CHCS Center for Health Care Strategies, Inc.

Profiles of State Innovation:

Roadmap for Rebalancing Long-Term Supports and Services

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Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services

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The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries.

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Foreword

The Affordable Care Act of 2010 presents national policymakers and state leadership across the country with the opportunity to improve quality outcomes for low-income adults receiving long-term supports and services (LTSS). Even prior to its passage, a number of states had developed successful long-term care models, particularly in the home- and community-based service area. The SCAN Foundation wanted to create an opportunity for all states not only to learn about these various model programs, but also to provide a specific roadmap for states interested in implementing similar programs. Key issues include what concrete steps state officials need to consider within their own state as well as how to best interface with the Centers for Medicare & Medicaid Services to implement these options.

To this end, the Center for Health Care Strategies (CHCS) has developed three ***Profiles of State Innovation*** roadmaps to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community-based services; (2) the development and implementation of a managed LTSS program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare.

The mission of The SCAN Foundation is to advance the development of a sustainable continuum of quality care for seniors. The ***Profiles of State Innovation*** roadmaps outline ways to achieve a more balanced, integrated, and efficient LTSS system. The information included in each roadmap has the potential to ensure that older adults and people with disabilities can age with dignity, choice, and independence while remaining in their homes or in the environment they prefer.

We thank all of those who have contributed to this series, especially the state and program innovators profiled, and members of the project's National Advisory Group, who gave so generously of their time and expertise. We also acknowledge the dedication and hard work of the CHCS staff: Stephen A. Somers, Alice Lind, Lindsey Barnette, Suzanne Gore, and Lorie Martin.

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Top Ten Mileposts for Rebalancing Long-Term Supports and Services

This roadmap outlines best practices to help states reach the following critical mileposts in developing programs to rebalance long-term supports and services (LTSS).

1. Communicate a clear vision for LTSS and identify a champion to promote program goals.
2. Bridge the gaps between state officials responsible for medical assistance and long-term care.
3. Engage stakeholders to achieve buy-in and foster smooth program implementation.
4. Embrace a "No Wrong Door" philosophy for all HCBS to help consumers fully understand their options.
5. Deploy case management resources strategically.
6. Use a uniform assessment tool, independent of provider influence, to ensure consistent access to necessary LTSS services.
7. Support innovative alternatives to nursing homes.
8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.
9. Take advantage of initiatives that help people move out of nursing homes and into the community.
10. Analyze relevant data to track quality of care metrics that reflect the vision of the long-term care program.

Introduction

Many pages into the 906-page Affordable Care Act of 2010 (ACA)[1] is a section titled "Removal of Barriers to Providing Home- and Community-Based Services." This section offers support for stakeholders across the country who have advocated for a system of care that is: "responsive to the changing needs and choices of beneficiaries … and that provides strategies for beneficiaries receiving such services to maximize their independence."[2] But those stakeholders also know that they need more than the aspirations and legislative intent embodied in the ACA, they also need guidance from experts within the leading states that have already taken many of the necessary steps toward building such a system of care.

The states that have succeeded in creating innovative systems of long-term supports and services (LTSS) are pioneers who learned by trial and error how to build and improve their programs. These pioneering states, some which launched successful programs to rebalance or fully integrate care as far back as the 1980s, have achieved dramatic shifts away from institutional care and toward the home and community settings that maximize independence and are preferred by most beneficiaries. Within these states, consumers have a choice of options that focus both on keeping them in their communities and achieving their personal goals.

IN BRIEF

Medicaid pays for more than 40 percent of the nation's long-term supports and services (LTSS) costs. Although costs for LTSS represent almost one-third of all Medicaid spending, these services are often disconnected and financially misaligned. Overhauling the delivery of long-term care offers significant opportunities for states to improve health care quality, control costs, and enhance the quality of life for millions of Americans. Particularly today, health reform legislation extends new funding options for states to achieve a more equitable balance between institutional and home- and community-based care.

This roadmap culls from state best practices across the country to outline key elements for rebalancing LTSS programs to provide high-quality, consumer-focused, and cost-effective care.

The purpose of this project, *Profiles of State Innovation*, was to draw lessons from these LTSS pioneers and create roadmaps for other states to follow as they develop new or improved systems of LTSS. With support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) conducted an environmental scan to identify state best practices in three key areas:

- Rebalancing LTSS toward community-based care through care management or other non-capitated approaches;
- Developing and implementing a managed long-term supports and services (MLTS) program; and
- Integrating care for adults who are dually eligible for Medicare and Medicaid.

For this *Roadmap for Rebalancing Long-Term Supports and Services*, CHCS, with assistance from an advisory group of state staff and other experts,[3] identified four innovative states with expertise in

[1] Patient Protection and Affordable Care Act of 2010, page 183 found at http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590ENR/pdf/BILLS-111hr3590ENR.pdf
[2] Ibid.
[3] See appendix for list of advisory group members.

developing and implementing programs to help individuals with long-term care needs live in community settings (see sidebar for selection criteria). The lessons herein were gathered through interviews and in-depth site visits.

The four profiled states—Georgia, Oregon, Vermont, and Washington—each have different approaches to rebalancing care toward greater use of community-based services. These state efforts illustrate how success can be achieved in both rural and urban settings, in dramatically different geographical and political environments, and in programs initiated in the 1980s as well as those launched in the new millennium.

State Selection Criteria

To identify state innovators, CHCS and advisory group members referenced several information sources on state progress in improving LTSS systems, including the Kaiser Family Foundation and Thomson Reuters' reports on waiver expenditures, and an AARP report that breaks out LTSS expenditures by eligibility category.

General criteria:

- State's system for assessment, determination of need, and case management of LTSS is independent of providers.
- State collects and analyzes data for performance measurement, and mines data to track utilization and program impacts on costs.
- Consumers and other stakeholders are engaged in program design and quality monitoring.
- State is committed to continuous quality improvement of its LTSS to achieve a statewide system that supports multiple populations.
- State has formal and informal bridges across medical/LTSS systems.

Criteria for rebalancing states:

- State is committed and making progress toward supporting more than 50 percent of LTSS users with home- and community-based services (HCBS), or spends more than 50 percent of LTSS funds on HCBS.
- State conducts pre-admission assessment and care planning when beneficiaries transition from hospital to the nursing home.
- State either has commitment to eliminate the waiting list for HCBS, or limits its waiting list in a strategic way.
- State has an innovative approach/infrastructure to developing and supporting the LTSS workforce.
- State has engaged the nursing home industry to redirect resources to support people living in community.

State Environment

The criteria used to select innovative states for this environmental scan created a high bar, and no state has achieved success on every one of the criteria. In fact, it is striking how different the political and geographic environment is from state to state, even among those states leading the way on a more balanced proportion of spending on home- and community-based care for beneficiaries. This section briefly outlines the current national LTSS environment and principal factors motivating the focus on home- and community-based options in the four interviewed states.

Innovative states prioritize community settings and consumer choice.

