Single Point of Entry Opportunities in Alabama

Prepared for:
Alabama Medicaid Agency

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I. EXECUTIVE SUMMARY

Rapidly growing numbers of persons of advanced age, lengthening waiting lists for HCBS Medicaid waiver services for persons with disabilities, and mushrooming healthcare costs for these Long Term Care (LTC) populations have created the most challenging operating environment the U.S. human services system has experienced to date. Mounting demand necessitates more effective strategies for coordinating information about and access to LTC services and supports.

However, Americans in need of LTC services and their families are faced with a confusing maze of disconnected services, mind-boggling paper work, and a dearth of consolidated, easy to understand information on LTC services and options. Faced with such daunting challenges, people in need of LTC services and their families may not find adequate services or quality services and spend too much time and money on services that are not their preference or needed.

In recent years, Alabama has made significant enhancements to its LTC services and delivery systems for people of advanced age and persons with life-long disabilities. After the 1999 U.S. Supreme Court decision in ***Olmstead***, the state assembled a coalition to develop Alabama's ***Olmstead*** response as well as to address consumer preferences for home and community-based services (HCBS) over services delivered in nursing homes or other institutions. In 2001, the Alabama Medicaid Agency applied for and received a Real Choice Systems Change Grant from the federal Centers for Medicare and Medicaid Services (CMS).

These funds have been used to further enhance the state's LTC service system. A key undertaking of Alabama's Real Choice Grant initiative is to study ways of providing consistent, easy to find information on and access to LTC services. Nationally, such consolidated LTC information and access programs are called "single point of entry" systems. In Fall 2003, the Alabama Medicaid Agency contracted with The Lewin Group to conduct a single point of entry (SPE) feasibility study. To that end, Lewin and the Alabama Medicaid Agency staffed a SPE Work Group composed of Alabama consumers and other LTC stakeholders; this work group guided the study.

With the oversight of the SPE Work Group and Alabama Medicaid Agency staff, Lewin conducted a literature search on SPE best practices and national initiatives and studied the SPE development and operational experiences of the states of Colorado, Nebraska, and Washington State. Lewin staff also interviewed a variety of Alabama stakeholders (i.e., state agency staff, consumers and families, and LTC service providers) to gain an understanding of what they felt would enhance LTC services as well as their thoughts on a possible SPE system. This information was used to develop three possible Alabama SPE models: a) a virtual SPE system composed of a Website and phone system; b) a network of three regional SPE offices that would operate in tandem with the virtual system; and c) a statewide network of highly localized SPE offices.

Each of these optional models presents and array of pros and cons that Alabama stakeholder holders and policymakers will need to consider. Regardless of which option Alabama pursues, SPE systems are an important tool for states as they strive to support an aging population and growing number of persons with disabilities in the manner they prefer but also cost effectively for the state.

II. INTRODUCTION

In recent years, Alabama has made great strides to improve the delivery of long term care (LTC) services to Alabamians of advanced age as well as those with disabilities. After the 1999 Supreme Court's ***Olmstead*** decision, the state assembled a coalition to develop Alabama's response as well as to address consumer preferences for home and community based services (HCBS) over institutional care.[1] The ***Olmstead*** Planning Initiative is supported by the Alabama Medicaid Agency and the Governor's Office on Disability (GOOD) and numerous other interested stakeholders.

In 2001, the Alabama Medicaid Agency applied for and received a Real Choice Systems Change Grant, entitled *Sweet Home Alabama: Under Construction,* from the federal Centers for Medicare and Medicaid Services (CMS) totaling $2 million. The current undertaking to create a single point of entry system (SPE) is a key component of the state's Real Choice Grant efforts and its ***Olmstead*** initiative.

A. Purpose

LTC services include an array of medical and non-medical services and supports for individuals requiring ongoing assistance. Supports and services may include periodic physician visits or physical therapy, assistance with transportation, personal care in the workplace, and even homemaker or chore services. Because of the diversity of services and supports, the state systems that allow individuals to learn about, access, and receive LTC services have evolved in a fragmented fashion with programs and related functions divided among state agencies in Alabama as well as in virtually every other state.

In recent years, states have attempted to consolidate and centralize services that provide information about LTC services to individuals and caregivers, assist them with making LTC planning decisions, and provide intake and access to publicly-funded LTC services and supports. Furthermore, the SPE concept is a system by which persons with LTC needs and their families can access information about the array of ongoing services and supports in one place. This report contains options for consideration of a possible SPE system in Alabama.

B. Method

In January 2004, the Alabama Medicaid Agency contracted with The Lewin Group to perform a feasibility study on the creation of a SPE system. To do so, The Lewin Group took a two-pronged approach.

First, a literature search, interviews with program staff, and an analysis of current SPE and "No Wrong Door" approaches was conducted. As part of this analysis, the experiences of three states (Washington, Colorado, and Nebraska) were closely examined. These states were chosen

[1] In June 1999, the Supreme Court issued a decision in ***L.C. v. Olmstead*** indicating that persons with disabilities must be served in the "most integrated setting appropriate" and according to individual choices between institutional and home and community-based services.

because of their similarity to the State of Alabama in both the size of their programs and the level of effort dedicated to creation of a SPE system.

Second, The Lewin Group convened a series of focus group sessions with consumers and providers of LTC services in Alabama. Panelists were asked to comment on the overall LTC delivery system, identify obstacles to access to care, and suggest improvements in policies or procedures in the state's LTC system.

C. Structure of Report

The remainder of this document is laid out as follows:

Section III, Overview of LTC

This section provides an overview of national trends in LTC.

Section IV, Overview of Alabama LTC

This section provides information about the populations served, services available, and administrative infrastructure in Alabama. It also provides projections on the number of individuals who will need LTC services in the future and stakeholder perspectives on LTC.

Section V, Overview of Single Point of Entry Systems

For several years, states have been building and operating SPE systems. Section four provides a snapshot of existing SPE systems throughout the United States.

Section VI, State Experiences

Since other states already have implemented Resource Center systems for information, assistance and access to LTC services, Alabama can learn from these experiences. This section examines the experiences of three states -- Colorado, Nebraska, and Washington -- in their development of SPE systems.

Section VII, Alabama Single Point of Entry

Alabama has many of the needed building blocks for a SPE system. This section offers three options for implementing a SPE in Alabama. While the options are stand alone models, they also build on one another and could be implemented using a phased in approach, over time, as funds become available.

Section VIII, Possible SPE Offsets

If HCBS expansions are implemented in certain ways, the State may realize savings in other areas, such as nursing home costs. Section 8 offers a cost analysis for nursing home diversion.

Section IX, Conclusion

The report concludes with observations on possible next steps for the State of Alabama on the road to implementing a SPE system.

III. OVERVIEW OF LTC

A. National Context

The Medicaid program was designed to provide health care and supportive services to certain eligible low-income individuals. The program is jointly funded by the federal and state governments, but administered at the state level. As such, each program is unique in its design and delivery system, although they operate within broad federal rules. Medicaid is the primary provider of long term care (LTC) services and supports in the United States and in Alabama.

LTC services include an array of medical and non-medical services and supports for individuals requiring ongoing assistance with activities of daily living (ADL). Supports and services may include periodic physician visits or physical therapy, assistance with transportation, personal care in the workplace, and even homemaker or chore services. Populations of individuals receiving LTC supports and services include persons age 65 and older and persons of all ages with disabilities including physical disabilities, mental illness, sensory disabilities (i.e., blind and/or deaf), traumatic brain injuries, and cognitive disabilities including mental retardation and related developmental disabilities (MR/DD).

It is important to note that age and disability are not discrete categories in regard to individuals (i.e., someone may be over age 65 and have a disability). Additionally, some people with disabilities have multiple disabilities such as MR/DD and a mental illness or a physical disability and a sensory disability. Also, many individuals who are receiving Medicaid-financed LTC services also are Medicare beneficiaries (i.e., dually eligible).

1. LTC Service Financing

Medicaid is the key purchaser of LTC services. On a national basis, Medicaid programs cover the care of nearly 70 percent of all nursing facility residents and finance over 50 percent of the revenue base of the nursing home industry. The federally administered Medicare program does not offer ongoing LTC services but, as noted above, many Medicare beneficiaries who are dually eligible for Medicare and Medicaid are using Medicaid-financed LTC services. For these individuals, Medicare covers acute care services, such as visits to doctors' offices and inpatient care. Medicaid covers LTC services such as nursing home placements and other important services, such as pharmaceuticals, that Medicare does not cover.

2. LTC Service Delivery

LTC services are delivered under both mandatory and optional state Medicaid plan benefits (see Table 1 below). As state plan benefits, these services, both mandatory and optional, are considered an entitlement and must be made available statewide to all individuals found eligible within 90 days of application. The one exception to the entitlement nature of state plan benefits is Targeted Case Management; states have special flexibility to "target" this benefit to particular populations and/or geographic regions.

Table 1
Medicaid LTC Benefits[2]

LTC Mandatory Items and Services	LTC Optional Items and Services
Institutional Services	*Institutional Services*
Nursing Facility (NF) services for persons over age 21	Intermediate care facility for individuals with mental retardation (ICF/MR) services Inpatient and nursing facility services for individuals 65 or over in an institution for mental diseases (IMD) Inpatient psychiatric hospital services for individuals under age 21
Noninstitutional Services	*Noninstitutional Services*
Home Health Care services for everyone entitled to NF services	Home health care services Case management services Respiratory care services for ventilator-dependent Individuals Personal care services Private duty nursing services Hospice care Services furnished under a PACE program Home and community-based services (under budget neutrality waiver)

In addition to state plan benefits, Section 1915(c) of the Social Security Act allows the federal Department of Health and Human Services to approve federal Medicaid matching payments for certain LTC services that would not otherwise qualify for federal financial support. Section 1915(c) waivers, typically called home and community-based services (HCBS) waivers, "waive" certain provisions of federal law. Provisions of federal law which may be waived include:

- State plan benefits must be available statewide. Waiver services may be targeted to only parts or a part of a state.
- State plan benefits are an entitlement and must be provided to everyone who is found eligible. Services designed and delivered in a HCBS waiver program may be delivered to a limited number of individuals. Stated another way, states may "cap" the number of waiver participants.
- State plan benefits must be made available to meet all of a beneficiaries assessed needs and a state may not limit the scope or duration of services below any federal limitations. In HCBS waivers, states may define service limitations as long as the health, safety and welfare of HCBS waiver participants are guaranteed.

[2] Schneider, Andy and Elias, Risa. "Medicaid as a Long-term Care Program: Current Benefits and Flexibility." Kaiser Commission on Medicaid and the Uninsured. November 2003, p. 4.

However, waivers do not create new eligibility groups. Participants must be categorically eligible for Medicaid (i.e., over age 65, disabled, or a child with a special need). Additionally, HCBS waivers, and the services they include, are considered alternatives to institutional care, such as nursing homes. Functional eligibility for a waiver must be associated with an institutional alternative such as a nursing home, hospital, or intermediate care facility for persons with mental retardation (ICF/MR).

Waivers also are related to their institutional equivalents by costs. Waiver costs may not exceed the cost of services had participants been served in an institutional setting. Waiver services are provided in participants' homes and in the community which includes workplaces. All states except Arizona have at least one HCBS waiver.

3. Trends in LTC Service Delivery

From the 1960's, when Medicaid was established, through the early 1980s, the primary vehicles for LTC service delivery were institutional settings: nursing homes, ICFs/MR, and hospitals. Today, most states no longer solely emphasize institutional care and have developed or expanded non-institutional LTC services such as Medicaid-financed state plan option personal assistance services and home health care benefits, and HCBS waivers. States have pursued non-institutional system development to:

- Honor consumer and family preference for HCBS over institutional services;
- Pursue HCBS development that, on average, is generally less costly than institutional services; and
- Respond to the Supreme Court's 1999 ***Olmstead*** decision.[3]

4. State Fiscal Pressures and LTC

Increasingly tight state budgets have left Medicaid programs throughout the country struggling to provide care both to current beneficiaries and to address growing demand from potential enrollees. To address these challenges, as noted previously, every state has made alterations to its Medicaid program to contain costs. Despite programmatic trimming, the national Medicaid budget shortfall in 2003 was $70 billion.[4] Very few cost containment activities were focused on controlling spending on LTC services. In fact, in the last year, Medicaid payment rates for nursing homes were increased in 33 states and many states pursued new, non-institutional services (see below). [5] Overall spending on LTC services in 2002 was about $82 billion.[6]

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[3] In June 1999, the U.S. Supreme Court issued a ruling under the Americans with Disabilities Act (ADA) that requires states to provide LTC services in the most community integrated setting.

[4] Smith, Vernon et. al. "States Respond to Fiscal Pressures: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured. September 2003, pp. 2 and 32.

[5] Ibid.

[6] Schneider, Andy and Risa Elias. "Medicaid as a Long-Term Care Program: Current Benefits and Flexibility," Kaiser Commission on Medicaid and the Uninsured. November 2003, p. 4.

In the last several years, every state has made alterations to its Medicaid program to contain costs. However, legislators and program administrators have resisted cutting LTC services, relying instead on savings from reducing or freezing provider payments, containing prescription drug expenditures, and adding cost sharing requirements for certain supplies or services.[7] In fact, in the last year, Medicaid payment rates for nursing homes were increased in 33 states, and many states pursued new HCBS waivers or expanded existing waivers.[8] Three states added Personal Care services to their state Medicaid plans.

Additionally, a dozen states have begun development of comprehensive Resource Centers (i.e., SPE or No Wrong Door (NWD) programs) for LTC services and supports, a significant undertaking. These states are the recipients of Aging and Disability Resource Centers (ADRC) grants. Part of the White House's New Freedom Initiative, these systems changes grants are jointly funded and awarded by CMS and the federal Administration on Aging.

[7] Of course, in addition to traditional LTC services, older adults and working age persons with disabilities are also heavy users of pharmaceuticals, physical therapy, and ambulatory medical care, for which cost containment strategies have been implemented.

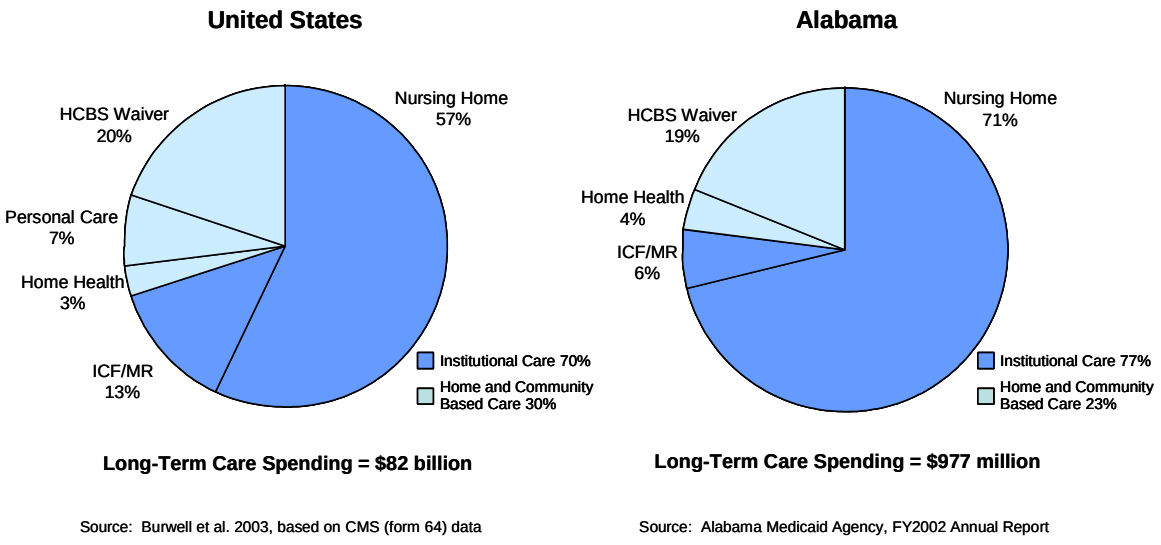
[8] Smith, Vernon et. al. "States Respond to Fiscal Pressures: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004," Kaiser Commission on Medicaid and the Uninsured. September 2003, pp. 2 and 32.

