Older Adults Waiver for Home and Community Based Services

Final Report

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I. BACKGROUND AND SCOPE OF WORK OF THE PROJECT

The Lewin Group responded to a Request for Proposal (RFP) issued by the University of Maryland, Baltimore County (UMBC) for consultant services to prepare and present a report on the Older Adults Waiver for Home and Community Based Services. This project was initiated in response to the Maryland Department of Health and Mental Hygiene (DHMH) and the Maryland Older Adults Waiver Redesign Committee's desire to improve the program. The Center for Health Program Development and Management, a division of UMBC, was the operational entity managing the bid process and the project and maintains a Memorandum of Agreement with the DHMH.

The RFP requested consultant services to present options for redesigning the Maryland Older Adults Waiver for Home and Community Based Services establishing:

- a more customer-focused and streamlined enrollment process for beneficiaries and providers;
- reducing enrollment time for beneficiaries and providers;
- recruiting and maintaining an appropriate provider base while complying with state and federal requirements;
- a budget impact analysis; and
- improved quality of care.

Major tasks outlined in the RFP included:

1) Examining and reviewing, conducting follow-up interviews as necessary, and providing a draft report on:

   a) findings of focus groups conducted with local Area Agencies on Aging (AAAs) and Adult Evaluation and Review Services (AERS) staff;
   b) findings from interviews of waiver providers and consumers, AERS and AAA staff, members of the Redesign Workgroup, and other key stakeholders and experts; and
   c) findings of the workflow study of the eligibility determination process.

2) Facilitating one or more meetings of an appointed Advisory Committee in November, 2002, designed to select a redesign option, work with the Committee to select a recommended redesign option, and prepare a draft report on the recommended option.

3) Preparing a draft report which will include: a) examination of best practices in other states, b) examination of best practices at the local level, and c) a comprehensive literature search of national best practices regarding streamlined eligibility processes, provider recruitment, and retention; developing a draft report on options for redesigning the waiver which describe advantages / disadvantages, required resources including staffing, and implementation processes; and preparing a Final Report summarizing the findings, analysis and recommendations for redesigning the Older Adults Waiver.

In this Final Report, our recommendations are based on studies of the existing processes; actions taken by DHMH, the Maryland Department of Aging (MDoA), the Division of Eligibility Waiver Services (DEWS), and AAAs and AERS to improve the eligibility process;

local and national best practices; interviews with direct service staff and the Redesign Committee; interviews with leading states; and experience managing and evaluating long-term care systems in many states.

II. FINDINGS OF KEY STAKEHOLDERS

A. Common Themes Across Stakeholder Groups

The experience of many stakeholders with the Maryland Older Adult Waiver program was obtained through numerous interviews, focus groups, and meetings. Stakeholders were encouraged to identify problems with the current system and recommend improvements. The following set of themes emerged across all these groups:

- *Problem*: Multiple agency involvement, with fragmented policies and poor communications.

  Recommendation: Support for a program that places greater authority at the local level and in which policies are communicated in a systematic and efficient manner.

- *Problem*: Staffing and work load challenges at the state units and local agencies.

  Recommendation: Support for adequate funding and staffing levels to accommodate program growth.

- *Problem:* Inability to efficiently and effectively track applications and inform clients of status.

  Recommendation: Support for an automated system to streamline the eligibility process and share appropriate information across agencies and with consumers.

- *Problem:* Multiple obstacles to provider recruitment and retention.

  Recommendation: Support for a more simplified application process, efficient payment and billing mechanisms, and adequate provider rates.

The following presents more detailed findings from the workflow analysis, consumer interviews, provider interviews, and meetings with the Redesign Committee.

B. Focus Groups with AAA and AERS Staff

Two focus groups were held with eight AAA and nine AERS staff. The focus groups were facilitated by staff at the Center for Health Program Development and Management at UMBC and also attended by representatives from DHMH and MDoA.

The key findings from the focus groups were:

- Inadequate communications and information distribution
- Insufficient staffing and training
- Unreasonable time requirements
- Low morale
- Lack of standards, definitions, coordination, and quality assurance system
- Provider recruitment difficulties

C. Waiver Providers

Providers were interviewed regarding their experience with the waiver program, including: 18 assisted living providers, 8 personal care providers, and 4 other types of providers. The major issues reported by the providers pertained to coordination and communication, the application process, timeliness of payment and payment amount, and adequate training.

Assisted living providers reported:

- A lack of coordination between requirements for licensure and the Waiver qualifications
- The application process was complicated
- The application was too long, sometimes redundant, and contained lengthy sections that did not apply to them
- Difficulties in obtaining assistance with completing the application because there was not always someone available to help and sometimes there was conflicting information from different people at the state or local levels
- Nurse monitoring requirements were redundant
- Inadequate rates
- The time between submission of bills and receipt of payments was too long and some providers had difficulty getting payment issues resolved because they could not get through to the state agency that handles payments

Personal care and other types of providers added that their agencies have difficulties in recruiting and retaining workers in rural areas, which is also a national problem. They encountered similar problems to the assisted living providers regarding the application process and billing. These providers felt that there was insufficient staffing and training, inadequate communications and information distribution, and unreasonable time requirements. Providers felt that the lack of standards, definitions, coordination, and an inadequate quality assurance system were areas in which to focus improvement.

D. Waiver Consumers

Interviews were also conducted with 38 Waiver participants from 14 counties in the state. Nearly 60% of the interviewees resided at home and about 40% in an assisted living facility. Consumers were generally happy to have the program and emphatically did not want services reduced. They felt that the program allows flexibility in where and how they live and what kind of care they receive. Consumers and their families also identified several areas for improvement. They reported encountering long, inexplicable delays in processing their waiver application and receiving an eligibility determination. The lack of information about the status of one's application and frequent mistakes during the application process made an already complex process more frustrating. For example, several consumers reported misplaced applications or parts thereof, and phone calls they placed that were not returned throughout the process.

Several consumers also remarked that the renewal process is cumbersome and redundant. As said by one respondent, "Each year I have to send in pages and pages of the same information that they have already. My [family member's] disability is not going to go away, but I have to dig up that information every year." Another interviewee added:

> I received the recertification packet just a few days before the deadline printed on it [it said the participant would be dropped from the program if the deadline was not met.] I raced around collecting all this information and paperwork that was redundant anyway. Then when I called to ask a question, they said the deadline is not firm. If it's not firm, why is it on there? How am I supposed to trust a process like this?

Finally, consumers were concerned with the quality of some case managers and personal care agencies. Several consumers cited insufficient screening, training, and information-sharing as their main concerns with their use of personal care provider agencies. Consumers reported different experiences with case managers—some perceived their case manager as being very helpful and others felt that the case manger was not involved or responsive.

E. Redesign Committee

The major issues identified from interviews with committee members were:

- Communication break downs among agencies
- Differing philosophies among agencies
- Provider application process is too complex and the payment system too slow
- Client application process too long and difficult
- Level of care determinations unpredictable
- Inadequate and non-interfacing information systems
- Inadequate appeal notification and timing

F. Workflow Analysis

A 2001 workflow analysis was conducted by UMBC to map the consumer application process from start to finish and examine application processing times at various stages of the process. The study was based on 2001 data, the first year of program implementation, and performance levels do not reflect recent improvements in the process, such as suspending the telephone and face-to-face interviews and allowing AERS nurses to sign the 3871 form instead of requiring signatures exclusively from physicians or nurse practitioners. From the 2001 data, it was found that 90% of applications took more than three months to process, the processing lag was throughout the process, and the application processing time and distribution of duties varied by county. ***Exhibit 1*** presents a comparison of the actual performance in Maryland in 2001 with the stated target, focusing on six operational benchmarks.

Exhibit 1: 2001 Workflow Analysis -- Actual vs. Target in Processing of Applications in Maryland

Operational Benchmarks	2001 Performance in Maryland	Stated Target in Maryland
Time from Application Receipt Date to ATP Sent To DEWS	72% take more than 3 months	30 days
Time from Application Receipt Date to Date received by Delmarva	65% take 2 months or more	24 hours to send to AERS 10 days for AERS assess Total: 11 days in this step
LOC determination by Delmarva	55% are completed within 7 days	48-72 hours
Time at MDoA to issue ATP	Not measured	48 hours
Processing Time from Date ATP is sent to DEWS to Date of Final Determination	46% take more than 1 month	None noted
Average client application processing time	90% take more than 3 months 50% take more than 6 months	30 days

III. FINDINGS OF BEST PRACTICES

A. Best Practices in Three States

The Lewin Group surveyed state officials from three leading states of Medicaid Waiver programs for the elderly, to assess "best practices" of consumer enrollment and provider recruitment and retention. The selection of Colorado, Washington, and Wisconsin was based on discussions with national experts, a focused literature review, and insight from personal experience in managing and evaluating long-term care (LTC) systems in multiple states. These states have had established elderly waivers for 11, 19, and 15 years, respectively. The Family Care pilot program in Wisconsin was enacted in 1999 under Wisconsin Act 9 and its concurrent 1915 (b)/(c) waiver approved in 2001. All three states have:

- Reallocated Medicaid funds and made substantial efforts to shift LTC from institutional settings to home and community-based settings;
- Developed controls to manage the growth of home and community-based services and the impact on the provision of services;
- Innovated with strong, locally-based systems and established a single point of entry (SPE) through which level of care and financial eligibility is determined, LTC information and assistance is provided to consumers, and consumers are assisted with applications and communicated with about their application and enrollment status; and

- Implemented a variety of strategies to streamline provider enrollment, including simplifying the application process, establishing a recognizable point-of-contact, and tailoring provider requirements.

