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Community-based long-term services financed by Medicaid: Managing resources to provide appropriate Medicaid services

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Introduction

Historically, most long-term services and supports financed by Medicaid have been provided in institutions, but the trend is toward providing more community-based services. Over half of state Medicaid programs enhanced community-based services in fiscal year 2006 and 38 states report that expansions are planned for fiscal year 2007.[1] The shift away from institutions has been prompted by states' cost containment goals and by political pressure to integrate people with disabilities into communities. States' approaches to providing long-term services differ as does the extent to which community-based services are available. In fiscal year 2005, for example, the proportion of Medicaid long-term service expenditures for the elderly and individuals with disabilities devoted to community-based services in the 50 states and the District of Columbia ranged from one percent to 54 percent.[2]

All states face the challenge of using limited resources to meet a substantial and growing demand for long-term services. The financial eligibility criteria states use to determine who qualifies for program benefits represent one method for targeting program benefits. These criteria receive considerable attention in debates about who should receive services. The criteria and processes used in states to assess functional eligibility and develop care plans also have a significant impact on who gets services and what kind of services they get, but they receive less public attention.

Three types of benefits account for most Medicaid spending on community-based long-term services. They are: 1) Home and community-based waiver program services, also known as 1915(c) waivers or HCBS waivers, which allow states to waive certain federal requirements and to provide community-based services to individuals who otherwise would require institutional care; 2) home health services, which all states must cover under the Medicaid state plans; and 3) optional state plan ser-

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vices, such as personal care and rehabilitative services, which states may cover under Medicaid state plans. A few states also provide long-term care services under Section 1115 waivers, which allow states to make fundamental changes to the Medicaid program. Currently, the majority of spending for Medicaid-financed community-based services is through home and community-based waiver programs.[3] The Deficit Reduction Act of 2005 (DRA) permits states, beginning in January 2007, to provide community-based waiver services as state plan services. This may change the way Medicaid-financed long-term care services are delivered in the future (see Box).

Generally, HCBS waivers are used to provide services to particular groups of people, such as people with intellectual or other developmental disabilities, people with spinal cord injuries or traumatic brain injuries, people with AIDS, the frail elderly, and people with physical disabilities. Regardless of the population served, however, certain requirements affect all individuals who apply for or receive waiver services. First, the state Medicaid program must certify that they meet the requirements for a "nursing facility level-of-care." Each state sets its own "level-of-care" criteria. Second, each beneficiary must have a written plan of care. A driving force in the design of Medicaid HCBS waiver service programs had been the "budget neutrality requirement," which mandates that federal costs for home and community-based waiver services not be greater than the cost of institutional services.

As states strive to provide optimal services at a reasonable cost, two sets of questions should be part of the deliberation:

1. How should functional eligibility or "level-of-care" be determined?
    - What criteria should be used?
    - Should the same process be used to assess functional eligibility for all service settings?
    - Should states use more than one level of care?
    - Who should conduct assessments for functional eligibility?
    - What kind of training should be provided?
2. How should care plans be developed?
    - To what extent should consumers be involved in care planning?
    - Should cost limits be applied to care plans?

This issue brief examines these questions, describes current state policies and practices, and provides examples to show how states make functional eligibility determinations and develop plans for community-based long-term services financed by Medicaid.

The Impact of the Deficit Reduction Act on the Delivery of Community-Based Services

The Deficit Reduction Act of 2005 (DRA) permits states, beginning in January 2007, to provide community-based waiver services as state plan services. States are permitted to establish enrollment caps, maintain waiting lists, and provide services only in certain parts of a state for this new state plan service. The DRA also permits states to allow self-direction of services without seeking a waiver and to limit the use of the self-direction option to certain populations or certain parts of the state. Thus, states have another option for the delivery of long-term services.4

