

Rebalancing Long-Term Care Systems in Pennsylvania: Experience up to July 31, 2005

Abbreviated Report

submitted to the

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The overall project is being conducted through a Task Order under a CMS Master Contract between CMS and the CNA Corporation, Arlington, VA, and subcontracts and consultant agreements between CNAC and the various researchers. The 3-year study calls for case studies of the experience of 8 states—other states in the study are: Arkansas, Florida, Minnesota, New Mexico, Texas, Vermont, and Washington. The baseline case study covers a period through July 31, 2005. Updates will be prepared for the period ending July 31, 2006 and 2007.

A slightly earlier version of this Abbreviated Report was presented for discussion at a CMS Open Door Forum, February 22, 2006. The statements and opinions in the report are those of the writers and do not necessarily reflect the views of CMS or any of its staff, or the State liaisons to the project, or any other state staff or persons who spoke to us from participating states. We thank the Pennsylvania liaison to the study, Dale Laninga, Director, Long-Term Care Reform Project, Governor's Office of Health Care Reform.

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Rebalancing Long-Term Care Systems in Pennsylvania: Abbreviated Report

Highlights

Pennsylvania has a long history of providing home and community based services for multiple populations.¹ The state pioneered in developing case management capacity for seniors, attendant programs for younger people with disabilities, and other program initiatives. These efforts preceded the availability of federal funding. State appropriations and Older American's Act monies were initially used, and later, Pennsylvania ear-marked lottery revenues for aging services. The state came relatively late to its rapidly proliferating HCBS waiver programs, having already built a service structure. Although Pennsylvania's efforts to rebalance its efforts towards HCBS show rather modest results in terms of shifting the balance of utilization and expenditures, because of its current initiatives and focus the state may well be poised for major shifts in its service system. Among the highlights in system development for long-term living, the term Pennsylvania has recently used for long-term care, are the following:

- Governor Rendell, who took office in 2003, made long-term care a priority. In his first Executive Order after taking office, he established the Office of Health Care Reform (OHCR), whose director is part of the Cabinet. The OHCR Director, in turn, organized the new Office with parallel tracks for acute health care and long-term living.
- By dint of its mandate and structure, the OHCR is empowered to direct health care reform. The OHCR Director chairs a high-level Governor's Health Care Reform Cabinet, also created by the Executive Order. OHCR is not developing its own elaborate bureaucracy but has been accorded, with the Governor's approval, the role of activating other government agencies to take on the necessary analytic functions and policy changes related to program operation and regulation.
- Long term support programs in Pennsylvania are spread across many cabinet agencies (primarily the Department of Aging, the Department of Public Welfare, and the Department of Health) each with its own programmatic divisions, and also involves the Department of Labor, the PA Housing Authority, and the Insurance Commission. It is also spread across 11 home and community based services (HCBS) waiver programs, and multiple provider networks. Fragmentation at policy, operational, and regulatory levels has been widely recognized as a problem and the OHCR is empowered to reform the system.

¹ This abbreviated report is a synopsis of a much longer report on rebalancing long-term care systems in Pennsylvania, performed under contract between the University of Minnesota and CNAC Corporation through a Master Contract between CMS and CNAC. The full-length report, which contains organizational charts, references, and much more detail, appears on the website [HCBS.org](http://www.hcbs.org) and on the University of Minnesota Principal Investigator's Website <http://www.hpm.umn.edu/LTCResourceCenter/>. Similar abbreviated and full case studies have been prepared for the States of Arkansas, Florida, Minnesota, New Mexico, Texas, Vermont, and Washington. The case study covers a period up to July 31, 2005; subsequent reports will update the information as of July 2006 and July 2007.

- Prior to the formation of the OHCR, the main intradepartmental organization for long-term care was the Intra-Governmental Council on Long Term Care, established in 1986 and chaired by the Secretary of Aging. This Council conducted a number of seminal studies through the late 1980s and 1990s. The OHCR, thus, has a good foundation on which to build and because leaders from the Council have moved to the OHCR, continuity is ensured. Multiple initiatives for reform in long term living have been initiated. All told, Pennsylvania was the successful recipient of \$4,539,201 in 6 separate Real Choice Systems Change grants between 2002 and 2004, all of which have been designed to develop components of Pennsylvania's system of services.