IV. ALABAMA LTC

The Alabama Medicaid Agency has responsibility for administering or overseeing, via contracts or memoranda of agreement, all aspects of the state's Medicaid program. The state matching funds are allocated through the Alabama Medicaid Agency budget. Because of the relatively low median income in Alabama, the federal/ state split on Medicaid spending is about seventy percent federal dollars to thirty percent state dollars. That is, for every $30 that the state spends, the federal government contributes $70. Like other states, Alabama faces increasing demand for long term care (LTC) services, for which Medicaid is the key funding source. At the same time, the state is facing unprecedented budgetary constraints.

The two venues for LTC service delivery are institutional settings (i.e., nursing homes, intermediate care facilities, etc.) and home and community-based settings. The Alabama Medicaid Agency oversees both Medicaid-financed institutional services and home and community based services (HCBS). Nursing home expenditures account for about three quarters of total Medicaid spending on LTC in Alabama. Chart 1 below displays the breakdown of United States and Alabama's Medicaid LTC spending in fiscal year 2002.[9]

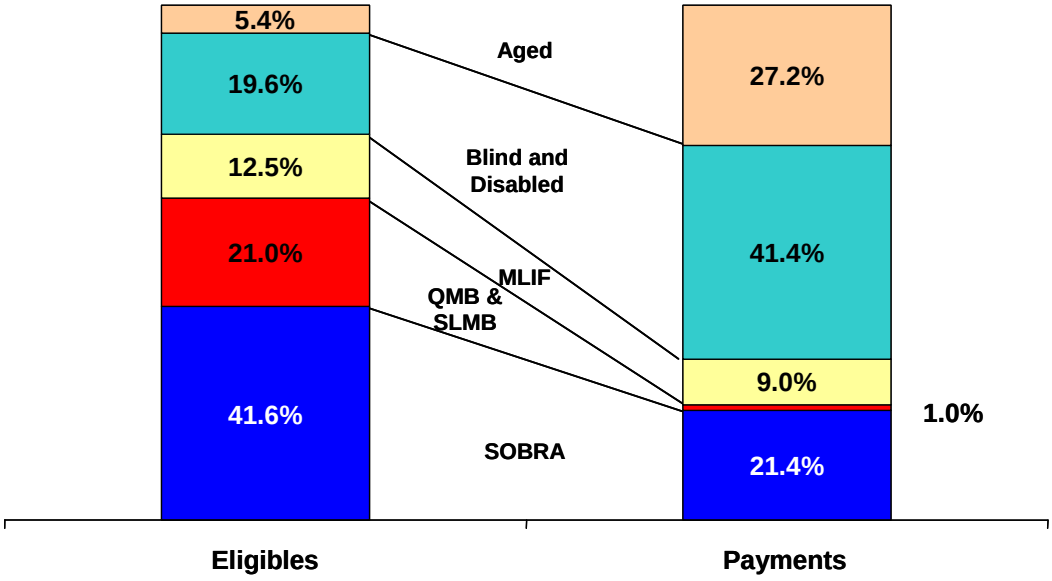
Chart 1
Medicaid Spending on Long-Term Care, by Type of Service, 2002



Individuals who receive LTC services account for 25% of total Medicaid beneficiaries, but over 60% of Alabama Medicaid LTC expenditures, because of the high cost of ongoing care for persons with high levels of need (see chart 2).

[9] For both the national and Alabama State, fiscal year 2002 is defined as October 1, 2001 – September 30, 2002.

Chart 2
Eligibles and Payments Percent Distribution by Category of Aid, FY 2002[10]



Source: Alabama Medicaid Agency, FY 2002 Annual Report

A. LTC Services and Delivery

As noted above, LTC services are delivered in institutional settings and in the home and the community. Currently, the Alabama Medicaid Agency supports six 1915(c) Home and Community-Based Services (HCBS) waivers to serve seniors and persons with disabilities (see Table 2 below). In Alabama, responsibility for managing day-to-day waiver operations is housed in a variety of agencies, including the Alabama Medicaid Agency, the Department of Senior Services (ADSS), the Department of Public Health (ADPH), the Department of Mental Health and Mental Retardation (DMH/MR), and the Department of Rehabilitation Services (ADRS).

For example, ADSS and ADPH operate the Elderly and Disabled Waiver. DMH/MR coordinates the Mental Retardation/ Developmentally Disabled waiver. ADRS oversees the Homebound/ State of Alabama Independent Living (SAIL) waiver, which serves adults with neurological impairments.[11] These agencies, considered waiver "operating agencies," operate the waivers under a memorandum of agreement with the Alabama Medicaid Agency, which is

[10] MLIF: Medicaid for Low-Income Families; QMB: Qualified Medicare Beneficiary; SLMB Special Low-Income Beneficiary, SOBRA: Sixth Omnibus Budget Reconciliation Act) women and children's group.

[11] For the SAIL waiver, neurological impairments are defined as services are provided to, but not limited to, individuals with the following diagnoses: Quadriplegia, Traumatic Brain Injury, Amyotrophic lateral sclerosis, Multiple Sclerosis, Muscular dystrophy, Spinal muscular atrophy, Severe cerebral palsy, Stroke, Other substantial neurological impairments, severely debilitating disease or rare genetic diseases (such as Lesch-Nehan Syndrome).

ultimately responsible for the waivers, and all Medicaid programs, as the single state Medicaid agency.

Table 2
Alabama HCBS Waiver Overview[12]

HCBS Waiver	Population	Agency	Per Member Annual Costs	FY 2002 Annual Costs	FY 2002 Enrollment	Approved Slots, FY 2004
Elderly and Disabled (1982)	Alabamians who meet the nursing home level of care	ADSS, ADPH	$5400	$38.9 million	7,203	7,500
MR/DD (1981)	Individuals with MR who meet the ICF level of care	DMH/MR	$28,072	$128.9 million	4,594	5,200
Homebound/ SAIL (1992)	Adults with neurological disabilities who meet the nursing home level of care	ADRS	$17,098	$7.3 million	463	550
Living at Home (2002)	Individuals with MR who meet the ICF level of care	DMH/MR	N/A	N/A	N/A	449
Technology Assisted (2003)	Adults who require private duty nursing and meet the nursing home level of care, who had previously been eligible for EPSDT[13]	Medicaid	N/A	N/A	N/A	35
HIV/AIDS (2003)	Persons with a diagnosis of HIV/AIDS who meet the nursing home level of care	ADPH	N/A	N/A	N/A	150

Source: Alabama Medicaid Agency website, N/A indicates not available[14]

The percentage of spending on HCBS, in comparison to institutional services, has grown in recent years. Between FY 2001 and 2002, the amount spent on HCBS grew 19.3%, while nursing home expenditures grew only 2.9% and ICF-MR spending decreased by 2.3%.[15] However, the proportion of institutional spending, as displayed in chart 1 above, remains high compared to the national average.

1. Other Community-Based Services

In addition to the waiver services, the State provides a variety of other Medicaid-financed services to persons living in the community through the Medicaid State Plan. These services include:

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12 Waiver data derived from CMS 372 reports for the 2001-2002 waiver reporting periods.

13 EPSDT (Early and Periodic Screening, Diagnostic and Treatment) refers to comprehensive services provided to individuals under age 21.

14 Because the Living at Home, Technology Assisted and HIV/AIDS waivers were implemented in the past two years, enrollment and cost data is not yet available.

15 Burwell, Alabama Medicaid LTC Expenditures, FY 1997-2002, http://wwwHCBS.org/files/3/143/Alabama.htm.

- **Home Health Services –** These are services provided to nursing home eligible individuals. Benefits under this service include skilled nursing and home health aide services. They are provided in the beneficiary's place of residence as part of a written plan of care. Home health can be provided on a part-time or intermittent basis.
- **Durable Medical Equipment** – Medically necessary equipment that receives repetitive use and is appropriate and is suitable for use in the home.
- **Targeted Case Management** – These are case management services that assist Medicaid beneficiaries in gaining access to needed medical, social, educational, and other services. States have the option to "target" these services to certain subsets of the Medicaid population.
- **Private Duty Nursing –** Private duty nursing is available to children under the age of 21, whose medical problem requires stabilization or whose caregiver requires education and training.
- **Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR) –** ICF/MR certified facilities provide or coordinate health and rehabilitative services.
- **Hospice –** A comprehensive home care program which provides comfort and support to terminally ill patients and their families.

Alabama also supports institutions for mental diseases (IMD). These facilities provide diagnosis, treatment, or care of persons with mental illness. These services do not qualify for federal Medicaid matching funds for persons ages 22-64. However, Alabama does provide Medicaid-financed rehabilitative services to persons with mental illness and/or chemical dependency in the community.

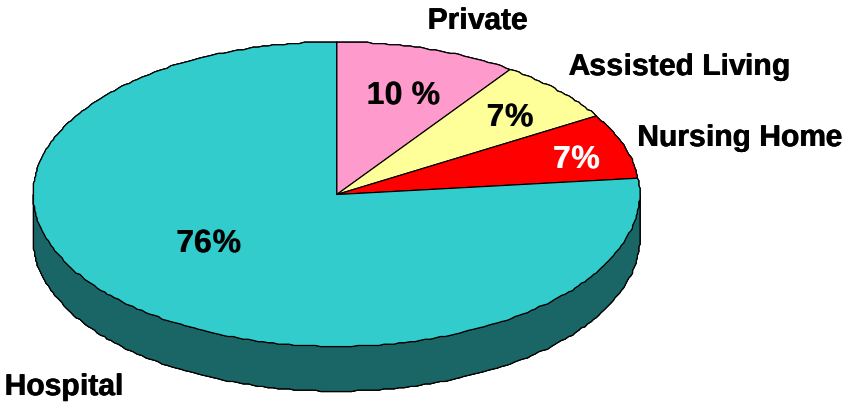
2. Institutional Services

Despite this array of HCBS options, Alabama continues to invest a significant amount of its Medicaid LTC budget in facility-based care. In FY 2002, Alabama spent about three quarters of its LTC Medicaid dollars, approximately $704 million, on facility-based services (see chart 1 on page 8). Since 2000, the average daily cost per Medicaid-funded nursing home resident has risen from $84 to $95. The average annual Medicaid cost in state fiscal year 2002 for Alabamian nursing home residents was $26,000.

Over 70 percent of nursing facility residents are Medicaid beneficiaries.[16] Alabama has about 48 residential care beds per 1,000 residents age 65 and older, compared to 12 home and community based beds for the same group. In sum, Alabama residents with LTC needs rely heavily on institutional care resulting in a 91 percent nursing facility occupancy rate in 2001, the seventh highest in the country.[17] Consistent with other states, most nursing home residents in Alabama, 76 percent, were admitted from hospitals (see chart 3 below).

[16] S. Gregory and M. Gibson, Across the States 2002: Profiles of Long-Term Care, 2002.
[17] Ibid.

Chart 3
Prior Residence of Alabama Nursing Home Residents



Source: University of Alabama at Birmingham Center for Aging

The high percentage of individuals who transfer to nursing facilities from hospitals highlights a systemic challenge that all states face. Many Alabamians with LTC needs, their families and hospital discharge staff are unaware of home and community-based alternatives.

The second key institutional benefit offered in Alabama is Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services. In federal FY 2002, state Medicaid programs across the country funded 6,615 ICFs/MR. These facilities provided care to approximately 110,572 individuals at a nationwide total cost of $10.7 billion.[18] In federal fiscal year 2002, Alabama served approximately 472 individuals in ICFs/MR at an annual average cost of $115,000 per person.[19] Cumulatively, during that period, the State spent approximately $61 million for these services. While Alabama has made significant strides in reducing its reliance on ICFs/MR and increasingly serving persons with mental retardation and related developmental disabilities under its MR/DD HCBS waiver (see above), the State is among the top fifteen highest spenders per ICF/MR resident.

B. LTC Administrative Infrastructure

As noted above, LTC in Alabama is operated through five state level departments, and through a variety of regional offices. Some are co-located, but many are not. Table 3 below displays the volume of regional offices by service population.

[18] Prouty, R.W., Smith, G., Lakin, K.C. *"Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2002."* University of Minnesota. June 2003.

[19] Ibid.

Table 3
LTC Service Administration Regions by Service Population

Regional Office	Population	Department	Number of Regions
Area Agencies on Aging	Seniors	ADSS	13
Mental Retardation Service Areas	Persons with Mental Retardation	DMH/MR	5
County Health Departments	Varies	ADPH	66
Vocational Rehabilitation Offices	Person with Disabilities	ADRS	22
Independent Living Offices	Persons with Disabilities	ADRS	7
Children's Rehabilitation Offices	Children with Disabilities	ADRS	14
Early Intervention Offices	Children with Disabilities	ADRS	7
Medicaid District Offices	Varies	Alabama Medicaid Agency	10

While the functions are separate, each of these regional offices has a wealth of information and sophisticated systems for ensuring that client needs are met within the bounds of that program. However, clients and families with more than one need or an array of needs must contact multiple offices. Further, for individuals moving among programs, (either because of aging or increased needs) the system is not seamless. At these critical transition points, consumers are not shepherded through the system and some have encountered considerable difficulty gathering basic information such as eligibility options and processes, phone numbers of appropriate state and local staff with whom to speak, and rudimentary information on the panoply of LTC options the state offers (see below).

C. Demand for LTC Services in Alabama

Demand for LTC services will continue to grow during the foreseeable future. Increasing numbers of persons of advanced age and the lower mortality rates of persons with disabilities will strain Alabama's LTC system. To aid states in planning for future LTC demand, The Lewin Group developed a statistical tool for estimating the potential number of non-institutionalized individuals who will need some support services. Using the HCBS Population Tool, Lewin estimated the LTC demand in Alabama up to the year 2010.[20] Table 4 contains these estimates of persons age 18 and older with an annual income up to 250 percent of the Federal Poverty Level (FPL). All of these individuals, have limitations in two or more Activities of Daily Living (ADLs).[21] (Note: Medicaid eligibility is linked to 300% of the Supplemental Security Income

[20] The Lewin HCBS Population Tool uses Census data to estimate the number of non-institutionalized people in a given state who meet specified disability criteria. To view the population tool, go to http://www.lewin.com/Areas_of_Expertise/Long_Term_Care/The_HCBS_State-by-State_Population_Tool.htm.

[21] Activities of Daily Living (ADL) are functional measures of individuals' support needs. ADLs include eating, toileting, bathing, and mobility.

(SSI) level; FPL changes with family size and with age of householder. The Lewin Population Tool does not take into account this varied household composition and uses FPL as a proxy. For this analysis, The Lewin Group used 250% FPL as a conservative estimate of 300% SSI. By using 250% FPL, the analysis probably captures more individuals than 300% SSI.)