While there is some interest in the option, the Centers for Medicare and Medicaid Services (CMS) have yet to issue guidance for states. To date, only Iowa has received approval to provide community-based services under the state plan. As they wait for guidance from CMS, state officials cite some practical considerations that may limit the use of the option. First, states currently are allowed to set the income limit for HCBS waivers at a level up to 300 percent of the SSI benefit ($22,428 annually for an individual in 2007) and the majority of states do.5 The upper income limit for the state plan service is 150 percent of the poverty line ($15,315 annually for an individual in 2007), about two-thirds of the upper limit for the waivers. Second, there is some uncertainty about the range of community-based services that can be covered under the state plan. As currently written, the DRA appears to exclude "other services requested by the State as the Secretary may approve," a set of services that has been important in many state HCBS waiver programs. A third complication is that although states are allowed to offer community-based services through both waiver and state plan programs, waiver rules specify that waiver services may supplement but may not duplicate services available under the state plan.6 Finally, in a handful of states that already have used 1915(c) or 1115 waiver authority to make major changes to their long-term care programs, the new rules may represent more restrictive rather than more expansive options.

Under the DRA, states that opt to cover community-based care as a state plan service will be required to establish less stringent eligibility criteria for community services than for institutional services. This option can be used to extend eligibility to individuals who have a lesser degree of disability than the group currently served and expand the pool of those eligible for services. If the new flexibility is used to establish more stringent level-of-care criteria for institutional care, however, some individuals who qualify for institutional care now may not qualify in the future and the pool of those eligible for services would be smaller.

The DRA also gives states "adjustment authority" to change eligibility for community-based services under the new state plan option if actual enrollment exceeds projected enrollment. This gives states the leeway to experiment with more expansive criteria, but also introduces an element of uncertainty for beneficiaries.

Determining functional eligibility or "level-of-care"

Current rules specify that HCBS waiver services can be provided to individuals with disabilities as long as the services are required to keep a person from being institutionalized. Each state Medicaid program must establish level-of-care criteria, which explicitly describe the type and level or severity of functional limitations or needs an individual must have in order to be admitted to an institutional setting such as a nursing facility or an intermediate care facility. States use a variety of terms in addition to "level-of-care" criteria, including health and functional criteria, need criteria, targeting criteria, and service criteria.[7]

Assessments were not required prior to the use of HCBS waivers, but most states had developed pre-admission screening and assessment protocols for nursing facilities in an effort to control costs and place applicants.[8] Most were developed in-house and adjusted over time as policies and circumstances changed.[9] The original assessments were not developed to identify the population best served in the community. With the implementation of the waivers, much more assessment has occurred. A study published in 2001 reported that overall, in 48 states, 247 screening and assessment programs for long-term services were administered by 190 different agencies.[10]

Setting level-of-care criteria poses a challenge for states. Criteria that are too broad may be problematic if the size of the population qualifying for services cannot be supported by available resources. Long waiting lists may be anticipated. On the other hand, if restrictive criteria are used, some very needy individuals may not have access at all to needed services. Some of the important questions states must consider when they establish the criteria and the process to determine functional eligibility are discussed in more detail below.

1. What criteria should be used?

Established level-of-care criteria vary substantially among states. The criteria used most frequently to determine eligibility for Medicaid-financed long-term services include the need for assistance with activities of daily living (ADLs) and evidence of mental impairment or medical conditions. ADLs include activities such as bathing, dressing, eating, transferring to and from a bed or chair, toileting, and continence. More systematic study of the efficacy of different level-of-care criteria would likely be helpful to states. There is some evidence to suggest, for example, that older persons with significant limitations in several instrumental activities of daily living (IADLs), such as shopping, meal preparation, house cleaning, and transportation, have levels of disability that

are comparable to those experienced by people with two or more ADL limitations.[11] A 2001 examination of practices in states found that only Arizona, Colorado, and Maine used uniform criteria for all long-term service programs including nursing facilities, intermediate care facilities, residential care or assisted living programs, HCBS waiver services, home health, and personal care services. Of the remaining states, 25 used uniform criteria for nursing facility and HCBS assessments. The need for assistance with IADLs, the need for supervision, and the lack of formal and informal support are measures used more frequently in evaluations for community-based services than for institutional services. It is important to note, also, that although states may use the same criteria for several programs, the specific combination or weights of criteria to qualify for care vary widely within and across state long-term service programs.[12]

