

**MEDICAID REDESIGN - LONG TERM CARE WORK GROUP**  
**Subgroup on Elders and Adults with Disabilities**

**INTERIM REPORT**  
**November 6, 2009**

During the months of October and November, the Long Term Care Subgroup on Elders and Adults with Disabilities held three meetings focusing its work on examining how persons access the long term care system and how financial eligibility is determined with special attention to the impact of the application of spousal rules regarding income/resources to persons on home and community waiver services. This Interim Report contains the findings and recommendations from these subgroup meetings. The Subgroup also explored issues relating to assisted living funding and discussed ideas for assisted living provider payment reform in order to increase access to assisted living services for persons on Medicaid long term care. The Subgroup recognized that the Housing Work Group has included recommendations to increase assisted living capacity for low income persons, that capacity issues are being examined under the Real Choices consultant contract and that an Internal state group may be developing recommendations in this area. To avoid duplicating policy work, the Subgroup deferred making specific recommendations regarding assisted living but can share the ideas it has discussed to date. The Subgroup recognizes that much of its discussion has been more relevant to the age 65 and over long term care recipient and that there are special issues relating to adults with disabilities that warrant further policy review as the Work Groups continue to meet. We plan to share this report with the Long Term Care Developmentally Disabled subgroup, learn about their findings and recommendations and work to identify common system reform issues and opportunities for improvement. We also acknowledge the work that has been accomplished by the Employment Workgroup and will collaborate with them as well as the Children with Special Health Care Needs Workgroup as we continue our policy review of the system of long term care supports and services for adults with various disabilities. A list of persons participating in the Subgroup follows the recommendations.

**Recommendations to Improve State-Funded Long Term Care Access**

The Subgroup on Elders and Adults with Disabilities reviewed the processes for accessing Medicaid-funded long term care services. The purpose of the review was to familiarize Work Group members with how the current system works, to identify opportunities for promoting a more efficient and customer-friendly access process and to support the Global Waiver's long term care rebalancing goal. With the assistance of state staff subgroup members Flow Charts of the access process were developed and are attached to this report. The Work Group recognizes the state's ongoing efforts to implement the construct of the Assessment and Coordination Organization (ACO) detailed in the Global Waiver agreement. We believe our recommended actions are consistent with and support this continuing work.

Identified Issue/Problem/Need	Recommended Action	Resources Needed
<p><b>1. Need to streamline processes for elders and adults with disabilities wherever there is any duplication of effort among different agencies or repetitive practices related to assessment or eligibility determination practices</b></p>	<p><b>1.1 Integrate Home and Community-based Service Programs offered by DEA into DHS organization</b></p> <p><b>1.2 Continue to unify tools being used by LTC field offices and contracted case management agencies and to implement recommendations of the “Perry-Sullivan” Access Work Group</b></p> <p><b>1.3 Avoid LTC Field staff, DEA staff and OMR staff duplicating steps in LOC assessment process by having assessment items only done one time whenever possible and using hardware and software improvements</b></p> <p><b>1.4 Allow PACE medical and nursing staff to do LOC assessments</b></p> <p><b>1.5 To preserve continuity of care and increase efficiency, maintain clients (including those in preventive services) with known or current case management (oversight) agency when transitioning client from one level of care or site of care such as from nursing home to community.</b></p>	<p><b>Assess need for statutory change \$0 for coordination activities</b></p> <p><b>May involve costs of technology transfer of existing software for all entities doing assessments</b></p> <p><b>Staff resources for research on policy/operational issues</b></p>
<p><b>2. Delays in receiving medical documentation from physician offices can hold up approval of Medicaid long term care applications</b></p>	<p><b>2. Review legal requirements for medical documentation and identify any opportunities for streamlining process (Ex. can pharmacy give medication list? Can functional assessment be submitted</b></p>	<p><b>\$0</b></p> <p><b>Staff resources for research</b></p>

	<b>to physician by case managers)</b>	
<b>3. Need to refer persons determined to meet Preventive LOC only but who do not meet financial eligibility for community Medicaid (categorically eligible) to alternate assistance programs</b>	<b>3. Make automatic referral to DEA copay Program for persons age 65 and over or to other available non-Medicaid programs such as respite and FOSH</b>	<b>\$0 Staff resources to operationalize</b>
<b>4. Need to review financial eligibility and service package for Preventive services which could avoid need for more costly care and Medicaid spending, e.g. Preventive services are only available to those who are categorically eligible and co-pay program only available to persons age 65 and over</b>	<b>4. Maintain DEA co pay program as cost effective service that avoids full Medicaid participation; Explore expanding co pay program to low income adults with disabilities with income under 200% ineligible for other programs (??Population 19 in Global Waiver); explore inclusion of other preventive services in co pay program such as assistance with medication management when not covered by Medicare.</b>	<b>Staff time needed needed to conduct Cost analysis</b>
<b>5. Need to consider both family supports and family needs such as respite during assessment and service planning</b>	<b>5.1 Include family support item in assessment and care planning tools</b>  <b>5.2 Allow home care workers to provide services to other family members on limited and case by case basis. Ex. If laundry being done for parent, could include children's clothing.</b>  <b>5.3 Do needs assessment for caregiver respite services for non-Medicaid elders and disabled adults and pursue federal funding (CNOM, OAA, CMS)</b>	<b>Staff resources to revise assessment tool</b>  <b>Explore potential for using Real Choices grant funds to do respite service needs assessment</b>
<b>6. Persons may be admitted for in-patient hospital care due to lack of knowledge of long term care services or delays in access to long term care services</b>	<b>6.1 Provide ongoing physician and office staff education re Home and Community Care programs.</b>	<b>Physician education costs to be incorporated into comprehensive public education campaign. (See # 10)</b>