Innovative management features include:

- The OHCR itself as a perhaps time-limited but highly visible organization for change.
- A Community Choices pilot being conducted to streamline and expedite financial and functional eligibility requirements in one geographic region, utilizing presumptive eligibility and fast-track approaches so that initial assessments and service initiation can start within a few days.
- A Nursing Home Transition program, initiated prior to the establishment of OHCR.
- Strategies to reduce the supply of nursing homes.
- Strategies to develop and retain a long-term support labor force.
- Strategies to develop and increase information about affordable, accessible housing options.
- Exploration of the efficacy of a Pennsylvania version of the national PACE program for dually eligible and low income individuals.
- Development of quality management capacity based on improved data and a proactive monitoring system.

To date, Pennsylvania has made progress in reducing dependence on institutions but still lags behind most states in quantitative markers of rebalancing as shown by utilization and expenditure figures. State officials and advocates hope that all the initiatives begun in the last five years or so can coalesce into state-wide system change that will result in improved rebalancing milestones.

Context

- A large, populous state with a high rate of very old individuals in the populations.
- Budget shortfalls in Medicaid and extreme attention to developing efficiencies in programs rather than cutting eligibility or services. These financial pressures are occurring against a backdrop of a priority on building economic growth and development, employment, full insurance, and lower taxes for Pennsylvania.
- A legacy of intensive litigation around HCBS, especially the nationally famous *Pennhurst* case that ordered the closing of large state MR/DD institutions.

- A large and varied network of service provider organizations.
- A strong county presence in the management of all services.
- Increasing rhetoric affirming the values of choice and care at home, articulation of rebalancing as an explicit goal by the Governor, legislators, and executive agencies, and a tying of that goal to expected economic savings.
- A vigorous group of advocacy communities, and a record of working with stakeholders on specific program initiatives in recent years.
- Considerable fragmentation in the licensing and monitoring of community group residential settings and considerable policy disagreement among stakeholders about the proper role for personal care homes and domiciliary homes. At present, Pennsylvania has no mechanism for residents of its large number of personal care homes to receive HCBS waiver services, given that nursing-home level clientele are precluded from residing in personal care homes.

Real Choice Systems Change (RCSC) Grants

Pennsylvania has received a total of RCSC grants and \$4,531, 209 in RCSC grant funding, counting its Aging and Disability Resource Center (ADRC), from 2001 to 2004.² (Pennsylvania also had a grant for nursing home transitions, awarded in 2000 before the RCSC Initiative started and is not counted in this total.) The 2002 Real Choice grant set the stage with its goal to “develop a system of access to home and community based services and supports for people of all ages that is cross-disability, comprehensive, understandable, and responsible to the needs of local communities.” All the large grants have been used for planning and local demonstrations, and most have built-in capacity building training for consumer and provider stakeholders, including local and government officials. The grants have been used to construct the building blocks of the system, including transition processes, data systems, housing capacity, and expedited access. The access improvements have been accelerated by the ADRC, developed in the region where the rapid intake system was implemented.

Programs and Services

Pennsylvania operates 11 Medicaid home and community based services waivers. The aging waiver (PDA waiver) is administered by the Department of Aging. Within the Department of Public Welfare, the Office of Social Programs operates five waivers; two are managed by the

² In 2002, Pennsylvania received a System Change Grant (\$1,285, 000). In 2003, Pennsylvania was awarded a Money Follows the Person grant (\$698,211), a Quality Assurance/Quality Improvement Grant (\$498,650), and an Aging and Disability Resource Center (\$764,000), the latter from the Administration on Aging. In 2004, Pennsylvania was awarded a Mental Health Systems Transformation grant (\$300,000) to create a network of certified peer specialists, and a Integrating Supportive Services and Housing grant (\$498, 650).

Office of Medical Assistance Programs and three are managed by the Office of Mental Retardation.

Additionally, Medicaid state plan and state-funded community LTC services provide many services with the following programs among the most important building blocks.

