

Home and Community Based Services in Oklahoma: *A Systems Review*

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Executive summary

The Oklahoma Department of Human Services, Aging Services Division (OkDHS/ASD) received a Real Choice Systems Change grant from the Centers for Medicare & Medicaid Services to: promote accountability of the service delivery system to consumers, providers, and policy makers; produce available, reliable, appropriate, and quality personal assistance services; and create supports for consumers transitioning from institutional settings into community living. OkDHS/ASD contracted with the Long Term Care Authority – Oklahoma (LTCA-Oklahoma) to carry out the grant activities.

To further the purposes of the grant, the Long Term Care Authority-Oklahoma contracted with the National Academy for State Health Policy (NASHP) to review Oklahoma's long term care policies, programs, services and delivery system; to make recommendations that address cost, quality and access; and to describe options for improving the balance among community, residential and institutional services. This report is based on interviews with key officials and staff at the Oklahoma Health Care Authority (OHCA), the Oklahoma Department of Human Services (OkDHS), the OkDHS Aging Services Division, LTCAs of Tulsa and Enid d/b/a/ LTCA–Oklahoma, case management agencies and consumers.

Oklahoma has made significant progress toward balancing its long term care system in the past five years. Spending on home and community based services for elders and individuals with physical disabilities increased 364% between SFY 1999 and SFY 2004 and the percentage of Medicaid long term care funds spent on home and community-based services (*ADvantage*, State Plan personal care and home health) rose from 14% in SFY 1999 to 21% in SFY 2004.

Oklahoma has a unique structure for administering Medicaid long term care programs. OHCA is the Medicaid single state agency and has an interagency agreement with the Oklahoma Department of Human Services (OkDHS) to operate the *ADvantage* waiver program and the Medicaid State Plan personal care benefit. The OkDHS contracts with the LTCA d/b/a/ LTCA–Oklahoma to manage the *ADvantage* waiver program. The LTCA–Oklahoma has the staff expertise and information systems to operate as an Administrative Agent on behalf of OHCA and OkDHS to establish standards, recruit and certify providers and manage and track care plans and expenditures.

The report suggests steps that might be taken to describe the mission and purpose of the state's long term care system, strengthen the structure of the policy and budgeting process, streamline access to services, create a mechanism for shifting funds from institutional to community services, improve the quality assurance and quality improvement system and strengthen consumer directed options.

Introduction

The Oklahoma Department of Human Services, Aging Services Division (OkDHS/ASD) received a Real Choice Systems Change grant from the Centers for Medicare & Medicaid Services to: promote accountability of the service delivery system to consumers, providers, and policy makers; produce available, reliable, appropriate, and quality personal assistance services; and create supports for consumer transitioning from institutional settings into community living. OkDHS/ASD contracted with the LTCA-Oklahoma to carry out the grant activities.

To further the purposes of the grant, the LTCA-Oklahoma contracted with the National Academy for State Health Policy (NASHP) to review Oklahoma's long term care policies, programs, services and delivery system and to make recommendations that address cost, quality and access; to describe options for improving the balance among community, residential and institutional services; and to present options for the design and implementation of a single entry system.

NASHP assembled a team of experts to carry out the project. Robert Mollica, Senior Program Director at NASHP, led the project. The team included Susan Reinhard, Co-Director of the Rutgers Center for State Health Policy; Maureen Booth, Director of the Quality Improvement Program Area, Edmund S. Muskie School of Public Services at the University of Southern Maine; and Leslie Hendrickson, consultant and former official with the New Jersey Department of Health and Senior Services and the Oregon Senior and Disabled Services Division. The team interviewed state officials and staff from OHCA, the Oklahoma Department of Human Services (OkDHS) and the OkDHS Aging Services Division (ASD); LTCA–Oklahoma officials and staff; case management agencies; and consumers during a three day site visit in June 2005. The team obtained and reviewed program and policy documents, legislation, reports, and expenditure and caseload data. Information from other states was also reviewed.

The report has two sections. Section I contains an overview and trends observed in Oklahoma, a description of relevant characteristics of state long term care systems, findings from interviews with key informants and a review of related materials from Oklahoma, and promising practices gleaned from the experiences of other states. Section II contains recommendations for strengthening Oklahoma's long term care system based on findings and promising practices.

Section I

Overview and trends

Oklahoma is home to 3.5 million residents and 13.2% of the population was over age 65 in 2003. By 2010, the number of residents over age 65 will increase 8.6% to 495,000 people and the number age 85 and older will grow 23.4% to 70,515 people. The projected growth, despite declining disability rates, is likely to increase demand for long term care services.

Oklahoma relies heavily on nursing homes to provide long term care services. The supply of nursing home beds per thousand people over age 65 in Oklahoma is 69.3 compared to a national

average of 46.3 beds per thousand.¹ State officials noted that statewide nursing home occupancy rates are about 70% due to excess supply and the availability of alternative services through the *ADvantage* program that supports nursing home eligible Medicaid beneficiaries in the community.

Oklahoma ranks 16th among the states in the number of nursing homes, but it ranks 35th among the states in the average number of beds per nursing home. Thus, Oklahoma has more nursing homes, but the average size is smaller than the national average. It ranks 46th in the number of persons over the age of 65 per nursing home bed among the states, implying that according to national standards, the state has more nursing home beds than needed (see Table 1).

Table 1: Oklahoma Nursing Home Statistics		
	Oklahoma	Rank Among States
Number of people over 65 years of age, 2003	464,000	27th
Number of nursing home residents, 2002	21,828	24th
Nursing home residents as percentage of persons over 65 years of age	4.62%	19th
Total number of nursing home beds, 2002	31,445	20th
Number of persons over 65 per each nursing home bed	15.01	46th
Average facility occupancy rates for certified nursing homes, 2002	68.3	51st
Total number of nursing homes, 2002	368	16th
Number of beds per nursing home, 2002	86	35th

Other Midwest states, Iowa, Kansas, Nebraska, and South Dakota, also tend to have many smaller nursing homes. The nursing homes in rural mid-western area are an important part of the rural economy. Doeksen and Schott of the Department of Agricultural Economics at Oklahoma State University published an analysis of the economic importance of the health care sector in rural Oklahoma in the Jan-Jun 2003 issue of *Rural Remote Health*. They found that about 19% of the local economy consists of health-related activities.

The low nursing home occupancy rate in Oklahoma is not due to the high prices of nursing homes in the state. These same Midwest states tend to have low nursing home per diems. Genworth Financial, which tracks the cost of private nursing homes, reports that Oklahoma had the lowest rate for private rooms, \$116 per day, in the country in 2005. Other states with low rates included Arkansas, Kansas and North Dakota.²

Declining population and preferences for receiving care in the home have put pressure on nursing homes, especially rural homes. Oklahomans, like persons in other states, prefer to receive care in their own homes as long as possible. In May 2003, AARP conducted a phone survey of 800 Oklahomans and found that less than one in ten would prefer to receive long-term care in a nursing home and six out of ten would prefer to obtain care from friends or relative in their own home. Twenty-five percent would prefer a residential situation such as assisted living.³

¹ Calculations are based on Census Bureau population projections for July 2004 and December 2004 OSCAR bed supply data. See appendix for a national table.

² See, <http://www.genworth.com/comweb/pdfs/coc05tables.pdf>

³ Available at http://assets.aarp.org/rgcenter/health/ok_nursing.pdf

Continuing comments about low staffing levels in Oklahoma and other controversies further dissuade potential users of nursing homes. The Minority Staff Report of the House Committee on Government Reform, *Nursing Home Staffing Levels Are Inadequate in Oklahoma* May 24, 2001 found that the majority of Oklahoma nursing homes did not have adequate staff to care for residents. In January 2005, Governor Henry announced a nursing home reform effort. Among other things, the governor proposed hiring more state health inspectors and mandating greater scrutiny of employees to improve safety in Oklahoma nursing homes.