All the state staff interviewed agreed that providing options and support for beneficiaries to live in community settings instead of institutions was an important role of their agencies. One reason they cited is the general belief that more people can be served in the community versus in institutions, which can help eliminate wait lists for waiver services. In some of the states, eliminating the wait list was a goal in itself. In Vermont, the individuals who meet the "Highest Needs" criteria have immediate access to the long-term care setting of their choice. A wait list is used periodically for this Highest Needs Group as a control against unlimited expansion. Vermont also identifies a Moderate Needs Group to offer a smaller menu of services for earlier intervention to delay more intensive services for those whose clinical needs do not qualify for the waiver.

Another motivating factor for states in supporting home and community options is clear consumer preference. In a recent survey of 500 AARP members in Vermont, 65 percent noted that they would prefer to receive long-term care in their own homes, 18 percent would like to receive care in an assisted living residence, and only three percent indicated that they would prefer to receive care in a nursing home.[4]

Innovative states are "all over the map."

Innovative states interviewed for this scan represent three of the four corners of the contiguous United States, and have dramatically different geographical challenges, with remote parts of Vermont perhaps the hardest to reach in winter. Vermont has one of the more challenging political environments as well: annual town meetings give every citizen the opportunity to challenge public officials face-to-face on the allocation of their tax dollars. States' eligibility criteria for LTSS vary dramatically, but low per capita home- and community-based services (HCBS) spending does not rule out success in rebalancing efforts. States interviewed included those that ranked second and fourth (Oregon and Washington) and last (Vermont) in spending for HCBS nationally.[5]

Rebalancing: Overall successes and challenges.

State interviewees uniformly reported that their biggest accomplishment was in successfully serving more than 50 percent of the beneficiaries in need of LTSS in the community. It is important to note that the definition of a "community" setting varies broadly for each of the interviewed states. While most people prefer to remain in or return to their own home, successful rebalancing states provide a range of home-like options to support beneficiaries' needs (see State Long-Term Supports and Services Rebalancing Program Dashboard (Figure #1) for an overview of programs in interviewed states).

[4] A. Bonner. "2010 Survey of AARP Vermont Members Age 50+ on Health and Livable Community Issues," AARP Knowledge Management. Available at http://www.aarp.org/home-garden/livable-communities/info-03-2010/vt_hlc_10.html. This survey was commissioned by AARP's Vermont Office in partnership with the Vermont Department Aging and Independent Living.
[5] B. Burwell. "Medicaid Long Term Care Expenditures FY 2007," Thomson Reuters, 9/26/2008.

However, even in states with longstanding success, challenges remain. In many states, for example, the beneficiaries who are initially moved out of institutional care are considered the "easiest" to move, and those still in institutions typically have more intense care needs. Some of the successful rebalancing states have many examples to the contrary. Oregon, for example, noted supporting individuals on ventilators in the community (see Milepost 9 on Money Follows the Person and similar initiatives). Special challenges also exist in rural areas where transportation is expensive and provider choice may be more limited.

Moreover, all of the states interviewed are facing the pressure of budget cuts. In some states, cuts are imposed across budget categories regardless of the proven cost-effectiveness of the program. All of the interviewed states have experienced staffing reductions that begin to cause some anxiety about their ability to effectively monitor quality of care and safety of beneficiaries. In order to maintain their innovative edge, states need to be able to hire and retain a cadre of staff with the background and commitment to support a high-quality program.

Figure 1: State Long-Term Supports and Services Rebalancing Program Dashboard

	Georgia	Oregon	Washington	Vermont
Implementation Date	1997	1981	Early 1983 1st Medicaid Waiver	2005
Medicaid Authority	1915c	1915c	1915c and Medicaid State Plan 1915i and Medicaid Personal Care	1115
Eligibility	SSI eligibility (frail elderly and disabled)	Aged and disabled beneficiaries; up to 300% SSI-income level; nursing facility level of care.	Aged and disabled beneficiaries; up to 300% SSI income level; nursing facility level of care.	Categorically needy, medically needy, and working disabled; up to 300% SSI-level income. High and highest-needs groups meet traditional nursing facility (NF) level of care.
Beneficiaries Served	18,000	32,000	31,250	4,000
Covered Benefits	PCP network, care management, LTSS including service coordination, personal care, home health, emergency response systems, and respite.	Home- and community-based services, including personal care.	Home- and community-based services, including personal care and a variety of creative services.	LTSS, including services provided to residents of NF and enhanced residential care.
Care Management Overview	Case manager makes initial home visit to complete assessment and quarterly to complete care path protocol. Coordinates care in collaboration with PCP.	Medicaid-funded case managers through state plan. Most in Area Agencies on Aging (AAAs), social workers by background.	All clients are assigned case managers (NF and HCBS recipients). AAA's case managers have responsibility for case management of clients living in their own homes. Most are social workers, all have access to RNs to assist with assessment and service planning related to medical conditions.	Home-based beneficiaries choose case managers from AAA or home health agency. Develop care plans that include services paid from other sources.
Performance Measurement Overview	Extensive readiness reviews include provider network adequacy. Ongoing monitoring includes claims review, monthly reports on utilization/sentinel events, and program integrity audits.	Quality assurance on federal assurances, including monitoring of care plan development, timeliness of reassessment. Quality improvement on whether individual preferences honored.	CMS core elements are monitored and reported annually. Have conducted quality of life survey. Inter-rater reliability of comprehensive assessments by case managers.	Monitors system indicators, such as time from application to enrollment, waiting lists, use of services by provider type, percent in HCBS by county. Routine client surveys conducted.

	Georgia	Oregon	Washington	Vermont
Percent Spent on HCBS[6]	11%	55%	54%	(not included in AARP report)
Route of Access to HCBS	To access SOURCE, consumers are generally referred by AAAs/state directly to a SOURCE site (in most areas, there are at least two choices of SOURCE providers, in some areas there are as many as four). Choice is based on PCP network.	State offices and AAAs both have front door entry. Computerized tool all on OR ACCESS system. Once screened, eligibility determined for both Medicaid and Older American Act (OAA) services.	Financial/functional eligibility assessment conducted by state staff and entered into CARE database. In-home Medicaid and OAA services provided by AAA staff.	Clients apply through eligibility office using combined clinical and financial application form. Clinical coordinators perform assessment for level of care.

[6] E. Kassner et al. *A Balancing Act: State Long Term Care Reform*, July 2008. Available at www.AARP.org/PPI.

Implementation Mileposts

Based on the experiences of four best practice states, this section describes the top 10 critical mileposts for states to meet in effectively implementing a strategy to support HCBS options.

1. Communicate a clear and compelling vision and identify a champion to promote the goal of increased HCBS delivery.

Health Reform Initiatives: The ACA, in §2406, expresses Congressional intent to expand the provision of home- and community-based long-term supports and services. This section supports local champions by providing direction from the federal level to expand HCBS offerings and guarantee that seniors and people with disabilities have the services they need in the settings of their choice.