- The Department of Aging administers the OPTIONS and Bridge Programs for elders who are eligible for the Aging waiver. These two state-funded programs cover the same services as the aging waiver program, except for nursing home transition services. OPTIONS services are funded by proceeds from the state lottery. There is no functional eligibility threshold, income or asset limit. Services are capped at \$625 a month. Consumers with incomes below 125% of the federal poverty level do not pay a share of the costs and consumers with incomes that exceed 300% of the federal poverty level pay the full cost of services. In FY 2004, OPTIONS served about 15,000 older adults at a cost of \$207.8 million. The Bridge Program serves people who meet the nursing home level of care criteria but do not meet the Medicaid income or asset limits. Consumers who have income below 300% of the SSI benefit and assets between \$8,000 and \$40,000 are included. The Bridge program spent \$5.8 million in FY 2004.
- The Attendant Care Services Act, or Act 150, is a state-funded program covering the same services as the Attendant Care Waiver for adults aged 18-59 who have a physical disability, 3 functional limitations and do not meet the income or functional eligibility for the waiver. Functional eligibility is determined by AAAs. Eligible consumers chose from 15 contracted providers across the state.

Featured Management Approaches

Governor's Office of Health Care Reform

In 2003, Governor Rendell established the Governor's Office of Health Care Reform (OHCR) to facilitate the analysis of administrative, fiscal and regulatory policies and practices; oversee the design of operation and infrastructure and direct the creation and maintenance of a system to assure the accountability of designated agencies. The Director of the OHCR also chairs the Governor's Health Care Reform Cabinet, which consists of the Secretary of Aging, the Adjutant General, the Secretary of Health, Commissioner of Insurance, Secretary of Public Welfare, Director of the Governor's Policy Office, and the Secretary of the Budget.

The OHCR set a goal to develop a long term living system that is efficient and effective (cost and program), is focused on the well-being of consumers and their family members, and operates within the financial wherewithal of the state. The OHCR found that policies tend to be organized around departments rather than the delivery of services. Accordingly, the OHCR developed several key questions to guide future development of long term living services and financing:

- How much money is being spent and how much should be spent on health and long-term living?
- What fact based data is available to monitor program outcomes of providers?

- What has been should be and could be the priority spending patterns on state supported access efforts?
- What statutory and regulatory changes are needed to achieve accessible, affordable care?
- What socio-economic trends will have the greatest impact on the demographics and the severity of need for state paid health and long term care services over the next five years?

In these deliberations, the OHCR is considering long-term care in tandem with its consideration of acute-care in a way that elevates the discussion of long-term care. The OHCR also devoted efforts to what proved to be a highly successful grant-seeking effort to fund its developmental processes.

Community Choices

A fast track approach (renamed Community Choice) has been implemented for ten of the state's eleven HCBS waivers (a waiting list for services made it impractical to expedite the eligibility process for the MR/DD waiver). It was guided by two primary goals: changes must focus on consumers and the results should increase consumer choices and options. Planning involving both state and local officials began in July 2003, with the expectation that the changes would be implemented in four counties in Southwestern Pennsylvania by October 2003 and six counties in the Philadelphia area by December 2003.

During the first year of operation, the Community Choice pilot sites received 8,810 applications. Eighty nine percent of the applicants were 60 years of age or older. Twelve percent of all applications were processed within 72 hours and 5 percent within 24 hours. Nearly 75% of applicants were found eligible, about 10% were either financially or functionally ineligible, and another 10% remained pending at the end of each reporting period.

As of July 2005, the Community Choice program is operating in ten counties. Expansion to additional counties has been delayed pending the collection of more data on the impact of the process on nursing home utilization. State agencies are adapting existing information systems to determine the impact on nursing home admissions and Medicaid bed days in the demonstration counties.

Nursing Home Transition Program

Pennsylvania received one of the original nursing home transition grants from CMS in 2000. The Pennsylvania Transition to Home Program (PATH) was established "to assist people to transition from nursing homes into the community and learn about perceived or real barriers that nursing home residents face when considering alternatives to living in a nursing home."³ The PATH transition coordinators worked with existing service programs and organizations to help "consumers connect to the services they needed and facilitated the move from institutional living to community living."⁴ During a 22 month period, transition coordinators worked with 82 nursing homes in seven counties and successfully transitioned 51 of the 119 consumers referred for relocation assistance. Over half (55%) were female and 47% were 60 years of age or older. Almost half had family members involved with their transition.

³ PATH: Final Report. Intra-Governmental Council on Long Term Care. March 2004.

⁴ Ibid.

