001). The state now employs 29 primary nurses to provide this counseling. However, hiring freezes in 2002 may reduce this workforce.

An evaluation of the Community Choice Counseling program found that the counselors see themselves as educators and advocates, helping older adults and their families understand and act upon their long-term care choices (Palmer and Howell-White 2001). Most people who made these choices left nursing homes and returned to a home or apartment with no unmet needs (Howell-White, Palmer, and Bjerklie 2001).

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

prepared for the New York City Department for the Aging
by Allison Armour-Garb

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DRAFT

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.

Resources & Contacts:

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.

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/

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