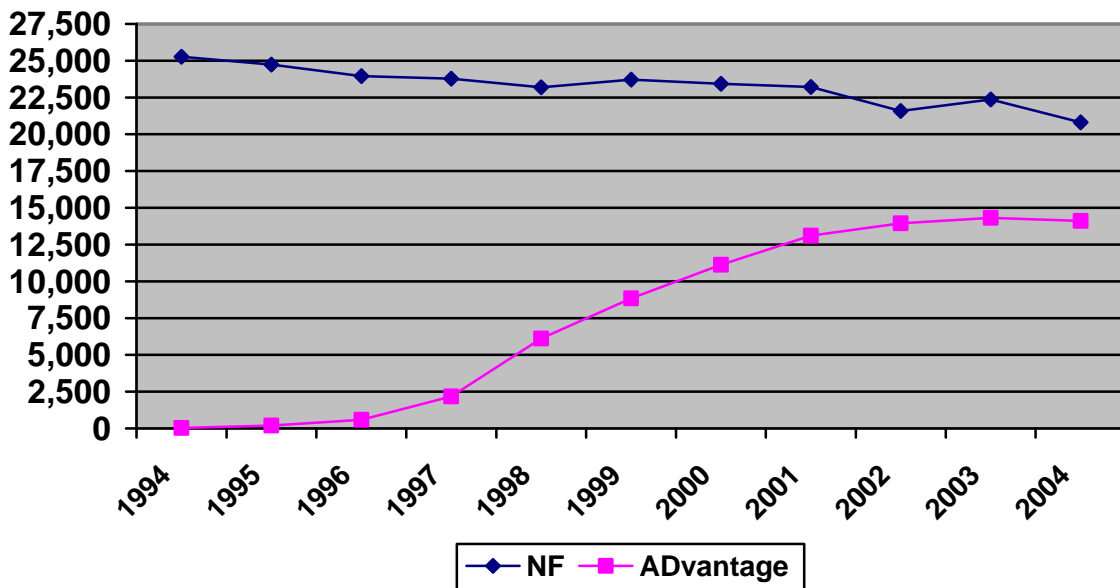
Key trends

We examined three variables over a ten year period to understand nursing home and ADvantage waiver program trends – nursing home caseload, expenditures and participant days.

Caseload

As shown in Figure 1, enrollment in ADvantage was very slow during the start up phase, expanded rapidly between 1997 and 2001 and stabilized between 2001 and 2004. This is a normal pattern. The first phase of program implementation is spent building the framework and infrastructure: getting funding, hiring staff, developing policy and procedures, recruiting and certifying providers, training case managers and outreach to consumers. Success in building the system’s infrastructure created the opportunity for further growth.

Figure 1. Caseload trends



In contrast, the Medicaid nursing home caseload gradually declined by 4,454 beneficiaries from 25,268 in SFY 1994 to 20,814 in SFY 2004. The rate of decline is about 1% a year since 2000. ADvantage caseloads went up but the rate of increase in the caseload steadily declined until the

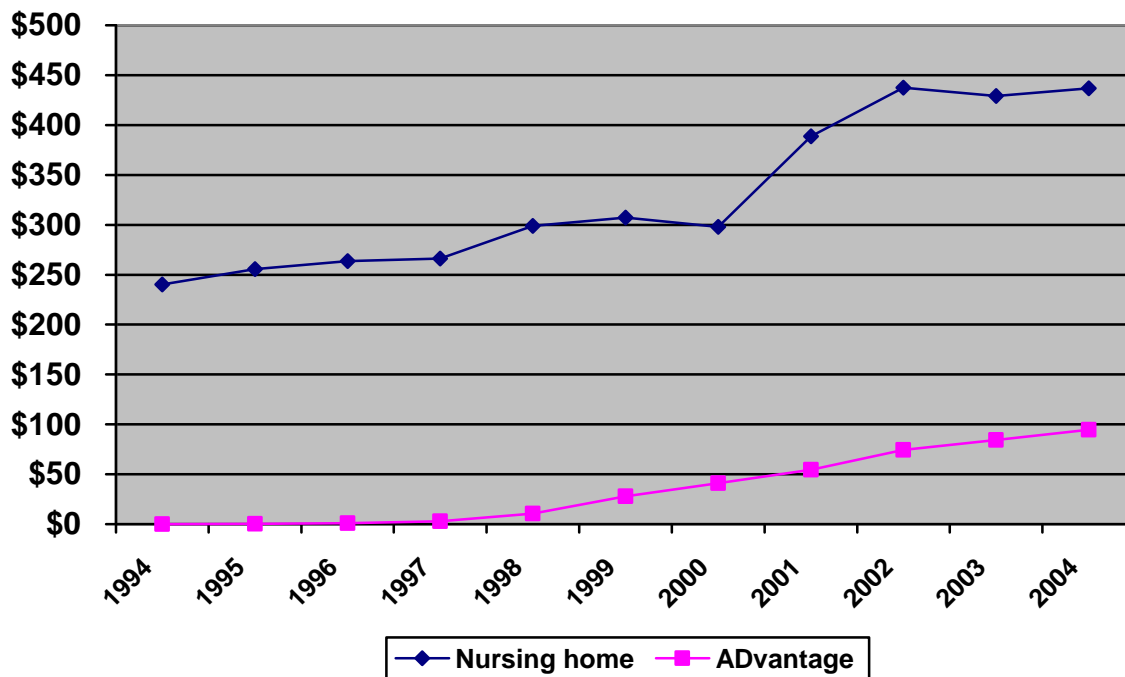
caseload dropped slightly in SFY 2004. Interviews with staff in different agencies suggested that the State had budget shortfalls which resulted in fewer persons receiving *ADvantage* services in SFY 2004 than anticipated.

Expenditures

Expenditures for nursing home services rose from \$240 million in SFY 1994 to \$434 million in 2004. See figure 2. Oklahoma uses a prospective reimbursement methodology to determine nursing home rates based on cost reports. The rate is “rebased” each year from approved cost reports. However, rate increases must be approved by the legislature. Rate increases typically ranged from 1-3%. In SFY 1999, no increase was approved and a 7% increase was approved in January 2004. Spending rose significantly in SFY 2001 due to implementation of a quality assessment fee that raised the average rate from \$66.75 per day to \$80.09.

Spending for *ADvantage* waiver services rose from \$.4 million in SFY 1994 to \$94 million in SFY 2004. Expenditures grew slowly until SFY 1998. Expenditures reflect changes in enrollment, utilization, and provider rate changes. The case management rate includes an adjustment that reflects the higher travel costs in rural areas. Billing for personal care services is now based on 15 minute increments rather than 60 minute increments.

Figure 2. Nursing home and *ADvantage* Expenditures (millions)



If the *ADvantage* waiver were not in place and only one third of its participants entered a nursing home, nursing home spending would have increased by \$97.7 million in SFY 2004 based on the per person Medicaid nursing home costs.

The most recent complete data submitted to CMS shows that the average annual Medicaid expenditure for nursing home beneficiaries was \$23,510 in SFY 2001 and \$8,514 for *ADvantage* participants. Program expenditure reports show that about 83% of personal care services authorized under care plans are delivered. Contacts with selected states found that the ratio of delivered to authorized services generally fall between 95% and 100% for consumer directed programs and lower for home care agencies. The ratio of delivered services to authorized services for home care agencies varied from 80% in Ohio to 85% in Massachusetts and 95% in Vermont. Area Agencies on Aging in Washington include the ratio as a performance indicator for reviewing home care agency contracts.

Total service days

Focusing on expenditures masks the impact of rate increases and policy changes. The number of paid Medicaid days is a more reliable indicator of utilization trends because it adjusts for provider rate increase, implementation of the provider tax, and rebasing of nursing home rates.

Nursing home days declined from a high of 6.5 million days in SFY 1995 to 5.7 million days in SFY 2004. *ADvantage* waiver days rose from a low of just over 3,000 during its first year to 4.0 million days in SFY 2003. In SFY 2004, *ADvantage* days declined by 120,000 due to budget reductions. See figure 3 and table 2. Medicaid nursing home days have declined steadily as *ADvantage* days increased. Key informants indicated that enrollment in the *ADvantage* program slowed in SFY 2004 to limit spending growth. The increases in nursing home days in SFY 2004 and the decrease in home and community based *ADvantage* waiver services days seem related.

Figure 3. Total service days (millions)