A telephone interview guide was developed to capture specific information about each state's elderly waiver program under three main components: system operations, consumer enrollment, and provider recruitment and retention (see ***Exhibit 2***). The full interview guide is located in ***Appendix B.***

Exhibit 2: State Survey Components

System Operations	Consumer Enrollment	Provider Recruitment and Retention
Administrative structure	Level of care eligibility	Provider eligibility
Intergovernmental agreements	Financial eligibility	Provider enrollment processes
Communication strategies	Eligibility redetermination	Requirements across provider types
Level of automation	Enrollment standards	Billing and payment standards
Required resources	Communication with consumers/families	Communication with providers

The following describes key findings from the interviews. State profiles of consumer eligibility and provider enrollment components as well as procedural flow charts of consumer eligibility in Colorado and Washington, as compared to the approval process in Maryland, can be found in ***Appendix C***.

1. Colorado

Highlights of Colorado's best practices include:

- Implementation of a single entry point (SEP) system for client enrollment, through an RFP process
- Level of care and financial eligibility responsibilities are split between entities, but staff work closely together through established procedures and timelines
- SEPs are paid on a capitated basis
- Fast track eligibility system
- Plan of care is finalized after the financial eligibility determination
- Fiscal agent assists providers during application process
- Providers directly bill fiscal agent

Background

Colorado currently operates 11 Medicaid waivers; the aged and disabled waiver, HCBS-EBD, is one of the state's six 1915(c) waivers and has approximately 15,000 enrollees. Two priorities were outlined in Colorado's recent history of system reform efforts: 1) to develop a new

consumer assessment instrument to cross all populations and 2) to implement a single point of entry system. The state developed the concept of a single point of entry system (SEP) over a few years prior to passing the 1991 legislation that authorized its creation. Colorado phased-in the implementation of the SEP, beginning with five in 1993, one in 1994, and the rest in 1995. The SEP agencies were phased-in over approximately three years, though the implementation period depended on local conditions. It was reported that the SEP could have logistically been implemented in two years, but, politically, it was important that certain districts chosen to initiate the SEP were those most ready for implementation and that could help work bugs out of the system.

Colorado's SEP is a locally-administered, state-supervised system based on contracts with each SEP agency and county government. The SEP requirements were formalized in state rules and the state issued an RFP. County commissioners recommended the agencies and the State contracted only with qualified agencies. The state contracted with 26 local level SEP agencies in districts across the state, comprising a total of 160 local FTE staff. The SEP agencies include: 10 county departments of human services; 10 private, not-for-profit agencies (e.g., stand-alone case management agencies); 5 county nursing services (public health) operating in rural areas; and 1 Area Agency on Aging (AAA). There are 10 State Department FTE staff, located in the state Medicaid agency (out of 170 Medicaid staff), responsible for overseeing the waiver, monitoring the activities of the SEP agencies, and providing training to the SEP agencies.

The districts did not receive start-up funds, but they did receive some funding for regional implementation and technological support. Each SEP received approximately $1,000 for a new computer and $3,000 per year was allocated to multiple county districts to account for economies of scale issues (i.e., supporting the SEP in rural areas). The districts also leveraged resources from the existing state-funded Home Care Allowance program in which county assessments previously funded by block grant and county dollars became a Medicaid administrative service eligible for federal matching funds. Once districts converted to SEP, they increased available resources by about 25% with use of the matching funds. Many of the SEP agencies immediately enrolled existing clients so they started accounting for consumer enrollments immediately. Dedicated state staff were involved with initial and ongoing training with the SEP staff. There were also some reportedly minimal additional resources for the PROs to move to an automated system.

Consumer Enrollment

In Colorado, consumers apply for long-term care support through the local SEP agency. The SEP agency administers an initial phone screen and if the applicant is in need of long-term care, the SEP refers the applicant to contact the county department of human services to have them mail financial eligibility forms to the applicant. In the meantime, the SEP agency case manager conducts an in-home level of care (LOC) assessment. The SEP is required to complete the level of care assessment within two days if the applicant is in an institutional setting, and within five days if residing in the community—a performance measure that is audited by the state. The state contact reported that the SEPs usually complete the assessment sooner than the time requirement. The SEP uses a tracking system which starts tracking consumers when they request an assessment. After the assessment is complete, the case manager enters the data in an automated system. The case manager then sends the assessment to a peer review organization (PRO) who reviews the information within 24 hours. According to the state contact, the state

feels that the PROs are a "rubber stamp" and may eliminate this step and transfer the authority to the SEP agencies.

After determining level of care eligibility, the PRO faxes the decision back to the case manager and contacts the county department of human services for them to begin the financial eligibility process.[1] The financial eligibility assessment is required to be completed within 45 days; the state contact reported that the average is 44 days and believed the timing could be shortened if the county departments were staffed adequately. After reviewing the financial information, the county department notifies the SEP case manager of the client's eligibility determination. Although there is no tracking system in place for the financial eligibility process, the SEP case managers have strong working relationships with the county department staff and can call them to inquire about an applicant's status. The case manager then notifies the applicant of the eligibility decision and if the applicant is deemed financially-eligible, the case manager visits the consumer to finalize a plan of care.

In an effort to address the financial eligibility delay, over the past two years the state has implemented a "fast track" eligibility system. The goal of "fast track" is to prioritize hospital patients who are likely to qualify for Medicaid and are in need of long-term care community support, and assess them prior to their discharge (within three days). The state contact estimated that approximately 100 persons are fast-tracked per year. The department of social services in Denver even has financial eligibility workers stationed at local hospitals.

Consumers can choose to keep the same case manager who performed the initial assessment once enrolled in the program. Case managers are required to make a home visit every quarter and call monthly. Case managers use a standardized checklist guide at their appointments. Reassessments are performed annually or more frequently if a client's condition changes. There are ticklers in the financial eligibility system now that prompt workers, but this is separate from the level of care reassessment.

The SEP agencies are funded on a per capita per month payment (approximately $785 per year per person) based on the number of community-based LTC clients they are serving. The average caseload of a SEP case manager is 56-58 clients. The SEP agency is not paid for an assessment when a consumer who is assessed goes to a nursing home; they are only paid if the consumer goes on to receive home and community-based care. This creates a strong incentive to deter consumers from, or to move residents out of, nursing homes. SEPs have been required to administer consumer surveys to a sample of clients since 1993.[2] The county departments receive Medicaid matching funds for Medicaid eligibility based on FTEs and the state funds are allocated based on the consumer population served.

The state contact reported that there is open communication among the SEP agency, county department, and state staff. SEP agency and county department staff used to meet more frequently, but now meet as-needed. The state has always held joint trainings for the level of care and financial eligibility workers; the joint meetings were held every two to three months

[1] The county department performs financial eligibility determinations for all Medicaid services.

[2] The state requires the SEP sample; 10% of clients or 10 clients for smaller agencies.

when the SEP was implemented, but now are held annually. Administrative meetings between SEP agency and county department administrators are held monthly.

Provider Recruitment and Retention

Providers can apply to the system through multiple entry points. SEP agencies are not paid to recruit providers but, by rule and contract, are required to identify service gaps in their area. The SEP agencies can call around for interested providers and send them an application to be certified as a Medicaid provider. SEP agencies receive state recognition at the end of the year for provider recruitment. Generally, a MMIS fiscal agent assists providers with the application process and sends them information packets. If state staff receive questions from providers, they try to answer them and can refer the provider to the fiscal agent.

The certification step is different for different providers, but most providers are certified through the Department of Health. Home health agencies, for example, contact the Department of Health, who then sends a form to a fiscal agent to assist providers during the process and obtain a Medicaid number from MMIS. Durable medical equipment (DME) suppliers contact the State department to request an application to be a Medicaid provider. SEPs certify adult care facilities (assisted living) and perform annual on-site certification of these facilities, while the Department of Health assesses board and care homes. There is also flexibility in the system so that if a SEP agency wants to arrange ramp construction for a client, the case manager can call around and enroll them as a Medicaid provider agency. The state requires individual, personal care providers to be affiliated with an agency. It is reportedly fairly simple for informal personal care workers (e.g., neighbors) to join an agency, except in more rural areas of the state. Criminal background checks are not performed for providers unless they are applying for the state's consumer-directed program.