In Table 4, column two displays the total estimated population of Alabama.[22] Narrowing this estimate, column three, moving left to right, shows the number of Alabamians with MR/DD with incomes of 250 percent FPL or less who also have two or more ADL support needs in each year. Column three provides the total number of Alabamians with two more ADL limitations without a cognitive impairment or a mental illness (see column six). Individuals counted in column four are persons of advanced age with two or more ADL limitations or individuals age 18 to 64 with physical disabilities. Column five provides a total of columns three and four; column six provides an estimate of the number of persons with severe mental illness who would meet the two ADL test and the income test.

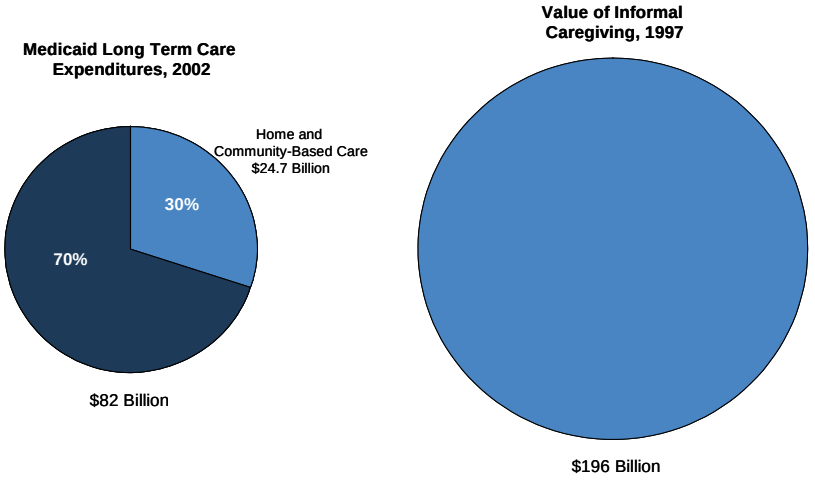
Table 4
Numbers of Alabamians with 2 or More ADL Support Needs
With Incomes of 250% FPL or less[23]

Year	Total Population	MR/DD	2+ ADLs (Aged and Physical Disabilities	Total MR/DD or Functional	Severe Mental Illness
2002	1,629,689	21,037	32,408	53,445	172,979
2005	1,679,047	21,656	33,559	55,215	178,284
2010	1,764,669	22,646	35,844	58,490	187,640

This trend continues more dramatically after 2010 when the first of the "baby boomers" reach age 65. Additionally, concurrent to aging, many of these individuals also will develop a lifelong disability. Complicating matters further, research indicates that the vast majority of LTC is provided informally by friends and family members. A 1999 study indicates that the estimated national economic value of informal care-giving was $197 billion in 1997; in federal fiscal year 2002, total Medicaid LTC spending was $82 billion (see Chart 4 below). As these caregivers also age, state LTC systems will face even greater pressures.

[22] The Alabama Medicaid Agency does not use ADL deficiencies in determining nursing home level of care. Instead, the state uses a holistic approach to determine functional level and requires documentation that the client needs services at the institutional level. In their proposed Nursing Home Criteria Changes, the Alabama Medic aid Agency had recommended changing this to require deficiencies in two ADLs. While these were voted down, they provide a proxy for the Lewin analysis. (Nancy Headley, Associate Director of Admissions/Records provided this recommendation.)

Chart 4
Comparison of LTC Support Costs



Source: The MEDSTAT Group, Medicaid HCBS Waiver Expenditures, FY 2002

Source: P. Arno, et al., The Economic Value of Informal Caregiving, Health Affairs, Vol. 18, No. 2

D. Stakeholder Perspectives on Alabama LTC

As part of the research conducted for the project, The Lewin Group convened a series of focus groups with state agency staff, providers, and consumers. In some of the conversations, similar themes emerged, with recommendations for improving the system of care. In general, focus group participants noted that the systems in place for older Alabamians, persons with MR/DD and children were well organized, noting gaps in services for persons with physical disabilities and mental illness.

1. Consumers and Families

Consumers noted that information on LTC services and programs is difficult to locate. Beneficiaries and their families learn about programs and services primarily through word-of-mouth. Focus group participants noted that state and some local staff are not prepared to answer questions about specific service availability or eligibility. They also note that program staff (i.e., MR/DD, mental health, etc.) have very limited knowledge, if any, about services outside their particular area of expertise.

For example, one focus group participant has an elderly mother using the elderly and disabled waiver and a sibling with a disability. When initially exploring services, this person had to "start from scratch" for both of her family members to initiate services and faces similar challenges when changes need to be made.

Consumers noted that the application process for Medicaid eligibility is cumbersome. First, it is not easy to find the application on-line and consumers noted that it is complicated to fill out. Because of its complexity, many applications are returned incomplete, delaying processing and, therefore, inception of services. Focus group participants also noted significant difficulty in gathering information on Medicaid services and Medicaid eligibility, especially when trying to

reach central office or local district office staff who can explain eligibility options; many noted receiving conflicting information. Consumers and families also noted difficulty in:

- Gathering information about the general LTC options in their county or region;
- Contacting providers (once eligible for services) and understanding what their provider options are;
- Identifying state and local staff able to share correct information about program eligibility and waiting list processes.

Panelists who had been able to gain access to Medicaid LTC services were in consensus that their service packages were comprehensive and covered their needs adequately. In general, panelists thought that the LTC system in Alabama had all the right pieces, but that it could and should be better coordinated.

Exceptions to the difficulties described above include the Alabama Area Agencies on Aging (AAA) and, to a slightly lesser degree, the regional MR/DD authorities. Consumers and families indicated that both the AAAs and the MR/DD authorities offer effective intake services, as well as a robust array information and referral to link consumers and their families with LTC services.

Persons with physical disabilities, sensory disabilities, individuals with mental illness, and families with children with special needs and disabilities fall outside the service scopes of AAA and local MR/DD authorities; they face considerable challenges in gathering useful information on LTC options and accessing needed services.

2. Community-Based LTC Providers

Participation in the provider focus group was limited but some useful observations were made. First, providers of services note difficulties similar to consumers when attempting to gather information on Medicaid-financed LTC services, eligibility, and options. Some noted that recently the Alabama Medicaid Agency and other State agencies have conducted regional or local trainings on Medicaid services and options but felt that an ongoing system for training and sharing information on program changes and updates was needed.

Most reported good relationships with program agencies (i.e., the MR/DD agency, the aging agency, etc.), but noted difficulty when trying to contact a Medicaid agency staff person about eligibility, billing or claims payment. Several were unaware that Electronic Data Systems (EDS) provides bulletins on program changes and virtually all were unaware of the Alabama Medicaid Agency website and resources it offered.

3. Operating Agencies

As noted earlier, the Alabama Medicaid Agency has formal relationships with sister state agencies that support day-to-day operation of Medicaid-financed LTC services including the Medicaid HCBS waivers. State agency staff participating in the focus group noted some challenges similar to those discussed above but also identified several recent areas of improvement in LTC. In terms of communication, operating agencies noted that in the past

year the Alabama Medicaid Agency has made significant improvements in processing eligibility and in providing information on Medicaid program changes. Participants stated that they rely on Medicaid staff for technical questions but have begun to contact Medicaid's outreach and education staff for general program information.

Operating agency staff had only very limited knowledge of their partner agencies' programs, services, and operating procedures and expressed the need for a more regular way for their agencies to interact at the State level. Staff also noted that there is very little overlap in their local and regional offices. All operating agencies interact with local, district Medicaid offices but none knew of any region of Alabama where local LTC programs had made a coordinated effort to cross-train staff on services and function, share provider information, or share client information. These interactions happen only on an as-needed basis.

Conversely, Medicaid LTC division staff noted many improvements regarding the sharing of information with operating agency staff but acknowledged only a limited understanding of how their partner agencies conduct business and provide services. They also indicated that beyond standardized reporting on Medicaid programs, they receive no information on program performance from operating agencies.

In terms of interacting with consumers, the Alabama Medicaid Agency recently established LTC outreach and education staff. Prior to the designation of these staff, outreach to constituents was performed by the Olmstead Core Workgroup. The consumer-based Olmstead Core Workgroup collaborated with the Alabama Medicaid Agency in establishing overall goals for the Real Choice Systems Change Grant proposal/ initiative. As a result of this collaborative effort, not only were LTC outreach and education staff designated, but more importantly, a permanent Disability and Aging Policy Advisory Group has been established in the LTC Division as a mechanism for ongoing consumer input and outreach. Group membership ensures substantial participation by consumers, family members, and advocates nominated by members of the Olmstead Core Workgroup.

V. OVERVIEW OF SINGLE POINT OF ENTRY SYSTEMS

Rapidly growing numbers of persons of advanced age, lengthening waiting lists for home and community-based services (HCBS) Medicaid waiver services for persons with disabilities, and mushrooming healthcare costs for LTC populations have created the most challenging operating environment the U.S. human service system has experienced to date. Mounting demand necessitates more effective strategies for coordinating information about and access to long term care (LTC) services.

Americans in need of LTC services and their families are faced with a confusing labyrinth of disconnected services, mind-boggling paper work, and a dearth of consolidated, easy to understand information on LTC services and options. Faced with such daunting challenges, usually at a time of financial and/or personal crisis, users of LTC and their families may not find adequate services or quality services, spend too much time and money on the wrong service or course of action, and/or find themselves in an institutional setting.

A. Changing Philosophies

Recognizing mounting demand and requests from consumers, several states undertook development of programs intended to provide "Resource Center shop" LTC Information and Referral (I&R) services and, in some instances, entry into LTC systems, programs and related benefits. The structure, organization, and services of these Resource Center shops, sometimes called single points of entry (SPE) or no wrong door (NWD) programs, varies widely from state to state. SPE and NWD systems are the "front end" of LTC programs addressing information needs, intake, and providing only short term services. These programs typically do not administer LTC services.

While every SPE system is unique, each SPE aims to help LTC consumers in three general areas: 1) awareness/information; 2) assistance; and 3) access.[24]

B. Systemic Changes

To simplify access to LTC information and programs, states studied how people find out about LTC and the protocols for entry into LTC services. After identifying problem areas and information and services gaps, states developed improved strategies for disseminating correct and reliable information in an easy to understand format. These states also created ways to share this information widely to all key audiences including users of LTC services, family members (i.e., caregivers), LTC service providers, and professionals in the field, both government and private. They also consolidated intake, application and enrollment processes for LTC, and many streamlined these processes so people in the greatest need of help could access services quickly.

[24] Susan Reinhart and Lisa Alecxih, 2004, Resource Center Design Options, CMS Systems Change 2004 Presentation.

In developing Resource Center shops for LTC needs, states built on the existing LTC networks and service delivery systems. Common building blocks include AAA systems, local offices for developmental disability services, and centers for independent living (CILs). States also used existing information systems but modified these systems to accommodate, for example, more users and more LTC populations. In states where the SPE functions were consolidated under a single network of Resource Center shops, administrators also had to consolidate various funding streams, such as Medicaid, Older Americans Act funds, and state general fund dollars, in order to reconcile an existing process with multiple sources operating under distinct authorities. While SPE systems may vary in terms of their services and responsibilities, states have created SPE service arrays that coordinate the I&R, access and assistance functions of multiple agencies. The SPE system formalizes these relationships and presents services to consumers that are as seamless as possible.

In this re-organization process, states must be particularly cognizant of how authority and responsibilities are divided among state agencies, as well as at local levels. In implementing and operating an SPE system, states have taken different approaches to developing needed relationships between state and local entities. For example, Washington has a state-operated SPE system with state employees providing services in multiple locations. On the other hand, in Wisconsin, which has traditionally relied on a county-based system for its HCBS care, local entities have significant obligations in its SPE system outlined through Memoranda of Understanding with the State.[25] New Jersey gives its counties broad discretion in directing its SPE system, allowing counties to adopt different models with the State's role mainly limited to providing training and technical assistance.[26]

C. Basic Single Point of Entry and No Wrong Door Features

Because there is a wide array of LTC service options, a web of eligibility requirements and several funding sources, obtaining appropriate services can be a complicated and frustrating process. As noted above, states have designed systems and processes aimed at reducing the steps a consumer or family must take before receiving needed information or assistance. Consumers and families benefit from these Resource Center shops that integrate information on the panoply of LTC services and supports by providing one point of contact on LTC needs.

For a SPE, typical functions include screening for services, nursing facility preadmission assessment screening, ICF/MR preadmission screening, financial and functional assessment, short term service plan development and authorization, support with implementing and monitoring a short term service plan, reassessment, benefits counseling, and protective services. They may also offer short term case management services during a crisis or emergency or while a consumer is being enrolled in a publicly-funded LTC program such as a HCBS Medicaid waiver.

The differentiation between a "single point of entry" system and a "no wrong door" system is artistic rather than scientific; as yet, no formal definitions have been articulated. However,

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[25] The Lewin Group, 2003, Older Adults Waiver for Home and Community Based Services: Final Report.

[26] Susan Reinhart and M.A. Scala, 2001, Navigating the Long-term Care Maze: New Approaches to Information and Assistance in Three States.

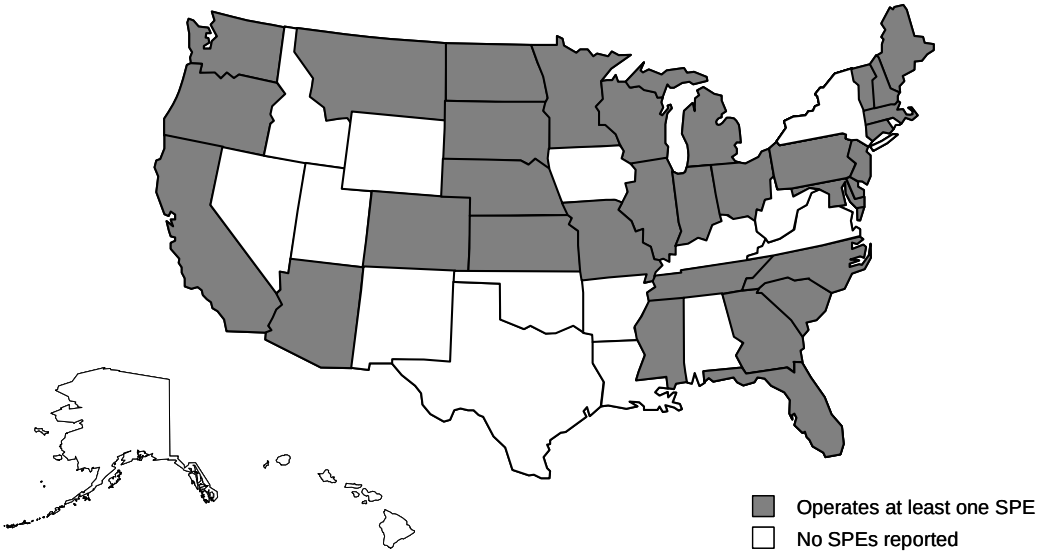
based on state perspectives of what they have developed, a NWD system provides the same services as a SPE. Rather than establishing a stand alone network of SPEs, however, that link out to LTC program offices and services, in NWD, all LTC program offices can provide SPE functions. Some states consider NWD systems to be a comprehensive website that consumers, caregivers, providers and the general public can access. The website helps to ensure that all visitors are given consistent, accurate and timely information regardless of how or where they choose to enter the system. NWD systems may include online provider directories, information about provider capacity, what services are covered under different programs, and more. The State of Ohio is taking this approach under its federal Real Choice Systems Change Grant.