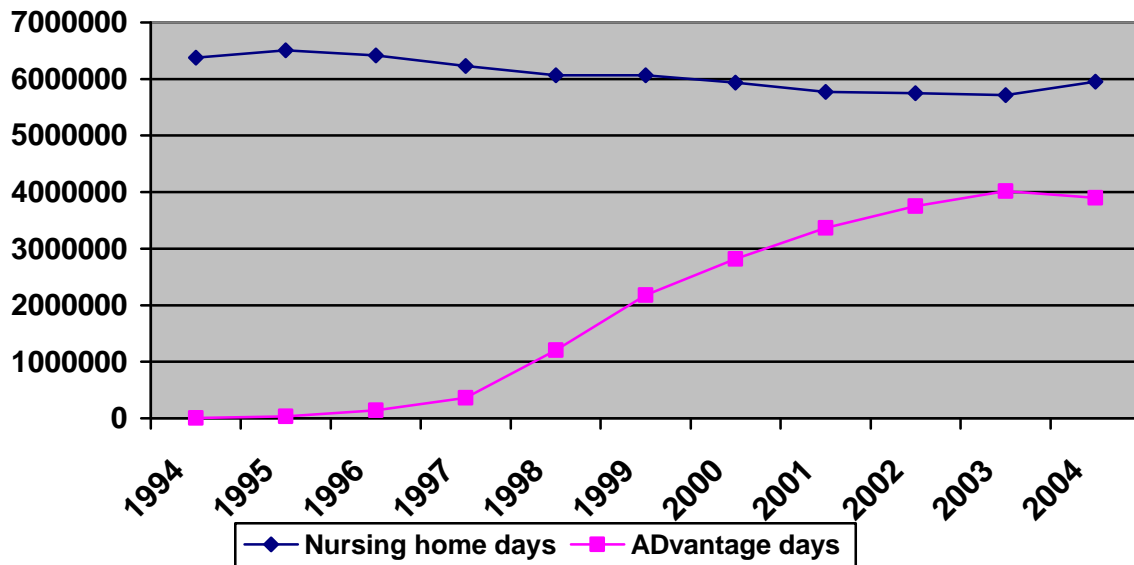


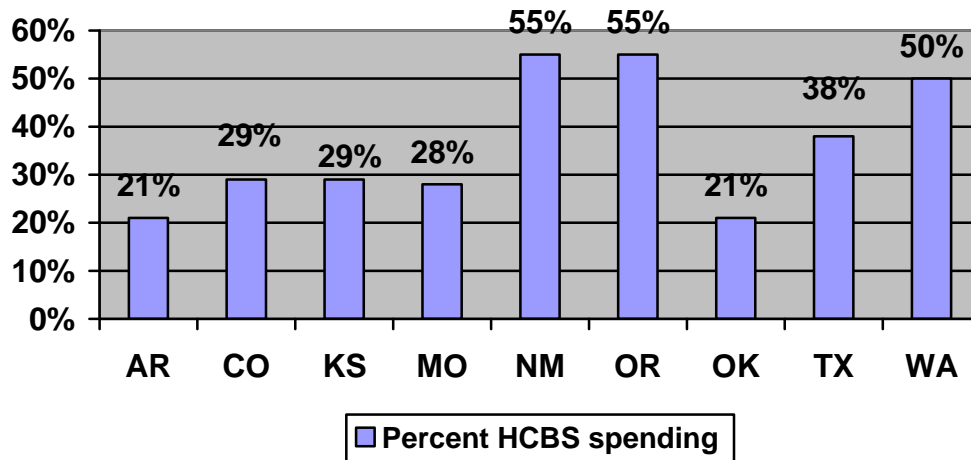
Table 2: Number of Medicaid Total Service Days				
Year	Nursing home Number of Days	% Change	ADvantage Number of Days	% Change
1994	6,375,877	--	3,172	--
1995	6,509,228	2.09%	31,591	895.93%
1996	6,419,876	-1.37%	142,847	352.18%
1997	6,231,501	-2.93%	362,526	153.79%
1998	6,067,157	-2.64%	1,164,349	221.18%
1999	6,067,152	0.00%	2,180,690	87.29%
2000	5,934,635	-2.18%	2,819,772	29.31%
2001	5,772,373	-2.73%	3,364,471	19.32%
2002	5,748,378	-0.42%	3,749,930	11.46%
2003	5,714,501	-0.59%	4,019,065	7.18%
2004	5,955,142	4.21%	3,897,453	-3.03%
Est. FY 2005	5,623,744	-5.56%		

Shifting resources to create balance

Oklahoma has made progress shifting resources to home and community-based services (HCBS). In SFY 1999, 14% of Medicaid long term care expenditures for elders and adults with physical disabilities were spent on community care.⁴ In SFY 2004, 21% of Medicaid long term care expenditures for elders and adults with physical disabilities paid for care in the community (see Figure 4). Further progress is possible. Oregon and Washington, two states that have made the most progress toward a balanced system, spent 55% and 50% of Medicaid long term care funds on home and community based services respectively. New Mexico reached 55% in SFY 2004, primarily through growth in the state plan personal care program implemented in 2000. Applicants must meet the nursing home level of care criteria to receive state plan personal care services in New Mexico. In 2004, New Mexico spent almost as much for personal care as it spent for nursing home services. Among neighboring states, Oklahoma trails Texas (38%), Colorado (30%), Kansas (29%), and Missouri (28%) in the percentage of Medicaid long term care funds spent on HCBS.

⁴ Medicaid expenditure data is based on data compiled by Thomson Medstat for the Centers for Medicare & Medicaid Services. May 2005.

Figure 4. FY 2004 Medicaid HCBS spending



It is difficult to compare waiver expenditures across waivers and states since the services covered vary and every state has a different medical or functional threshold to receive waiver services. Data prepared by Medstat does compare state per capita spending. For example, in SFY 04, Oklahoma spent \$23.21 on ADvantage waiver services per capita (total state population), \$8.59 for Medicaid state plan personal care services (\$39.65 for both ADvantage and state plan personal care services) and \$131.40 on nursing home care (see figures 5 and 6).

Figure 5. Per capita waiver spending

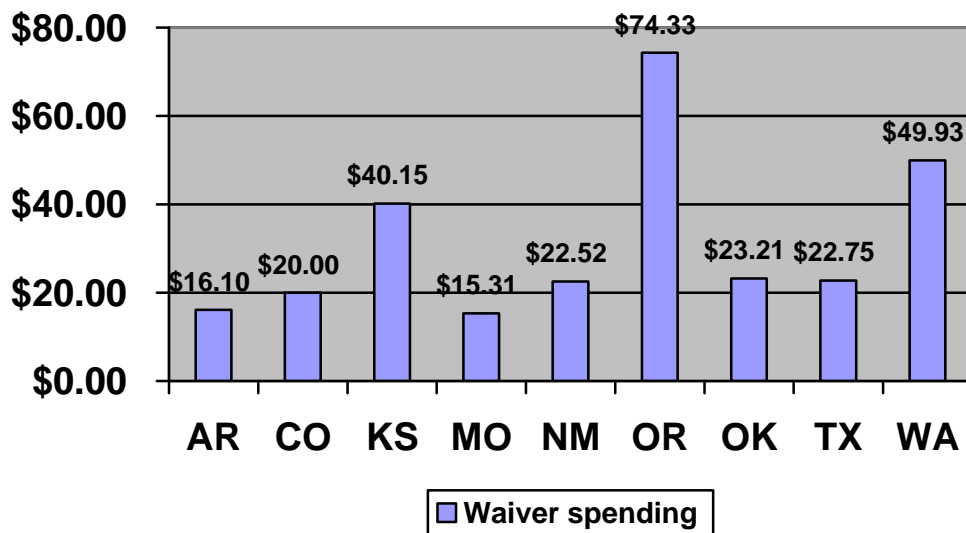
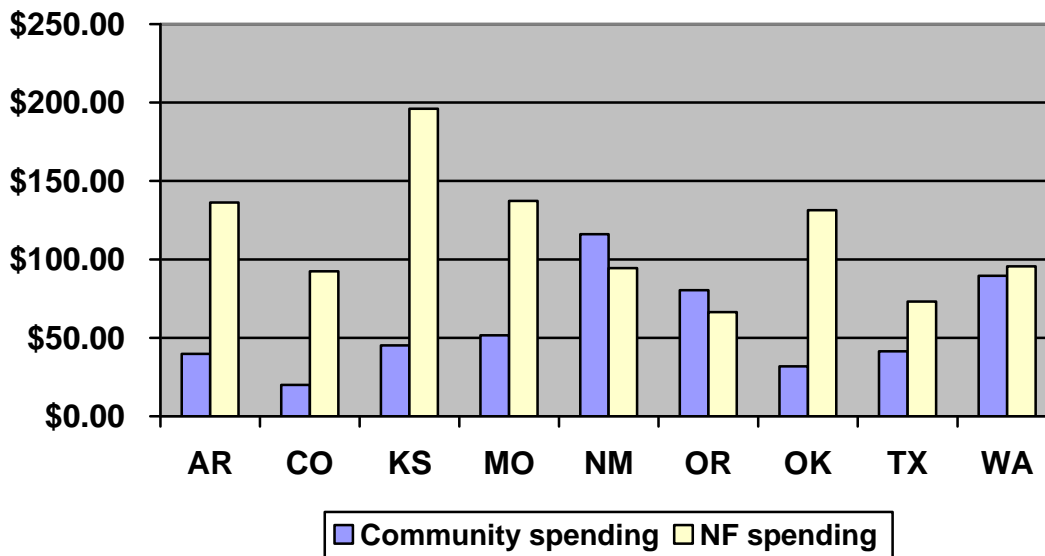


Figure 6 compares per capita state Medicaid spending for personal care and waiver services to nursing home spending. In SFY 2004, Oklahoma spent \$31.80 per resident on community services and \$131.40 on nursing home services. Colorado, which does not cover personal care

under the Medicaid state plan, spent \$20 on community services and \$92.41 on nursing home care. New Mexico spent \$116.06 on community services and \$94.49 on nursing home care.

Figure 6. Per capita Medicaid community and NF spending



States are required to submit annual data to CMS that reports the unduplicated number of people served and the average expenditures for waiver services. In SFY 2001, the ADvantage program served 15,519 people at an average annual per person cost of \$3,512. See table 3 for a comparison of selected states.