Across the innovative states, a common theme was the need for the leadership of the LTSS program to establish a clear and strategic vision with a sense of accountability for community-based care. When Vermont implemented its HCBS program in 2005, its overriding LTSS goal was to eliminate the nursing home bias in the state's long-term care program. In Washington, which launched its program in the early '80s, overcoming the historical precedence that the nursing home services budget had over HCBS alternatives was a key goal. As the program was rolled out, every new service was tested against the principle, "will this help people live independently?" Charlie Reed, the head of Washington State's long-term care program at the time, brought nursing home and home- and community-based services together under one administration, as a way to overcome the obstacle of moving people into the community.

Based on their experiences, the interviewed states reported that the vision should clearly address the needs of the community. Identifying a champion within the responsible/accountable state agency is critical to communicating that vision to the broader group of stakeholders. Client advocates can then help support the goals of the state agency. For example, there was a groundswell of support for consumer preference in Washington, but the legislature was also feeling pressure because of a budget crisis that occurred in the 1980s. Charlie Reed convinced the legislature that providing LTSS in the community would save state funds over the long run, and worked with the legislature and stakeholders to pass major reform of the long-term care system. A consumer advisory council was formed to advise the state on its new LTSS program.

Over time, it has become the standard and extremely valuable practice for states to seek advice and input from consumer stakeholders. When consumers are highly engaged, the state can solicit their unique expertise in activities that might fall short without their participation, such as assisting in designing educational materials and planning community events. One pitfall to avoid is setting expectations too high. For example, at one point, Vermont began its community meetings by asking "what is missing from the current 1915c waiver?" This led some stakeholders to believe that everyone would get exactly what they wanted from the new waiver. Balancing consumer expectations with a transparent discussion about the pros, cons, and feasibility of program design options can greatly enhance stakeholder understanding and buy-in.

Oregon: Cementing a Vision for Long-Term Care

In 1981, Oregon developed a uniform vision to guide the merger of all aging-related program responsibilities, including eligibility, case management, Older Americans Act services, etc. The state was guided by the philosophy that every beneficiary should be able to live outside of institutions. Although these programmatic changes happened more than 30 years ago, staff still refer to the leadership as having produced a visionary piece of work that led to the state staff's "obsession" with getting people out of nursing homes. A critical partnership was formed between state leaders and retirees. "Waves of seniors with buttons" hit the legislature with strong lobbying for funding alternatives to nursing home care.

2. Bridge the gaps between leaders and staff for medical assistance and long-term care.

In most states, Medicaid responsibility is typically divided across medical and LTSS programs, but if both programs report to the same agency head, that leader can ensure a united purpose. Oregon and Washington's experiences illustrate variations in how program leadership can influence cross-divisional collaboration. In Oregon, the heads of the long-term care and the medical divisions were seen as equal partners in managing Medicaid, which was viewed as a funding source as opposed to a single program. In Washington, the heads of the long-term care and medical administrations reported to a single agency head, and over decades, the agency has enjoyed leadership that valued collaboration. It is worth noting that currently in both states, new initiatives are carving the responsibility for medical assistance out of the agency that has responsibility for long-term care. This is a challenge to the ongoing successful delivery of home- and community-based services, which relies on the single state authority for Medicaid to submit and revise waivers, communicate with the Centers for Medicare & Medicaid Services (CMS), etc. Moving forward, both Oregon and Washington will need formal agreements for such activities where informal arrangements of shared leadership have sufficed. In these days of scarce staff resources, they may also need formal agreements to designate staff to cross-agency teams for work to be accomplished.

Vermont: Cross-Divisional Bridges to Ensure Program Success

In states that have achieved success in rebalancing home- and community-based care, there is a great deal of behind-the-scenes, cross-divisional work. In Vermont, internal planning groups met for two years to detail the step-by-step implementation of its new program. Realizing how critical it would be for the system to function smoothly across departments, the planning team included Medicaid Management Information System (MMIS) and eligibility system staff along with LTSS program operations staff. In retrospect, Vermont's planning team wished they had invested six more months in addressing system issues prior to implementation, because once the program launched, it became much harder to make adjustments. Even so, the state continues to make refinements to improve the system, and the staff continue to work in cross-divisional teams to implement these upgrades. This example is also applicable to work across agencies, which can be even more challenging than cross-divisional collaboration.

3. Engage stakeholders early and often to achieve buy-in and ensure smooth implementation and sustainability of programs.

If a state does not have a strong consumer stakeholder presence, the loudest lobbying voice is usually that of the provider community. As one state cautioned, the providers' message to legislators is usually, "don't change anything." States need to consider the political environment and what will support reform efforts, for example, using new services to reduce or eliminate the waiting list, reduce overuse of certain expensive or scarce resources, etc.

In many states, the nursing home industry is the most vociferous lobbying group. For that reason, states need to think strategically about how to bring nursing homes into the stakeholder process early, and to consider what role they might play in a reformed LTSS environment.

In Washington, the 1993 reform legislation directly addressed the role of nursing home care, putting the industry simultaneously at ease but also on notice: "The legislature recognizes that nursing home care will continue to be a critical part of the state's long-term care options, and that such services should promote individual dignity, autonomy, and a homelike environment."[7] Even as the occupancy rate dropped from 94 to 84 percent, the legislature took action to support the viability and diversification of nursing homes. For example, an add-on rate was authorized for facilities that converted nursing home beds to assisted living units; a case-mix payment system was created to fund patients who have heavier care needs at higher rates; and nursing homes were allowed to "bank" licensed beds if their future use became necessary. These actions ensured that the nursing homes would survive a drop of almost 7,000 Medicaid-funded residents between 1992-2009.

[7] HB 2098, codified in RCW 74.39A.

Georgia: SOURCE Program Engages Providers

Georgia began its first elderly and disabled waiver, called the Community Care Services Program (CCSP), in 1982. Because progress under the waiver was slow, the state also pursued other programs to achieve a better balance of HCBS. Although the state was interested in a Programs of All-Inclusive Care for the Elderly (PACE) approach, local interest for this model was absent due to the capital investments needed. Instead, the state created an alternative PACE-like model: SOURCE, or Service Options Using Resources in a Community Environment. SOURCE was designed to strengthen aspects of the traditional HCBS waiver program by linking participants with a coordinated service system that included the primary care physician. SOURCE contractors were required to develop a pool of PCPs and provide access to them. In 1997, the first three SOURCE sites were established in partnership with three local hospital systems. As the program evolved, SOURCE sites were also anchored around Area Agencies on Aging and other for profit and not-for-profit providers. In 2005, two large LTC providers known for nursing facility care in Georgia joined the program as SOURCE sites, expanding their businesses into HCBS. Today there are 12 SOURCE sites across the state.

4. Embrace a "No Wrong Door" philosophy for all HCBS to help consumers fully understand and exercise their options.

Health Reform Initiatives: The ACA contains several provisions designed to help states finance the development of a streamlined eligibility and assessment system for access to HCBS.