	<p><b>6.2 Assign regional case management agencies to work with targeted physician practices to offer I/R/A for LTC services</b></p> <p><b>6.3 Promote medical home model with nurse care coordinators knowledgeable re H/C options and benefits</b></p>	<p><b>Explore use of Older Americans Act funding for this activity</b></p> <p><b>\$0 for Medicaid as this is part of managed care model of acute care – See recommendations of Work Group on Duals</b></p>
<p><b>7. Need for greater provider knowledge, especially among hospital discharge staff and primary care physicians, about home and community-based services and how to access them</b></p>	<p><b>7. Provide ongoing and periodic education to hospital discharge planners re H/C services. Identify barriers to discharge to community placements such as Assisted Living capacity and Assisted Living licensing requirements.</b></p>	<p><b>To be funded as component of comprehensive public education and communications strategy</b></p> <p><b>Internal and External Staff time needed for planning and conducting trainings</b></p>
<p><b>8. Need to make access to Home/Community services as expeditious as that for nursing facility care. 30 days and longer not acceptable.</b></p>	<p><b>8.1 Research Best Practices on Presumptive Eligibility</b></p> <p><b>8.2 Review Expedited Eligibility regulations and steps in process for potential for further expediting</b></p> <p><b>8.3 Formalize screening tool for use prior to full assessment</b></p> <p><b>8.4 Provide families/clients upfront with list of all info they will need for LTC Medicaid financial application</b></p>	<p><b>\$0 (staff resources needed for necessary research and any policy development)</b></p>
<p><b>9. Need for better coordination of behavioral health care and long term care services and access to behavioral health services for persons needing such services to be provided in home. Ex. Adults with behavioral health issues in SSI enhanced Assisted Living program and those living at home unable or unwilling to go to out</b></p>	<p><b>9. Review where case management is being done and avoid duplication of service delivery and payment; allow for interagency case reviews when necessary and appropriate. Clarify scope and limitations of Medicaid funding such as the Rehab option for use by clients with both behavioral health issues and long</b></p>	<p><b>\$0 (staff resources needed for research and policy development)</b></p>

<p>of home for service.</p>	<p>term service needs (MHRH and DHS). Develop policy and procedures to streamline access and service delivery for those at home and identify funding sources. Identify need for federal or state statute or regulatory changes if applicable such as provisions relating to Institutes for Mental Diseases or provider restrictions...</p>	
<p><b>10. Need for ongoing public education about public and private long term care services including home and community care options and support services to include consumer friendly materials, web-site tools that clearly explain Medicaid long term care eligibility and initial self-screening tool for use by family or potential client.</b></p>	<p><b>10.1 Institute LTC OPTIONS counseling program directed by 2009 law</b></p> <p><b>10.2 Review and implement recommendations for public education campaign from Perry- Sullivan Finance Work Group Education subcommittee (Tagline: Home. Community. Independence) using funding available from changes in Perry-Sullivan law made through passage of S-0242 and Real Choices grant</b></p> <p><b>10.3 Provide ongoing training programs for providers and communication materials to keep them updated on system reforms</b></p>	<p><b>Staff time needed to develop LTC options counseling program</b></p> <p><b>Develop initial and annual budget for implementing LTC options counseling and public education program.</b></p> <p><b>Identify funds available from Perry-Sullivan and Real Choices grant</b></p> <p><b>Staff time needed to conduct trainings and develop ongoing communications</b></p>

**Recommendations on Financial Eligibility**

The goal of these recommendations is to provide practical financial incentives for persons to choose home and community based services consistent with the vision of the Global Waiver to: remove the traditional institutional bias in Medicaid long term care eligibility and access, promote care in the least restrictive setting and provide services at a time early enough to maximize independence and prevent functional decline.