State	Unduplicated beneficiaries	Average cost of waiver services
Arkansas	3,831	\$ 8,430
Colorado	5,131	\$14,082
Kansas		
Aged	7,771	\$ 6,975
Disabled	4,666	\$12,786
Missouri	24,307	\$ 2,900
New Mexico	1,441	\$14,657
Oregon	31,661	\$ 6,992
Oklahoma	15,519	\$ 3,512
Texas	30,908	\$11,410
Washington	30,515	\$ 9,003

⁵ Available at http://www.pascenter.org/state_based_stats/medicaid_waiver.php?state=oklahoma#e179. The data in this report differs from the figures provided by LTCA-Oklahoma which shows Oklahoma served 13,110 beneficiaries at an average cost of \$4,157.

Comprehensive community based systems

Background

State policy makers and stakeholders frequently support the development of a “balanced” long term care system. Though not clearly defined, balance is most often discussed in relation to the percentage of Medicaid funds that are spend on home and community based services compared to nursing home care, the number of beneficiaries served in community settings versus institutional settings, and nursing home supply and occupancy rates. Setting goals based on the percentage of Medicaid long term care funds spent on community versus institutional services may be misleading since nursing home spending can be affected by rate increases and provider tax strategies that mask shifts in utilization. Measuring the percentage of beneficiaries served in institutional and community settings and the number of Medicaid bed days and Advantage service days offer better benchmarks to measure progress toward a balanced system.

State leaders content that balance is achieved by developing a comprehensive system rather than implementing individual strategies. While each strategy plays its own important role, officials in states with the most balanced system suggest that the whole is more important than the sum of its parts.

The components of a comprehensive long term care systems include: a well defined philosophy of care; consolidation of responsibilities in a single agency; appropriation of Medicaid funds for long term care services in a single line item; the availability of multiple financing sources; streamlined access through comprehensive entry points; streamlined/expedited processes for determining medical and financial eligibility; a comprehensive array of service options (in-home, consumer-directed care, community, residential and institutional); and the availability of nursing home relocation services.

Philosophy of care

Background

Setting and implementing public policy is an arduous task that involves executive branch agencies, the legislature, providers, consumers, families, and advocacy organizations. Reaching consensus requires balancing the different perspectives and interests of each group of stakeholders. Developing a philosophy establishes a baseline for the consideration of policy options and strategies. Once stakeholders agree, new proposals can be evaluated based on whether they are consistent with the purpose and philosophy of the system.

Findings

During our review, **we did not find a written statement of the state’s philosophy for its long term care programs in statute, regulations or policy materials.** A philosophy is a starting point for developing a road map or strategic plan for long term care. It is especially important in states that want to change the balance between institutional and community care, especially during difficult budget times.

Promising practices

Several states have described a philosophy for long term care programs. The philosophy guides policy, budget and program decisions. Oregon's philosophy is stated in statute and states that:

The Legislative Assembly finds and declares that, in keeping with the traditional concept of the inherent dignity of the individual in our democratic society, the older citizens of this state are entitled to enjoy their later years in health, honor, dignity, and disabled citizens are entitled to live lives of maximum freedom and independence. (§410.010)

The statute directs that policies coordinate the effective and efficient provision of community services to older citizens and disabled citizens so that services will be readily available to the greatest number over the widest geographic area; that information on these services is available in each locality and assure that older citizens and disabled citizens retain the right of free choice in planning and managing their lives; by increasing the number of options in life styles available by strengthening the natural support systems of family, friends and neighbors to further self-care and independent living (§410.020).

State law in Washington directs the state agency to “establish a balanced range of health, social and supportive services that deliver long term care services to chronically, functionally disabled persons of all ages and to ensure that services are provided in the most independent living situation consistent with individual needs” (Revised Code of Washington (RCW) §74.391.05) and “to the extent of available funding, the department shall expand cost effective options for home and community services for consumers” (RCW, 74.39A.030).

Each state considers program options and budget decisions in the context of their own state. Legislators in Oregon and Washington consider funding and policy changes in light of the philosophy contained in statute. Revenue shortfalls pose challenges for states as they make policy and program decisions about spending for institutional and home and community based services. Many states are able to respond to budget constraints by moving resources from institutional to community services. Washington was able to avoid reductions in its community based programs because its commitment to reducing the nursing home caseload and expand HCBS waiver spending.

Organizational structure

Background

States perform multiple responsibilities for long term care. Among the key responsibilities, states set policy, license and regulate providers, set rates, determine financial and functional eligibility, establish systems for accessing and delivering services, and provide quality oversight. The responsibilities may be assigned to one or more state, county or local organizations. The allocation of responsibilities affects the state's ability to effectively manage resources and meet the needs of consumers served by the long term care system.

The Medicaid Home and Community-Based Services (HCBS) waiver program permits states to furnish an array of home and community-based services that assist Medicaid beneficiaries to live

in the community and avoid institutionalization. States have broad discretion to design programs to address the needs of the waiver's target population.

In its introduction to the revised waiver application, CMS states that it recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the state, service delivery system structure, state goals and objectives, and other factors.

The waiver application describes how the waiver will be administered, who will be eligible, how many beneficiaries will be served, the services that will be provided, and the procedures that will be used to develop, implement and monitor the participant-centered service plan.

The waiver application requires a set of assurances that specify the safeguards the state has established to assure the health and welfare of waiver participants in specified areas; the quality management strategy; the methods by which the state makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation; demonstrates that the waiver is cost-neutral and how the state informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

The assurances also include a description of the necessary safeguards that will be taken to protect the health and welfare of persons receiving services under this waiver; adequate standards for all types of providers that provide services under this waiver; assurance that the standards of any state licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver. The state assures that these requirements are met on the date that the services are furnished; and the financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services appropriate financial records documenting the cost of services provided under the waiver.

Under the quality management section of the waiver application, states must operate a formal, comprehensive system to ensure that the waiver meets the assurances and other waiver application requirements. Using an ongoing process of discovery, remediation and improvement, states assure the health and welfare of participants by monitoring: level of care determinations; individual service plans and service delivery; provider qualifications; participant health and welfare; financial oversight and administrative oversight of the waiver. States further assure that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem.

These health and welfare assurances exceed the requirements for ensuring the quality of Medicaid State Plan services.

Several models are used by states to operate and manage access to waiver services. States may use state agencies, county agencies, non-profit organizations and provider organizations to manage Medicaid HCBS waiver and state plan services (nursing home and personal care). The CMS HCBS waiver application form requires that states indicate whether administrative functions will be performed by the single state agency, a state agency that is not the single state agency or a contracted entity such as LTCA-Oklahoma.

The new waiver format requires that when a contracted entity is used, the state must identify the state agency that will assess the performance of the entity, the methods to be used, and the frequency of the assessments. The functions that must be performed, and may be performed by a contracted entity, include:

- Dissemination of information concerning the waiver to enrollees;
- Assisting individuals to enroll in the waiver;
- Managing enrollment in relation to approved limits;
- Monitoring expenditures against approved levels;
- Conducting level of care assessments;
- Reviewing participant service plans to ensure that waiver requirements are met;
- Prior authorizing waiver services;
- Conducting utilization management functions;
- Recruiting providers;
- Determining waiver payment rates; and
- Conducting training and technical assistance concerning waiver requirements.

Findings

Oklahoma has a unique and complex organizational structure for managing long term care services for elders and adults with physical disabilities. Responsibility for long term care is spread among three state agencies and two local government public trust authorities. The uniqueness derives from “privatizing” waiver administration, waiver management, case management and service delivery through contracts with a local government public trust authority, and community based organizations.

Responsibilities for administering long term care services in Oklahoma are assigned as follows:

- OHCA is the designated State Medicaid Agency and manages acute care services and nursing home care. OHCA was formed in 1994 to implement a managed care program for acute care services.
- OkDHS is responsible for administering Medicaid state plan personal care services and home and community based waiver services under an interagency agreement with OHCA.
- The OkDHS responsibilities are managed by the Aging Services Division (OkDHS/ASD). OHCA also has an interagency agreement with the OkDHS, previously the State Medicaid agency, to manage personal care state plan and HCBS. Community based long term care programs remained with OkDHS when OHCA was established.
- OkDHS contracts with the LTCAs of Tulsa and Enid d/b/a LTCA-Oklahoma to administer the *ADvantage* waiver program.
- Medicaid financial eligibility is determined by OkDHS Office of Family Support.
- The Oklahoma State Department of Health (OSDH) is responsible for licensing nursing homes, residential settings such as assisted living centers and residential care facilities, and home health agencies.

OkDHS is a multipurpose umbrella agency with over 7,400 full time equivalent positions that is governed by a nine-member board whose members are appointed by the Governor to staggered nine year-year terms. The Commission appoints the Director of Human Services, approves program budgets, funding, and policies and procedures that direct the Department's program and service delivery.