Consumers and coordinators faced several barriers. Care plans for several consumers exceeded limits established for waivers with an individual expenditure cap. Waivers with aggregate caps, in contrast, were able to accommodate consumers with more costly care plans. Consumers with multiple disabilities, including dual diagnosis or a disability that is not addressed by a waiver program, were especially likely to experience delays in obtaining services. Delays in obtaining specialized equipment also caused consumers' transitions to be prolonged.

The overall lack of affordable and accessible housing was the foremost problem faced by consumers leaving nursing homes. Several of the counties in the PATH demonstration project had waiting lists (some more than a year long) for accessible housing units. Also, some housing authorities refused to provide a listing of their individual Section 8 landlords, making it difficult for a consumer to search for accessible units and limiting consumer choice.

In response to these difficulties, amendments were submitted to four waivers administered by the Office of Social Programs and the Aging waiver to add transition services as a covered service. Community Transition Services are defined as one-time expenses, not to exceed \$4,000 per consumer. These are "set-up expenses" for individuals who make the transition from an institution to their own home, apartment or family/friend/foster care living arrangement. The service may not include payment for rent.

To continue the coordination activity, the Department on Aging and the Office of Social Programs allocated \$1.4 million approved by the legislature to support transition coordinators. A joint RFP was developed by OSP and PDA. Funds were awarded to organizations in local communities that submitted a collaborative plan.

Institutional Downsizing

In 1998, the Department of Public Welfare developed the County Commissioners Association of Pennsylvania – Program for Alternative Community Care (CCAP-PACC) program to create incentives for County funded/operated nursing facilities to develop alternative services by downsizing their existing bed capacity and converting space to other uses, such as renovated or expanded physical therapy departments, independent housing units, adult day care centers or community outreach programs. The DPW funds the renovations, makes transition payments to support the phase-in cost of independent housing units and allocates additional home and community based waiver slots to the Area Agency on Aging.

Twenty nine counties participate in the program. By 2005, 1,582 nursing home beds have been de-licensed and 2,322 home and community based services waiver slots have been allocated. State officials indicated that the program has expanded in-home services, created additional independent housing units, reduced the number of beds per room, and created more home-like environments and increased efficiency by spreading operating expenses, administration and staff costs over fewer units.

In 1997, 81% of all licensed nursing homes participated in the Medicaid program and Medicaid paid for 66% of the occupied bed days.⁵ An analysis of nursing home admissions in 1996 found that 78% of the individuals admitted were Medicaid beneficiaries on the day of

⁵ Statement of Policy. Pennsylvania Bulletin, Vol 28, No 2, January, 10, 1998.

admission or within 60 days of admission, an increase of 20% since 1994. The Department of Public Welfare concluded that the supply of beds exceeded the amount needed to offer Medicaid beneficiaries a choice of settings. OMAP introduced a new contracting policy in 1997 when the certificate of need law expired. The policy prohibits nursing homes and ICF-MRs from expanding their capacity without first receiving approval from OMAP.

DPW concluded there would be a surplus of 5,634 beds by 2000 and spending for nursing home care created an imbalance. About \$2 billion, or 35% of the Medicaid budget, went to nursing home care while only \$76 million was spent on community services. The Department stated that “a policy that results in an unconstrained increase in the supply of nursing facility beds financed at taxpayer expense is unacceptable. The Department believes it is in the best interests of the residents of this Commonwealth with long term care needs to develop a fuller array of long term care supports and services.”⁶ As a result, the Department considers requests for the expansion of existing facilities and approval of new facilities based not on the need for institutional health services, but on whether the Medicaid program needs additional services and the most appropriate way to meet those needs. Applications are reviewed based on the availability of home and community based services funding in the area, the applicant’s willingness to serve Medicaid beneficiaries, willingness to serve technology dependent individuals, past history and the willingness to employ public assistance and medical assistance beneficiaries. No new facilities have been approved since the policy went into effect and Medicaid bed days have declined about 2% a year despite an increase in the population age 85 and older.

Housing Initiatives

Pennsylvania is implementing several initiatives to expand housing resources. The state offers 15 programs that pay for home modifications which are covered by a number of Medicaid waiver and state funded programs. This plurality of programs makes it difficult for consumers and case managers to access the most appropriate services. The Governor’s Office of Health Care Reform convened a work group to streamline access to services. A decision tree was developed and will be posted on the OHCR web site that will direct users to the most appropriate program based on answers to a series of questions. Information about the array of programs covering home modifications will be provided to Area Agencies on Aging and Independent Living Centers.