Provider rates are set at the state level, mostly through the legislature. The legislature sets the total budget amount, the rate per unit, and the number of people to be served. The state contact reported that this was an advantage for the department because it does not get blamed for low rates and it eliminates any potential conflict-of-interest for enrollment agencies. Providers generally remain in the waiver programs even though they complain to the legislature that their pay rates are too low.

When the SEP case manager completes a plan of care, the plan becomes a prior authorization request and is sent to the fiscal agent.[3] The provider bills directly to the fiscal agent, which is usually done electronically by the larger providers. Providers are reimbursed through checks paid on behalf of the State, typically within 7 days of bill submission. The fiscal agent is responsible for tracking claims processing and also handles any provider complaints or appeals. Colorado does not have presumptive eligibility; for prospective clients who are not yet Medicaid-eligible, if the client becomes eligible, providers can be retrospectively paid up to 90 days. The state contact noted that many home health agencies are not willing to take the financial risk. Except for home health agencies, there is no sponsored training on billing procedures for most providers.

[3] Colorado used to contract with EDS, but now uses ACS as their fiscal agent.

2. Washington

Highlights of Washington's best practices include:

- Implementation of SEP with state employees at local offices
- Co-location of level of care and financial eligibility workers fosters teamwork
- High level of automation for level of care eligibility and service authorizations
- Case management and redetermination in residential settings performed by state employees, in-home case management and redetermination performed by AAA staff
- Automated record of financial eligibility for all programs
- Mandatory provider training

Background

Washington is a national leader in innovative home and community-based delivery systems. The Community Options Program Entry System (COPES) is the Medicaid waiver serving approximately 30,000 home and community-based aged and disabled persons. There is administrative consolidation of aging and disability services at the state and local level, which has promoted administrative and policy coordination throughout the system. The Aging and Adult Services Administration (AASA), within the Department of Social and Health Services (DSHS is the single state Medicaid agency), has broad administrative and policy responsibility of all Medicaid and non-Medicaid long-term care programs.

The AASA conducts annual monitoring of AAAs for administrative and fiscal requirements, develops standardized client assessment tools, conducts the initial assessments and service authorization, runs a mandatory training program for providers, sets the requirements for a criminal background check, establishes case manager contact standards, operates a system for complaints and investigations, and establishes program standards for AAAs and their subcontractors.

A SEP system was implemented at the local level for all publicly-financed services. The full system was implemented in less than three years and, reportedly, could have been implemented much sooner if they did not have the degree of political considerations (i.e., deciding to make that entry point with state staff level only and converting work assignments). State employees at the local DSHS offices perform level of care and financial eligibility and provide case management for people in nursing facilities and nonmedical residential facilities (i.e., adult family homes, adult residential care, and assisted living).[4] AAAs provide ongoing case management and reauthorization of in-home services. The state contacts reported that the relationships between the state and the AAAs were very good. The AAAs pay vendors for their services and are then reimbursed by the state Medicaid agency. Independent providers are paid directly by the state.

Washington had been operating the waiver and building their program for over 15 years, establishing a solid infrastructure that was already in place at the time the SEP system was

[4] Washington has a very high supply of community-based residential facilities compared to other states.

implemented. Because they had an assessment tool and the necessary staff in place, the SEP implementation activities mostly involved transferring cases to the aging network for ongoing case management and using existing resources for developing and publishing program brochures. Their major investment has been in a tool to automate their system for level of care determination and service authorization. The redesign of their assessment instrument into a multifunctional, automated tool has taken nearly five years and cost approximately $3 million in total funding.

Consumer Enrollment

Consumers in need of long-term care support contact the local DSHS office (SEP) to be assessed for publicly-financed programs. Level of care assessments are administered by local nurses, social workers and case managers of the SEP office and are required to be completed in-home within seven days. The level of care assessment is heavily technologically based. Case workers use a software program on their laptops that guides the case worker through the assessment, which is uploaded to the mainframe. It has the capability of determining level of care and real-time automated computations for service authorizations. According to a recently completed workload study, the total level of care assessment takes 5.5 hours to complete. The level of care assessment and care plan must be completed within 30 days. The state contacts reported that the timeline is usually adhered to, although the providers might not be lined up within that time.

The software can produce a care plan and future upgrades will allow for an applicant's electronic signature on the plan during the same visit. If the client already has chosen a provider and knows what informal supports are available, data could be immediately entered. After the care plan is entered, the client and case worker are able to know how many hours of service the client is eligible for, who the providers will be, the days and frequency of service, etc. This will also be linked to a provider database, in which clients could search and select providers based on their own criteria, to be included in a service plan.

At the time the local DSHS office (SEP) conducts an initial intake, the worker can verify if the consumer's information is already in the financial eligibility system. If the consumer is not registered in the system, a financial eligibility worker at the same local office is notified to begin the financial eligibility process.

The social worker performing the level of care assessment often assists the financial worker in collecting the necessary financial information. Otherwise, financial information is gathered by mail; Washington is trying to move to using more electronic methods for this piece. Financial eligibility determination must be completed within 45 days from the time the financial worker gets notification that the consumer would like to apply; sometimes all they start with is a name and address. The state contacts reported that the large majority of financial determinations are completed within the 45 day requirement. They noted that an entire culture has developed around meeting the timeline and it has become a staff performance measurement. Financial eligibility workers are pressed to be aggressive in gathering the necessary information. The local offices monitor the process and supervisors receive reports of those determinations taking longer than the established timeframe, which financial workers must be able to explain. There is an internal standard to complete the determination in 15 days. Once an applicant's financial information is gathered and entered into the system, the technology used by the local SEPs

generates automated records of all public programs for which the client is eligible (Medicaid waiver program, personal care, food stamps, etc.).

Both level of care and financial redeterminations are required annually. Level of care assessments must also be completed if there is a change in status. Reportedly, the current assessment does not build in assurances that all needs are addressed. The state will be launching a new assessment tool in the near future in which, at the time of reassessment, the case manager would note changes in a client's status and also verify those elements in the previous assessment that have not changed. AAAs have a caseload goal of 85 clients per case manager. The 1:85 caseload equates to a visit within 30 days of assignment, a minimum of two phone contacts, a six-month visit, and an annual visit. In reality, the average caseload is closer to 95 clients although sometimes it falls below 85. The AAAs are required to submit a FTE staffing plan with their annual renewal contracts.

Provider Recruitment and Retention

The Washington Department of Health initially licenses all in-home agency providers. Over the past few years, the state has worked to streamline this process and reduce the paperwork. Residential Care Services, within the AASA, centrally manages the licensing and complaint investigation of boarding homes (comprising adult residential care homes and assisted living facilities). Provider information is immediately entered into the computer system (SSPS). Within the DSHS, there is a centralized background unit to check provider criminal records. All long-term care providers, including independent providers, must submit to a criminal background check. The local SEPs contract with enrolled providers and the case managers are responsible for ensuring that once providers have passed background checks, they complete a state-required training program. The training program varies depending on type of provider and experience.

The AAAs are required by contract to set standards for providers regarding: billing procedures, time sheets for all agency workers and independent providers, and performance evaluations for all agency workers. In contrast, most of the requirements for independent providers pertain to when they are initially hired and there is far less oversight and accountability controls than with agency providers. The AAAs monitor service providers and send the results to the Department of Health. The state is moving away from emphasizing administrative requirements for quality assurance and toward implementing more performance and program results monitoring.

When the state SPSS system receives an invoice from a provider, it generates an invoice for the next payment cycle that providers verify via touch-tone phone on a monthly basis. The case managers also verify provider hours and type of service with their clients. Case managers sample a percentage of time sheets to make sure the timesheets match the services provided. Providers are currently issued monthly checks and the state contacts reported that providers seem satisfied with the system. However, independent providers have requested checks to be issued twice per month, which the SPSS system cannot accommodate. The state does not want to move to another system because SPSS is timely and other systems, such as MMIS, lack the capability of handling the tax functions required to pay independent providers. The state has set up a toll-free number for providers to call regarding payment issues, although some calls do go to the state DSHS office or case managers.

The DSHS sets provider rates, but sometimes the legislature makes the decision. The DSHS and other stakeholders have spent the last five years researching ways to improve the community rate system (especially for residential care providers). Adult family homes, adult residential care and assisted living facilities are reimbursed according to geography and level of disability. The aged and disabled waiver offers the same hourly rate for home care services as other waivers.

Though the individuals on COPES can receive services up to the cost of 90 percent of the going rate of nursing home care, the state contact reported that the state budgets about 40 percent of nursing home costs. In fiscal year 2000, the average monthly cost of COPE enrollees was $959. Over 55% of COPES clients use independent providers rather than agencies. State regulations require that clients who need more than 112 hours of service per month must use an independent provider.[5] The prior emphasis has been to remain in budget through the limitation of hours, but the new emphasis is to control costs by allocating more services to those who are in need of more services and fewer services to those who need less.

The state is initiating several projects to respond to workforce shortage problems. Washington allows nurse delegation, which reduces the need of higher-paid skilled nursing staff. The state is hoping to expand the practice of nurse delegation. They were a recipient of a CMS Real Choice Systems Grant for caregiver recruitment and retention. In addition, they have established two pilot projects that focus on recruitment and retention at the local level. This has included the development of a provider registry of "willing and ready-to-go workers" and the establishment of training programs pertaining to consumer supervision.