Identified Issue/Problem/Need	Recommended Action	Resources Needed
<p><b>1. Financial eligibility provisions for Medicaid long term care are complex and hard for consumers and families to understand.</b></p>	<p><b>1. Develop and publish clear regulations detailing long term care financial eligibility that cover allowable resources, including spousal situations, income thresholds (if applicable) and client share or contribution to cost of services. Use language that consumers can understand and show typical examples. Consider developing a consumer guide to Medicaid long term care eligibility or guide persons to applicable regulations through a “bookmark” to the long term care section on the DHS website. Note: Department of Elderly Affairs publication on spousal rules and nursing home care should be updated to cover home and community-based waiver services.</b></p>	<p><b>Staff time to develop regulations and Consumer Guide and edit website</b></p>
<p><b>2. Current allowable monthly income deductions for individuals in home and community waiver programs who meet Highest or High Level of Care are either \$922 (categorical eligible and low income categorically eligible) or \$822 (medically needy). Having two standards can be confusing and causes inequities in amounts persons have available to meet living expenses. In addition, the levels of income deduction may be inadequate for some individuals to meet monthly expenses especially when they are living in their own homes or paying fair market rents as they are not allowed the Utility allowance or Excess shelter income deductions available to couples. To help</b></p>	<p><b>2.1. Standardize monthly deduction for all individuals to \$922.50 to eliminate disparity.</b></p> <p><b>2.2. Institute the \$400 income disregard for individuals on a phased in basis starting with \$200. This would give individuals \$1122.50 to cover monthly living expenses and serve as a practical incentive for persons to opt for home and community services.</b></p> <p><b>Alternate 2.2. Allow a shelter allowance for individuals similar to that used for spousal situations to ensure adequate income for community living.</b></p>	<p><b>DHS Data needed to compute cost. However, Work Group believes recommended changes will promote use of less costly home and community services with net savings to state over time.</b></p> <p><b>Assess need for statutory, regulatory changes</b></p> <p><u>Note:</u> This recommendation may have impact on access to Medicaid Acute care services</p>

<p><b>individuals meet monthly maintenance expenses, the Global Waiver agreement called for the State to apply the medically needy income standard plus \$400 for medically needy individuals receiving 1915c like services. In its application it called for raising the income deduction from \$758 (the 2008 standard) by \$400 (\$100 heat, \$100 electric, \$200 rent/mortgage) for a total of \$1158. To date, the state has deferred instituting the \$400 provision.</b></p>		
<p><b>3. Resource allowances for individuals are either \$2000 (categorical eligibility or \$4000 (low income categorically eligible and medically needy). For couples, spousal rules now apply for both institutional and home and community-based waiver services. Essentially, this allows the non-institutionalized spouse to retain a minimum of \$21,912 of a couples total cash assets and a maximum of \$109,560 (figures adjusted annually). In recognition of the need for persons living in community to have resources to meet unexpected home maintenance expenses or to be able to use their resources for home modifications necessary for them to remain at home, some states have considered allowing higher levels of resources for persons living in the community (Vermont is one example).</b></p>	<p><b>3. Standardize the resource allowance to \$4000 and consider allowing individuals living in own homes to retain an additional \$6000 for a total of \$10,000. This would provide homeowner's with resources needed for non-routine home maintenance expenses such as roof repairs and make it consistent with resource allowance for Working Adults with Disabilities eligibility category (RI Medicaid Rule 0373.10.10). Also, consider a mechanism for a special resource set-aside from individual's resources to pay for home modifications or transition costs that will allow persons to remain at home. This could avoid government subsidies for such expenses.</b></p>	<p><b>DHS Data needed to compute cost. However, Work Group believes recommended change to standard \$4000 resource limit will not be substantial and increased allowance for homeowners will help persons to remain in own homes avoiding more costly nursing facility care with net savings to state over time.</b></p> <p><b>Review need for legal authority (regulatory or statutory change)</b></p>
<p><b>4. The new requirements to apply spousal rules for couples when one spouse is</b></p>	<p><b>Provide beneficiaries with clear information about changes in client</b></p>	<p><b>\$0 cost as client currently not paying higher share</b></p>

<p>receiving home and community waiver services has had (or will have at recertification time) a negative impact for some couples as the client share may be substantially increased. In some instances, it will go from \$0 client share to several hundreds of dollars. One work group member reported a client share increasing from \$900 to \$2000. This could result in a hardship for some couples who have total limited resources.</p>	<p>shares and rights to appeal. Establish a standard hardship exemption. One practical method may be to defer share increases for couples whose total combined resources are less than the minimal spousal resource allowance (\$21,912 in 2009).</p>	<p>Review need for legal authority (regulatory or statutory change)</p>
<p>5. Application of the spousal rules may result in a client spouse not having sufficient income available to pay for room and board in assisted living. (Note: Under federal Medicaid law, Medicaid can not pay for room and board in assisted living although it is included in Medicaid nursing home payments.)</p>	<p>5. DHS should address the impact of application of the spousal rules especially as they effect low income couples with higher living costs.</p>	<p>Cost related to policy change</p>

**Persons participating in at least one of the Elder-Adults with Disabilities subgroup meetings held on Oct. 8, Oct. 22 and Nov. 5 include:** Maureen Maigret, Neil Barker, Sharon Brinkworth, Tom Conlon (guest presenter), Elizabeth Earls, Lynda Giarrusso, James Hardy, Linnea Tuttle, Elaine Goldstein, Dr. Alan Post, Joan Kwiatkowski, Paulla Lipsey, Everett Maxwell, Kathy McKeon, Kathleen Kelly, Roberta Merkle, Ann Mulready, Jim Nyberg, Lori Quaranta, Gail Sheahan, Janet Spinelli, Michelle Szylin, Diane Taft, Judith Taylor, Alan Tavares, Lisa Vitri, Joan Wood