- §10202- *Incentives for States to Offer Home- and Community-Based Services as a Long-Term Care Alternative to Nursing Homes* authorizes incentive payments to qualifying states that are working to rebalance the proportion of LTSS provided in the community. To qualify for this incentive payment, states must have a "no wrong door" network that provides access or referrals to all LTSS from any point of entry into the system. This incentive payment will increase the federal match (FMAP) on a state's total HCBS spending by either two or five percentage points.
- §2405 – *Funding to Expand Aging and Disability Resource Centers* (ADRCs) provides states with funding to streamline access to LTSS through the continued development of ADRCs. Many states use ADRCs as part of their "no wrong door" networks.

Many states have embraced a "no wrong door" philosophy across their Medicaid and non-Medicaid funded system of service delivery. That means that no matter how a consumer accesses the system, all the services they are eligible for will be described if not provided to them. For people needing LTSS, the best doorway to the system is usually at the local level, for example, the Area Agency on Aging (AAA) office, the Aging and Disability Resource Center (ADRC), or through field offices. However, in most states, federal rules do not allow the community-based entity that performs functional eligibility determination to also conduct financial eligibility determination (Oregon is the only exception, as it allows AAAs to do financial eligibility). The interviewed states identified various ways to address this policy barrier, for example, having state employees in locally based offices performing both eligibility determinations, or delegating both to county officials.

Above all else, it is critical that the eligibility process is seamless for the consumer, which Vermont accomplished by merging multiple forms into a single application. Additionally, the timing and review process needs to be accommodating to the applicant. Oregon and Washington both offer concurrent review of financial and functional eligibility to expedite determination decisions for consumers. Both states use field offices to conduct these reviews, and in Oregon, field offices can determine eligibility for the Older American Act and Medicaid services. In Oregon and Washington, the AAAs also have a role in screening for services; in both states, the AAAs determine eligibility for Older Americans Act, state family caregiver support, and senior citizens' act services.

Through the above processes, Oregon and Washington have streamlined the path to eligibility, a challenge Vermont is still wrestling with. Even though staff responsible for Vermont's financial and clinical eligibility are co-located in the same building, financial determinations take longer than clinical eligibility decisions, thus impeding a smooth eligibility procedure for consumers. Vermont is currently establishing a process to provide clinically eligible elders, who meet initial financial eligibility criteria prescribed by the department, with LTSS benefits while their full eligibility is being determined. Washington uses a "fast track" system of presumptive financial eligibility when appropriate so that long-term care services can be authorized in emergent situations where it appears the person will meet financial eligibility requirements.

Georgia: Aging and Disability Resource Center as Gateway to HCBS

Georgia allows beneficiaries to use their Aging and Disability Resource Centers (ADRCs), which include statewide entities, as their gateway to the HCBS provider network. The ADRC pilots in Georgia began in 2004 in two regions. A process evaluation of the first three years of the program describes the early challenges and achievements of the ADRCs.[8] For example, the pilots used different organizational structures and governance to reach the goals of: (1) uniform intake and eligibility determination; and (2) consistent provision of information and referrals. One of the pilots deployed ADRC staff throughout AAAs, while providing standardized training and access to common resource databases. Since the pilot period, Georgia's program has grown to nine ADRCs, covering 118 counties. In 2009, the program handled 47,511 people seeking HCBS, and maintained a long-term care database with 19,000 resources.[9]

In an interview with one ADRC, the organization described its role in providing options counseling to ensure that beneficiaries get the appropriate services at the appropriate time. The ADRC conducts eligibility screening to determine if consumers are eligible for any of Georgia's LTSS programs including SOURCE and, for those who are eligible, provides options on all SOURCE providers in the local area including itself in the case of two AAAs that also serve as SOURCE sites. Because the ADRC is meant to be unbiased in its role, it provides generic SOURCE information and neutral referrals. It has a rotation list for referrals if an individual does not request a specific SOURCE provider. The ADRCs run monthly reports on referrals to all SOURCE sites.

[8] A.P. Martínez and G. M. Landers. "Georgia Aging and Disability Resource Connection Expansion Evaluation," Prepared for the Georgia Department of Human Resources Division of Aging Services by the Georgia Health Policy Center, August 2007. Found at http://www.georgiaadrc.com/Portals/_AgencySite/pdf/Final%20ADRC%20Process%20Evaluation.pdf

[9] ADRC Accomplishments, found at http://www.georgiaadrc.com/site/418/adrc_accomplishments.aspx

5. Deploy case management resources strategically.

Health Reform Initiatives: As discussed in Milepost 4, §10202 of the ACA authorizes an incentive payment to qualifying states that are working to rebalance the proportion of LTSS provided in the community. A second condition that states must meet to qualify for this incentive payment is to provide "conflict free" case management. More guidance on this provision is expected in the next several months.

States with innovative LTSS programs have invested extensive resources in case management services. Most of the interviewed states have an explicit goal of "conflict-free case management," meaning that the provider agency (which stands to benefit from increased service utilization) does not determine the level of services authorized under the care plan. Indeed, the importance of conflict-free case management is addressed in ACA, which notes that this standard must be met for states to apply for federal "balancing incentive" funds.

The interviewed states use a variety of strategies to achieve conflict-free case management:

In Vermont, the beneficiary is allowed to choose his or her case management provider. Vermont allows Home-based and Enhanced Residential Care beneficiaries to choose a case manager[10] from either a home health agency or an AAA. The state's long term care ombudsman reports that although individuals choose both options, they are more likely to switch to the AAA for case management. While such switching is not necessarily due to the potential for conflict related to the provider agency coordinating services, offering consumers the choice has nonetheless increased the level of conflict-free case management. In Vermont, the state sets the standards for case management, allowing both nurses and social workers to play this role.

In Washington, case management responsibility is assigned based on the beneficiary's location. The responsibility is split between state staff and AAAs. Washington's Aging and Disability Services Administration is split into two divisions: (1) Home and Community Services, which provides case management for beneficiaries in residential settings (adult family homes, boarding homes, and nursing facilities); and (2) the State Unit on Aging, which oversees AAAs that provide case management for beneficiaries living in their own homes. Washington feels it is essential to provide case management for nursing home residents to increase transitions to home and community settings.

In Georgia, care management includes close coordination with the medical system. Upon enrollment in Georgia SOURCE, the care manager completes an assessment during a home visit and prior to review by the multidisciplinary care team. The care manager works closely with the beneficiary, the beneficiary's primary care physician and the agency medical director to coordinate care. The assessment provides more extensive information to the physician about the beneficiary's social history, home environment, and functional status than would be obtained during a traditional physician visit. Care managers contact participants at least once a month and make home visits at least once every quarter. Care path outcomes are monitored at each quarterly home visit.

[10] Interviewed states use both care manager and case manager designations. Although care manager typically refers to a nurse and case manager to a social worker, these terms vary across states. This paper refers to state-specific nomenclature.