3. Wisconsin

Highlights of Wisconsin's best practices include:

- Under the Family Care system, Memoranda of Understanding were developed at the state and local levels and contracts with specific obligations were developed
- Delegated authority to the local level to make eligibility determinations and authorizations
- Merged assessment and level of care
- Established a single contact for providers in each county, the Network Developer
- Consumer-defined quality of care performance measurement system

Background

Wisconsin has always relied on a strong county-based system for the administration of home and community-based long-term care in which the bulk of services are delivered through contracts with community providers. The state has operated the Community Options Program on a statewide basis since 1986. County participation in the Community Options Program Waiver for elderly and physically disabled was mandated in 1990. The state contacts reported that approximately 18,000 individuals are served in all waiver programs, with 9,000 on waiting

[5] It was noted that the administrative costs associated with the use of independent providers are borne by the AAAs.

lists maintained at the county level.[6] Even though Wisconsin's existing long-term care system was already considered a national model, the state desired to decrease fragmentation and increase access to high quality, cost-efficient home and community-based services by introducing the Family Care program. Family Care was authorized as a pilot redesign of their long-term care system by 1999 Wisconsin Act 9. There are currently about 6,800 enrollees in this new capitated system that is being piloted in several counties.

The Family Care model uses Aging and Disability Resource Centers on the front end, designed to create "one-stop shopping" (SEP) for information and assistance for the elderly, physically, and developmentally disabled. Of the nine county Resource Centers currently operating, seven were piloted in year 1, one in year 2, and one in year 3. In 2002, the nine Resource Centers had a total of 140.56 FTEs (a 22% increase from 2001). The number of functional screens completed per FTE during January to March 2002 ranged from eight to 52 screens. County Resource Centers received an annual budget from the Wisconsin Department of Health and Family Services (DHFS) in the form of prepayments equal to one-twelfth of the grant amount for each of the first three months of the contract. Future monthly payments made by the DHFS were based on expense reports submitted by the Resource Center. Total start-up funding from calendar year 1998 through 2000 amounted to nearly $3 million in addition to $5.5 million in reallocated funds for Resource Center contracts. In 2000, total spending for all Resource Centers was $4.6 million (ranging from $101,452 to $1.5 million).

The full model of Family Care also includes the use of a Care Management Organizations to care plan, coordinate and manage an array of long-term care services. Across counties in 2002, caseloads ranged from 30 to 50 consumers per social worker for elderly and physically disabled consumers and from 30 to 45 for developmentally disabled consumers. Caseloads of registered nurses ranged from 50 to 125 per RN. Start-up funds for the five Care Management Organizations from calendar year 1998 through 2000 amounted to approximately $6.4 million; total Care Management Organization spending was nearly $32 million in 2000. The state provided funds within the counties' start-up grants for information technology development. Spending on information technology represented 32% of all Family Care start-up funds.

Resource Centers and Care Management Organizations are overseen by the DHFS. Family Care operates under a 1915 b/c waiver combination. Economic Support Units are county entities under the Wisconsin Department for Workforce Development that are responsible for determining financial eligibility across different low-income populations for the regular waiver and Family Care programs. Economic Support workers are employees of different county organizations (e.g., human service departments). The state reported that the feel they have less control of Economic Support workers because they are from a different state unit. There has historically been tension between the state and counties. Regional staff meetings are held with regional and state level staff to discuss policy and program issues, but problem-solving is not much of a priority at these meetings. Under Family Care, memoranda of understanding were developed at the state level between different departments and among partners at the local level by requiring Resource Centers to develop an "access plan" of how the various local partners would coordinate service delivery. Contracts for Resource Centers and for Care

[6] The developmentally disabled and the physically disabled populations comprise the largest and longest part of the waiting lists.

Management Organizations were developed by the state to specify obligations and accountability, replacing the vague language of the waiver manual.

Consumer Enrollment

In Wisconsin, consumers know that the application process for long-term care begins with counties. Under the older system, the county agency processed level of care eligibility using manual screening tools. They sent the paperwork to a contracted agency for review and to process the assessment and plan of care. Notice of level of care eligibility was then sent to the Economic Support Unit, which handled financial eligibility for all public programs for low-income populations. The review and final approval process by the state took a long time.

Under Family Care, both level of care and financial eligibility is processed at the county level. Level of care eligibility determination is conducted by the Resource Centers using an automated, Web-based functional screen tool to handle level of care eligibility determinations. CMS considers the screen to be the initial assessment from which one can develop an initial plan of care and put services in place. The automated screen is now being used outside the Family Care pilot sites.[7] The automated functional screen has built-in logarithms that produce level of care determinations and can discern which nursing home level, developmentally disabled level, and if the individual is waiver-eligible or eligible for the state COP program. Some information on the functional screen needs to be verified by a physician, but the screen does not need a physician sign-off.

The functional screen is sent to the state and communicated to the Economic Support Unit. The Economic Support workers have access to the state database. Once the Economic Support worker receives level of care eligibility notification, the worker contacts the consumer to collect more documents to process the financial eligibility. In the old system, the Economic Support workers handled financial eligibility for mixed low-income populations. While waiver recipients, as a proportion of measured Economic Support worker functions, generally constitute a small percentage of total worker caseloads, the proportion of the caseload accounted for by waiver enrollments nearly tripled in some of the counties since the start of the Care Management Organizations. Under Family Care, Economic Support workers have begun to specialize in waiver and nursing home eligibility determinations.

Prior to Family Care, the entire eligibility process took about 2.5 months. Under Family Care, the new screen has shortened the front end substantially and level of care eligibility can be processed in about one week, because it bypasses state approval. The state implemented a certification requirement for those using the new screen. The screeners take a Web-based training course consisting of a series of 10 tests. The state feels that with the use of the new screen, eligibility cannot be "stretched" as much as under the old system. There is a new prescription drug program in Wisconsin and it is the hope of the state that this will prevent stretching the functional screen to fit the need for drugs.

According to program requirements, everyone meeting the "comprehensive" level of care eligibility is assured of receiving services in a timely manner. Everyone who meets the

[7] The state contacts reported that 20 of Wisconsin's 72 counties currently use the Web-based screen and expect that it will be adopted by many more counties next year.

"intermediate" (lower) level of care eligibility and who is Medicaid-eligible or has a confirmed need for adult protective services is also assured prompt access to Family Care services. Others at the intermediate level not meeting the above state criteria are eligible for services, but may be placed on a waiting list if funding is not immediately available.

If a consumer is approved for Family Care, they must meet with an enrollment counselor to receive "choice counseling" prior to enrolling in the program with a Care Management Organizations. For waiver approvals, CMS was concerned about the potential for conflict of interest if a single entity (the county) was responsible for all aspects of eligibility determination and enrollment—creating an opportunity to restrict care or limit eligibility. CMS approved the DHFS' solution to use an independent enrollment broker to provide consumers with unbiased information about available program services.

Tracking the application process is done through an on-line system. There is a lag of a few days in the system, but it starts a 30-day eligibility clock. A notice is generated for consumers if the process is being delayed for some reason. The case worker from the Resource Center communicates with the applicant throughout the process. The state contacts reported that consumers get a notice in the mail that is generated by the computer system and can be confusing for the applicant. As a result, the Resource Center case worker often has to explain the notice and many case workers call before the notice is generated to avoid confusion. Applicants who receive denial notices receive a notice of appeal on the same notice.

The eligibility database system automatically generates notices to Economic Support workers of those clients in need of financial recertification on a 12-month cycle. Care managers are responsible for developing annual care plans and perform the level of care reassessments, as needed. The use of the new functional screen requires annual updates, which the care managers perform. Methods of notification to care managers of reassessments differ across counties. Some counties have automated systems to notify care managers, others have care managers track it themselves.

Under the older system, counties received payments for front-end functions: $110 per screen and $200 per care plan. Family Care uses a capitated model in which Care Management Organizations receive payments per person per month to manage and pay for care for members who live in their own homes, group living situations, or nursing facilities. A large portion of the Care Management Organization's administration is in the form of care management. Under the older system, the state contributes most of the administration dollars; several counties put in county dollars for other administrative costs in the old waiver program and receive a federal match. With Family Care, the state provides administrative at 7% and the counties devote their dollars for service costs. Most of the funds for Family Care are redirected federal Medicaid match and existing state spending for the old state and Medicaid 1915(c) waiver programs. Counties are also providing gap funding and in-kind support for some administrative functions.

The rate methodology has continued to evolve toward a prospective payment system. The DHFS implemented prospective payments with retrospective adjustments based on historical use cost bands and are moving to a prospective rate based entirely on data from the functional screen. The pilot counties argued that they were not adequately funded by the state and that the Economic Support function is not adequately staffed. Processing financial determinations under

Family Care produced a significant strain on the Economic Support workloads which DHFS did not forecast largely due to operating in a separate state division. This created a significant backlog in Milwaukee County. The allocation to Economic Support Units has grown with increased Family Care enrollees.