Assessment procedures vary tremendously among states in terms of tools and methods used.[13] A 1996 review of assessment instruments by the General Accounting Office showed that administration was not uniform for many of the instruments reviewed. Only 35 percent of the instruments specified wording of any of the interview questions and often the order of the topics to be covered was not specified. The study authors note that the lack of uniformity may lead to unnecessary variation in responses.[14] A description from the early 2000's notes that, "The vast majority of the nearly 250 state-sponsored long-term service screening programs rely on 'homegrown' instruments that have not been tested empirically."[15] A more recent examination of assessment tools notes that many states are considering, or are in the process of refining, their long-term service assessment instruments and processes.[16]

The move towards more standard tools and assessment processes has been accompanied, and in some cases fostered, by the increased use of technology. Eleven of twelve states recently surveyed have automated assessment tools.[17] In Arizona, Colorado, and Maine, each of which uses the same eligibility criteria, tool and needs assessment process for all clients regardless of age or disability type, automated databases help with the coordination of level-of-care screening and needs assessment.[18]

The Wisconsin *Family Care* Program uses a web-based functional screen. Social workers and registered nurses may become certified screeners after they take an on-line training course and pass an exam. The assessment tool was developed with input from a variety of stakeholders and looks not only at ADLs and IADLs, but at an array of measures including cognition and behavior, indicators for mental health problems, substance abuse and other conditions that put a person at-

risk of institutionalization, and the need for assistance with medically-oriented tasks, transportation and employment. Eligibility logic, based on previous state experience, is built into the system so that eligibility determinations can be made immediately. The functional eligibility screen is seen as an objective and consistent tool, having been systematically tested for reliability and validity.[19]

2. Should the same processes be used to assess functional eligibility for all service settings?

Traditionally, decisions about where to receive services often preceded an initial inquiry or application for services, and eligibility determinations were conducted for particular programs or settings. A survey of states conducted in 1999 found that 29 states used the same assessment process and forms for nursing facility and home and community-based services. The methods used to determine functional eligibility generally were more cumbersome for home and community-based services in the other 21 states. For example, four states used a standard form for all applicants seeking long-term services, but required that applicants for waiver services complete additional forms. In the 17 states that used different forms depending on the type of services requested, HCBS waiver forms were 10.5 pages long compared to 6.5 pages, on average, for nursing facility forms.[20] In a recent examination of assessment instruments in 12 states, half used the same forms for HCBS and nursing facility services.[21]

As states have developed more options for community-based services, and are more committed to providing consumers with choices for services, more are using a single process to make "level-of-care" assessments before decisions about the setting occur. Most experts believe that adopting a standard assessment tool encourages more objective screening and is more equitable for beneficiaries.[22] Another argument for developing uniform assessment procedures for HCBS waiver programs and nursing facilities is that administrative efficiency improves.[23] Duplication of effort occurs when consumers must complete more than one application for different types of long-term services and multiple administrators must review applications.

In Maine, the same assessment process is used for all long-term service programs in the state. Thus, the same criteria are used regardless of whether applicants are frail elders, individuals with physical disabilities or individuals with mental retardation or developmental disabilities and regardless of the setting where services will be provided. An expansive set of criteria — including limitations in ADLS and IADLs, the need for

skilled nursing care, and measures of behavior and cognition — is considered. Assessors consult with consumers about their preferences and consumers are required to sign a "choice" letter during the assessment, which indicates the type of care they have chosen. Initially, applicants were only required to sign if they chose community-based care, but that process was seen as biased in favor of nursing facilities. Therefore, it was changed so that signatures are required regardless of the type of care chosen.[24]

Proponents of choice for the setting where long-term services are provided note that choice is more likely to occur when one process is used to determine functional eligibility. One reason for this is that Federal law requires that applicants for HCBS waiver services be told about the option for institutional placement, but institutions are not required to inform applicants about the availability of alternate settings.[25] When a uniform process is used, all applicants are considered for and informed about all options for services. Applicants need not decide on the setting before they apply. The use of a single instrument is more likely to promote diversion from a nursing facility to the community.[26] As states have developed policies to promote diversion from nursing facilities and transitions from institutions to the community, interest in the use of uniform tools and processes has increased. Early studies from Connecticut, Florida, Minnesota, South Carolina, and Virginia demonstrated that the use of uniform pre-admission reviews resulted in lower utilization of Medicaid-financed nursing facility services and the provision of more services in the community.[27]