Meanwhile, still other states are making more significant systemic changes to accommodate their NWD philosophy. Maine, Massachusetts, and Minnesota all are developing NWD systems by merging functions across entities such as AAA and CILs. Under their systems, all consumers would receive the same sorts of information and services regardless of whether they contacted an AAA or a CIL.

D. National Overview of Single Points of Entry

Thirty-one states and the District of Columbia operate SPE systems serving at least one population. In total, there are 43 SPEs in the country, the majority of which serve more than one population. There are more SPE systems than states operating Resource Center networks because some states operate parallel but distinct systems for LTC subpopulations. These states are typically operating a SPE system for seniors, a separate system for people with physical disabilities and/or a separate system for people with developmental disabilities. Twenty-four SPEs nationwide are designed to assist older adults, the population most commonly served.[27]

Figure 1
States with SPEs Nationwide



Source: Robert Mollica and Jennifer Gillepsie, 2003. Single Entry Point Systems: State Survey Results.

[27] Robert Mollica and Jennifer Gillespie, 2003, Single Entry Point Systems: State Survey Results.

1. Structure and Organization Varies Widely

A wide range of organizations function as SPE agencies. States can designate a state or local government entity to serve as an SPE or contract with a private organization. The most common organizations are state agency regional or local offices. Other common networks used include AAAs, and private, community-based non-profit organizations.[28] Other entities include county departments of health or social services agencies, CILs, and home health agencies.

States also vary in terms of whether all LTC services are consolidated and accessed through one network of organizations or through differing entities. For example, state field offices in Delaware and county Aging and Disability Resource Centers (ADRCs) in Wisconsin are responsible for all SPE functions in their respective states. In Pennsylvania, by contrast, AAAs, county departments, and community resource centers all serve as SPEs for different populations. In most states, SPEs are assigned a specific geographic service area. However, in Arizona, Connecticut, Hawaii, Kansas, and Montana, consumers may use any SPE, not just the entity in the area of their residence.[29]

2. Services May Differ by State and by Single Point Systems

a. Consumer Assistance

Because consumers have a myriad of long-term care options to consider, SPEs play an important role in helping them make the best LTC choices based on the alternatives available to them. The SPE level of involvement can vary, ranging from referrals to other organizations to benefits counseling. Some possible consumer assistance services are described in Table 5.

Table 5
Typical Consumer Assistance Services

Service	Definition
LTC Options and Benefits Counseling	Assisting consumers identify, select, and obtain LTC services and identify benefits and services that are appropriate for them. These include public and private services and important benefits such as Social Security.
Referrals	Directing consumers or making connections for consumers to appropriate LTC providers, both within the state LTC system and in the private sector.
Short-Term Case Management	Short-term case management facilitates access to needed services and benefits until they are linked with more permanent case managers
Crisis Intervention	Delivery of counseling and services in urgent cases

[28] Ibid.
[29] Ibid.

b. Access to Services

In addition to providing information and helping consumers choose among LTC options, SPEs assist consumers in accessing their needed care. Table 6, below, provides an overview of typical access services.[30]

Table 6
Typical Access Services

Service	Definition
Development of Short-term Plans of Care	Maps out interim services or plans of action to support the consumer and their families while a crisis has passed or until permanent services are secured.
Monitoring Short-term Service Delivery	Ensuring that providers provide appropriate short term services and the plan of care is followed
Assessments and Re-Assessments	Designed to assess a consumer's capacity and service needs
Initial Screening	Brief assessment by phone or in person to determine the type of assistance needed
Financial Eligibility	Determination of whether an applicant meets the income and resource requirements to qualify for program services
Functional Eligibility	Determination of whether an applicant meets the functional requirements to qualify for program services, typically measured in ADLs (Activities of Daily Living) and IADLs (Instrumental Activities of Daily Living)
Nursing Facility and ICF/MR Preadmission Screening;	Evaluation of a consumer's health, functional capacity, environment, and cognitive status; used to determine eligibility or a nursing or ICF/MR facility.
Private Pay Consumer and Family Support	Services to link individuals who are not eligible for Medicaid to providers that accept private pay or private insurance.

All SPEs generally help develop short term plans of care and monitor service delivery; nearly all perform assessments and re-assessments and authorize services. Of the 43 SPEs currently in operation, 38 also conduct initial screening and determine functional eligibility. In terms of coordinating the eligibility process, 17 SPEs conduct determinations for both financial and functional eligibility.

3. Diversion

To meet mounting LTC demand, states and stakeholders have pursued the development of Medicaid HCBS waivers based on evidence (see below) that providing services in peoples'

[30] Ibid.

homes and communities is less expensive. Creating a streamlined access point for all community-based LTC services is particularly critical for states with policy goals relating to lower nursing home utilization and attempting to lower their overall LTC spending while continuing to serve as many or more individuals.

Typically, nursing homes have significant application and entry advantages over HCBS programs; 76 percent of nursing home admissions originate in hospitals. In Alabama, hospital discharge planners conduct initial Medicaid eligibility assessments for individuals who will likely need ongoing care or support. Alabama Medicaid's LTC outreach and education staff have only recently begun efforts to educate hospital discharge planners about HCBS options. Thus, many families and consumers are directed to nursing facility care that may be undesirable or more comprehensive than the consumer needs. For individuals seeking LTC services, nursing homes may conduct the assessment to verify need for nursing home level of care and are required to assist the consumer with the Medicaid financial eligibility application. Medicaid HCBS providers may not conduct such intake functions and must refer people to local operating agency offices. The net effect is that many consumers and families find themselves pursuing facility-based options because they are easier to find and access.

A SPE system can serve as an important tool in the reduction of nursing home utilization by "diverting" people from facility-based services. SPEs divert people from nursing homes and other facilities, such as intermediate care facilities for persons with mental retardation and related developmental disabilities, by providing information about HCBS options, which are less well known, and helping consumers and families to gain access to these services. SPEs can also provide or coordinate short term services, such as respite, that help families through crisis situations that might otherwise have ended in an unnecessary facility placement. Resource Center systems can also support streamlined enrollment processes that make it easier to access home and community-based care.

In aiming to shift more of the nursing home eligible population into HCBS care rather than institutions, states must in particular focus on hospital patients looking to nursing homes for extended care. The institutional bias is strong in hospitals, which provide nursing homes with 65 percent of all of their admissions.[31] This holds particularly true for the Medicare-eligible population, who after receiving hospital coverage also have nursing home coverage under Medicare for six months directly after their discharge. After this six month period, residents who still require nursing-level care often naturally wish to remain in their current environment and will next turn to Medicaid for their nursing home coverage. SPEs can address the institutional influence on hospitals by anticipating hospital patients who need extended care after their discharge, and by reducing the difficulty they have in entering home and community-based care programs.

One state that has targeted hospital patients is Colorado, which has implemented a "fast track" eligibility system into their Medicaid HCBS programs for patients who likely qualify for Medicaid and will need long-term care services. The goal is to determine the eligibility of these patients prior to their discharge. In Denver, financial eligibility workers are located at local

[31] The National Nursing Home Survey: 1999 Summary.

hospitals to expedite the eligibility process. The state estimates that it "fast-tracks" the eligibility of about 100 hospital patients each year.[32]

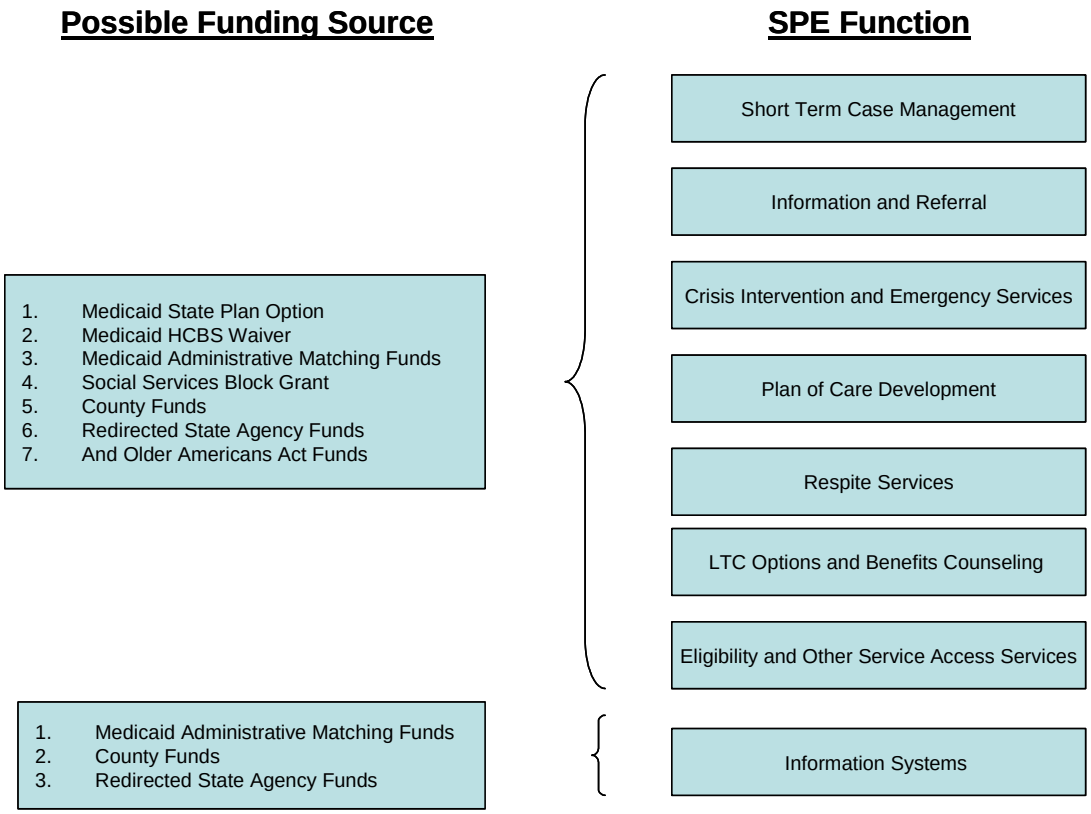
4. Financing

SPEs have access to multiple financing options, depending on the nature of their system and the populations they serve. A key advantage of an SPE system is its ability to consolidate services funded by many different sources into one seamless point of entry for consumers. SPEs in virtually all states access financing through multiple sources; Wisconsin's SPE system, for example, receives funds from the state and county general revenue, four Medicaid HCBS waivers, and through its Medicaid state plan.[33] While SPEs in New Hampshire manage six different funding sources, SPEs in Maryland, Missouri, and Nebraska each only manage one.[34]

Virtually all of the SPEs currently in operation (42 of 43) access funding through HCBS waivers. A majority are also financed by general revenue from the state (35), and from their Medicaid state plan (26).[35] Still other states have been very successful in drawing down Medicaid Administrative Match for eligibility functions in SPE systems as well as by amending their Medicaid Management of Information Systems (MMIS) Advanced Planning Document (APD) to garner federal funds for information systems additions or changes that support the SPE system. Figure 2 below provides an overview of common funding sources.

[32] The Lewin Group, 2003, Older Adults Waiver for Home and Community Based Services: Final Report.
[33] The Lewin Group, 2003, Wisconsin Family Care Final Evaluation Report.
[34] Robert Mollica and Jennifer Gillespie, 2003, Single Entry Point Systems: State Survey Results.
[35] Ibid.

Figure 2
Typical SPE Funding Sources



VI. STATE EXPERIENCES

A. Overview

A useful strategy for states pursuing systems change initiatives is to investigate the experiences of other states. Examining road-blocks and strategies to overcome them, as well as needed resources and implementation strategies can help a state avoid the same mistakes when designing a similar program. To inform the study of a possible Alabama single point of entry (SPE) system, The Lewin Group studied the SPE experiences of Colorado, Nebraska, and Washington. These states were chosen by Alabama because of their relative similarity to Alabama in terms of state geography (all have large rural areas), the amount of resources available, and because they have effective systems in place.

As noted above, a SPE system is a network of physical locations and/or virtual location(s) where consumers receive a variety of information and referral (I&R) assistance as well as some services. Typical SPE functions include screening for services, nursing facility preadmission assessment screening, intermediate care facility for persons with mental retardation (ICF/MR) preadmission screening, financial and functional assessments, service plan development and authorization, support with implementing and monitoring a short term service plan, reassessment, benefits counseling, and protective services. They may also offer short term case management services.

The case study states all have operational SPE systems that help link consumers to needed services. However, they vary significantly in almost every other way, including by the types of people they serve, the services they offer or coordinate, the types of organizations that can be SPEs, how they were developed, how much they cost to start-up and operate, and in many more ways. Table 7, below, illustrates different approaches taken by each of the case study states across three different areas.

Table 7
Key SPE Features in Case Study States

	Colorado	Nebraska	Washington
Administration	• Locally administered system	• Administered mainly by local entities	• State SPE staff work in local offices
IT Features	• Provides each SPE $1,000 for IT needs	• Uses client tracking database to track client care plan and services, as well as potential services	• All SPE workers have access to central client database • Case workers use laptops to conduct level of care assessments in client homes
Rural Issues	• Provides additional funding for rural areas	• Conducts level of care assessments in client home • Flexible standards for independent providers	• Conducts level of care assessments in client home • Frequent use of independent providers

B. Policy Development Process

All three states studied for this report indicated that the long term care (LTC) reform process is difficult, requiring a strong understanding of the existing structure and its strengths and weaknesses, a great deal of work and negotiation with stakeholders and public officials, as well as careful planning to ensure that all the legislative and regulatory steps have been taken.

1. Nebraska

Support for a new LTC system in Nebraska began in 1996 after a State LTC study. Previously, Nebraska had an Aged and Disabled waiver in place, coordinated by Health and Human Services System (HHSS) staff, but the study identified the varying roles different agencies could play in a LTC system, mainly shifting Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) from their previous role as advocacy organizations to ones performing direct service to clients. Nebraska parsimoniously focused on the existing LTC structure as a foundation. Developing a SPE proposal in 1998, the state actively recruited stakeholder involvement, including the nursing home association, as well as input from AAA and CIL staff.

Nebraska uses a loosely coordinated approach for its SPE system, where different entities are responsible for separate populations. The AAAs serve seniors, CILs serve persons with disabilities, and the State assists children. The State is responsible for quality assurance functions over all other entities in the SPE system. The current Nebraska SPE system was built on the existing I&R and 211 systems. Due to the use of "individual providers" (e.g. friends or relatives), Nebraska staff report that there are few unmet needs, even in rural areas. The State is also flexible in funding a wide array of support services, including assistive technology, home modifications, and home loan/relocation programs.

Nebraska HHSS has a close working relationship with the AAAs and the CILs and has made inter-agency communication a priority. Before policy decisions are made, the AAAs and CILs are contacted for their opinions. For example, they are currently developing a new computer system which will integrate information from both systems on a common platform. AAA and CIL staff have been consulted and involved at every step of the development process.

2. Washington

Washington began development of its SPE system in 1995. Because Washington already had a solid LTC structure, it also relied heavily on an existing system. The most significant changes involved granting the state broad authority over the long-term care system, and setting up the common database with all entities having access and sharing the same interface.