Provider Recruitment and Retention

Under the older system, county agencies recruit and contract with providers and certify adult family homes (1 to 2 residents). The state certifies large housing providers. For personal care providers, the state is responsible for certifying large providers and the county certifies smaller agencies. Counties can certify self-employed providers under state requirements in a memo that details standards that the county has to apply to small providers. Also, a number of counties run their own personal care services because there are not enough providers. Under Family Care, counties are responsible for building a network of providers to offer consumers choice and promote quality. Each CMO funds the position of a "Network Developer" who is responsible for developing the network and acts as the main contact with providers.

The process of becoming a Medicaid provider is relatively fast. Providers can operate under a provisional license during the waiting period, which can be about 45 days for an entity that is already functioning. The state requires criminal background checks for providers. The state maintains a criminal justice registry and a caregiver abuse registry (records substantiated allegations of misuse of funds, treatment, etc. of individual caregivers). Much has been done at the state level to revamp the requirements recently. There are training requirements for residential providers that must be met annually; home health and personal care providers have their own requirements to meet for certification and each county has its own certification process.

Under the older system, waiver rates are similar to Medical Assistance card services, which are set at the state level. Under Family Care, counties negotiate rates with providers. Providers have an opportunity to be paid a higher rate if the organization delivers a higher quality product. Also, rather than receiving 1/12 of the payment up-front at the beginning of the month, Family Care providers bill for the number of units of service provided and then get paid. The county generates checks to the providers and reports to the state when payment has been made. Under the old waiver, the county agency is responsible for ensuring that billing is accurate and matches the services delivered; in Family Care, this is the responsibility of both the care manger and the Network Developer. Furthermore, the annual screen has quality checks in place to prevent ineligible consumers from receiving services. Under Family Care, eligibility cannot be back-dated because payment is not received until the consumer is enrolled.

Quality assurance activities under Family Care have diminished the autonomy that providers had in the old system. Previously, providers would drive the care plan and just sign off on how many hours they worked. Under Family Care, providers only get paid for services delivered, which are verified at the individual level. Oversight of the waiver program is the state's role. In the older waiver, a state contractor tried to visit all the counties at least once every two years. In Family Care, the EQRO reviews care plans on a periodic basis. Each initial care plan is reviewed by quality assurance staff at the beginning of service.

Beginning with Family Care, the state developed a Member Outcomes tool in conjunction with consumers and quality assurance experts with experience implementing consumer-defined quality reform in the developmentally disabled field. Individuals are trained to conduct interviews with consumers and their care mangers pertaining to 14 consumer-developed outcomes. The interviews are more conversational than standard surveys to allow for as individualized responses as possible. Two rounds of interviews have taken place with two different samples of Family Care members, and the tool was also administered to samples of other state long-term care program participants.

B. Best Practices at the Local Level

The Lewin Group team made on-site visits to four Area Agency on Aging (AAA) offices and conducted interviews with key AAA staff. Each visit lasted approximately three hours. On three of the visits, we also interviewed key staff of the Adult Evaluation and Review Service agency (AERS). The purpose of the visits was to get a local perspective on the operation of the Waiver, solicit suggestions on how to improve the eligibility process and examine best practices that could be replicated in other jurisdictions in Maryland. The locations were chosen in consultation with DHMH and MDoA leadership. They were Anne Arundel, Baltimore, Howard and Prince George's counties.

AAA and AERS staffs have taken many positive actions to improve the efficiency and effectiveness of the Older Adults Waiver. Most of the actions we identified as "best practices" addressed coordination, communication and provider recruitment issues.

1. Coordination

AAA and AERS staffs work together at the local level to assess an individual's need for services and develop a plan of care. This requires an initial request from the AAA to AERS to conduct an assessment, have the completed assessment sent to Delmarva to determine whether the individual meets the level of care criteria, and team-based development and approval of a plan of care. Although this may appear relatively easy, the process involves coordination and cooperation with many individuals. The AAA must also coordinate with the Division of Eligibility Waiver Services (DEWS) of the DHMH.

Best Practices

- In Anne Arundel and Howard counties, AAA and AERS staff were located in the same building. This made it much easier to request assessments, convene meetings to develop plans of care and communicate about applicant status.
- In Baltimore County, AAA and AERS staff do field assessments together whenever possible. This makes it much more efficient in developing a plan of care, as both entities have similar information on an individual's needs. Often, the initial discussion of a plan of care begins on the way home from the assessment visit.
- In Prince George's County, AAA and AERS staff meet weekly to discuss and jointly sign-off plans of care.

2. Communication

A major issue identified and addressed by many of the AAAs visited was the lack of organized tracking of an applicant's application and communication about the status.

Best Practice

Applicant databases to track the eligibility process have been established in three of the counties visited. While the staff are not normally able to tell an applicant the result of the eligibility determination, they are able to communicate what steps have been completed and what steps still need action. This ability to communicate application status may prevent additional phone calls to entities involved in the eligibility process.

3. Provider Recruitment and Retention

AAAs have taken responsibility for addressing provider shortages by taking certain actions to address provider recruitment and retention.

Best Practices

- In Howard County, the AAA uses direct mail and face-to-face meetings with assisted living providers to encourage provider participation in the Waiver.
- In Prince George's County, the AAA holds monthly provider training sessions on the application and billing process.
- In Anne Arundel County, the AAA holds provider meetings to improve communication and encourage Waiver participation.
- In Howard County, the AAA operates an electronic billing program through MDoA, which has resulted in more rapid payment for providers.

C. Best Practices from Literature Search

The Lewin Group conducted a focused literature search of states' long-term care system reform initiatives for streamlining consumer enrollment processes and improving provider recruitment and retention processes. The search was restricted to literature on Medicaid waiver programs for the aged and disabled populations; it excluded states' program experience with other types of waivers (e.g., MR/DD, HIV/AIDS, and TBI). The review of state reform initiatives focused on available information about process redesign methods, administrative structure and required resources (fiscal, staff, technology, and time).

1. Consumer Enrollment Process

States are pursuing multiple strategies to reform existing fragmented and uncoordinated long-term care service delivery into more seamless systems of care. Several leading states in aged and disabled waiver provision are pursuing consumer-responsive single point-of-entry systems (SPE) as a means of more efficiently allocating resources that fund outreach, information, application processing, eligibility determination, enrollment, and case management. Many other states are currently in the planning process to follow their lead. Constituents feel strongly about improved coordination and administration. As written in the 2002 AARP Policy Book

"states should be required to implement a single point of entry for LTC [long-term care] services."[i] Some states, such as New Jersey, Indiana, and Wisconsin, are pursuing SPEs on a statewide basis, while others, like California and Georgia, are providing regional efforts.

The Centers for Medicare and Medicaid Services (CMS) has identified "promising practices" of several states that are attempting to simplify access to home and community-based services for their older adult populations, including Illinois, New Jersey, Colorado, and Wisconsin. The single point-of-entry system initiatives taken by Illinois and New Jersey as described on the CMS Web site (http://www.cms.gov) appear below; those pursued by Colorado and Wisconsin (in addition to Washington) are detailed in the "3 states' best practices" section of this report.

Illinois

Illinois established "Case Coordination Units (CCUs)" in 1983 to provide single entry points targeted to older persons and persons with disabilities age 60 and older.[ii] Through the state's 47 CCUs, consumers can access a range of private and public community-based services, including Medicaid Waiver services, state-funded home and community-based services, and Older Americans Act services. CCU case managers meet face-to-face with applicants to administer a standard assessment in determining program eligibility. All nursing home applicants are required to be assessed by a CCU case manager, even if the applicant is ineligible for Medicaid. For applicants who are deemed eligible for publicly-funded services, the CCU case manager provides ongoing assistance. Level of care and financial eligibility are reassessed annually.

The state's AAAs chose which areas would be served by each CCU. The CCUs are selected via a competitive bidding process and represent a range of organizations (e.g., senior centers, social service agencies, county human service departments, county health departments, and visiting nurse associations [VNAs]). It was estimated that in FY 2000, CCUs case managed approximately 38,000 persons per month in the Waiver program and provided over 114,000 assessments. The state paid CCUs an estimated $20.8 million in state fiscal year 2000 for case management services (includes Medicaid reimbursement for case management as an administrative function and additional state funds). CCUs also received $5.3 million in Older Americans Act dollars. Total administrative expenditures were $26.1 million, which was approximately 10% of the Community Care Program and Older Americans Act services expenditures.