OkDHS has seven divisions. Material from the Governor's Budget document and the OkDHS web site contained the following information about each Division:

- The Aging Services Division (ASD) serves as the focal point for all matters relating to the needs of older persons. ASD works with and through DHS county offices, area agencies, local governments, local agencies and organizations of older persons. The division is responsible for advocacy, planning, developing, conducting, monitoring and evaluating programs and services. The division administers the *ADvantage* program, Older Americans Act activities, and the ombudsman program. ASD is also responsible for long term care medical assessments and level of care determinations for nursing home, state plan personal care and *ADvantage* waiver services.
- The Family Support Services Division (FSSD) has responsibility for determining eligibility for Financial Assistance, Family Social Services and Food and Nutrition Services. Financial Assistance Program responsibilities include developing and monitoring the implementation of policies and procedures for determining eligibility for Temporary Assistance to Needy Families (TANF), Food Stamps, Low Income Home Energy Assistance Payments (LIHEAP), Medical Assistance, Refugee Assistance via contracts and State Aid to the Aged, Blind and Disabled. Family Social Service responsibilities include developing and monitoring the implementation of policies and procedures for determining eligibility and developing service plans for child care, TANF work, health-related services and refugee social services. The adult protective services program has been transferred from ASD to FSSD.
- The Division of Children and Family Services (DCFS) administers programs to children and families at the home, community and residential level. The DCFS also administers two shelter programs: the Oklahoma County Juvenile Center in Oklahoma City and the Dester Center in Tulsa.
- The Field Operations Division is responsible for coordinating the delivery of all agency services at the local level as well as supervision of local Child Welfare, and Family Support programs through county directors in 87 local offices and six area directors. County directors oversee personnel, housing, equipment and supplies for all local staff housed in the county and coordinate with all program divisions to ensure that client and staff needs are met. The Office of Field Operations also directs the AIDS Coordination and Information Services (ACIS) Unit. This unit works with DHS divisions and other public and private entities to coordinate the development and provision of services to persons with AIDS and HIV infection.
- The Division of Child Care is responsible for licensing child care programs.
- The Child Support Enforcement Division is responsible for the establishment and enforcement of the child support responsibilities of absent parents.
- The Developmental Disabilities Services Division (DDSD) is responsible for the administration and coordination of community-based and institutional programs for

individuals who with developmental disabilities. DDS services are provided by private contractors. Residential services include supported living, specialized foster care, adult companions, and group homes. Employment services include sheltered workshops and community integrated employment. The range of support services available include therapy, psychological services, habilitative training, nursing services, architectural modifications, adaptive equipment, transportation, emergency services and family income support. Case management is provided through three area offices DDS operates three public and 24 private Intermediate Care facilities for the Mentally Retarded.

- The Office of Finance, under the Direction of the Chief Financial Officer, supports the delivery of program services by presenting the agency's annual Budget Request, preparing and monitoring the annual Budget Work Program, monitoring receipts and expenditures, processing vendor and some client payments, producing financial reports and statements to meet state and federal requirements, preparing the agency payroll, distributing food stamps and administering the Electronic Benefit Transfer (EBT) program for distribution of client assistance payments.
- The Office of Volunteerism utilizes volunteers to provide services, staff support and resource development in each division of the agency. Volunteer services are used throughout DHS to augment the agency's mandated programs and fill gaps in available services.
- The Office of Client Advocacy (OCA) provides a variety of protection and advocacy services for DHS clients. OCA's Ombudsmen provide advocacy assistance to individuals with developmental disabilities. An Ombudsman is a person who assists individuals in resolving problems with regard to services they need and the quality of those services.
- The Office of the Inspector General investigates situations that involve possible fraud, abuse or error, to assure DHS accountability in all programs administered by the department.

The Oklahoma Health Care Authority (OHCA) was established as the Single State Medicaid Agency to transition from Medicaid's traditional fee-for-service program to a coordinated system of managed care. OHCA's mission is to purchase state and federally funded health care in the most efficient and comprehensive manner possible and to study and recommend strategies for optimizing the accessibility and quality of health care. As the single state Medicaid agency, OHCA is responsible for assuring compliance with federal Medicaid requirements and has delegated long term care functions to the OkDHS and OSDH. OHCA and OkDHS have separate appropriations for nursing home (OHCA) and personal care and *ADvantage* waiver services (OkDHS). While agency officials and staff work collaboratively, the separation of responsibilities makes it difficult for the state to improve management and policy development of the long term care system.

Long term care comprises 36% of the total Medicaid budget – 23% for older adults and individuals with physical disabilities – yet because of the assignment of responsibilities among multiple agencies, no single agency or official is responsible or accountable for long term care. **Because of its narrower mission, OHCA may be better able to focus on developing a strategic plan to create a balanced long term care system.**

Role of the Long Term Care Authority

Oklahoma's community long term care system emerged gradually with the creation of the Long Term Care Authority of Tulsa in 1987. Formed as a planning, research and program development organization, the LTCA–Tulsa received grants to conduct research on Oklahoma's long term care systems and case management programs. In 1995 a second Long Term Care Authority was established (LTCA of Enid).

The Department of Human Services Commission made a strategic decision about fifteen years ago to build the management and service delivery system outside of state government. Several states (Florida, Illinois, Indiana, Maine, Massachusetts, Ohio, and Pennsylvania) contract with area agencies on aging or other community based organizations for case management activities. Oklahoma developed a unique partnership between OkDHS, LTCA-Tulsa and LTCA-Enid, d/b/a/ LTCA-Oklahoma, to develop the capacity to offer consumers services to remain in their homes. The Medicaid *ADvantage* HCBS Waiver program was approved in 1992 and implemented in 1993.

OkDHS contracts with the LTCAs to serve as the administrative agent (AA) for the home and community based services waiver program. As the administrative agent, LTCA-Oklahoma manages many functions that would otherwise require additional state employees – managers, policy, IT and support staff and other costs associated with the functions preformed by LTCA-Oklahoma. Through its contract with the AA, OkDHS has the flexibility to design and implement change more quickly than is typically possible through state procedures.

LTCA-Oklahoma developed, manages and monitors the case management infrastructure needed to deliver services to consumers. LTCA-Oklahoma developed service standards, conditions of participation, program service standards, consumer assurances and service delivery principles to create the infrastructure for the program. The purpose of a second authority was to address rural health care issues and assist in providing AA oversight for *ADvantage* in western Oklahoma counties.

The LTCA–Oklahoma's roles and responsibilities as the AA are described in the Community Systems Development Program contract with OkDHS and encompass the following:

- Certify, recertify or decertify *ADvantage* Program service providers as qualified to deliver Medicaid services;
- Review and approve each consumer's waiver services for delivery and payment through a service plan approval process;
- Implement processes and procedures to assess consumer satisfaction and quality of services delivered;
- Implement processes and procedures to monitor consumers' health and safety and to verify that services are delivered in accordance with the service plan;
- Respond to and resolve inquiries regarding the *ADvantage* Program's service delivery system's inability to meet an individual consumer's needs;
- Maintain Waiver Management Information Systems (WMIS) to support *ADvantage*

Program functions and collect and provide comparative data for quality management and planning purposes. Functions supported by WMIS include Consumer Inquiry Services, waiting list management, consumer tracking, provider tracking, consumer approved services and approved service plan tracking, prior-authorization and claims processing, comprehensive provider audits, Continuous Quality Improvement (program and provider), research, OkDHS monitoring of LTCA-Oklahoma, and Oklahoma Health Care Authority audits;

- Provide to MMIS prior-authorization for all Medicaid services requiring authorization of an approved *ADvantage* Program service;
- Recruit providers and facilitate completion of the *ADvantage* and state plan personal care program provider application;
- Research and identify consumer needs and service gaps in the *ADvantage* Program service-delivery system and design and propose to OkDHS new systems or modifications to existing systems to meet those needs or bridge service gaps. Develop, for review by OkDHS, amendments to the *ADvantage* Program waiver document, revisions to Oklahoma Health Care Authority or OkDHS rules, revisions to instructions to staff or revisions to forms and rate change justifications;
- Provide support to OkDHS or the OHCA as requested to provide information for the budget process, to comply with federal or state audits related to the *ADvantage* Program or state plan personal care;
- Provide on-going evaluation and resources to evaluate and enhance the *ADvantage* Program case management system;
- Provide ongoing educational experiences to enhance the case management system as defined in the *ADvantage* Program waiver;
- Provide a statewide Intake and Screening service system for access and referral to Medicaid long term care services for citizens of Oklahoma; and
- Implement quality assurance and continuous quality improvement activities.