The current emphasis on "single-entry-point" systems, including Aging and Disability Resource Centers, is another change that promotes uniformity and encourages a choice of setting, removing some of the traditional institutional bias.[28] It is important to note that "single-entry-point" systems that provide the fullest range of services are likely to be most efficient and effective at assessing applicants and developing care plans for those who qualify because resource center staff have a broad understanding of the services available in the community and they can help arrange for the provision and payment of services.[29] The systems function differently across states, however. A 2003 survey of states identified 15 of 29 states with single entry points where older adults applying for long-term services could have a functional eligibility determination made, and a care plan developed.[30]

In Colorado, Single Entry Point (SEP) agencies are the entry point for several populations seeking community-based long-term services and supports: the elderly, people who are blind and people with other dis-

abilities, individuals with brain injuries, people with mentally illnesses, and persons living with AIDS. Some 23 SEP agencies across the state make level-of-care assessments for community-based long-term service programs and provide care planning and case management for individuals in these programs. Other entities, Community Centered Boards, are the entry point for individuals with developmental disabilities seeking long-term services or supports.[31]

3. Should states use more than one level of care?

Traditionally, the level-of-care criteria have been used as the basis for making an "either/or" decision. Applicants either do or do not qualify for care. Those who meet the criteria qualify for a range of long-term services financed by Medicaid and those who do not meet the criteria do not receive any services. Put another way, the level-of-care criteria serve a gate-keeping function.[32]

Proponents of an approach that uses different sets of criteria for different levels of care believe that it gives states the opportunity to provide services to more people at different levels of intensity. Many believe that if some community-based services are made available to individuals with more modest needs, [use of ??] more costly services can be delayed or avoided.[33] Maine evaluates applicants not only to determine eligibility for particular programs, but within those programs, to determine eligibility for different levels of services. Each level of services for each program has a cost cap, and a range of a number of hours per week that can be prescribed.

Vermont's 1115 waiver program for individuals 18 and older with disabilities, including the frail elderly, defines three levels of need for long-term services. Individuals who meet the clinical criteria for the "Highest Need" and "High Need" groups meet the nursing home level-of-care criteria that had been used previously in Vermont. A third, "Moderate Need" group is an expansion group of people who do not qualify for institutional care, but are eligible for case management, adult day care, and homemaker services. With the 1115 criteria in place, people who would not have qualified for services previously — the Moderate Need group — may receive some assistance. The availability of services depends on the availability of funds, however. Similarly, the state has permission to create waiting lists for the High Need group if necessary for budgetary reasons. Thus, there is a possibility that some individuals who have been entitled to services under the old system will not receive services immediately. The program has an aggregate funding cap based on projections regarding the demand for and cost of services.[34]

A study in Ohio, which examined the effectiveness of preadmission reviews, notes that the preadmission process used at the time provided useful decision-making information to applicants, but that the utility was greatest for those living in the community. The study authors observed that many states had developed preadmission review processes based on the assumption that nursing facilities would be the "last home for the aged," when, in fact, a substantial proportion of those admitted to nursing facilities had left the facility six months later. Thus, they recommended a modified assessment process that recognizes the different and changing needs of those who apply for long-term services.[35] More recently, recognizing that length of stay is an important predictor of whether individuals will move back to the community, some states, such as Indiana, Maine, Nebraska, New Jersey, and Oregon, certify that individuals meet the level-of-care standards for specific limited periods of time — generally three to six months — after which a reassessment must occur.[36]

4. Who should conduct assessments for functional eligibility?

The question of whether service providers should assess needs has been debated over the years. One opinion is that service providers are well qualified to determine what would be most beneficial for individuals with long-term service needs. Another is that providers may be more likely than others to focus on the needs associated with the services they provide. Some states have built safeguards, such as having state personnel review assessments or authorize care plans made locally, into the assessment process.[37] In Vermont, for example, case managers employed by home health agencies or Area Agencies on Aging work with clients to develop care plans. To assure that conflict of interest does not occur when service providers make care plans, case managers submit care plans with service planning worksheets that show the amount of time allocated for each activity in the plan for review and authorization by long-term care clinical coordinators employed by the state, but located in communities.[38]