Washington: Intensive Chronic Care Management Program for LTSS Beneficiaries

Washington State's Intensive Chronic Care Management (ICCM) program started in 2002 as a combined effort of Aging and Adult Services and Medical Assistance. The program grew out of a realization that the most expensive LTSS beneficiaries were also the most costly for Medical Assistance. The model, supported with funding from both Medical Assistance and the state's Aging division, was designed to improve outcomes and lower costs. During the pilot phase, eligibility for the program was limited to the diagnoses of paraplegia, quadriplegia, or morbid obesity. After a two-year pilot, the eligibility was expanded to include other high-cost beneficiaries, identified through predictive modeling as being in the top 20 percent of risk. In addition, beneficiaries were eligible if they received long-term care and met one of five criteria: live alone; have a self-rating of health status as fair/poor; are assessed at a low level of self-sufficiency; have documented agitation/irritability; or are on six or more medications. Beneficiaries are randomly assigned to either a treatment or control group.

Nurses who work for AAAs operate the program. They have full access to the Predictive Risk Intelligence System (PRISM), which is Washington's in-house predictive modeling system. Through PRISM, nurses can look for utilization data, including labs, emergency department visits, medications, a calculated risk score, and identified gaps in care.

Key features of ICCM:

- Face-to-face contact, in combination with telephonic contact;
- A multidisciplinary approach, with the social worker as a valued member of the team;
- Use of Patient Activation Measures[11] and motivational interviewing to guide the coaching and education; and
- Fidelity to the model: file review is conducted on every client every four to six weeks.

Based on the program's success, the state will add ICCM as a state plan benefit with a goal of statewide availability.

6. Use a uniform assessment tool, independent of provider influence, to ensure consistent access to necessary LTSS services.

Health Reform Initiatives: As discussed in Mileposts 4 and 5, §10202 of the ACA provides an incentive payment to qualifying states that are working to rebalance their system of LTSS. One of the conditions that states must meet to qualify for this incentive payment is utilization of a core standardized assessment instrument. This instrument must be used statewide to determine eligibility for HCBS and develop individual service plans to address identified needs.

One way to help ensure objectivity in the assessment and authorization of services is to implement a standardized system for data collection, determination of need, and case management of LTSS. In ACA, this is described as having "core standardized assessment instruments" that generate individual service plans. States emphasized different aspects of the assessment process as contributing to their overall success in rebalancing. The assessment tools in many states began as "needs-based" instruments and

[11] For more information on Patient Activation Measures, visit http://www.insigniahealth.com/products/pam.html.

evolved to also recognize beneficiaries' strengths. In addition, the population living in the community has been increasingly recognized as having complex clinical and social issues, so uniform assessment tools have to address the full range of complex needs. The interviewed states have also added screening for physical and mental health care needs, and diverse family and community support situations. In sum, the uniform assessment cannot be a short or simple tool.

In Vermont, the clinical assessment is conducted by a state-employed nurse clinical coordinator, a separate function from the case managers (who may work for a service provider). The clinical coordinators are locally based but centrally hired and trained and supervised by the state. Vermont attributes its low turnover of nurses to the intensive six-week training before the program was implemented. This gives the otherwise geographically dispersed nurses a chance to develop operational consistency and supports.

In Oregon, non-clinical field staff use a computer-based standard tool for service assessment.[13] This establishes a "priority" indication on a scale of 1-99, where those eligible for services are ranked 1-13. The assessment is driven by a series of screening tools, which prompt the person conducting the assessment for details on activities of daily living (ADL), natural supports, and diagnoses. In addition, the beneficiary's goals are taken into account in developing the plan of care. Completion of the service planning tool leads to the authorization of LTSS (adult day, meals, etc).

Washington: Using the Automated CARE Tool to Assess Beneficiary Needs

Washington's electronic CARE tool was originally modeled after a similar assessment tool used by Oregon's Medicaid agency.[12] The tool identifies a level of acuity ranging from 1-17 using clinical complexity, behavioral scores, ADLs, and cognition. The minimum data set (MDS) is built in, which allows comparison of ADL scores across the population, whether in a nursing facility or a home or community setting. For ADLs, both the need and whether it is met or unmet is documented. Other built-in screens include mental health and depression screening and a protocol to assess skin condition, including case management triggers for potential skilled nursing intervention.

Algorithms are used to automatically determine the specific number of personal care hours and the specified reimbursement rate for facility-based care. For personal care, a maximum of 420 hours is generated by the assessment, but an exception process can be used if the hours authorized are not enough to guarantee health and safety (1 – 2 percent are on exception). As Washington's staff stated, the rates are based on specific personal care needs. In every state, this was an underlying theme: in order to move people out of institutions a certain comfort with the inherent risk in living unsupervised has to be tolerated, not only by beneficiaries and their families, but just as importantly by care managers and providers.

Georgia chose to adopt the Minimum Data Set-Home Care (MDS-HC) assessment tool for use in both its Community Care Services and SOURCE programs. MDS-HC data elements have been cross-walked to the state's level of care criteria for nursing home admission to assure that participants meet the required institutional level of care. To further assure level of care compliance, the state has contracted with a software development company to automate the assessment process, resulting in less subjectivity in the level of care determination, but it has been slow to roll out.

[12] Found at http://www.adsa.dshs.wa.gov/professional/hcs.htm.
[13] For more information, see http://www.dhs.state.or.us/spd/tools/cm/capstools/index.htm. The CAPS Tools section of this link provides information on the tool used for assessment. The Full CAPS Assessment – Paper Tool includes a PDF of the actual tool.

7. Support the development of or invest in innovative settings to provide alternatives to nursing homes.

Health Reform Initiatives: The ACA includes several provisions that support the expansion of community-based alternatives for LTSS. While these provisions do not specifically fund the development of specialized community-based housing, states may consider the following provisions to expand access to HCBS.

- §2401 – *The Community First Choice Option* establishes a new state plan option for attendant services and provides increased federal financial participation for these supports. This provision also grants states the option to cover transitional services, such as the first month's rent and household furnishings, through the state plan.
- §2403 – *The Money Follows the Person (MFP) Rebalancing Demonstration* extends MFP through 2016 and reduces the length of time that an individual must reside in a facility prior to participating in MFP. All MFP participants must transition to a "qualified residence" as defined by §6071(b)(6) of the *Deficit Reduction Act of 2005.* A qualified residence includes an individual's private residence, a family home, or a home in which no more than four unrelated individuals reside.
- §10202 – As discussed in Milestones 4-6, §10202 provides incentive payments to qualifying states that expand HCBS options.

States are testing a variety of community-based alternatives to expand care options for eligible beneficiaries. Oregon and Washington use adult family homes and other alternative settings for home-like care environments. Oregon has supported the conversion of nursing home wings for adult day and other services.

States may find that engaging nursing homes to create alternative settings may open the door for creative options that would otherwise not be possible given limited state resources in today's tight budget environment. The Oregon long-term care director said that in the early days of their HCBS waiver (1980s) when the state budget was on firmer footing, they had the luxury of reinvesting saved dollars in the program. Therefore, they were able to invest money in new facilities, converting nursing home beds and creating adult family homes. He said he doubted most "unbalanced" states would be able to do that now, and instead they would be better off focusing on keeping people in their own homes.