An affordable and accessible housing data base has been designed. The data base will be managed and maintained by the Pennsylvania Housing Finance Agency (PHFA). Initially, developers that have received financing from PHFA will be required to list vacancies and update the list weekly. Other housing owners will be asked to join the program over time.

PHFA has increased the set aside for accessible units for developers seeking Low Income Housing Tax Credits from five to ten percent of the total number of units supported by tax credits. Finally, a planned study of future housing needs will be expanded to include the housing needs of individuals who will need long term care services. .

⁶ Ibid.

Workforce Initiative

In 2000, the Intra-Governmental Council on Long Term Care commissioned surveys of provider agencies and of frontline long-term care workers to explore trends in workforce issues and develop recruitment and retention strategies to support the state's effort to balance its long-term care system. The Council recommended increasing training standards, increasing incentives to improve the workplace, funding a demonstration program to test workplace incentives, establishing a peer mentoring program, supporting evidence-based practices in improving wages, benefits and supervision through one-day conferences, and supporting a social marketing campaign.

The OHCR worked with the Department of Labor and Industries to design and implement a resource center for direct care workers who provide long term care, acute care, mental health and mental retardation services. In 2005, the Tri-County Patriots for Independent Living, an Independent Living Center, was selected through a RFP to operate the center. The resource center will develop a registry to help consumers find workers. The Center will combine several activities related to recruitment and retention of workers and improving job satisfaction.

Department of Aging Level of Care Integrity Project

The Department of Aging has initiated a study of level of care determinations completed by Area Agencies on Aging. The objectives of the study are to determine the percentage of correct and incorrect level of care decisions made by AAAs and any identifiable patterns among incorrect decisions. Two panels will be convened. An expert panel and a peer review panel will review a range of assessments using the criteria that establish whether a person meets the nursing home level of care criteria. The expert panel will review 50 randomly selected assessments and the peer review panel will review 100 assessments.

Quantitative Markers of Rebalancing

Markers of Change in Nursing Home Residents

To assess the potential effect of HCBS on nursing home use, we examined the MDS data on all Pennsylvania nursing homes for the years 2002, 2003, and 2004. We reasoned that if HCBS was having an effect, the case mix in nursing homes should become higher, i.e., the level of disability (both functional and cognitive) should increase. Because nursing homes serve at least two streams of clients, one requiring post-acute care (PAC) after discharge from hospitals and the more traditional long-term resident, we examined the case mix at two points in time: admission and three months after admission. The former would include the PAC population, but the latter should be a more direct reflection of long-term care that HCBS was intended to defray.

Table 1 shows the changes in the NH case mix on admission and 3 months after admission for 2002, 2003, and 2004. The latter is a better test of the long-term care population. Between 2002 and 2004, the functioning level of elders admitted to NHs in PA deteriorated slightly from the average ADL score of 15.69 in 2002 to an average ADL score of 16.16 in 2004 (the possible score of the ADL variable is between 0 and 24: a higher score means higher ADL dependence). Moreover, the proportion of residents admitted with no ADL dependencies, or very few, decreased. During the same period of time, the cognitive functioning of elders admitted into NHs improved slightly. The average CPS score went down from 1.64 in 2002 to 1.62 in 2004 (the

possible score for CPS is between 0 and 6: a higher CPS score means lower cognitive functioning). Moreover, the rate of persons with no cognitive impairment decreased while those with mild impairment increased.

Table 1: Change in Nursing Home Acuity at Admission and 3 Months Post Admission in Pennsylvania, 2002-2004

	2002	2003	2004
At Admission			
Mean ADL	15.69	16.12	16.16
Mean CPS	1.64	1.65	1.62
3 Months Post Admission			
Mean ADL	15.27	15.49	15.60
Mean CPS	2.43	2.44	2.40

The ADL functioning at 3 months after admission deteriorated slightly between 2002 and 2004. The average ADL scores in 2002, 2003, and 2004 were 15.27, 15.49, and 15.60 respectively. The proportion of persons with no or few ADL dependencies also dropped. The CPS scores improved slightly between 2002 and 2004. The CPS score in 2002 is 2.43 and dropped to 2.40 in 2004. Although the proportion of residents with no cognitive impairment decreased, the proportion with little cognitive impairment increased. This pattern suggests that HCBS may have achieved part of its goals in deflecting the clients with lower ADL needs to other sources, but the same effect was not seen for cognition.