The impetus for Washington's SPE program began in its Medicaid agency. In addition to the goals of streamlining access and increasing information about LTC programs, the State was particularly concerned with the large number of beneficiaries entering nursing homes. Afraid that they would not be able to financially sustain the high cost of nursing home care for an increasing number of enrollees, State officials were in favor of implementing a LTC system that was not only more consumer-friendly, but also provided information and services that would to encourage consumers to consider HCBS options including Medicaid waivers and short term or low intensity services, such as case management and respite, that can delay or prevent institutionalization.

The state worked closely with stakeholders, particularly advocates and the nursing home industry, in developing its SPE proposal. While a move to encourage entry into services beyond institutional care could prove to be a point of contention with nursing homes, Washington State officials said that discussions with the nursing home lobby were productive and helped gain the industry's support. Perhaps the most difficult group were the AAAs, which felt that the state was gaining too much authority at the expense of the AAAs, who wanted to serve as the SPEs in Washington.

When the legislation was passed in 1995, the Department of Social and Health Services (DSHS) assumed a wide array of responsibilities. In addition to its intake and case management responsibilities, the State also was given considerable authority over providers. Other new responsibilities included setting rates for home and community services, establishing rules for and imposing penalties on facilities, and creating minimum standards for provider training. It took a little less than three years for the SPE system to be fully operational, and reportedly it could have been done in a shorter time frame had there not been as much controversy over shifting so much responsibility to the state level.

3. Colorado

In 1988, Colorado began development of a plan to reform the long term care system. The effort was developed by the state, but the Advisory Committee for the effort included providers, advocates, county staff and other interested stakeholders. The plan included development of a single entry point system, which was established in 1991.

As designed, Colorado's SPE system is a locally administered, state-supervised system. The Colorado Department of Health Care Policy and Financing contracts on an individual basis with county governments and, in some instances, private non-profit organizations to serve as SPEs. The State issues an RFP to for public and private entities to bid, and the State only contracts with qualified entities based on the recommendations of county commissioners.

SPEs in Colorado conduct functional assessments for eligibility for Medicaid nursing facility services, long term home health benefits (over 60 days), six Medicaid waivers and other state-funded programs. They provide case management for all of these services (except nursing facilities) for both Medicaid and private pay clients.[36]

C. Resources

1. Administrative Infrastructure

Start-up costs for an SPE system can vary considerably, depending on what resources are already in place and what new features must be added. While Colorado did not give any of its SPEs funds for start-up, SPEs received funds for technology. Because the State contracted with entities across the State to serve as SPEs, it did not need to hire new workers for SPE functions, but Colorado does allocates 10 state department full time equivalent (FTE) staff to oversee its waiver programs, monitor the SPEs, and provide ongoing training for SPE staff.

Nebraska estimated the initial startup cost at about $300,000 (including information technology (IT) expenses), plus any ongoing maintenance costs. While Washington also worked from its existing LTC system, it invested heavily in new aspects of its LTC structure. The State estimates that it cost about $10 million to start up its SPE system in the first year (the State claims that the investment has resulted in $23 million in savings through shifting beneficiaries away from nursing homes). About $3 million was paid to Deloitte to help set up the central database with its internal IT staff (this amount does not include state resources devoted to the system). The State estimates that in the SPE's first year, 48 additional FTEs were added; 24 new FTEs were needed in the second year.

In Colorado, the state contracts with 26 agencies to serve as SPEs including: 10 county departments of human services, 10 private, non-profit agencies, five county nursing services in rural areas, and one AAA. Only seven counties have their own SPE agencies; the remaining 57 counties are in multi-county districts with a combined SPE. Multi-county districts receive an incentive from the state of $8,000 per county per year to offset their operating costs (e.g. a three-county district would receive $24,000 per year). SPEs conduct functional assessments for Medicaid eligibility as well as prior authorization for long term home health (over 60 days) under the Medicaid State Plan. The SPE staff screen applicants, refer them to Medicaid , if appropriate, conduct in home functional assessments, develop plans of care, and make referrals for services.

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[36] Eiken, Steve and Alexandra Heesand. "Promising Practice in Long Term Care Systems Reform: Colorado's Single Entry Point System," Prepared by MedSTAT for the Centers for Medicare and Medicaid Services. This report is available on-line at: http://www.hcbs.org/files/34/1678/CO_final.doc.

The Washington State SPE system is State-managed. The Aging and Adults Services Administration (AASA) within DSHS operates the system and has broad responsibility of all LTC programs. Regional DSHS offices serve as the SPEs, with state employees performing SPE responsibilities. Staff handles functional and financial eligibility, level of care assessments, and case management for people in nursing facilities and non-medical residential facilities. The State contracts with AAAs across the state to perform case management and reauthorization services for consumers over the age of 18 in in-home settings. (In some cases, the AAAs are co-located with the SPEs.) A key feature of Washington's SPE structure is a central computer database that contains all SPE client and provider information. Both the SPEs and AAAs input information into the same software interface, and all employees have direct access to the data.

2. Information Technology

IT is a critical component of a SPE system because the primary goal of an SPE system is to streamline access into LTC programs. IT enables case managers to have access to resources such as client information, available providers, and can be particularly useful in helping states serve clients in rural communities. States vary considerably in terms of their investment in IT, as well as their reliance on their IT resources on a day-to-day basis.

Colorado provides each contracted SPE with $1,000 for computer/ IT needs. The State also provides additional funding for SPEs in rural areas to assist them in serving their larger geographic service areas. In terms of its IT resources, Nebraska uses a client tracking system that includes respite, family support, and programs for children with special health care needs and seniors. The database tracks both the care plan and services that the client is receiving from other programs, as well as case notes on other services that the person could use, but that are not funded. The State can also access the database and run queries to learn about the services provided and unmet needs in the community.

Nebraska has recently contracted with the University of Nebraska Public Policy Center to work on linking the multiple databases. When this linkage is complete, the system will be seamless to the consumer (i.e. the operating agency will not lose its on-line "identity" and the consumer will be unaware that anything has changed). However, it will allow each piece of the system to access information on other programs and services.

The SPE system in Washington is heavily dependent on its IT. The central database is critical for employees at all levels to input and access information in a streamlined process. Washington's investment in this database is extensive; the State designates 15 FTEs for its ongoing maintenance. State employees all have access to this database, providing a central source for information. Case workers in Washington use IT in their daily eligibility process. The case worker visits each applicant's home with a laptop computer to perform the level of care assessment; software guides the case worker through the assessment.

The information is then uploaded to the mainframe, which determines the level of care and provides real-time automated computations for service. The software can produce a care plan and provides recommended hours and frequencies of services. Soon, the State also will be activating a provider database which will allow consumers to search among and select providers.

3. Funding Sources

As described earlier, SPEs are funded through a variety of financing sources, mainly at the federal and state levels. The bulk of these dollars come from Medicaid, but because SPEs serve a wide range of populations, they also have access to funding opportunities designed to serve certain groups, such as children with special health needs and seniors. For example, Nebraska funding sources include the Early Intervention Program, the administrative appropriation for waiver services, respite, and children with special health care needs programs. Most of Washington's services are funded by Medicaid, either through waivers or the personal care option. State dollars are appropriated to the SPE through a variety of legislative mandates for specific services, such as the Caregiver Support Program, and the Senior Citizens Service Act, which provides the AAAs $6 million for their SPE responsibilities.

D. Rural Issues

SPEs are often challenged with the goal of making their services available to consumers in rural areas. SPE systems are characterized by multiple locations designed to serve clients in all regions of the state and states experience difficulty reaching consumers in these areas. Many states recognize this challenge and devote additional resources to help rural consumers. Colorado, for example, gives an additional $3,000 annually to its SPEs in rural areas to assist them in serving their larger geographic areas.

Nebraska and Washington, two states with large rural areas, often send their workers to the homes of clients who are not near an SPE location. In Nebraska, where a client can live two hours away from the nearest AAA, assessments are conducted in a client's home. The effort to complete in-home assessments is considerable, with some visits conducted on a monthly basis. As described earlier, Washington also conducts in-home visits to reach consumers in rural areas, using a sophisticated information system to transfer information.

A critical issue for rural consumers is not just access to information and the eligibility process, but also having providers available. To deal with provider shortages in rural areas, Nebraska and Washington both allow for a large number of independent providers—friends or relatives who are paid to provide approved services to a client. The use of independent providers is especially critical and prevalent in Nebraska, where about 80 percent of beneficiaries use independent providers for a variety of services, including chores, transportation, and respite.

However, Nebraskan officials have expressed concern that the parameters may be too flexible, and that they might be paying for services that relatives would otherwise perform free of charge. Nebraska still faces challenges associated with identifying home health agencies and adult day centers in certain areas. In cases where an independent provider is not available or not desired, the State actively looks for providers that may be able to serve the client's needs. The State claims that consumers are rarely unable to find a provider, but it sometimes takes time to identify a provider network.

In addition to frequent use of independent providers, Washington invests heavily in recruiting providers to serve its LTC clients in rural areas. Particularly for adult family homes, the state actively publicizes opportunities for providers to perform state-funded services, as well as

allocates significant resources for licensing providers and monitoring capacity. Washington also has received grant-funded opportunities to build community facilities in rural areas. Two have already been created, with six more on the way.

Appendix C of this report offers additional information on the case study states including:

- Comparison of Consumer Eligibility Process;
- Provider Enrollment; and
- Eligibility Approval Process.

VII. ALABAMA SINGLE POINT OF ENTRY

When designing its Real Choice Systems Change Grant work plan, the State of Alabama recognized that the development of a single point of entry (SPE) system could offer a many advantages. For state agencies, the establishment of a consolidated information and referral (I&R) and/or intake system could create administrative efficiencies since agencies could pool resources and share in overhead costs related to: a) collection or development and subsequent dissemination of program information (i.e., outreach and education); b) administrative costs related to eligibility and other application processing costs; c) better coordination of services that would reduce duplication of services and realize state savings. Additionally, some states have identified savings related nursing home diversion initiatives housed in SPE networks. Alabama might also realize savings from diversion. Later in this section, The Lewin Group provides a rough estimate of potential savings related to diversionary strategies.

Alabamian consumers indicated that they have substantial difficulty gathering useful, accurate information about Medicaid-financed long term care (LTC) services and about their program options. They also indicated frustration with the amount of time it takes to complete the eligibility process and to find a qualified provider once enrolled. However, interviewed consumers and families indicated that once enrolled, they were very pleased with received services. A SPE system would ameliorate many of the basic challenges Alabamians face.

LTC service providers and disability professionals also noted that a major service challenge is the lack of a consistent source of accurate information about Medicaid LTC programs and service options. A SPE system also would address their needs. In terms of Alabama's LTC system, a more coordinated approach to providing information about LTC options, both public and private, and delivering services and assistance more efficiently would also help the state meet the mounting demand for LTC services and supports.

A. SPE Guiding Principles

In considering the development of an Alabama SPE system, the SPE Work Group developed a set of values for such a LTC Resource Center network (see Table 8 below). The development and operation of a SPE in Alabama, regardless of form, will embrace these concepts.

Table 8
Alabama SPE Guiding Principles

Values and Principles for Consumers of Services and their Families	State Agencies and Partner Organizations	Everyday Community
▪ "Live people should be reachable"; ▪ Awareness of and accommodations for all sorts of disabilities and impairments (i.e., communication, etc.) ▪ Everyone is treated with respect and is welcome; ▪ People are made aware of an guaranteed privacy and confidentiality; ▪ Consumers and families are "in charge" with support from SPE staff; and ▪ Basic Staff competencies will include: o Strong base of knowledge o Strong client skills o Listening and Counseling skills	▪ For state agencies there will be no extra work and no drain on funds; ▪ For state agencies, will yield new efficiencies and possibly realize savings by consolidating administrative functions with other agencies; ▪ Agencies must be willing to accept change; ▪ All must focus on consumers as a mission; ▪ Agencies must plan the SPE development with staff at all levels from the beginning; ▪ Secure buy-in and focus from the top to maintain momentum; ▪ SPE will reduce time for waiting for consumers; ▪ Agree that there will be services to refer people to (i.e., HCB capacity must be there for referrals) ; and ▪ Currently begin a provider recruitment and retention initiative.	▪ Become relevant to local communities and help local leaders understand the value of supporting the SPE mission: o Possible efficiencies by consolidating administrative functions; o LTC service planning as made aware of aging phenomenon and service demand; and o Possibility of new jobs as new HCBS providers are established.

B. Building Blocks

Alabama need not start from scratch to establish coordinated entry to LTC services and supports; important building blocks already are available.

1. Information and Referral

The Alabama Department of Senior Service (ADSS) has developed a sophisticated statewide I&R system, known as *ElderConnect Alabama*. The program provides standardized information about LTC services and LTC service providers, consumers, families, and LTC professionals can find information at the local level using *ElderConnect Alabama.* This system has been operational since October 2002 and is available both to case managers and to the general public, via the ADSS website.

As of March 2004, the *ElderConnect Alabama* site included information about over 2,600 providers. The database includes general information (e.g. name, address, contact information) for providers of senior services in Alabama, as well as detailed information about the hours of operation, rates, and eligibility criteria. The database also includes extensive search capabilities that allow case managers or consumers to search by service, geographic area, or fee structure. The AAAs also provide staff-delivered I&R services to consumers who visit or call. The mental retardation/ developmental disabilities (MR/DD) local authorities provide similar services in their community offices but the MR/DD network does not offer as sophisticated a site as *ElderConnect Alabama* or a 211-like system.

Additionally, the Alabama Medicaid Agency has recently designated resources and staff to LTC outreach and education. These staff could be redirected to the SPE initiative. Currently, these LTC outreach and education staff are not permanently funded. However, if the LTC outreach

and education staff and programs were shifted over to support the SPE initiative, and therefore were directly related to outreach and education about Medicaid eligibility for LTC services and Medicaid-financed LTC services, the state could draw down administrative matching funds to cover a portion of the expenses.

2. Consumer Access and Assistance Services

Currently, all of Alabama's LTC program agencies provide some local or regional supports. The staff in these offices have valuable knowledge of programs, consumers and families in their coverage area, as well as providers; these would be essential resources in SPE planning and implementation. While all of Alabama's LTC program agencies provide some services, two networks stand out -- AAA and the local MR/DD authorities. These provide a more robust array of consumer services and support aimed at providing information about LTC options and providing assistance with service access.

3. Eligibility and Information Technology

While Medicaid eligibility is not automated in Alabama, the State has made significant improvements in processing applications. The typical timeline for processing a new application for Medicaid is 45 days; Alabama Medicaid Agency staff report that it previously took close to twice that time. The time reductions are related to new information technology (IT) tools the State now uses. For individuals who already are Medicaid eligible, processing waiver eligibility can take as little as one to two business days. Operating agencies also noted that Medicaid's eligibility training series has been extremely helpful to central office and local office staff. Additionally, the State no longer processes functional eligibility and financial eligibility sequentially. The two processes occur concurrently. This change, implemented approximately a year ago, has met with success.

ADSS has a client tracking tool for use by AAA staff or contractors to help them manage care for their clients. The Aging Information Management System (AIMS) is also available on the ADSS website, but requires users to log into the site for access. AIMS collects data from Alabama's 13 AAAs regarding the persons they serve and the units of service the clients access. The database includes information from Title III programs, the Elderly and Disabled Waiver program, the state-funded prescription drug program known as SeniorRx, and other programs.