Vermont has some beneficiaries in HCBS who live in unlicensed home settings, which is especially helpful as a local source of care for people with dementia. States have different rules about which services can be used in combination, but allowing beneficiaries to access adult day services while living in a supportive environment is another strategy for meeting the needs of people with Alzheimer's and other cognitive impairment.

Alternative Settings

Vermont has taken an active role in developing specialty care settings for beneficiaries with Huntington's disease and those who are dependent on ventilators. The goal of these specialty settings is to bring groups of beneficiaries back to Vermont who were housed outside the state due to inadequate in-state resources. These specialty settings rely on shared resources and staff from local hospitals, as well as innovative rate-setting. Vermont also has over 300 beneficiaries in Enhanced Residential Care, which provides 24-hour care in licensed Residential Care Homes and Assisted Living Residences.

Georgia supports more than 2,000 beneficiaries in Alternative Living Services, which are licensed personal care homes providing 24-hour personal care and nursing supervision.

Oregon has made a huge investment in Relative and Non-Relative Foster Homes. In 2009, these homes accommodated 3,182 seniors and 1,317 people with disabilities, respectively. These Adult Foster Homes serve as an alternative to nursing home care for up to five residents.

Washington licenses both Adult Family Homes as alternatives to nursing home care for up to six residents, serving 4,393 beneficiaries in 2008. Boarding Homes, which are licensed to serve seven or more residents, accommodated more than 6,000 beneficiaries in 2008. Boarding Homes range from assisted living to Enhanced Adult Residential Care, which includes intermittent nursing care and specialized dementia care.

8. Expand the pool of personal care workers to increase the numbers of beneficiaries in home and community settings.

Health Reform Initiatives: Numerous provisions in the ACA focus on expanding the pool of direct care workers and enhancing training and development opportunities for them. Examples of these provisions include:

- §2401 – *The Community First Choice Option* establishes a new state plan option for attendant services and includes a provision for the compensation of family members (to be defined by the Secretary).
- §5302 – *Training Opportunities for Direct Care Workers* amends Title VII of the *Public Health Service Act* to offer grants to institutions of higher education and other qualified organizations to provide training to direct care workers in geriatrics, disability services, long-term supports and services, or chronic care management.
- §5305 – *The Geriatric Education and Training* provision provides organizations with grants to offer practical training for supporting frail elders and individuals with disabilities. This training must be provided at no charge or for a nominal fee to family caregivers and direct care providers.
- §5507 – *The Demonstration Grants for Developing Personal Care Aid Competencies* provision funds programs to develop core competencies, training curricula, and certification programs for personal and home care aides.
- §6703 – *The Elder Justice Act* directs the Secretary of Labor to provide incentives for individuals to train for and seek employment in direct care fields and to establish career ladders and wage or benefit increases to increase staffing for LTSS.

One mechanism for increasing the amount of funding available to HCBS beneficiaries is through broad delegation of skilled nursing tasks. Both Oregon and Washington have used this method, thereby allowing personal care providers to do many complex tasks otherwise performed by licensed personnel. States can negotiate "nurse delegation" policies and regulations, which require buy-in from the organized nurses in the state and the nursing commission. Over time, the services that can be delegated to a non-family member have expanded. For example, the most recent addition in Washington allows the administration of insulin by injection.

States made the point that all LTSS settings are drawing on the same pool of workers, so rather than increase the competition for workers, states need to identify creative ways to increase the pool if they want to serve more people. Most of the interviewed states allow paid family caregivers to provide care for beneficiaries. Paid family caregivers can play an important role in keeping people out of institutions.

The Vermont legislature authorized a study of the direct care workforce to gather information from providers and users of direct care to help address workforce shortages.[14] The study includes these core findings:

- "Wages and benefits are central to attracting and retaining direct care workers."

[14] Legislative Study of the Direct Care Workforce in Vermont, March 2008. Submitted to the Senate Committees on Appropriations and Health and Welfare and the House Committees on Appropriations and Human Services by J.K. Senecal, Commissioner, Department of Disabilities, Aging and Independent Living, Vermont Agency of Human Services. Prepared by J. A. Livingston and D. Reback. Available at http://dail.vermont.gov/dail-publications/publications-legis-studies/dcw-report-exec-summary.

- "The people who do this work value their relationships with the people they care for and support, and have a deep commitment to helping and making a difference in others' lives."

Several recommendations are useful for any state, although some carry a price tag:

- Direct care workers deserve a livable wage and health insurance.
- Turn to new sources (e.g., "young workers, mature workers, family caregivers," etc.) to recruit direct care workers.
- A career ladder should be available to direct care workers, with access to affordable training and education.

In Washington, Oregon, and Vermont, the use of consumer- or surrogate-directed personal care providers has outgrown the use of agency hired staff. In Vermont the fiscal intermediary assists consumer- and surrogate-directed employers with payroll; Washington State acts as a government fiscal agent and provides a level of reimbursement for health insurance for personal care workers. Washington State also operates a Home Care Referral Registry where Medicaid clients can access potential personal care employees who have been screened and completed a background check.[15] Personal care workers must attend and are reimbursed for required training. In Oregon, home care workers are a unionized work force that are represented by the Service Employees International Union. The state's Home Care Commission ensures quality in-home care services by establishing minimum qualifications, and offers training for home care workers around the state, which is not mandatory, but is reimbursed. The Home Care Commission also maintains the home care worker registry, which is publicly accessible (see Oregon Home Care Commission sidebar).

[15] Washington has home care referral registry website with videos and written resources about how to hire and supervise workers, found at http://www.hcrr.wa.gov/.

Oregon Home Care Commission: Resources for Beneficiaries and Employers

The Oregon Home Care Commission (OHCC) has four major responsibilities:

- Define the qualifications of home care workers;
- Create a statewide registry of home care workers;
- Provide training opportunities for home care workers and consumers (beneficiaries); and
- Serve as the "employer of record" for purposes of collective bargaining for home care workers whose pay comes from public funds.

The Oregon Home Care Commission maintains a searchable registry database for Medicaid beneficiaries, as well as members of the general public, interested in hiring a home care worker. The person interested in employing a home care worker enters characteristics about the employment setting (e.g., are they on a bus line, do they have pets in the house, are they a smoker?) and their characteristics and needs (gender, age, cognitive impairment, language, and services required). The employer indicates if the job is full-time, part-time, live-in, respite or short notice, and enters days of the week and the time of day a home care worker is needed. Beneficiaries who use the registry can also specify training in relevant areas: e.g., first aid, CPR, bathing and grooming, blindness and low vision, dementia and Alzheimer's, diabetes care, medication safety, stress management, and working with challenging behaviors.

Home care worker training is provided in various locations throughout the state, and in three languages. Home care workers who have completed core classes, safety training, and CPR/First Aid are eligible for Professional Development recognition.