New Jersey

New Jersey spent nearly five years implementing the New Jersey Easy Access, Single Entry (NJ EASE) system in an effort to address the problems of a fragmented system that required program applicants to visit multiple locations and provide repetitive information.[iii] The state of New Jersey, under the auspices of the governor's office, received a $238,251 grant from the Robert Wood Johnson Foundation in December 1994. Together with $400,592 in matching state monies, the grant supported NJ EASE planning. In 1999, the overall budget for NJ EASE was $6.4 million, covering: information and assistance, benefits screening and home visit outreach, comprehensive assessment, care planning, care management, and reassessment. The state began allocating funds to participating counties in 1997 for computers and software, and then increased funding for care management in 1999 when that responsibility shifted to the NJ EASE

offices. In late 2000, the state launched a sophisticated $500,000 promotional campaign for NJ EASE.[iv]

The state worked with county governments to develop a statewide toll-free number linked with county single entry offices. In 1996, NJ EASE was officially launched with four counties. The state initially worked with 13 counties who volunteered to participate, phasing in a few counties at a time. In four years after the creation of NJ EASE, all 21 counties had initiated the "information assistance" phase and the state launched a national toll-free number. Implementing the second phase of comprehensive SEPs was more challenging. Counties determined the lead agency of the single entry system in addition to the lead agency for the toll-free number. In each case, they designated the county office on aging (also serves as the AAA) as the lead agency. While the state took the lead on automating assessment tools and information and assistance systems, each of the 21 counties had to submit plans to improve their IT systems. State staff provided significant training and technical assistance to the counties on implementation and standardization. The state developed a standardized form to be completed during the initial screening process which is also the first two pages of a standardized comprehensive assessment.

In addition to those initiatives captured on the CMS Web site, there are several other states that have developed, or are developing, single point-of-entry systems for older adults as described in the literature.

Oregon

Oregon has consolidated all components of its long-term care programs into a single, administrative structure at the state level and a highly integrated delivery system at the local level. The Department of Human Services, which is the single state Medicaid agency, manages all of the state's community and institutional long-term care programs through its Seniors and People with Disabilities program unit. It manages Medicaid payments to nursing homes, Medicaid home and community services waivers, services provided under the Older Americans Act, licensure and regulation of all long-term care facilities, and federal and state community care funds for the elderly. AAAs affiliated with local units of government administer all community care programs in the most populated areas of the state and local state offices administer the programs in the rest of the state. These include Medicaid waiver programs, case management and preadmission screening services. AAAs also determine Medicaid eligibility for both nursing home and community care clients. Oregon uses very specific measures to determine level of care eligibility. Along with Illinois, Oregon employs an assessment tool to generate a numeric score. Through the score, care plans are automatically developed and services authorized. In 2000, client data from local servers were converted to a centralized data repository. In 2002, Oregon launched a Web-enabled data-reporting tool to allow central office and AAA field offices to query data entered into the database. This delivery system has been developed over the past twenty years with responsibilities and covered populations added incrementally during that period. [v]

Minnesota

The Minnesota Long-Term Care Task Force identified as its first priority in the 2001 legislative session to expand consumer information and assistance, develop a single point of access for all elderly in a local area, and make information more accessible to culturally and ethnically

diverse elders and to family caregivers.[vi] In the state's experience, the elderly and their families wanted one-stop shopping for information and services. They have decided to pilot test a redesign of the system that incorporates a single point of access for all elderly within a given geographic area, combines multiple public funding streams, and establishes a sliding fee scale for private pay consumers. In developing a single point of access, they are focusing on improved efficiencies through reduction in unnecessary paperwork and processes, and through application of technology. The state's initiative also involves exploring ways to make optimal use of staff, such as flexible hours and more use of the universal worker concept.

Indiana

In Indiana, the IN-Home Services Program housed within the Family and Social Services Administration (FSSA), administers all home and community services for older persons and younger adults with physical disabilities, including Medicaid benefits. [vii] The program was enacted into law as a statewide program in 1992. The Medicaid Waiver Unit (part of the IN-Home Services Program) administers the aged / disabled waiver and three other waivers. A separate Office of Medicaid Planning and Policy within FSSA sets overall policy for the waivers. The IN-Home Services Program also administers a state-funded program called CHOICE. Since 1992, the IN-Home Services Program has contracted with the state's 16 AAAs to serve as single points-of-entry (SEP) for administration of all home and community-based programs at the local level, including those for people with mental retardation or developmental disabilities. In fiscal year 2000, Indiana provided aged / disabled waiver services to approximately 2,300 persons in addition to over 10,000 persons through the CHOICE program.

Indiana uses statewide toll-free numbers through which consumers are linked to AAAs. AAA staff perform level of care assessments with a uniform tool, provide case management, and conduct pre-admission screening for all nursing home applicants. Each AAA has a liaison who works with the state Medicaid waiver unit to enhance communication. Prior to implementing the SEP, the AAAs already had an established case management system and were responsible for screening persons seeking admission to nursing homes. Indiana made a considerable investment in computerized assessment and quality assurance methods.

Michigan

Michigan's aged and disabled waiver program, MI Choice, began in 1992. Applicants for the MI Choice go through one of 23 "waiver agents" at the regional level. [viii] Thirteen of the waiver agents are AAAs, five are private non-profit organizations, one is a home health agency, another is a health system, and three are community mental health boards. Waiver agents assess applicants' functional, cognitive, and psychosocial status, and their need for services. They arrange and monitor service delivery. Applicants for the aged / disabled waiver program are first screened over the phone and if they appear eligible, participate in an in-home comprehensive assessment by a team (a nurse and social worker). The care management teams are given state-published guidelines to assess whether the applicant meets the state's nursing home level of care criteria. In quality reviews, it was found that the teams applied the criteria inconsistently. The state has since developed empirically-based screening and placement algorithms to put in practice. Throughout the development of the MI Choice Access System, the Department of Community Health provided a centralized administrative management function. All agents operate under the same contracts with standard protocols. The Department

was directly involved in problem solving with the local centers and created an ongoing partnership between the state and local agencies to assure ongoing quality improvement.

Most of the state's regions have multiple waiver agents, designed to give consumers choice. Some stakeholders in this state have reported that the use of multiple agents can be confusing and difficult to coordinate. In response, Michigan's Long Term Care Work Group recommended in June 2000 for the state to pursue a single point-of-entry system to better coordinate information and access at the local level.

Several themes in the literature cut across state long-term care initiatives to improve access: providing consumers with useful information about long-term care options and provider performance, ensuring reasonable access, and encouraging efficiencies and productivity, including use of labor-saving technology.[ix] [x] [xi] The Justice, et al. study in 1988,[xii] and the experience of other states since then has shown that successful features of quality home and community-based systems may include: set criteria and monitoring at the state-level with local administration; consolidation of responsibility for program entry functions[xiii] (screening, assessment, eligibility determinations, authorization, plan of care, and case management); automated assessment and level of care determination processes; improved communication through in-house coordination of functions and database use for tracking; and clear delineation of roles and responsibilities via interagency agreements and policies.[xiv]

2. Provider Recruitment and Retention

Most of the literature concerning provider recruitment and retention describes methods to increase rural provider participation and the need to increase reimbursement rates to providers under Medicaid. There is minimal coverage in the literature of state efforts to simplify the provider recruitment process and operational strategies to retain providers. States have generally used technology not as the answer, but as a tool, to improving application and billing processes. The following strategies are the more common examples of state strategies.

Reducing paperwork during provider application process

In Washington, for example, all home care agencies are initially licensed by the Washington Department of Health, but annual monitoring is conducted by the AAAs and the results sent to the Department of Health. The state has worked to streamline licensure requirements so that the process involves less paperwork for providers.[xv] However, Washington has set additional requirements that both agency providers and independent providers pass a criminal background check and also complete a state-developed standard caregiver training.

Requiring efficient and standard claims processing and payment

As described in a case study of Indiana's aged / disabled waiver program, stakeholders reported several systemic issues impacting provider participation.[xvi] They noted that waiver payment rates were too low to attract a sufficient number of providers to the program. They also identified problems with the billing system, in which there were payment delays up to 11 months. It was reported that the fiscal intermediary was not responsive to inquiries or monitoring claims processing. On review, state staff found that some late payments were due to providers not following procedures, which needed to be remedied through simplifying the process and training. Also, a state provider relations specialist is available to troubleshoot

billing problems. State staff are examining variation in the billing cycle to reduce the time from claim submission to payment.

Using automated payment and billing mechanisms

In Texas, all long-term care waiver and state-funded provider claims are processed and managed across a single system. Providers are given the option to submit claims either by paper or electronically through a Windows-based software, called TDHConnect, or through a third-party software that meets system requirements. TDHConnect is an expansion of the system previously developed for Medicaid acute care providers. Because the software is compatible, providers who serve both long-term care and acute care consumers can submit claims using just one system—the Claims Management System (CMS). The goals for using CMS are to:

- Present a more accurate way for providers to be reimbursed for the services provided
- Eliminate duplicate functions
- Provide flexibility for future modifications
- Improve community relations with all providers
- Lower the administrative costs associated with processing claims
- Replace divergent systems with a common payment and tracking system

A contracted insurance company edits the claims to verify the validity of the information on the claim and that the claims meet the requirements for the program being billed. A "Remittance & Status" report notifies providers if the claim is paid, denied, or in process. The insurance company is not involved in actual service authorization and does not act as a contract authorizing entity. A help desk is available for provider questions.