4. Related Efforts

The MR/DD agency is currently working to increase its capacity to provide comprehensive, Resource Center services. This year, Alabama received a Family 360 Resource Center Planning Grant from the federal Administration on Developmental Disabilities. With the grant, MR/DD stakeholders are studying strategies for providing enhanced I&R services to all families impacted by MR/DD and to provide intensive assistance and access services to a smaller pool of consumers and families.

C. Possible Alabamian Models

Alabama has workable systems in place for intake, I&R operating in its MR/DD system for adults and its Area Agency on Aging (AAA) system for seniors. Key gaps are statewide easily

accessed and reliable sources of information on Medicaid and operating agency eligibility, services and providers for all populations, except for those receiving services from the AAAs. Based on conversations with stakeholders, persons with physical disabilities and mental illness and children with special needs have the least resources when trying to access and use LTC services.

Considering Alabama's financial constraints, but also recognizing the State's vision for the future, The Lewin Group offers three models. These options may be treated as discreet models or as a work plan or strategy for eventually offering a comprehensive SPE system. A side-by-side comparison of the models is available in Appendix A.

1. No Wrong Door Model

The first approach involves developing a comprehensive I&R system through a phone-based system or a searchable Internet site. As noted in the values and principles above, an SPE framework must offer direct contact between support staff and consumers. To develop this model, Alabama would build on the existing *ElderConnect* and 211 systems. The program would provide information 24 hours a day, 7 days a week. A comprehensive Internet site, would also allow Alabamians to access the same information.

The website and phone system would provide an array of information so that individuals in need of LTC services or related benefits can become educated consumers and make wise choices regarding their needs. See Table 9 for categories of information that would be essential.

Table 9
Some I&R Data Warehouse Essentials

Information on Benefits and Publicly Funded Services	
Medicaid and Medicaid Waivers	Food Stamps
State Children's Health Insurance Programs	Low Income Home Energy Assistance Program (LIHEAP)
Vocational Rehabilitation	Housing programs
Children's Rehabilitative Services	HIV/AIDS programs
Mental Health resources	Respite Services
MR/DD services	Ambulatory Care Providers who accept Medicare and/or Medicaid
Transportation programs	Employment Opportunities
Information on Providers	
Population Served	Program Locations
Payment (i.e., private, Medicare, Medicaid)	Program Description
Waiting List Status and Policies	Application Forms and Submission Locations
Information on Consumer and Family Assistance Services	
Protection and Advocacy System	Self-Advocacy Organizations
Family Caregiver Support Groups	

A caller or website user would be referred or linked to information about program eligibility, information about the services included. Applications and instructions for completing application forms would be available at the website. Consumers also would be able to request that copies be mailed. For each of these areas, the website or hotline could have information on providers in each region.

This approach can be considered a NWD approach because all Alabamians may use the same system and receive the same information and same services regardless of LTC subpopulation (i.e., advanced age, physical disabilities, MR/DD, etc.).

c. Cost Estimate and Resources

Because of Alabama's existing robust 211 and *ElderConnect Alabama* systems, the cost of incorporating information on other programs would be considerably less than building a program. The infrastructure and staff to manage the system are already in place. The state of Hawaii, using its Real Choice Grant recently began implementation of a system similar to the framework described above. The state has invested approximately $1.2 million in the development of the site. Hawaii is not including a robust phone support system and this amount does not include outreach and education for the community on the new tool.

The state of Ohio is developing a system called "No Wrong Door Ohio" that will only offer the provider information component. The state is spending approximately $800,000. This dollar amount includes development of a website, but does include costs associated with ongoing stakeholder involvement (i.e., staff time to keep provider information up-to-date) and a public relations campaign to educate the Ohioans about the new system. According to Lewin Group research, there are approximately 24 companies offering software and systems that support phone and web-based information and referral systems. Pricing varies considerably based on purchaser preferences and add-ons such as ongoing training for staff, system updates options, licensing requirements. State spending on outreach and education on these information and referral systems to consumers, providers of services, and disability professionals varies widely from $8,000 to over $200,000 in Ohio.

As noted earlier, a considerable portion of I&R systems and web-based client eligibility screening tools are eligible for federal Medicaid matching funds as long as these efforts are directly related to supporting access to information on and services financed by Medicaid. Table 10 below provides and overview of which components federal Medicaid administrative matching rates would likely apply.

Table 10
Web-Based No Wrong Door Model Medicaid Matching Potential

Item	Match Rate
Purchase Software Licenses	75%
Customization of software to Alabama	
MMIS Modifications	
Hardware	
Monthly Operations	

d. Advantages and Disadvantages

Development of an on-line and telephone system for coordinating LTC services for all populations would be a good first step in ensuring all Alabamians have access to appropriate information. This system also would provide Alabamians with a resource noted by most stakeholders interviewed for this study, reliable, easily accessed information on LTC services and benefits – especially for persons with physical disabilities, sensory disabilities, mental illness and children with special needs. Another advantage to this phase is that families of persons needing LTC assistance in a rural or urban area would have access to the same level of I&R.

If Alabama developed a virtual I&R system, consumers would not have access to face-to-face assistance that some Alabama stakeholders believe is important. Virtual systems are not accessible to low-income families that do not have access to the Internet or might not have a phone. It also represents a barrier for those who do not know how to use the Internet and elders who spend most of their time at home alone (i.e., "shut ins"). Finally, the phone system presents difficulties for consumers and family members with speech and hearing impairments.

e. Possible Project Timeline

From experiences in other states, conceptualization, development and implementation of a web and phone based I&R system that also would offer some eligibility prescreening functions is approximately a year and a half assuming the necessary resources have been identified. See Table 11 below for an overview for rolling out a virtual system.

Table 11
Possible Timeline for Roll Out of Virtual No Wrong Door

Task	Timeframe
Stakeholder Input 1. Establish Work Group 2. Build No Wrong Door concept (i.e., ides for content, look and feel)	90 days
Contractor Section 1. Draft and Post Request for Proposals 2. Select Contractor	150 days
Development of System 1. Customization and merging with *Elder Connect* 2. MMIS Interface	230
Beta Testing	60 days
Training for Staff	10 days

2. Regional Resource Centers Model

In phase two, the State would provide the I&R system described above and would provide a three regional walk-in Resource Centers possibly located in Birmingham, Montgomery, and Huntsville. The primary role of these Resource Centers would be to provide I&R, with a heavy reliance on the previously developed system, while also providing direct assistance. The state could use existing AAAs and/or MR/DD local authorities; or, like Colorado, Alabama could develop a Request for Proposals (RFP) and select venders based on local officials' recommendations and the quality of response.

a. Services

In the One Stops, consumers and family members would receive I&R and a mix of SPE services. To keep costs down, Alabama could focus on offering a basic array of services relying on currently existing benefits and outside funds where possible:

- **Short Term Case Management** - which could be partially funded through the state's Targeted Case Management benefit and the waivers.
- **Eligibility Processing –** with the state's electronic Medicaid eligibility verification system and improved processing of new Medicaid applications, extending these functions to the SPE sites would be low cost. Some AAA and local MR/DD authorities may already have full access. The state could draw down Medicaid Administrative matching funds for changes and expansions to accommodate the Resource Centers.
- **Benefits Counseling –** the State receives grant funds from the Social Security Administration (SSA) to provide benefits counseling to SSA beneficiaries and recipients. Benefits counselors funded under these grants could be placed in the Resource Centers full time or part time.

- **Crisis Intervention Services –** these would be essential to reducing nursing home placements. Short term case management would be part of this component as well as aggressive I&R. Additionally, Alabama has an extensive respite network that could be leveraged under this service to prevent unnecessary nursing home or other facility-based placement. Funding could be derived from HCBS Waivers, Older Americans Act programs, Social Services Block Grants, and private pay dollars and insurance.
- **Caregiver Support –** these services also would focus on preventing institutional placement by prolonging natural, family supports. Already, AAAs participate in the National Family Caregiver Support Program that offers some services. Strong linkages to local, community-based resources, such as faith-based organizations and advocacy organizations such as AARP, The Arc, and the Alabama chapter of the National Alliance for the Mentally Ill, also could form an effective service net.
- **Respite Coordination –** this important service, strongly related to caregiver support, also would be coordinated by SPEs. Respite would include short term, drop-in assistance in the home or workplace, short term day programming, and short term, intermittent transportation services.

b. Outreach and Education

To be effective, people must know that the network exists and they must find the Resource Centers relevant to their needs (i.e., relevancy is a key value for Alabama's SPE framework). In addition, Resource Center staff should target their outreach approach to their locality. Resource Centers should explore opportunities such as Senior Centers and hospitals as natural outreach locations. They also should develop materials tailored to key audiences such as family caregivers, younger people with disabilities, health care professionals (i.e., hospital discharge planners, doctors, and nurses), and human resource managers with private companies.

c. Cost Estimate and Resources

Funding for Resource Centers can come from a variety of sources, including Medicaid, the Older Americans Act, United Way, and other public and private sources. Legitimate Medicaid administrative work includes all outreach and enrollment activities for Medicaid and Medicaid waivers. For these activities, the State can get federal matching funds to cover 50% of the cost. In addition, Medicaid can cover some information technology costs, as shown in Table 12, below.

Table 12
Federal Medicaid Match by Major Function

Major Function	Federal Match
Medicaid Eligibility Systems Modifications	50%
Level of Care Assessment Systems	50%
Support Needs Assessment Systems	50%
Case Management Information Systems	75 or 90%
Client Tracking/Management Reports	90%
I&R Software	75%

These information technology services are matched by federal dollars only if they are related to the State's Medicaid Management Information System (MMIS). To be eligible for matching funds, IT development must be directly tied to the MMIS through an integrated systems approach and interact with the MMIS data base. CMS has rigorous standards associated with receiving enhanced (more than 50 percent) rates for systems development. Most IT projects involving more than one federal agency (e.g. CMS, AoA, SAMHSA) are eligible for the 50 percent FFP matching rate for projects serving Medicaid beneficiaries. State MR/DD agencies have been particularly successful in garnering the 50 percent administrative match by associating functions with HCBS waivers.

Budgeting for Resource Centers will be highly dependent upon the final services array, host entity, and participating partners' capacity to redirect funds to the Centers. The Lewin Group reviewed the budgets for Resource Centers in several states. Table 13 below offers a snapshot of what a Resource Center's annual operating could entail.

Table 13
Resource Center Start Up Budget[37]

Function	Description/ Per unit cost	Total Cost
Personnel	Assumes one Center Manager and three full time staff	$277,000.00
Telephone	Phone equipment and usage costs	$8,508.00
Equipment	Excludes IT	$70,000.00
Supplies	Postage; printing of outreach materials	$5,000.00
IT	Hardware and software associated related to development of on-line database, and maintenance costs	$15,000.00
Education/Outreach	Includes design of outreach materials and community presentations	$35,000.00
Staff Training	Ongoing training for Resource Center staff	$8,000.00
Sub-Total		$418,508.00
Indirect	Rent or maintenance of space; licensure or certification of staff, etc.	$84,000.00
TOTAL		**$502,508.00**

For all three regional Resource Centers, the start up costs would total approximately $1.5 million; assuming Alabama also implements the complete virtual option described above, the total price for implementing this option would be approximately $2.5 million. Additionally, the State would have to develop a cost center within the Alabama Medicaid Agency, Senior Services, or another LTC program office to serve as an oversight entity for both the website and the regional resource centers. As noted in the state experiences section, the number of FTE devoted to these functions varies widely. Subsequent year operations would be less since initial costs associated with equipment and IT purchases would not be necessary.

[37] Costs based on operating experiences in 2001 of the Wisconsin Resource Centers.

Alabama could use the outreach and education staff as a starting point for such an oversight entity which would: a) develop, issue and award SPE contracts; b) allocate SPE funds; c) serve as the State point of contact for SPE policy questions and issues; and d) administer SPE evaluative and/or quality management functions. See Appendix B for an overview of Wisconsin's Resource Center and state agency interactions. This figure provides insights into how the state Medicaid agency, the Wisconsin Department of Health and Family Services, interfaces with locally operated Resource Centers.

d. Advantages and Disadvantages

Development of comprehensive Resource Centers meets more of the values set forth by the SPE Work Group and would likely impact more Alabamians. This is especially true for lower income populations and older persons, who are less likely to know how to use the Internet and might be intimidated by complex voice mail systems or phone trees when trying to use an information line. The Resource Center offers integrated functions across populations and service systems. It can serve all Alabamians, not just those who qualify for public services. Additionally, having SPE staff spread out across the state and engaged in outreach activities would allow staff to achieve a community presence and allow the program to function as an effective nursing home diversion strategy.

The development of Resource Centers is expensive, costing considerably more than the virtual option discussed above. The development of Resource Centers also creates potentially difficult political issues among local entities interested in becoming Resource Centers or concerned about losing resources or funding. Such an initiative might also create similar difficulties at the state level. States that have been successful in overcoming "turfism," have created well-balanced advisory committees to inform the initiative and have balanced concerns and fears with new opportunities.

3. Statewide Comprehensive Resource Centers Model

As a third option, Alabama could establish Resource Centers throughout the state. With a statewide network, it might not be necessary to operate a statewide telephone service and a website as robust as the system described under option one. Instead, local Resource Centers would develop their own local websites and phone service systems but might jointly purchase such services to leverage market place power (i.e., bulk purchasing).

Under this model, the State would issue an RFP for local SPE services. Local entities, private or public, would respond. Here again, Alabama could use the LTC outreach and education staff as a starting point, for such an oversight entity which would: a) develop, issue and award SPE contracts; b) allocate SPE funds; c) serve as the state point of contact for SPE policy questions and issues; and d) administer SPE evaluative and/or quality management functions. State oversight responsibilities under this model would be considerably greater since the State would be responsible for many Resource Centers, as opposed to just three, and the virtual system described in options one and two. The Resource Centers would provide a highly localized array of services, identical to those described in option two.

a. Cost Estimate and Resources

Costs per Resource Center would be similar to the total estimated under option two: $502,000 for start up. Some State costs might be diluted by having more counties or local communities participating in the purchase of IT systems and tools, sharing in costs associated with training curricula for staff, purchase of outreach and education materials and securing public relations contracts, and sharing in staff hiring initiatives. However, as noted earlier, other State costs might be higher due to increased oversight responsibilities associated with more SPE sites to establish, support, and monitor.

b. Advantages and Disadvantages

The SPE Work Group for this study indicated a strong desire that Alabamians be able to speak to helpful, polite, informed staff when seeking LTC support. Establishing a statewide network of Resource Centers would meet that need. A larger network would also increase the SPE network's opportunity to become visible and relevant to people and communities. Outcomes from greater community visibility include increased awareness of HCBS options and potential decreases in nursing facility use. Additionally, statewide, local SPE sites could provide the Alabama Medicaid Agency and its sister LTC agencies with more detailed information on LTC capacity by consolidating information on service provider capacity, sharing data on consumers and their families, and, therefore, better assessing need on a local level.

Conversely, implementation of a statewide SPE system presents many of the same challenges as the regional model but on a grander scale. The State could face more complex turfism challenges as well as greater IT costs should some areas not have SPE applicants with the necessary infrastructure. Proposing a substantial, new initiative in Alabama's current budgetary environment might also not be feasible without also offering substantial offsets.