Beneficiary training is provided through contracts with the Centers for Independent Living statewide. STEPS to Success with Homecare Workers provides small group or individual sessions designed to teach and reinforce skills needed for beneficiaries and/or designated representatives to function independently in the employer role. In Oregon, the state conducts criminal history checks, but beneficiaries are responsible for interviewing, checking references, and training home care workers to perform authorized tasks according to their needs and preferences.

An Employer Guide, developed by Oregon state personnel, is available through the Commission website. The Employer Guide provides helpful information for beneficiaries who need to hire a homecare worker, including:

- Checking references and conducting a background check;
- Hiring, including interview questions and questions to avoid;
- Setting expectations for home care workers;
- Evaluating and paying for work; and
- Handling termination of a worker.

In addition, the Home Care Commission website includes links to a variety of publications developed by Oregon Department of Health Services including the Employer Guide, Homecare Worker Guide, an Infection Control Self-Study Course, and a detailed manual about using the Registry and Referral System developed by the Commission. For more information, visit the links below:

Consumer/Employer Tools: http://www.oregon.gov/DHS/spd/adv/hcc/tools_emp.shtml

Home Care Worker Tools: http://www.oregon.gov/DHS/spd/adv/hcc/training.shtml

Registry and Referral System: https://www.or-hcc.org

9. Take advantage of Money Follows the Person and other initiatives that help move people out of nursing homes and into the community.

Health Reform Initiatives: Several provisions in the ACA enhance and expand existing supports and services for individuals transitioning from facilities to the community.

- §2401 – *The Community First Choice Option* builds on the success of MFP and grants states the authority to cover transition services through the state plan.
- §2403 – *The Money Follows the Person (MFP) Rebalancing Demonstration*, as discussed below, extends MFP through 2016 and reduces the length of time that an individual must reside in a facility prior to MFP enrollment. The MFP demonstration includes enhanced federal match and the opportunity for states to receive federal match for transition services, such as the support of a transition coordinator and funding for services such as the first month's rent and household furnishings.

In July 2010, CMS announced a renewed commitment to the Money Follows the Person (MFP) program. The MFP program was originally authorized under the Deficit Reduction Act of 2005 to help states transition Medicaid beneficiaries from nursing home settings to the community.[16] Currently, 29 states and the District of Columbia have implemented MFP programs.

Under the new MFP provisions, CMS has extended the authorization for these programs through September 2016, and added $2.25 billion to support implementation. Funding will be used for enhanced federal match for program infrastructure, technical assistance, HCBS, and "demonstration" services to assist in the transition to the community, as well as direct reimbursement of certain approved state administrative costs. A major change in the program under ACA is that individuals who have resided in institutions longer than 90 days are eligible to participate.

Innovative states have acted on MFP and similar initiatives during the 10 years since the Olmstead decision in 1999, a ruling under the Americans with Disabilities Act that required states to serve individuals with disabilities in the most integrated setting that fits their needs. To keep up the momentum generated by Olmstead, Oregon has placed diversion staff in field offices to link beneficiaries with appropriate home- and community-based options, including the state's MFP program.

Georgia has had an MFP program since 2006. The MFP transition coordinators interact closely with the SOURCE program case managers to identify and provide appropriate transition to HCBS services for eligible beneficiaries. The collaborative model between MFP and waiver staff, outlined here, is a good example for other states:

- Waiver Program case managers refer potentially eligible beneficiaries to MFP, but more often MFP refers beneficiaries to SOURCE and other waiver programs.
- MFP transition coordinators are responsible for recruitment and screening. They provide baseline information about each beneficiary, including goals, diagnoses, functional abilities, cognitive and language function, and the services the beneficiary currently uses as well as additional services that are needed.
- Waiver Program case managers are responsible for conducting the assessment, providing information to facilitate the transition, and collaborating on the care plan.

[16] For more information on Money Follows the Person, visit https://www.cms.gov/CommunityServices/Downloads/MFP2011SolicitationOAGMFinal_July23.pdf.

- A team approach to train the transition coordinators and case managers is conducted, including training on: waiver services; transition; self-direction; assistive technology; and community resources.

Washington: Innovations to Support Community-Based Living

Washington has several programs designed to move people out of nursing facilities (NF) and into the community, including the Roads to Community Living program, funded by an MFP grant. Based on Washington's experience, the state interviewees offered this advice.

- **Start early.** Ideally, the transition coordinator should determine the barriers to discharge within the first seven days of the beneficiary's admission to the NF.
- **Start with a big pool.** Staff may need to work with five beneficiaries who express interest in order to move one person out of a NF.
- **Use a facilitator.** This facilitator role is critical for finding housing, working with families, etc. Washington state staff are currently requesting an increase of these facilitator resources from the legislature.
- **Rely on existing data.** The Washington state staff are using MDS data differently within the MFP program. Since these data are captured for people in home and community settings as well as in NFs, staff can look for people residing in NFs who are at a similar level of need, as determined by the MDS. The staff have logically concluded that it is possible to meet those beneficiaries' needs in the community.
- **Showcase your successes.** Washington touts these numbers to its advantage: On average, an MFP client costs $2,900/month when moving home. Although they are more expensive than the average HCBS client (at $1,700/month), they are still cost-effective compared to the average $5,000/month spent on NF. Because of the proven success, the Washington legislature approved additional funding to assist individuals who want to move from a nursing home to community settings in each of the past two fiscal years.
- **Be patient with the process.** The average number of days from a beneficiary agreeing to move to the actual move date is 57 days. Of note, Washington is targeting the most complex clients under its MFP program. Nursing home relocations for non-MFP participants average 14 days.
- **Don't give up.** The oldest person to take advantage of MFP to move home was 100 years old; the person who resided longest in an NF had been there for 17 years before moving back to the community.

10. Gather utilization data and use them to track quality of care metrics that reflect the vision of the long-term care program.

States that are successful at rebalancing LTSS rely on the collection and use of electronic data on HCBS utilization. Most also collect and use assessment data electronically. In fact, the best data systems link screening, assessment, utilization, and cost data across the continuum of care, allowing states to compare care experiences for subsets of their LTSS populations. States are starting to publicly report on aggregated HCBS performance measures and should be ready to respond to increasing consumer demands for specific provider data similar to nursing facility data that are already in the public domain.

States with the majority of their beneficiaries in community settings tend to focus on a few key metrics that are tied to specific goals for their programs. Vermont, for example, tracks the proportion of the population served in nursing homes vs. home and community settings per county, and uses the result to focus quality improvement work at the local level. Early in the implementation of Oregon's waiver, staff met to review a similar metric on a weekly basis.

In order to maintain and improve their programs, the states have established robust provider oversight and monitoring requirements. Washington performs a remote audit on six percent of the electronic assessment data, allowing a comparison based on region or individual case manager. With recent budget cuts, the state is considering what can be monitored remotely and what needs to be done in person.