LTCA–Oklahoma certifies case management agencies and monitors the quality of case management services. The case management standards include requirements for a Continuous Quality Improvement (CQI) plan that must address a range of standards – access to services; intake, screening and referral; admission and discharge; orientation and education; service coordination; agency reporting, record keeping and documentation; resources to support quality activities; assessment; interdisciplinary team service planning; service development; service plan monitoring; risk management; changes in status; and emergencies.

Currently, 30 agencies have approved provider contracts with OHCA to provide case management services. Case management is defined as “a service that links and coordinates assistance both formal (paid) service providers and informal (unpaid) help from family and friends to enable consumers with chronic functional and/or cognitive limitations to obtain the highest level of independence consistent with their capacity and their preferences for care (OAC 3167:30-5-763).

LTCA–Oklahoma certifies two types of case management agencies. Independent Case Management agencies are community based organizations that do not provide direct services. There are 16 Independent Case Management agencies (six not-profit organizations; two for –

profit organizations, three Councils of Government; one Area Agency on Aging; two Independent Living Centers; one community action agency; and one college of nursing). Comprehensive Home Care (CHC) Case Management agencies are home health agencies that provide direct services to program participants in addition to case management. Twelve of the 14 CHCs are profit and two are non-profit. LTCA–Oklahoma also develops the training curricula and trains case managers.

The *ADvantage* program grew slowly as a new infrastructure of case management agencies and service providers formed. Between 1994 and 1996, the program expanded statewide. In 2004, *ADvantage* served 14,109 elders and adults with physical disabilities in the community while 20,814 Medicaid beneficiaries receive services in nursing homes.

Responsibilities for long term care services in Oklahoma are assigned to multiple state agencies. The leaders in each agency have played prominent roles for an extensive period and several OHCA officials worked in OkDHS when it was the single state Medicaid agency. **While the agency leaders described a very collaborative working relationship on budget and policy issues, we did not see a unified vision, strategic plan or long term goals for the system. Developing a strategic plan would create a framework for making future policy and budget decisions.**

Administrative costs

Because of the unique arrangement with LTCA-Oklahoma, questions were raised about the cost of managing the waiver through an Administrative Agent rather than state employees. Identifying and comparing the costs of administering waiver programs across waivers and states is difficult. The contract between DHS and LTCA-Oklahoma is approximately five percent of the total costs of the *ADvantage* program. On its face, this appears reasonable. These costs do not include other costs incurred by DHS and OHCA that are attributable to the waiver program. We contacted other states and learned that most do not track waiver administration costs. Further, there is considerable variation among states in the structure of HCBS waivers, the services covered, the number of participants, what might be considered an administration cost and the aggressiveness of the state in identifying and claiming federal reimbursement for eligible administrative costs. As a result, we were not able to compare the cost of administering the *ADvantage* waiver to the administrative costs in other states.

Promising practices

Oregon and Washington consolidated all long term care functions, including determining Medicaid financial eligibility, in a single agency. Vermont consolidated all the functions except Medicaid financial eligibility and Massachusetts and New Mexico implemented partial consolidations. Several key informants discussed the benefits and obstacles to consolidating responsibilities for long term care in a single agency similar to the structure implemented in Washington and Oregon in the 1990s. Responsibility for licensing nursing home and residential settings, budget, rate setting, policy, management, contracting, Medicaid financial eligibility and oversight are located in the Aging and Disability Services Administration in Washington and the Seniors and People with Disabilities Division in Oregon. One administrator is accountable for long term care. Controlling nursing home spending was a priority and the administrators were able to reduce spending by expanding HCBS services.

Charles Reed, a former Assistant Secretary in the state of Washington, indicates that as well as he collaborated with his peers prior to the reorganization, they often had different priorities and made decisions that did not support the goals and philosophy of the long term care system. Reed contends that it is much easier to implement the state's philosophy and policy when you have the authority to make decisions rather than negotiating with the director of another agency whose priorities are different from yours. For example, most state agencies responsible for licensing and oversight of nursing homes are concerned about compliance with regulations and the survey process. The long term care agency is concerned about helping people in nursing homes move to the community if they are able to do so. When these functions are consolidated, you can do both more easily.

The long term care organizations in Oregon and Washington are part of an umbrella agency. States that have not consolidated functions in a single agency may coordinate responsibilities across agencies. Pennsylvania created an Intra-Governmental Council on Long Term Care by Executive Order in 1998 and codified by Act 185 to study the long term care system from a funding, operational and consumer perspective and to make recommendations to the governor on ways to streamline administration of the system, and develop a full spectrum of options for consumers and their families. The Council is chaired by the Secretary of Aging and includes three members of the Cabinet, four legislators, providers and consumers. The Council's mandate includes:

- Providing a public forum for discussion on long term care issues;
- Analyzing and assessing the current system, examining options and suggesting recommendations for action;
- Developing a framework for a system of long term care services at the state and local level;
- Seeking short and long range options for financing long term care;
- Expanding efforts to educate consumers about long term care issues and alternatives;
- Examining and making recommendations on the organizational structure of services at the state and local level; and,
- Making recommendations on regulations and licensure of personal care homes.

The Council offers a mechanism for discussing long term care issues, identifying barriers and recommending policy changes.

In 1998, the New Mexico legislature passed the Long Term Care Services Act which created an Interagency Committee on Long Term Care Services. The Committee was charged with designing and implementing a coordinated service delivery system. Members of the Committee included the State Agency on Aging, the Human Services Department, the Department of Health, Children, Youth and Families Department, Labor Department, Governor's Committee on Disability, the Developmental Disabilities Planning Council, and the Department of Insurance. In 2002, membership was expanded to low income consumers with a disability, various disability organizations, the State Mortgage Finance Agency, the Department of Transportation and the Department of Finance and Administration. The Committee was not implemented until a new

administration supported the realignment of agency responsibilities and cross agency planning and collaboration.

Improving the balance between community and institutional services - Financing

Background

Policy makers often talk about balancing their long term care and allowing “money to follow the person” to offer consumers a choice of settings – institutional, residential and community – and services that meet their needs in a cost effective and efficient manner. To achieve progress toward a balanced system, state officials first need to define what “balance” means and to establish indicators that allow them to track their progress.

Achieving balance is difficult because of the inherent institutional bias that is built into Federal Medicaid policy. Institutional bias is attributable to several factors. Nursing home care, the most costly service, is an entitlement. Any Medicaid beneficiary that meets the state’s level of care criteria for admission must be served if a Medicaid provider is willing to admit them. Home and community based services are provided under waivers that allow states to limit expenditures. Enrollment is capped and waiting lists are established when the state reaches its approved capacity or appropriation. Waivers must also be budget neutral. Medicaid expenditures under the waiver may not exceed what would have been spent in the absence of the waiver. The array of waiver services is determined by the state and may be broad or narrow. Finally, delays in determining Medicaid financial and functional eligibility may mean that services cannot be initiated in a timely manner and, in the absence of services, applicants may need to enter a nursing home.

Findings

Oklahoma has made progress in shifting resources from institutional to community services. through a Medicaid HCBS waiver, personal care services under the Medicaid state plan and the Older Americans Act. Each program is managed separately. In 1994, at the beginning of the *ADvantage* program, the Oklahoma Medicaid program paid for over 7.1 million days in nursing homes. In SFY 2003, Medicaid nursing home beds days dropped to 5.7 million days and increased to slightly less than 5.5 million in SFY 2004. The number of Medicaid days paid for *ADvantage* participants rose gradually during the initial start up years, reaching 2 million in 1999 and 4 million in 2003. Days dropped below 4 million in 2004. Key informants suggested that a temporary halt in approving new enrollment in the *ADvantage* program may have increased nursing home use. Giving consumers a choice between nursing home and in-home services and the financing tools to support the choice appears to have led to a significant reduction of nursing homes beds days paid by Medicaid. We did not identify any targets for utilization of nursing home and HCBS.

Funding for nursing home and home and community based services in Oklahoma are appropriated to two different agencies. However, state officials indicated that they have the flexibility to transfer funds between programs and agencies. State officials felt that it was cost effective to use nursing home funds to pay for services for people whose cost of care was much higher in a nursing home than in the community. Funds are already budgeted for services in a

nursing home and by allowing the funds to “follow the person,” the cost of care is lower in the community.

One state official described interest in periodically shifting nursing home “savings” to the *ADvantage* program. Nursing home spending would be monitored monthly or quarterly. If spending dropped below the budget estimate, the difference would be transferred from the OHCA budget to the OkDHS long term care budget for allocation to the *ADvantage* Program to serve more waiver participants. Even though Oklahoma does not have a waiting list for *ADvantage* services, transferring funds creates incentives to manage spending across agency budgets and allows the state to expand home and community based services by reducing Medicaid nursing home spending. It allows the state to track Medicaid utilization and shift funds to HCBS programs rather than create waiting lists or temporarily suspend waiver enrollment while additional funding is sought from the legislature. An interagency agreement might be developed that tracks nursing home spending against the initial budget and transfers savings as the number of Medicaid bed days declines because of diversions or relocation from nursing homes.