4. Key Steps and Possible Timeline for Regional and Statewide Resource Centers

For the regional and statewide Resource Center models have common developmental steps and related timeframes for completion. Table 14, below, provides an overview of these tasks. Timelines and steps were developed from study of the three case study states and Lewin experiences with other states.

Table 14
Key Implementation Steps (in priority order)

Implementation Steps	*Completion Timeframe*
Complete plans for SPE request for proposals. Major stakeholder process to determine SPE functions, financing, populations served, and bidder qualifications	**12 Months**
Complete plans for alterations to financial and level of care process to accommodate SPE network. Assess other states' processes. Apply to CMS for changes and possible reimbursement for changes.	**12 Months**
Plan and implement a client tracking system for SPE users.	**9 Months**
Evaluate budget for staffing SPE initiative at the state level.	**3 Months**
Develop or modify intergovernmental agreements. These documents must clearly define functions, authority and accountability among state agencies supporting SPEs with resources or information. Establish a problem resolution process among agencies.	**3 Months**
Select and Activate SPE sites. Publicize SPEs and their services. Divert consumer calls from local operating agency offices to SPEs.	**3 Months**

VIII. POSSIBLE SINGLE POINT OF ENTRY OFFSETS

Implementing a single point of entry (SPE) system in Alabama could help the State reduce *total* long term care (LTC) costs by helping to divert consumers from nursing homes into Home and Community-Based Services (HCBS). SPEs also can coordinate short term, intermittent services, such as crisis services, respite and caregiver supports which could prevent or delay nursing home placement.

To incur real savings from these efforts, the Alabama Medicaid Agency would also need to concurrently implement carefully calibrated nursing home cost control mechanisms while expanding HCBS services. This section describes the impact of growing demand for LTC services on costs. It also discusses how SPE diversion programming, coupled with nursing home cost controls, could yield savings to Alabama. These savings could be counted as offsets to SPE expenses.

A. Overview

Despite gains in HCBS expansion, Alabama continues to invest a significant amount of its Medicaid LTC budget in expensive facility-based care. In FY 2002, Alabama spent about three quarters of its LTC Medicaid dollars on facility-based services (see chart 1 on page 9). To meet mounting demand, states and LTC stakeholders have pursued the development of Medicaid HCBS services based on evidence that providing services in peoples' homes and communities is less costly in the aggregate.

Most states and consumer advocacy organizations assert that the substitution of HCBS for institutional services provides savings.[38] However, many in the LTC field point out that comparisons of the cost of HCBS programs and institutional care are inherently difficult due to complex funding streams, differing administrative infrastructures and differing organization and delivery of services. Others point to the differences between the population served in each program (i.e., nursing facility residents have greater needs than HCBS waiver participants).[39] It is important to point out, however, that critics of HCBS cost-effectiveness acknowledge that research also has documented cost savings generated by reduced use of institutional services.[40]

Still other research suggests that expanding HCBS programs is more likely to increase rather than decrease ***total*** LTC costs.[41] The key reason noted is the so-called "woodwork effect." Under this argument, individuals who would forego nursing home services and rely on unpaid family caregivers will accept community-based options while nursing home beds continue to be filled by others who are willing to accept nursing home services. However, research in three states, Colorado, Oregon, and Washington, has provided more encouraging information on the cost-effectiveness of HCBS. A 1998 study of Colorado's Elderly, Blind and Disabled waiver

[38] Doty, Pamela. "Cost Effectiveness of Home and Community-Based LTC Services." U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation. 2000.

[39] "Issues of Cost Effectiveness for Home and Community-Based Services for Long-Term Care." American Health Care Association (AHCA). December 29, 2003.

[40] Doty, Pamela. 2000.

[41] "Medicaid Cost Containment, A Legislator's Tool Kit." National Conference of State Legislatures. March 2002.

found considerable savings to the state and highlighted a drop in the proportion of Colorado's population in nursing homes that was faster than the national average rate of decline.[42] All three of these states coupled HCBS service expansions with steps to reduce or control facility-based expenses. Alabama, like its sister states, has taken steps to grow its HCBS capacity both in response to consumer requests as well as evidence that HCBS programs are less costly in the aggregate. Alabama could magnify potential savings from HCBS expansion by adding strategies to control facility-based costs.

B. Nursing Home Bed Capacity

Alabama is in the middle of national statistical rankings regarding the number of nursing home beds per 1,000 residents age 65 and older (i.e., 48 beds per 1,000 over age 65).[43] Alabama has an average occupancy rate of approximately 66 percent, in comparison with the national average of 83 percent.[44] These two numbers indicate that Alabama is maintaining more Medicaid-licensed nursing home bed capacity than the state needs.

As noted earlier, Alabama has made substantial strides in HCBS growth. Expansions in HCBS are intended to provide consumers with choice while offering a generally less expensive LTC service. However, achieving lower costs for LTC services system wide is a two step process: 1) offering HCBS services in adequate supply to meet or approach demand; and 2) controlling or reducing institutional service capacity and expenditures. Alabama currently has some mechanisms in place to reduce institutional service growth and to reduce nursing home use as HCBS options are grown (i.e., strategies to prevent nursing home "back-fill.") The State has in place a "certificate of need" rule under which nursing home providers must obtain approval before initiating an expansion of services. And, the state have a Nursing Home Transition Grant from the federal Centers for Medicare and Medicaid Services (CMS) aimed at developing nursing home transition strategies.

Despite these efforts, Alabama has a high nursing home bed capacity, a low occupancy rate and, because of this, exposes itself to back-fill; Table 15 provides an overview of the Medicaid-funded bed capacity in Alabama. Discussed below is a possible method for estimating Alabama Medicaid savings that could be gleaned from reducing the number of Medicaid-funded nursing home beds and replacing those beds with HCBS beds.

Table 15
Number and Percent of Beds used by Medicaid in Alabama in FY 2002

Licensed Nursing Home Beds	Medicaid Monthly Average	Average percent of beds used by Medicaid
26,151	17,152	66%

Source: Alabama Medicaid Agency Annual Report, FY 2002

[42] Wiener, Joshua, and Stevenson, David, "Long-Term Care for the Elderly: Profiles of Thirteen States." The Urban Institute. August 1998, p. 25.

[43] Harrington, C. Across the States: 2002 , Profiles of Long Term Care. Fifth Edition. AARP Public Policy Institute. http://research.aarp.org/health/d17794_2002_ats_al.pdf.

[44] AARP LTC profiles, 2002.

C. Growing Nursing Bed Demand Could Lead to Significant Costs

In FY 2002, the Alabama Medicaid Agency reported approximately 7.4 million nursing facility bed days were paid for by Medicaid. As the population grows and demographics shift, the number of potential bed days in future years will increase considerably. Lewin has developed an estimate of the number of Medicaid bed days Alabama will need in the years 2005 and 2010 and compared that estimate with the current nursing home capacity to determine the need for future beds. These estimates were developed with data provided by the Alabama Medicaid Agency and by projecting demand forward using the Lewin HCBS Population Tool.[45]

To estimate the total number of persons who could potentially use nursing facility services in future years, Lewin trended forward the current Medicaid bed days using estimates of the number of persons in 2005 and 2010 who would meet the criteria for nursing home placement. The first step in the process was to develop a population trend for the segment of the Alabama population that meets the functional and financial requirements for Medicaid-sponsored nursing facility services. Using Alabama Medicaid Agency data, Lewin estimated the total number of beds likely to be needed in the future.

As show below in Table 16, Lewin established the potential rate or increase nursing home eligible individuals for the periods of 2002 to 2005 and then from 2005 to 2010. These rates, 3.5 percent and 6.8 percent, were applied to the number of nursing home bed days needed in 2002. This step ensures that Alabama will maintain nursing home capacity for the current occupancy level in the future by controlling for growth in demand.

Table 16
Projected Medicaid Bed Days Based on Current Population Served

2002 Medicaid Bed Days	7,407,712
Increase in Potential NF Population from 2002 to 2005	3.5%
Projected 2005 Bed Days	7,666,982
Increase in Population from 2005 to 2010	6.8%
Projected 2010 Bed Days	8,188,337

Source: Lewin analysis

Trending forward the current bed days at 2002 occupancy levels does not account for the potential use of nursing facilities by persons who meet the nursing home criteria but are not currently using nursing home care. Therefore, to develop a "high end" estimate, Lewin used data from the HCBS Population Tool to trend forward the nursing home population and develop a "worst case" estimate of the number of additional bed days that could be used if all persons who meet the nursing facility criteria were to use nursing homes. Table 13 illustrates this projection.

[45] http://lewingroup.liquidweb.com/cgi-bin/woodwork.pl

Table 17
High End Estimate of Nursing Facility Utilization

		2002	2005	2010
A	Number of Persons Who Meet NF Criteria without MR/DD Population Included[46]	32,498	33,559	35,844
B	Average Length of Stay	273[47]	273	273
C	Total Bed Days for Persons Meeting NF Criteria but not Currently in a NF C = A × B	8,871,954	9,161,607	9,785,412
D	Projected Bed Days Based on Current Utilization (From Table 16 above)	7,407,712	7,666,982	8,188,337

Source: Lewin analysis

Alabama has the potential to need between 8 million and 9 million bed days in 2010. These estimates are high because it is unlikely that all of these individuals will meet Alabama's eligibility requirements or need nursing home care. In 2002, the State had approximately 26,151 Medicaid licensed beds which could provide approximately 9.5 million bed days of service, assuming 365 days of availability.

Alabama Medicaid Agency data also shows a decreasing average length of stay (ALOS) in nursing homes. In 2000, the nursing home ALOS was 298 and in 2002, the ALOS was 273. If similar declines in ALOS continue, more capacity will be available. Considering the declining ALOS, and Alabama's current Medicaid bed capacity and low occupancy rate (i.e., 66 percent), the state will have enough nursing home bed capacity to meet demand.

D. Community-Based Diversion Coupled with Nursing Home Expenditure Controls Could Yield Savings

Lewin modeled the potential effects of adding HCBS waiver slots for up to 1,000 individuals who would need services at the nursing home level of care in 2010. The overall result of diverting individuals from nursing home settings is two-fold. First, the average acuity level and cost per person remaining in the nursing homes will likely increase as individuals with less intense service needs move into HCBS settings. Secondly, persons who were diverted from the nursing homes will receive HCBS services, which, on average, cost less per person. Lewin developed a model based on data from the Alabama Medicaid Agency on the increase in nursing home cost per bed day, as well as savings estimates based on annual person costs from the Elderly and Disabled waiver CMS-372 report.

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[46] Estimates for the number of individuals who would meet the nursing home level of care were developed using the Lewin HCBS Population Tool; see page 14 of this report.

[47] The Alabama Medicaid Agency estimates Average Length of Stay in long term stay nursing homes to be 273 days per year.

In Table 18 below, are three scenarios for potential savings based on the diversion of 200, 500, or 1000 people from nursing homes to HCBS and the permanent closure of these nursing home beds.

To arrive at the savings estimate, Lewin first calculated the total costs for each scenario had these individuals been served in nursing homes.

Table 18
Estimated Nursing Home Costs if No Diversion and Bed Closure

A	Number of Clients	200	500	1,000
B	Bed Days Diverted B = A × 273[48]	54,600	136,500	273,000
C	Number of Total Bed Days in 2010 (in millions) (see Table 17 above)	9.7		
D	Total Number of Bed Days if All Diversions Happen (in millions) D = C – B	9.6	9.5	9.4
E	Average Increase in Daily Rate for Acuity Increase[49]	$0.06	$0.16	$0.32
F	Increase in NF Costs for Remaining Residents (in millions) F = D × E	$.58	$1.5	$3
G	Total Costs if Clients had been served in nursing homes (in Millions) G = Daily Rate ($95)[50] x B	$5.2	$13	$26

Source: Lewin analysis

Once the potential nursing home costs have been estimated, lines F and G above, costs for serving individuals in the HCBS waiver must be calculated. Costs under each scenario are in Table 19, below. Savings are the difference between nursing home costs had these individuals been served in facilities and estimated waiver costs if the same individuals were served in their homes and communities (see line D below). These savings estimates, however, must be tempered with the potential increase in acuity for the remaining nursing home residents; see line E in Table 19.

[48] Average Length of Stay (ALOS) data was developed by the Alabama Medicaid Agency.

[49] Estimated increased rates based on acuity are derived from estimates made by the state of Indiana for its nursing home diversion initiative.

[50] In 2002, the average daily nursing home rate for Medicaid beneficiaries was $95 according to Alabama Medicaid Agency data.

Table 19
Estimated Savings from Diversion into HCBS and Bed Closure

A	Number of Clients	200	500	1,000
B	Average Cost Per Person in Waiver Services	$5,400		
C	Total Costs for Persons Diverted to Waiver Services (in millions) C = A × B[51]	$1.1	$2.7	$5.4
D	Gross Savings as a Result of Diversions (in millions) D = G (from Table 18) – C	$3.52	$8.8	$17.6
E	Net Savings as a Result of Diversions (in millions) E = D – F (from Table 18)	$2.94	$7.3	$14.6

These savings estimates do not account for two important factors which could erode the estimated savings. First, Lewin did not account for costs associated with diversionary services. Secondly, Lewin did not account for any increased use of state Medicaid plan services for individuals who are new to Medicaid and are enrolled in the waiver. These individuals also would have had access to the same state Medicaid plan services had they gone to a nursing home.

E. Building Community Capacity

In order for diversion to be successful, HCBS waiver policies would have to be changed and the service provider capacity would have to be assessed. Steps include:

1. Eligibility Changes to the Waiver

To ensure that individuals who would have been served in nursing homes are able to receive services under the Elderly and Disabled waiver, Alabama would need to increase the monthly income standard on the waiver from 100 percent of the Supplemental Security Income (SSI) level to 300 percent of the SSI payment level, putting it on par with the nursing home eligibility test. Or, the state could reduce nursing home eligibility to 100 percent of SSI while raising waiver eligibility; the option would bias the LTC system towards HCBS.

2. Add Waiver Slots

The Alabama Medicaid Agency would need to amend its waiver to add waiver slots. Some states, like Indiana, have received approval from CMS for a certain number of "priority diversion slots." Indiana has 1,000 slots that the state may use only for individuals who are in

[51] Cost per waiver participant is the average annual waiver service cost from the 2002 CMS 372 report on the Elderly and Disabled Waiver.

danger of nursing home placement. These slots are not available to people on the state's waiting list for Elderly and Disabled waiver services.

3. HCBS Provider Capacity

Alabama would have to assess its provider capacity to provide services to additional people due to diversion activities.

Several states, such as Nebraska, have taken steps to increase HCBS provider capacity and prevent growth in nursing home services by converting those resources, both service dollars and capital into community-based assets. The later step is critical to ensuring that HCBS expansions achieve cost neutrality or savings for the state.

In 1998, the state of Nebraska launched a groundbreaking program called the "Nursing Facility Conversion Cash Fund." The Fund established a grant program for existing nursing facilities to convert to assisting living and other alternatives to nursing facility care such as respite and adult day care services, services provided under the state's Aged and Disabled Medicaid Waiver. The cornerstone assumption for the initiative was that converting to assisted living and other more integrated forms of support would reduce the cost of providing care to Medicaid eligible individuals.