Overall, state LTSS systems require data collection for rational budgeting (unit basis of costs, provider costs and services, etc.). Vermont tracks expenditures by monthly monitoring (NF vs. HCBS) under a global budget approach. One value of collecting actual costs is that it helps the state negotiate rates with providers.

Vermont's Quality Oversight

In 2009, the University of Massachusetts Medical School issued a policy brief on Vermont's quality oversight strategies for its LTSS program.[17] The brief explores monitoring activities of CMS and various state agencies, and provides recommendations on streamlining the practices. Following is a subset of these recommendations that may provide value for other states:

- Ensure that licensing standards encompass consumer-centered principles.
- Share licensing data across agencies.
- Maximize the use of desk reviews of quality-related data.
- Conduct comprehensive reviews of case management agencies/organizations.
- Conduct large-scale surveys of beneficiaries who use HCBS.
- Use focused interviews with consumers, providers, and stakeholders to supplement quantitative data collection methods and point out possible solutions to systemic problems.

The states are all in search of more effective LTSS-focused measures. Several of them discussed the need for a standardized set of performance measures that reflect HCBS. This certainly appears to be an opportunity for national leadership at either the federal or non-profit level, to avoid having all 50 states reinvent the wheel. The Agency for Healthcare Research and Quality (AHRQ) recently released an environmental scan of measures in HCBS programs.[18] The Technical Expert Panel for this project organized measures into three domains: Client Functioning, Client Experience, and Program Performance. Measures under each domain were then rated for their feasibility.

[17] University of Massachusetts Medical School, "Vermont Choices for Care Policy Brief: Quality Oversight," April 2009.
[18] Environmental Scan of Measures for Medicaid Title XIX Home and Community-Based Services, accessed at http://www.ahrq.gov/research/ltc/hcbsreport/hcbssum.htm.

The resulting measures are organized by construct, such as maintenance of family relationships and opportunities to make choices about services. AHRQ has further work to do, but the agency has provided a new and helpful resource for states.

Vermont's recent work on improving performance measures involved stakeholders, including input from providers and beneficiaries as to which indicators should be measured. Georgia is developing a unique pay for performance program for nursing facilities. Measures from these states that appear promising, but will need work to standardize, include:

- Falls assessment and injuries related to falls (Washington);
- Skin observation protocol and incidence of breakdown (Washington);
- Quality of life surveys of beneficiaries and families (Washington);
- Pain protocol and outcomes (Oregon);
- Personal preference and providers' ability to individualize care (Oregon); and
- Client choice and whether it was honored (Vermont).

Conclusion

The states interviewed for this *Rebalancing Roadmap* project have proven that it is possible, and more urgent than ever, to achieve a more balanced system of long-term supports and services. Their success in navigating this journey relies on using strong case management, family caregivers, innovative settings, and new technology, but most importantly, leadership and highly motivated state staff who keep their eyes on a shared vision. As we all age and imagine ourselves as potential long-term care beneficiaries, we hope that all states will learn from the pioneers chronicled herein to help individuals across the country maintain their cherished independence and the ability to maintain maximum control over their lives.

Appendix A: List of State and Plan Interviewees

Georgia

Catherine Ivy, Director, Long Term Care Division, Georgia Department of Community Health

Cathie Berger, Director, Area Agency on Aging, Atlanta Regional Commission

Teresa Thompson, Director, Wesley Woods SOURCE Program, Wesley Woods Hospital of Emory Healthcare

Oregon

James Toews, Assistant Director, Seniors and People with Disabilities, Department of Human Services

DeAnna Hartwig , Administrator, Federal Resource & Financial Eligibility, Seniors and People with Disabilities

Angela Munkers, Interim Field Services Manager, Seniors and People with Disabilities

Judy Mohr-Peterson, Assistant Director, DHS Medical Assistance Programs

CareOregon
Rebecca Ramsey, Senior Manager of CareSupport and Clinical Programs

Washington

Kathryn P. Leitch, Assistant Secretary, State of Washington Department of Social and Health Services, Aging and Disability Services Administration

Bill Moss, Director, Home and Community Services Division

Candy Goehring, Unit Manager, ADSA, Home and Community Services Division

Bea Rector, Office Chief, ADSA, Home and Community Services Division, State Unit on Aging

Chris Imhoff, Office Chief, ADSA, Home and Community Services Division, Home and Community Programs

Vermont

Brendan Hogan, Acting Commissioner Agency of Human Services, Department of Disabilities, Aging and Independent Living

Marybeth McCaffrey, Director, Division of Disability and Aging Services

Adele Edelman, Director, Adult Services Unit

Camille George, Director, State Unit on Aging

Bard Hill, Director, Data and Planning Unit

David O'Vitt, Director, Clinical Services Unit

Nancy Marinelli, Medicaid Waiver Supervisor

Megan Tierney-Ward, Medicaid Waiver Supervisor

Merle Edwards-Orr, Consumer Direction Manager

Appendix B: National Advisory Group Members & CMS Participants (in addition to State Interviewees)

Joseph Caldwell
Director, Long-Term Services and Supports Policy, National Council on Aging

Mike Cheek
National Association of State United for Aging and Disabilities

Sara Galantowicz
Senior Research Leader, Thomson Reuters Research Department, Commuity Living Systems Group

Cyndy Johnson
Independent Consultant

Diane Justice
Senior Program Director, National Academy for State Health Policy

Enid Kassner
Director, Independent Living/LTC
AARP Public Policy Institute

Harriet L. Komisar
Senior Research Analyst
University of Maryland, Baltimore County
The Hilltop Institute

Barbara Lyons
Vice President, Deputy Director KCMU
Kaiser Family Foundation

Anne H. Montgomery
Senior Policy Advisor, Senate Special Committee on Aging

Martha Roherty
Executive Director, National Association of State United for Aging & Disabilities

James M. Verdier
Senior Fellow, Mathematica Policy Research, Inc.

Centers for Medicare & Medicaid Services

Linda Peltz
Director, Division of Coverage and Integration

Carrie Smith
Technical Director, Division of Coverage and Integration

Mary Sowers
Director, Division of Community and Institutional Services
Center for Medicaid, CHIP & Survey Certification
Disabled and Elderly Health Programs Group

CHCS Online Resources

This roadmap is part of CHCS' ***Profiles of State Innovation*** series, made possible through The SCAN Foundation to help Medicaid programs develop high-quality, cost-effective, and consumer-focused approaches for delivering long-term supports and services. Following are additional documents in the series as well as further resources available at www.chcs.org.

- ***Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*** – Outlines key mileposts to help states better manage the full array of long-term supports and services.
- ***Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles*** – Outlines key considerations to help states decide what direction to choose for designing integrated approaches for duals.
- ***Medicaid-Funded Long-Term Care: Toward More Home- and Community-Based Options*** – Outlines policy recommendations for reforming the nation's Medicaid-funded LTSS system to support more cost-effective and consumer-oriented long-term care options.
- ***Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*** – Presents novel alternatives for reforming the delivery of Medicaid-funded long-term care, including both innovations that have been implemented as well as promising practices.

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