Balance Between Institutional and Community Care

Figure 1 shows changes in the number of clients served under a various Medicaid programs. The largest sector of clients—nursing home residents—decreased slightly in 2004. The numbers served by the DD waivers have increased steadily since 2000. The numbers in the aging waiver are considerably less, but this waiver also increased steadily since 2001. These figures represent people served at any time during the year; some may not be covered for the full year.

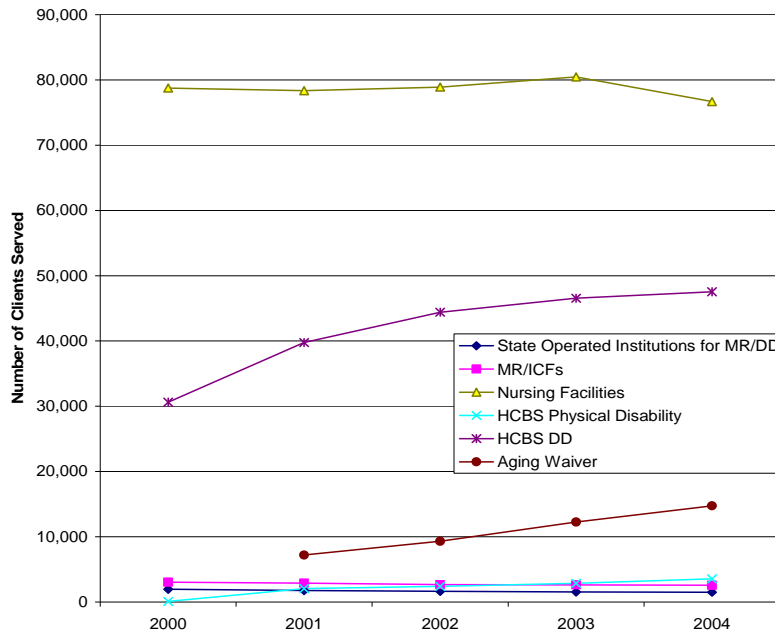


Figure 1. Clients Served in Selected Pennsylvania Programs, 2000-2004

Figure 2 traces the expenditures for these programs. The majority of the money goes to nursing homes, and this figure has increased steadily. The next largest expenditure is on facilities for MR-DD, both state operated and MR-ICFs. These expenditures have remained stable. Waiver funds are modest and steady.