5. What kind of training should be provided?

The need for training is a recurring theme in the literature and in discussions with state officials. In a review of assessment instruments conducted by the General Accounting Office, only 31 percent of the programs said they require that the assessor be trained in how to use the instrument.[39] Training efforts are more likely to be successful if they teach not only about the mechanics of the process, but also about how the assessment process fits into the broader goals for delivering long-term

services and supports effectively. Researchers note that when assessors do not understand or do not agree with the underlying rationale, they tend to regard the assessment as add-on work rather than as an important part of the process to provide quality services. In such instances the assessment forms tend to be completed after the fact.[40]

Some researchers note that assessment tools are only as good as their users and that assessors' preferences, priorities, values, and beliefs can influence the outcome of an assessment.[41] There is evidence also that some subjectivity may be associated with standard protocols. For example, in states that use structured assessment tools which generate scores, the qualifying scores are usually well known and some reviews have shown that many scores cluster just above the cut-off score.[42] Experts caution that standard assessment tools should not be viewed as a substitute for clinical judgment.[43] Recommendations to improve the assessment process have included the use of systems that use scores as a guide, but allow professionals to use their own judgment and over-ride the scores on occasion.[44]

Making care plans

Once individuals qualify to receive services, effective care planning is required to guarantee that appropriate services are provided in the right amounts and in the optimal setting.[45] Care planning for Medicaid beneficiaries is based on need, but the cost of services is also considered implicitly or explicitly. As with other aspects of the process to get long-term services to people who need them, care planning varies among and within the states. There is no single prescribed method to assess needs or to translate the results of an assessment into a care plan.[46] In a 1997 survey of care managers, supervisors, and administrators in four states, all respondents agreed that care managers have a good deal of flexibility in developing care plans.[47] As with other program functions, however, the greater use of technology has promoted the use of more standard approaches to care planning.

1. How should care plans be developed?

A recent survey of state practices concludes that states are moving toward integrating as many components of the eligibility determination, assessment, and care planning processes as possible.[48] As the use of systems that can transfer information electronically has become more common, so has integrated planning. Some concerns about integration should be considered, however. One is that systems that use "pre-structured" care plans can be problematic.[49] While the translation of computer-based assessments into care plans is efficient, certain circumstances

may not be recorded in the system. Thus, it is important to give assessors the option of amending the plan when necessary.[50]

Integration is advantageous for consumers in that they are not asked to supply the same information multiple times. They may also enjoy a sense of continuity if they work with the same individual through the assessment and care planning process. There are differences of opinion and practice, however, about whether the same person should be involved in assessing functional eligibility and planning care. Researchers have suggested that in some cases needs may be identified based in part on care planners' tendency to suggest certain services or their tendency to make the assessment data fit the resources available in the state program..[51] A study of the care planning process in Michigan concluded that care planners were less likely to identify and respond to some problems than others. Depression was often overlooked, perhaps in part because the case managers were not trained to recognize it or perhaps because they knew that they did not have the resources to address the problems. Also, the use of home health aides was recommended frequently, though not always appropriately.[52] Another consideration is whether individuals associated with service providers should make care plans. When providers have a financial interest in delivering services, there is concern that providers may have a tendency to exaggerate needs.[53]

Some case managers at local Area Agencies on Aging for the Ohio PASSPORT home care Medicaid waiver program assist with care planning. None of the agencies involved with assessment or care planning is a service provider, however. Officials note that because assessors use laptop computers with a software program containing current information on available providers, one efficient process can be used to assess needs and plan care. System data also can be used to generate reports on service use.[54]