Promoting equitable provider rates across programs

Components of Minnesota's long term care reform initiative have involved identifying levels of paperwork and documentation that are overwhelming and ineffective for providers as well as examining geographic disparities between similar services with different programs. They also identified the need to examine the extent to which the current reimbursement structure supports consumer-directed care. They identified the need to modify disparities in home and community-based provider rates to promote a more equitable and high-quality service system.[xvii]

Linking vendor payment levels to performance measures

Several states are promoting quality care by creating incentives for providers to meet consumers' needs as demonstrated through measurable outcomes. The Georgia Governor's Blue Ribbon Task Force on Home and Community-Based Service recommended that provider participation and reimbursement in the home and community-based service system be based on performance measures.[xviii] Similarly, Rhode Island passed legislation that ties home care reimbursement rates to increased performance by providers and staff.[xix]

IV. RECOMMENDATIONS

The recommendations are based on information from many sources, including:

- Review of actions taken by the Redesign Committee, state and local entities to improve the eligibility process;
- Extensive document review, including all of the UMBC interviews with the Redesign Committee, the summary of the focus group meetings with AAA and AERS staff conducted by UMBC, key manuals and regulations impacting waiver design and operations, the workflow analysis prepared by UMBC, the UMBC report on Medicaid nursing facility level of care in Maryland and many Older Adults Waiver program forms;
- Face-to-face interviews with the Redesign Committee, key state and local staff, including field visits with four AAA , three AERS and DEWS staffs;
- Telephone interviews with three leading states: Colorado, Washington and Wisconsin;
- Comprehensive literature search;
- Discussion with national experts; and
- Experience in managing and evaluating long-term care systems in many states.

A. Goals

We recommend that the following goals be adopted for the Redesign of the Older Adults Waiver:

- Simplify and expedite the eligibility and provider enrollment process;
- Identify clear roles and responsibilities for all entities;
- Promote accountability; and
- Utilize local infrastructure.

B. Critical Success Factors

We believe there are critical success factors for short and mid-term improvements in the eligibility process. They are:

- Commitment to delegate all functions to the local level, working under the criteria established by, and monitored at, the state level;
- Commitment by the local agencies to comply with criteria established at the state level, and to remedy deficiencies identified in periodic reviews;
- Development of an effective tracking system to enforce deadlines and to be able to determine where a consumer's application is within the process;
- Commitment to reduce deadlines at each step; and
- Improve staffing resources throughout the system.

There are additional critical success factors for long-term improvement in the eligibility process. They are:

- Commitment to use a single point-of-entry (SPE) at the local level to perform eligibility determinations, provide case management and perform certain other services. The functions currently performed by the AAA, AERS and DEWS would be the responsibility of the SPE;
- Commitment to automate the process, including level of care assessment and determination;
- Commitment among all entities to execute binding agreements that define roles, responsibilities, functions, areas of authority, and accountability for deadlines;
- Commitment to add additional resources and staff; and
- Commitment to link agency / vendor payment levels to performance measures for enhanced quality.

C. Customer-focused and Efficient Eligibility Process

To redesign the eligibility process to make it more customer-focused and efficient, we recommend (in priority order):

1) Implement a Single Point of Entry (SPE) system at the local level with responsibility for outreach, eligibility determination, assessment and plan of care development, case management and other services;
2) Implement automated financial and level of care eligibility systems to reduce enrollment time and provide better quality and easier access to needed data;
3) Implement an electronic, client eligibility tracking system that reinforces timelines and lets all parties know the status of individual applications;
4) Continue to analyze staffing and capital resources needed to accomplish stated goals and make the commitment to secure those resources; and
5) Implement agreements with all parties to the process that clearly define functions, authority and accountability, a commitment of resources and a problem resolution process.

Additionally, there are a number of action steps that can be taken in the short-term to make the eligibility process more customer-focused and efficient:

1) Reduce processing timelines by adding eligibility staff and communicate expectations to all parties involved;
2) Make AAAs the local point of contact for client contact and application tracking and publicize this fact to all parties involved;
3) Give AAAs the authority to approve plans of care, subject only to quality review by MDoA;
4) Develop intergovernmental agreements that clearly define functions, authority and accountability, which ensure commitment of resources and which establish a problem resolution process;

5) Ensure applications are as complete and accurate as possible by assigning responsibility to the AAAs to work with applicants toward that goal; application information must give clear examples of documentation requirements;
6) Allow AERS social workers to sign off on the level of care assessment form (3871), if they have proper training;
7) Notify applicants if they do not meet level of care criteria; financial assessments can be completed for other programs, but notification of denial of Waiver services should be sent; and
8) Examine all forms to ensure that data are being collected in a customer-friendly manner.

D. Customer-focused and Efficient Provider Recruitment, Enrollment and Retention

To redesign the Provider Recruitment, Enrollment and Retention system to make it more customer-focused and efficient and to recruit and maintain an appropriate provider base, we recommend (in priority order):

1) Implement a single point of contact at the local level with responsibility for provider recruitment, waiver enrollment and quality assurance;
2) Implement a single point of contact for provider payment issues;
3) Increase staffing at the Office of Heath Care Quality;
4) Simplify the provider enrollment process;
5) Implement electronic billing by providers and/or the SPE;
6) Implement automated licensure and inspection system to ensure that all parties to the process can know the status of applications for licensure and renewal and compliance with quality standards;
7) Implement changes in provider enrollment qualifications based on size and type of provider; and
8) Implement standardization of provider enrollment requirements and payments across all waivers.

E. Short, Medium, and Long-term Recommendations

As requested, below are short, medium and long-term recommendations for improving both the eligibility process and the provider recruitment, enrollment and retention systems, along with key implementation steps, timelines and preliminary estimates of necessary financial and staffing resources. The financial and staffing estimates continue to need refinement to ensure all Maryland-specific issues have been accounted for. The time frame recommendations should begin starting with the new budget year July 1, 2003.

Key Implementation Steps in Eligibility Reform: Short-Term (in priority order) Beginning 7/1/03

Implementation Steps	Completion Time Frame	Resources
1. Complete plans for Single Point of Entry RFP (to prepare for Mid-Term goal); major stakeholder process to determine functions, financing, populations served, qualified bidders	12 Months	$75,000 for consultant contract
2. Complete plans for automated financial and level of care eligibility systems (to prepare for Mid-Term goal); assess other states' level of care eligibility systems for adaptation to MD; apply for CMS approval	12 Months	$100,000 to IT consultant to define requirements; $340,000 per year ongoing (5 FTE) for DHMH project team to manage both SPE and automated eligibility systems projects
3. Plan and implement a client eligibility tracking system which reinforces timelines and lets all parties know status of client applications; utilize resources of UMBC and experience of other states' programs	9 Months	$200,000
4. Reduce processing timelines and communicate expectations to all parties involved	3 Months	Increase staff at DEWS; $200,000 per year ongoing expense (4 FTE) based on 1:350 ratio; Implement staffing ratios for AAAs; $800,000 per year ongoing (1:65 case managers; 1:200 admin. staff); Convert five positions at MDoA from contract to budgeted ($40,000 per year ongoing) Increase system maintenance ($40,000 per year ongoing)
5. Evaluate budget for staffing current and future system; acknowledge impact of automated systems; commitment by all stakeholders to secure resources	3 Months	These financial estimates are based on current funding for 3,135 consumers and may not account for additional resources needed to support past years' program expansion. If the size of the program increases, additional resources need to be committed.
6. Develop intergovernmental agreements. These agreements must clearly define functions, authority and accountability; ensure resources are committed by agencies; and establish a problem resolution process	3 Months	Existing
7. AAAs made the local point of contact for client contact and tracking; all parties acknowledge and publicize for efficiency and customer service; divert customer calls made to DEWS and Delmarva	3 Months	Existing

Note: Use of existing resources requires staff time to complete task; staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Eligibility Reform: Mid-Term (in priority order) Beginning 7/1/03

Implementation Steps	Completion Time Frame	Resources
1. Fully develop automated financial and level of care eligibility systems to coincide with initial implementation of the Single Point of Entry (SPE); commit to SPE even if automated systems are not ready for implementation	24-36 Months	$4.85 million; $485,000 to Budget and Management for contract oversight
2. Issue RFP for Single Point of Entry; make award and negotiate contracts; plan timing of statewide implementation	24 Months	$1.0 million per year ongoing for increased overhead/administrative costs; added to coincide with SPE implementation
3. Integrate the roles of AAA and AERS to create a single entry to perform level of care eligibility, outreach, technical eligibility, assessment and plan of care development; all done by that entity; shorten timelines	18 Months	Existing

Note: Use of existing resources requires staff time to complete task; staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Eligibility Reform: Long-Term (in priority order) Beginning 7/1/03