Promising practices

States need the financial tools to implement a balancing plan and to create a level playing field. Nursing home care is an entitlement under the Medicaid state plan while the preferred *ADvantage* waiver services can be capped. Fortunately, Oklahoma has had sufficient resources to avoid creating a waiting list for waiver services. Program specific appropriations can be a barrier to consumer choice and a balanced system. Creating a level playing field means removing barriers for individuals to choose community options.

Budgets for long term care services in Washington are based on caseload forecasts prepared by an independent Caseload Forecasting Council. The Council projects and adjusts the expected caseloads for nursing home and home and community based service programs for elders and adults with physical disabilities. Projections are based on historical trends and changes in policy that affect eligibility or the amount of services that may be authorized. Caseloads are projected for each month of the biennium. The home care caseload is expected to grow 3.0% from June 2005 to June 2006 and 2.9% from June 2006 to June 2007. The Medicaid nursing home caseload will decline 2.9% each year and the Medicaid personal care state plan caseload will rise 4.2% and 4.4% respectively.

In the mid-1990s, the Washington legislature directed the Aging and Disability Services Administration to reduce the nursing home census by 750 individuals. Funds for nursing home and home and community based services are appropriated in a single line item and the state agency has the ability to allocate and spend funds flexibly.

Over 10 years, the Medicaid nursing home census has dropped from 17,000 to 12,500 Medicaid beneficiaries. The savings allowed the home and community based services caseload to grow from 19,680 to 34,638 people. Seventy four percent of the people receiving services were served in the community. The average cost of serving one person in a community setting is one-third the cost of a nursing home. State officials estimate that if home and community based services had not expanded, the Medicaid nursing home census would have risen 3% a year. Spending for

nursing home care alone would have exceeded \$1 billion a year in SFY 2004, which is greater than the combined cost of nursing home and community spending. State officials believe that 5-10% of the remaining nursing home residents could be served in the community.

Vermont, a much smaller state, offers a similar example. Since 1995, Medicaid spending for home and community based services rose from 12% of Medicaid spending to 32% in 2005. The legislature passed Act 160 in 1996 which allowed unspent nursing home funds at the end of each fiscal year to be placed into a trust fund for use in subsequent years for home and community-based services or for mechanisms that reduce the number of nursing home beds. The law gave priority to nursing home residents who wanted to relocate to a community setting, anyone on a waiting list who was at the highest risk of admission to a nursing home, others at high risk and people with the greatest social and economic need.

The Department of Aging and Independent Living Services set a goal of spending 40% of long term care funds on community services and may raise the goal to 50% in the near future. The number of Medicaid nursing home beneficiaries declined by 12%, 466 people, between 1994 and 2004 and the number of HCBS participants rose 238% or 838 participants. State officials indicated that the shift reduced nursing home spending by 33% from what would have been spent if the number of waiver participants had not expanded.

Several years ago, Wisconsin created a budget strategy to shift funds from the nursing home appropriation to home and community based services. At the end of the fiscal year, the difference between the budgeted Medicaid bed days and actual Medicaid bed days was multiplied by the average Medicaid payment. The savings were available to be shifted to the HCBS waiver program in the following year.

Streamlining access to for consumers - Comprehensive entry points

Background

Consumers, family members and advocates frequently describe their frustration trying to obtain information about the long term care services that are available to them. Without a visible entity that offers seamless entry to the system, consumers often have to contact multiple agencies and organizations, complete several application forms and apply for programs that have different financial and functional eligibility criteria.

Comprehensive entry points (CEPs) have been established in many states to reduce fragmentation, provide information about long term care options and streamline access to services. CEPs enable consumers to access long term and supportive services through one agency or organization. In their broadest forms, these organizations perform a range of activities that may include information, referral and assistance; screening; nursing home pre-admission screening and options counseling; assessment, care planning; service authorization; monitoring; and reassessment using one or more funding sources. CEPs may also provide protective services. CEPs may utilize Internet web sites to provide information or screening tools that help consumers and family members understand their needs and the resources available to them. Organizations that only provide information, referral and assistance are not considered CEPs. A

CEP may serve all consumers, including private pay, and offer options or benefits counseling and nursing home relocation or transition assistance. CEPs do not typically provide services that they authorize.

Consumers and family members typically need long term care services during a crisis. Delays accessing services needed to stay at home, or return home after a hospital admission, can lead to preventable nursing home admissions. Short term nursing home stays can become long term stays if nursing home social workers do not actively implement a discharge plan or case managers from community agencies do not work with the individual to assess their needs and arrange for community services. States have used two strategies to help people make choices and remain in or return to their home.

Options counseling

Options counseling or benefits counseling is available in many states to inform individuals and family members who apply for admission to a nursing home about the community services that are available to help them remain at home. Options counseling is often mandatory for Medicaid beneficiaries seeking admission to a nursing home. It may be advisory for individuals who are not eligible for Medicaid but are likely to spend down within six months of admission. In this situation, the case manager informs the person about community alternatives. If the person does not meet the Medicaid level of care criteria, they are informed that Medicaid will not be able to pay for their care if they choose to enter a nursing home and later apply for Medicaid. Options counseling allows the individual to make an informed decision about entering a nursing home.

Nursing home relocation planning

A second strategy involves helping nursing home residents who are interested in moving back to the community. The Washington Aging and Disability Services Administration case managers are assigned to each nursing home to work with residents. Each case manager is responsible for working with residents in 2-3 facilities. Case managers had been assigned to hospitals to work with discharge planners but the state found that people being discharged from hospitals frequently needed short term rehabilitation services before they could return home. The state shifted staff from hospitals to nursing homes to work with residents as their potential to move home improves.

Case managers, who may be social workers or registered nurses, contact residents within seven days of admission to the nursing facility to inform them of their right to decide where they will live, discuss their preferences, likely care needs and the supports that are available in the community, and other service options. A full comprehensive assessment is completed when the consumer indicates that s/he is interested in working with the social worker to relocate and the nurse/social worker develops a transition plan with the consumer.

One important barrier a nursing home resident faces in relocating to the community is a lack of funds to maintain an existing home or to re-establish a residence. States have several options.

First, states can exempt income that would normally be paid to the nursing home to allow residents to maintain or establish a home in the community. Beneficiaries who qualify for Medicaid under the Special Income Level or Medically Needy program have income that is paid

to the nursing facility. Post-eligibility treatment of income rules (CFR435.832) permit states to exempt income so it can be used to maintain a home or to pay for costs related to moving to a residential or community setting. Exempting income raises the Medicaid payment to the nursing home during this transition period. The exemption is allowed for up to six months. A physician must certify that the length of stay will be for no more than six months. The exempt income can be used to cover rent, mortgage, property taxes, insurance, and utilities.

Other residents lack the funds to re-establish a home in the community. These costs could be covered as a transition service under the *ADvantage* waiver. CMS allows HCBS waivers to cover the reasonable costs of community transition services, such as security deposits that are required to obtain a lease on an apartment or home; essential furnishings and moving expenses required to occupy and use a community domicile; set-up fees or deposits for utility or services access (e.g. telephone, electricity, heating); health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy. Essential furnishings include a bed, table, chairs, window blinds, eating utensils and food preparation items. Televisions, cable TV access or VCRs may not be included when they are for purely diversional or recreational purposes, but may be justified by the State when they serve other functions, such as the prevention of isolation.

Presumptive eligibility

Providing access to appropriate long term care services as quickly as possible is an important goal of state long term care delivery systems. The array of community, residential and institutional service options, fragmented delivery system and the confusing, often time consuming, Medicaid eligibility process makes it difficult for individuals and family members to navigate the system.

States have an incentive to expedite applications from individuals seeking long term care services, although the incentive may be less apparent to the staff and managers responsible for these determinations. Eligibility delays influence the service choices that may be available to the applicant. Financial eligibility is often determined by an agency that is not under the direct control of the State Medicaid Agency (SMA) which makes setting priorities and managing work flow more difficult for the Medicaid agency. The Medicaid staff may be more concerned that errors will be made that force the agency to forego federal reimbursements for home and community based services.

A report to CMS from the Medstat Group, Inc. on presumptive eligibility reported that almost half of all nursing home residents are admitted from hospitals and another 11 percent are admitted from other nursing homes. Less than 30% come from private or semi-private residences. Delays in determining Medicaid eligibility may affect the decision about where services may be available. Nursing homes are more willing to admit individuals while their Medicaid application is pending than community care providers who face a higher risk of not being paid for services delivered. Residents who are found ineligible, or their families, can be charged for services delivered and expected to pay. Nursing homes are able to measure the resident's income and resources and judge whether they will become a Medicaid beneficiary or remain private pay.