2. To what extent should consumers be involved in care planning?

The extent to which individuals needing long-term services and their families are involved in the care planning process has increased considerably over the years. A report from the early 1990s indicates that in a typical agency, case managers did not systematically learn or record client preferences. But later studies show that client preferences had strong and consistent effects on case manager decision making.[55] Increasingly, states are using person-centered planning.[56] Early in 2006, some 22 states reported that they have or are actively planning individual budget-based community long-term service programs for the elderly. As a result, many more beneficiaries are actively involved in the care

planning process.[57] Individuals in Wisconsin's *Family Care* program who choose to direct their own services develop a care plan with a Care Management Organization team, which generally includes a social worker, nurse, and the client. Clients then receive vouchers that they can use to purchase services. The value of the vouchers is calculated based on prior experience with clients who received similar services.[58]

3. Should cost limits be applied to care plans?

Cost is a factor that affects decisions both about the level-of-care criteria used in a program and about the process used to plan care, but often the methods used to control costs are more apparent when it comes to care planning.

The crucial question with any approach that limits spending is how to set the limits. Cost caps may be set for individual plans or a more global cap may be set for the program's caseload. In either case, care planners must take the cost of services into account. In some programs, administrators must approve plans before they are implemented. Some researchers have noted that the use of a particular cap or limit for all individuals effectively rations services for those at higher-risk and may result in the overuse of services for those at low risk. Therefore, they recommend a care planning approach based on calculating clients' risk of costly outcomes if services are not provided.[59]

A study of states' efforts to capitate payment for long-term services notes that approaches differ because the markets, politics, and existing infrastructure differ across states. There are some common features, however, including financial incentives to reduce institutionalization and requirements for discounts from fee-for- service charges. Also, the general method for setting capitation rates is to base the amounts initially on the fee-for-service equivalents for comparable populations enrolled in Medicaid.[60]

As participant-centered planning has become more common so has the use of individual budgets, which represent the total dollar value of services and supports under the control of the program participant that are specified in the plan of care. The use of individual budgets for participant-centered plans is relatively recent. To date, states have generally used statistical models to base budgets on needs assessments. States may base budgets on the estimated cost of traditional services or may make adjustments as they gain experience with participant-centered planning.[61] While the flexibility to design an individual plan may be advantageous, some observers have noted that it is very important to monitor the adequacy of the individual budget.[62] Traditionally, most

long-term care plans are reviewed annually or when consumers report a change in circumstances. Recognizing that more frequent adjustments in service use are likely to occur with participant-centered planning, some state programs build flexibility into individual budgets so that a small portion of funds can be re-directed when needs change or the programs have protocols for counselors to authorize minor plan revisions quickly.[63]

Conclusion

As states refine their systems for the delivery of Medicaid-financed long-term services and supports, it is important that they consider the role that policies and procedures used to make determinations about functional eligibility for program services and to develop care plans can play in helping to achieve program goals. Certain program features can help ensure that individuals in need of long-term services receive appropriate types and amounts of services in a setting they choose. For example, a number of states now use a single process to make determinations about level-of-care and then, for those determined eligible, discuss options for the service setting. The establishment of single entry points where comprehensive information and assistance with applications are available to anyone seeking long-term services is also helpful.

Comprehensive assessment tools that have been tested for validity and reliability are more likely to be effective and more likely to be trusted by assessors. Early and ongoing training in the use of the tools and in the concepts on which the tools are based is recommended as are provisions to ensure that professionals have some flexibility and the ability to change plans as circumstances change. The use of electronic systems that accommodate an integrated process for determining eligibility and planning care can be effective. Those that track service use and expenditures provide data that can be used to monitor quality and cost, to refine functional eligibility criteria, and to develop individual spending plans as programs incorporating consumer-directed services become more common.

The level-of-care criteria used to determine eligibility for services will ideally provide needed services to as many people as possible. It may be useful to tie different levels of care to different types of services as some states have done, though this should be accomplished, ideally, by providing more expansive criteria for lower levels of care rather than making the criteria for institutional care more restrictive.

As states strive to increase access to community-based services and to control costs, it is helpful to understand other states' experience in

making determinations about functional eligibility for program services and in developing care plans. The examples presented here indicate that there may be policies and practices to emulate, but more attention must be given to evaluating the success of different methods employed in states to manage program resources and provide appropriate community-based long-term services.

Notes

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