Implementation Steps	Completion Time Frame	Resources
1. Phase-in of Single Point of Entry System statewide; reinforced commitment to solve problems and communicate with stakeholders	30-48 Months	$725,000 for computer equipment and software; $3.3 million for imaging system
2. Delegate financial eligibility determination to public entity located within the Single Point of Entry to determine financial eligibility with requirements for meeting timelines	30-48 Months	$800,000 for computer hardware; $600,000 per year ongoing web hosting; $110,000 per year ongoing for clearinghouse; $720,000 per year ongoing for system changes/maintenance; $165,000 per year ongoing for trainers (3 FTE)
3. Delegate level of care determination to Single Point of Entry with requirements for meeting timelines	30-48 Months	Existing

Note: Use of existing resources requires staff time to complete task; staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Provider Recruitment and Enrollment: Short Term (in priority order)

Beginning 7/1/03

Recommendation	Completion Time Frame	Resources
1. Simplify application process and designate local entity to assist providers	6 Months	TBD (depends on local entities' resources and current staffing levels)
2. Expand staff at OHCQ; commit to securing resources	3 Months	$300,000 per year ongoing to OHCQ (5-6 FTE); further analysis needed for long-term staffing resources
3. Complete plan for automating licensure and inspection system; ensure that all parties can know where applications for licensure/renewals are in the process	12 Months	$75,000 to IT consultant
4. Provide MDoA easier access to OHCQ complaint records for assisted living providers; if MDoA continues to review the complaint records of provider for waiver certification, process needs some form of automation; explore possibility of doing in-house	3 Months	$100,000 for Web-based system; less expense for in-house implementation, if feasible

Note: Use of existing resources requires staff time to complete task; staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Provider Recruitment and Enrollment: Long-Term (in priority order)

Beginning 7/1/03

Recommendation	Completion Time Frame	Resources
1. Complete plan for local entity to recruit and assist with enrollment of assisted living providers based on state criteria; evaluate the potential of local entities' delegated responsibility for monitoring	6 Months	TBD (depends on local entities' resources and current staffing levels)
2. Implement automated licensure and inspection system	24 Months	$2.5 Million; $250,000 to Budget and Management for contract oversight; $310,000 per year ongoing (6 FTE) to implement/maintain system
3. Plan and recommend changes to provider system to account for differences in provider size/type; requires review of current statutes; goal to ease unnecessary requirements on small providers	18 Months	May need more resources; dependent on recommended changes

Note: Use of existing resources requires staff time to complete task: staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Provider Retention: Short-Term (in priority order)

Beginning 7/1/03

Recommendation	Completion Time Frame	Resources
1. Plan and implement single point of contact for provider point of contact; communicate clearly that we want to assist with payment problems	6 Months	$80,000 per year ongoing expense (2 FTEs)
2. Develop plan for improving billing process; encourage direct billing by AAAs, if they have the resources and capabilities	12 Months	$160,000 per year ongoing expense (4 FTEs)
3. Complete plan to standardize provider requirements across waivers and state plan services, wherever feasible	9 Months	Existing

Note: Use of existing resources requires staff time to complete task; staffing levels may need to be adjusted based on current workloads.

Key Implementation Steps in Provider Retention: Long-Term (in priority order)

Beginning 7/1/03

Recommendation	Time Frame	Resources
1. Change billing process so providers bill directly to DHMH; encourage providers to use process by committing to established timelines for payment	30-48 Months	$500,000 (Software changes so that MMIS system has capabilities to automatically check plan of care against claims)
2. Complete provider payment rate study to ensure comparable rates	18 Months	**TBD** (depends on rate changes)

Note: Existing staff time is required to make MMIS changes and conduct study: other projects may need to be delayed.

F. Conclusion

Maryland's Older Adults Waiver serves an important need for the elderly of the state. It gives them the opportunity to continue to live in their own home or a substitute home, with dignity and independence, receiving needed services and supports. There is much support for this program from a variety of stakeholders including: elderly individuals, their families and their advocacy organizations; service providers, such as home health and home care agencies and assisted living residences; state and local public officials; and legislators. It was clear from our work that there is a strong and genuine commitment to this program and this population and a

desire to make the system work better for recipients and deliverers of service, whether public or private.

It should be understood and frequently noted that this program has been greatly expanded over the last few years. Many more people are receiving services than ever before. This has meant more applications have been processed, eligibility determinations and redeterminations completed, care plans developed and modified to meet the changing needs of this population, providers recruited, licensed and certified, accurate billing and payment and, most importantly, that services are being provided in an efficient, effective and caring manner. It should also be acknowledged that many staff had to be hired and trained and systems of all kinds needed to be implemented to accommodate the growth in this program.

As highlighted in this report, there are actions that can be taken in the short-term to improve both the eligibility process and the provider recruitment, enrollment and retention system. We encourage Maryland to take those actions. But it is clear that the Redesign Committee and other stakeholders we interviewed want a system that is, in fact, "redesigned". Our long-term recommendations envision a consumer-responsive system where:

- consumers can receive information and assistance about long-term care options, apply for assistance and a get an eligibility decision in a reasonable period of time, receive communication about their application status in a timely and supportive manner and receive high quality services from responsive providers in their own home or a substitute home;
- entities at every level understand their functions and responsibilities and are dedicated to resolving problems and continually improving the system;
- automated systems are developed to support needed operational efficiency; and
- providers deliver high-quality, cost-effective services and are compensated fairly, with incentives for achieving outstanding quality services.

It is clear that the Older Adults Waiver needs an investment of resources in the infrastructure that operates this program. It is not clear that an adequate investment was made when this Waiver was greatly expanded over the past number of years. There must be adequate funding for the human resources and automated support needed to operate the program, as it exists today, and as it is redesigned for the future. It should also be noted that even the most "advanced" states use a 45 day timeline for eligibility determinations, although many are completed well before that deadline. Maryland should consider amending its 30 day timeline to a more realistic objective.

As of the date of this report, Maryland, like most other states, is experiencing great fiscal challenges. It is difficult to consider adding resources at a time when public officials are looking at program cuts and elimination. We urge Maryland to take actions that are not costly in the short-term and adopt a detailed plan for a time when there are more resources available for investment. The automation projects, creating a single point of entry system at the local level and clearly establishing the role definition and problem resolution/quality improvement systems recommended in this report require research, planning and collaborative decision-making and require a reasonable amount of time to develop. There is also a very favorable federal match rate available for the information technology projects which will make state investment more affordable and should make the decision to implement more feasible. While

the favorable federal match rate is not assured, the projects recommended have received federal approval in other states. To reach the goal of a redesigned system within two to three or even four years requires hard work and committed action immediately. It should be acknowledged that any desired changes will take time, hard work and adequate resources.

In closing, we want to acknowledge the fact that Maryland has adopted a Quality Plan for the Older Adults Waiver. It appears to be a well-developed plan to meet federal requirements and ensure the health and welfare of waiver participants. In our work, it was not clear that all stakeholders were focused on the details of that plan. We know that there is work in progress which will focus greater attention on quality assurance systems across all waiver populations. We encourage that work. However, we also make the following observations pertaining to quality assurance. Staff need to understand their role in quality assurance; quality assurance requires clear definition and training. Programs that expand very quickly, as has this Waiver, often experience service quality problems. It can easily happen as focus is given to recruitment and enrollment of both participants and providers. All stakeholders should know who is ultimately responsible for each part of system quality and be encouraging the system to move to a quality improvement focus as well as quality assurance.

Finally, we want to acknowledge the excellent work and outstanding cooperation of the Center for Health Program Development and Management at UMBC, the leadership and staff of both the Department of Health and Mental Hygiene and the Department of Aging, the Area Agency on Aging staff we visited and the Waiver Redesign Committee. Their resources, commitment and support aided and helped guide our work. These stakeholders have all contributed to improving the services provided by the Older Adults Waiver and have been successful in many areas. We encourage you to continue improving the existing system while planning and implementing a more customer-responsive, efficient service delivery system.

ENDNOTES

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[v] Oregon ACCESS Information System Application Policy. Available at: http://www.sdsd.hr.state.or/transmit/el/2002/e102013.pdf.

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[ix] Long Term Care Innovations: Challenges and Solutions. Michigan's Long Term Care Work Group Report and Recommendations. Michigan Department of Community Health. June 2000

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[xii] Diane Justice, et al., State Long Term Care Reform: Development of Community Care Systems in Six States, National Governors' Association Center for Policy Research, Health Policy Studies, Washington, D.C., April 1988.

[xiii] Wiener, J. and Lutzky, S. (2001) Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Washington. Prepared for the Centers for Medicare and Medicaid Services.

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[xv] Wiener, J. and Lutzky, S. (2001) Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Washington. Prepared for the Centers for Medicare and Medicaid Services.

[xvi] Tilly, J. and Goldenson, S. (2001) Home and Community-Based Services for Older People and Younger Adults with Physical Disabilities in Indiana. Prepared for the Centers for Medicare and Medicaid Services.

[xvii] Reshaping Long Term Care in Minnesota. State of Minnesota Long-Term Care Task Force: Final Report. January 2001.

[xviii] Governor's Blue Ribbon Task Force on Home and Community-Based Services: Final Report (2001). Available at: http://www.ga-ddcouncil.org/blueribbon/final.htm.

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