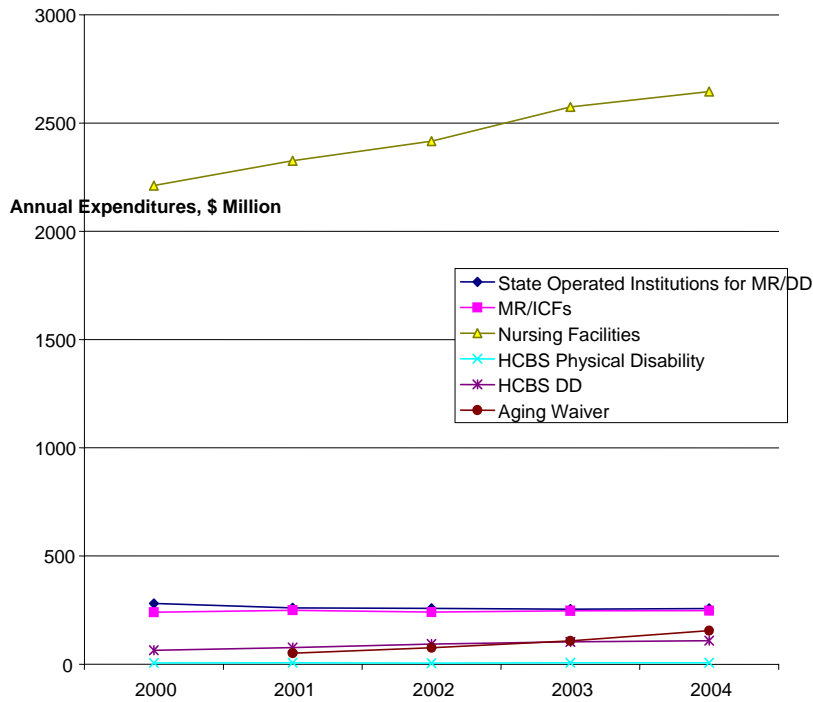


Figure 2. Expenditures for Selected Pennsylvania Programs, 2000-2004

Figure 3 examines the costs per person served. Again the figure represents people served at any time during the year; some may not be covered for the full year. The most expensive services are those in institutions for MR-DD, followed by nursing homes. The MR-DD costs per client have grown steadily, much faster than those for nursing homes. The costs per client served for physical disability waivers fell precipitously in 2001 and remained steady thereafter. In general waiver costs per client are much lower than costs for those in institutions.

Rebalancing Long-Term Care Systems in Pennsylvania

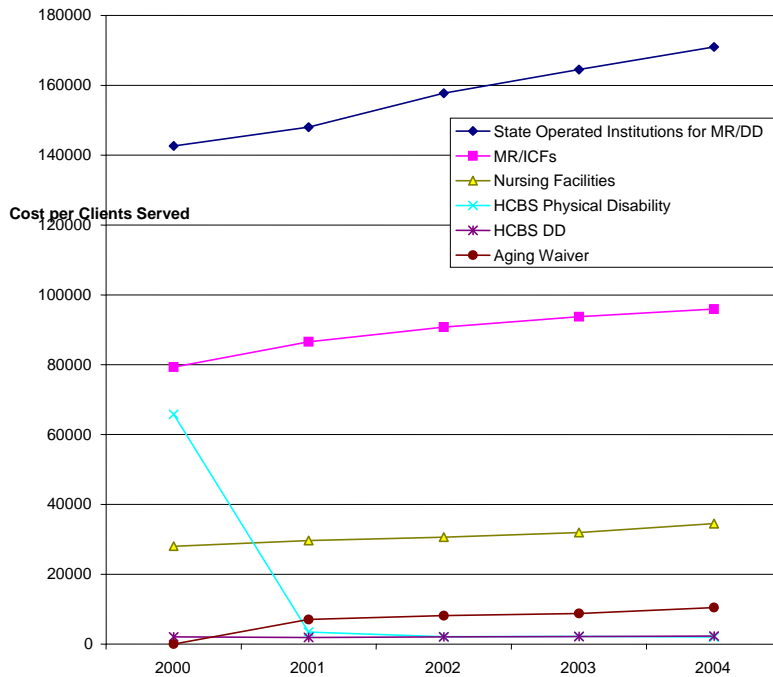


Figure 3. Per Capita Expenditures for Selected Pennsylvania Programs, 2000-2004

Conclusion

Pennsylvania is working intensively to rebalance a system that has remained tilted to institutions despite a long tradition of community care provision. The efforts are bolstered by a high level Office of Health Care Reform by the Governor. Pennsylvania has made progress, but more needs to be done to successfully balance the long-term care system. Quality assurance programs are well developed for nursing homes but less well-articulated in community settings. Although Pennsylvania has multiple home and community based waiver service programs, many are difficult to access, have waiting list, or serve just a small number of consumers.

The challenges have been well identified with the involvement of stakeholders from the advocacy and provider community. The Community Choice demonstration has shown that it is possible to reduce bureaucratic barriers to access, and will be implemented state-wide. Cash and counseling options are scheduled to be added to many waivers. The state is poised to move ahead in reducing dependence on nursing homes and to affect closure of the remaining state institutions in the MR/DD area.

Issues for Future Observation

- How the new quality management efforts develop.
- Whether the state is successful in promoting more affordable accessible housing options and more awareness of existing vacancies.

- Whether a new state governmental structure evolves along functional lines as has occurred in other states.
- How the personal care home sector will evolve in terms of quality and the acuity of those served. At present, advocate's concerns about quality issues in personal care homes is part of the reason why they resist changing the licensure to allow nursing-home certifiable consumers in personal care homes.

The backdrop of fiscal pressures has historically helped some states, including Oregon in the 1980s, move towards enhanced community care when a vision for such care had already been established. Pennsylvania appears to have achieved some clarity on the vision and may now be poised to transform itself to a more balanced system.