In rural areas of Nebraska, where the majority of grants were awarded, the average daily cost to Medicaid for nursing facility care is $68. Medicaid costs incurred using the waiver's assisted living benefit, for an analogous population, are $37 per day, resulting in a $31 per day/per client savings to the Medicaid program. These savings, in turn, provide a sustainable source of revenue to replenish the Nursing Home Conversion Cash Fund. In 2001, annual Medicaid savings at $31 per day totaled $5.5 million dollars.[52] Alabama could consider a similar initiative in order to increase the number of HCBS providers to meet demand and influence institutional costs. A SPE network that provides the service array described in option two, could also play a key role in a potentially cost saving diversion effort.

[52] "Nursing Facility Conversion Grant Program, 2001 Annual Report." Nebraska Health and Human Services System. January 2002, pgs. 1-3.

IX. CONCLUSION

In the future, Alabama will face significant demand for long term care (LTC) services and supports. The State will need to carefully craft a strategy to meet the needs of Alabamians that is financially sustainable. LTC planning that balanced institutional planning and home and community based services (HCBS) planning could help the state meet both goals of serving Alabamians within spending limitations.

A single point of entry (SPE) system could assist Alabama deliver LTC services in several ways:

- The development of and operation of a SPE network could help Alabama's LTC agencies to plan in a more coordinated fashion via meetings, shared service data, shared eligibility data, and shared information on provider capacity.
- A SPE would help Alabamians better understand their LTC service options, a need clearly articulated by all interviewed stakeholders.

At a minimum, Alabama should consider a more coordinated approach to collecting, vetting, and disseminating information to LTC consumers possibly using a strategy similar to option one. Over time, with stakeholder involvement, the state could address options and two and three.

As Alabama weighs the merits of a SPE network, the state should:

- Work closely with other agencies and stakeholders to develop a SPE proposal that can gain political support.
- Identify existing resources and infrastructure that could support a SPE system. Building on the State's existing LTC framework will likely require less time and resources to implement.
- Carefully identify and plan for new resource needs, such as infrastructure, technology, and full time equivalent staff.
- Develop a central oversight entity for coordination and cohesion.
- To adequately serve consumers in rural areas, design strategies to address disparities in access (technology, home visits, etc.)

Alabama also will need to consider several important SPE program design points including:

- What populations with disabilities will be served?
- What will be the geographic coverage regions (for regional and statewide resource center options, only)?
- Will the SPEs conduct the LTC level of care determinations?
- What efforts will the SPE be making to tap into the traditional pathways to institutional LTC services (e.g., working with hospital discharge planners, etc.)?

- What type of general outreach will the SPEs conduct? Will it be coordinated and standardized by the state or will each SPE craft its own outreach strategy and materials?
- What ability will the SPEs have to identify individuals at high risk for institutionalization and give them priority for accessing HCBS?
- Will the SPEs be able to offer presumptive eligibility for HCBS waivers?

One key tool that could help Alabama in the development of a SPE system is the federal government's Aging and Disability Resource Center (ADRC) initiative. The ADRC grant program is intended to stimulate the development of state systems that integrate I&R, benefits and options counseling services as well as facilitating access to publicly and privately financed LTC services and benefits. The program is jointly sponsored by the federal Administration on Aging and CMS. ADRC also is part of the President's LTC Re-balancing Initiative and New Freedom Initiative. In FY 2004, AoA and CMS awarded 12 ADRC grants and for FY 2005 they have awarded an additional 12 grants.

ADRCs are intended to provide individualized "Resource Center shop" I&R services as well as entry into LTC systems, programs and related benefits. ADRCs will be locally or regionally based and will provide support to individuals of advanced age and persons with disabilities, their family caregivers, and those planning for health long term support needs. The Centers are a resource for both public and private-pay individuals by helping families plan for future LTC needs, coordinate private LTC insurance with other benefits, access publicly funded LTC services, and link to important related programs such as Social Security, housing, employment, and transportation services as well as find providers of services. They also serve as a resource for health and long term support professionals and others who provider services to the elderly and to people with disabilities.

Securing an ADRC grant and developing a well rounded guiding body for SPE service planning would aid Alabama in meeting mounting demand through a more coordinated service delivery approach.

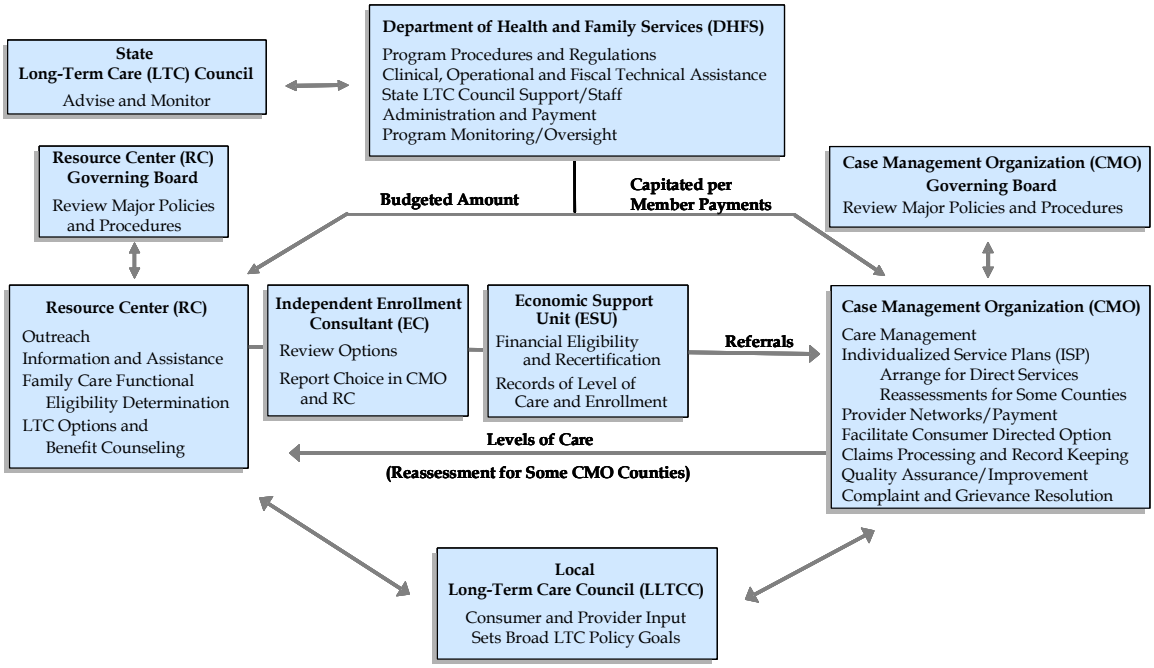
Appendix A

Summary Comparison of Three Proposed Models

	No Wrong Door Website	*Regional Resource Centers*	*Statewide Comprehensive Resource Centers*
Advantages	➢ Brings together reliable, easily accessed information ➢ Families in other locations would be able to easily access information	➢ Includes face-to-face assistance for persons in three regional centers. ➢ Includes some SPE services (e.g. short-term case management, crisis intervention services)	➢ Greater community awareness, because Resource Centers are located throughout the state ➢ Ability to collect and analyze statewide data on capacity and demand for LTC services
Disadvantages	➢ No face-to-face assistance ➢ Access problems for low income, who may not have phones/ internet access ➢ Difficult for persons with hearing/ speech difficulties	➢ Potential political arguments about location of Resource Centers ➢ More expensive	➢ Very expensive
Approximate Cost	$1 million	$2.5 million (assumes NWD data integration and three centers)	$6 million (assumes NWD data integration and ten centers)

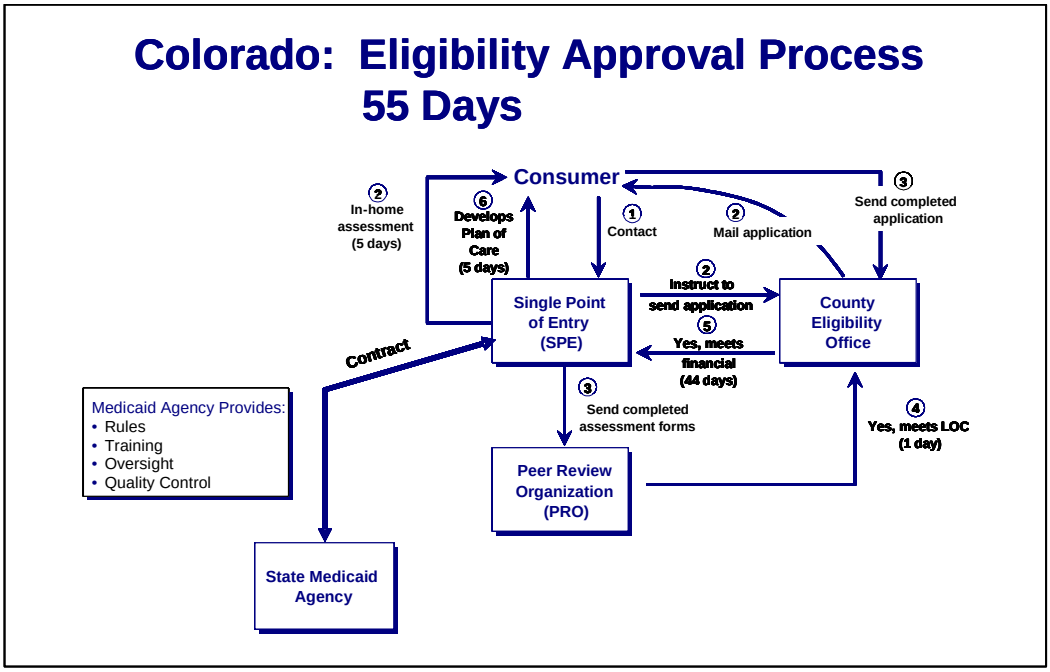
Appendix B

Roles and Responsibilities in Wisconsin's Resource Center Infrastructure

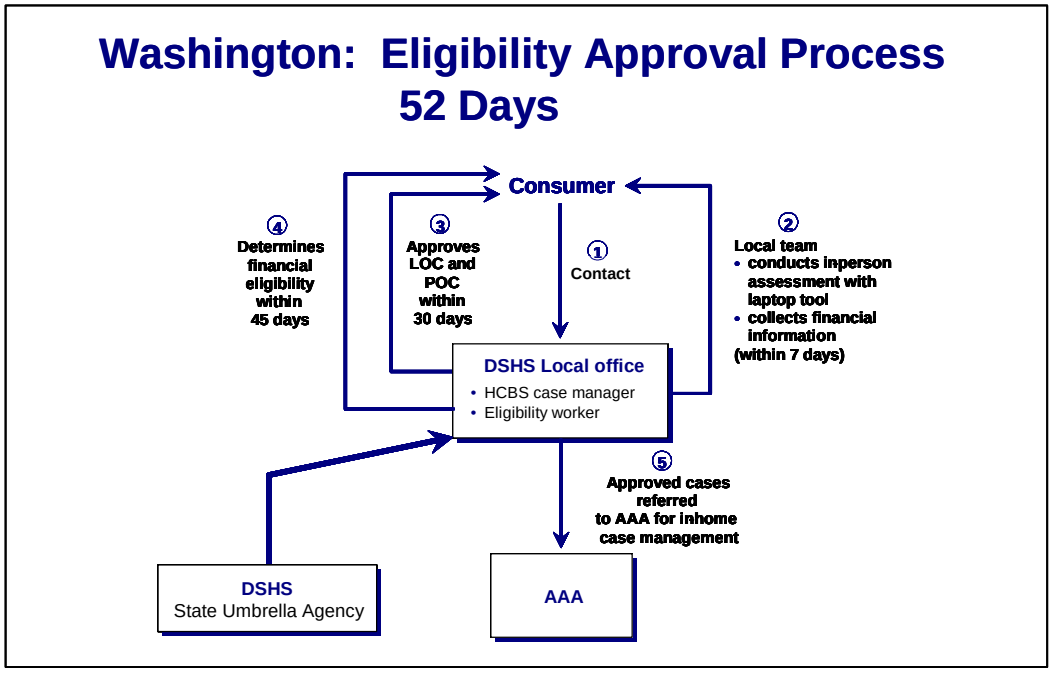


Source: *Wisconsin Family Care Final Evaluation Report, The Lewin Group. June 30, 2003.*

Appendix C

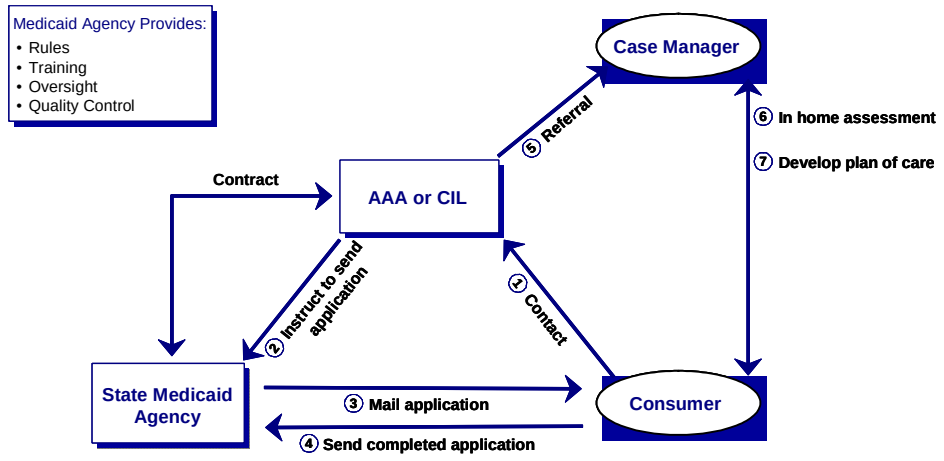


Source: The Lewin Group



Source: The Lewin Group

Nebraska: Eligibility Approval Process



Source: The Lewin Group

States Profile: Comparison of Consumer Eligibility Process

	CO	WA	NE
Functional Eligibility	Local SEP agency performs assessment; PEER Review Organization (PRO) review	State employees at local DSHS office	Contracted to AAAs and CILs
Standards	Institution: within 2 days Community: within 5 days PRO review: 1 day	Assessment and care plan must be completed within 30 days; on average, assessment takes 5.5 hours	Not Available
Level of Automation	Assessment entered into automated system; eligibility tracking system	Automated system that produces LOC determination and plan of care; eligibility tracking system	Internet-based client tracking system
Financial Eligibility	County departments of social services	State employed financial workers– co-located with social workers who perform functional eligibility	Determined by HHSS
Standards	within 45 days; implemented "Fast Track" for hospitalized 3 days	within 45 days; internal standard within 15 days	Not Available
Plan of Care	Developed by case manager via home visit; some have lap tops	Automated plan of care	Not Available
Redetermination	Annually for both financial and functional; Tickler to prompt financial reassessment	At least annually for both financial and functional	Not Available

Source: The Lewin Group

States Profile: Provider Enrollment

	CO	WA	NE
Entry Point	Multiple entry points Fiscal agent assists during process	Multiple entry points	Multiple Entry Points
Criminal Background Check	No, except consumer directed program	Yes, centralized unit in DSHS	Not Available
Certification and Licensure	Differs by service provider; most by Department of Health	Differs by service provider; Residential Care Services is DSHS Unit	Not Available
Individual Providers	Personal care providers must be affiliated with an agency	Must have 2 hour orientation; after 120 days must complete 28 hour workshop "Fundamentals of Caregiving"	Able to pay friends or relatives as individual providers

Source: The Lewin Group