Community service agencies have less experience with Medicaid eligibility criteria and less assurance that individuals who are found ineligible will be able to pay for services. Uncertainty about Medicaid eligibility and a source of payment means that community agencies are less willing to accept a referral while the Medicaid application is processed. Therefore, individuals who are not able to pay privately for in-home or residential services are more likely to enter a nursing home. There are two primary ways to expedite eligibility. Presumptive eligibility allows eligibility workers or case managers, nurses or social workers responsible for the functional assessment and level of care decision to decide whether the individual is likely to be financially eligible based on decided criteria and to initiate services before the official determination has been made by the eligibility staff.

Fast track initiatives accelerate the process and address the factors that are most likely to cause delays – fully completing the application and providing the necessary documentation. Under these arrangements, staff, usually affiliated with the agency responsible for administering and managing home and community based services, helps the individual or family member complete the application and attach sufficient documentation of income, bank accounts, and other assets to allow the financial eligibility worker to make a decision. Fast track processes reduce the time it takes to complete a financial application using the normal channels. Staff responsible for making the decision does not change.

Findings

Comprehensive entry point functions in Oklahoma are split among agencies and vary with the type of service - nursing home, *ADvantage* or state plan personal care. OkDHS/ASD long term care nurses function as the gateway to long term care, although there are three distinct processes for accessing services (see figure 7):

- **Nursing Home Pathway:** Individuals admitted to a nursing home are referred to OkDHS by the nursing home for a determination of their medical eligibility within 5 days of admission.
- **Personal Care Services Pathway:** Individuals referred for state plan personal care services are assessed by OkDHS nurses who determine medical eligibility, develop a care plan and forward the information to home health agencies for service.
- ***ADvantage* Pathway:** OkDHS/ASD nurses complete an assessment and determine medical eligibility for individuals who are seeking HCBS waiver services. Assessments are completed by OkDHS/ASD registered nurses (RNs) in county field offices. The RNs report to an Area Nurse who makes the level of care determination. Applicants receive information from the OkDHS/ASD RNs about their case management and home care provider options and select a case management agency and a home care provider from the agencies certified by LTCA–Oklahoma in their area. Case management representatives suggested that consumers are not always assigned to the agency of their choice, but it was not clear how often this might happen and the circumstances when it does occur. If the applicant chooses not to select an agency, the OkDHS/ASD nurse is instructed to leave the selection blank. A waiver referral packet (completed assessment tool, level of care approval, case management agency selection and financial eligibility approval) is sent from the OkDHS to the LTCA–Oklahoma. If the referral does not include a selection of a case management or home care provider, applicants are auto-assigned by computer.

Approximately forty percent of applicants are auto-assigned. LTCA–Oklahoma forwards service plan development authorization and referrals to the case management agency specified by OkDHS or auto-assigned by Round Robin. The case manager makes a home visit within 10 days to update the assessment and develop a plan of care. The plan of care is reviewed by LTCA-Oklahoma and, if the plan adequately addresses consumer health and safety issues, is approved by LTCA-Oklahoma and returned to the case management agency for implementation.

OkDHS nurses complete approximately 1,400 assessments a month – about 42% for nursing home eligibility, 15% for personal care eligibility and 43% for waiver services eligibility. Medical or functional eligibility is re-determined every three years, and Medicaid financial eligibility is re-determined annually.

Figure 7a shows changes to the process that are planned by OkDHS. Under the change, OkDHS long term care nurses would collect enough information to determine the level of care for nursing home, HCBS, or personal care services. Once the level of care is determined, a referral will be sent to LTCA-Oklahoma, a home care agency or a nursing home.

LTCA–Oklahoma currently operates a toll free number to provide information and assistance to consumers and family members about *ADvantage* services. However, this system is not uniformly utilized statewide. Several rural OkDHS county offices provide intake and screening for residents seeking assistance. In addition, if a consumer is already Medicaid eligible, the intake and screening function is performed by the OkDHS county office.

State officials indicated that it takes three to four weeks from the date of referral to approval for waiver services and up to 45 days, and longer for complex applications, to established Medicaid financial eligibility. In an emergency, OkDHS ASD RNs are able to “presume” financial eligibility and begin services within three days. However, this authority is not used very often.

Promising practices

Twenty-four states operate CEPs that serve older adults. All CEPs manage access to Medicaid funded home and community-based services and many manage Medicaid state plan services, Older Americans Act services and programs funded by state general revenues. CEP functions may be combined in a single agency or split among agencies. In most cases, a particular agency or organization is the CEP, although some of the functions are contracted out to other organizations. For example, the local Area Agencies on Aging may serve as the CEP and contract with local community based nonprofit organizations to perform specific tasks, but the AAA is the responsible party. In other cases, functions are split between agencies. For example, in Washington, the state agency performs the assessment, eligibility determination, service authorization and ongoing case management for individuals in nursing homes, adult family homes and assisted living while Area Agencies on Aging implement the consumer’s care plan and provide ongoing case management for individuals living in the community. Other states may separate the information and screening functions from the authorization and care management activities. SEPs in a particular state may facilitate access to one or more, but not necessarily all, funding sources or programs.

Figure 7 – Oklahoma Access Pathways to Long Term Care

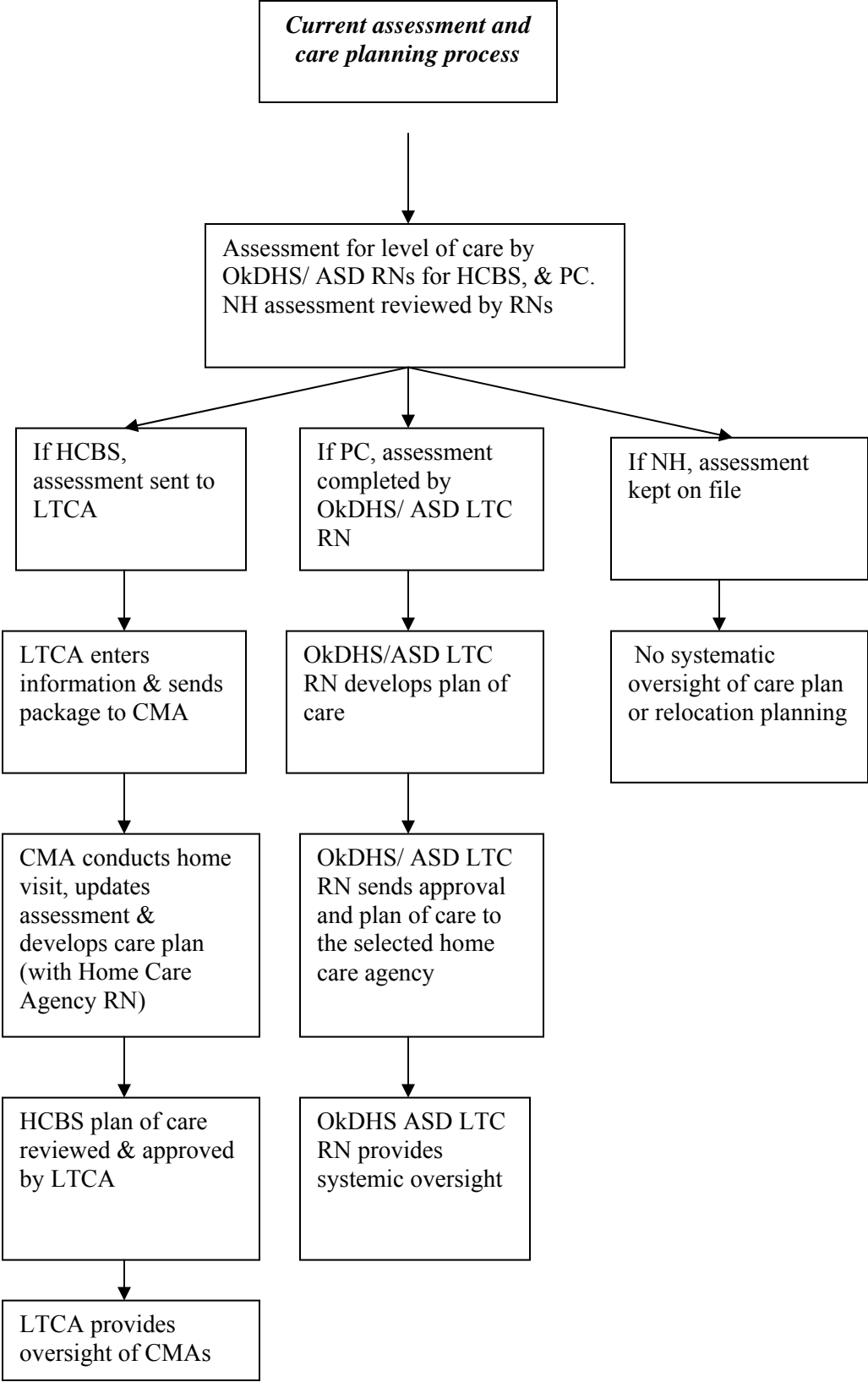
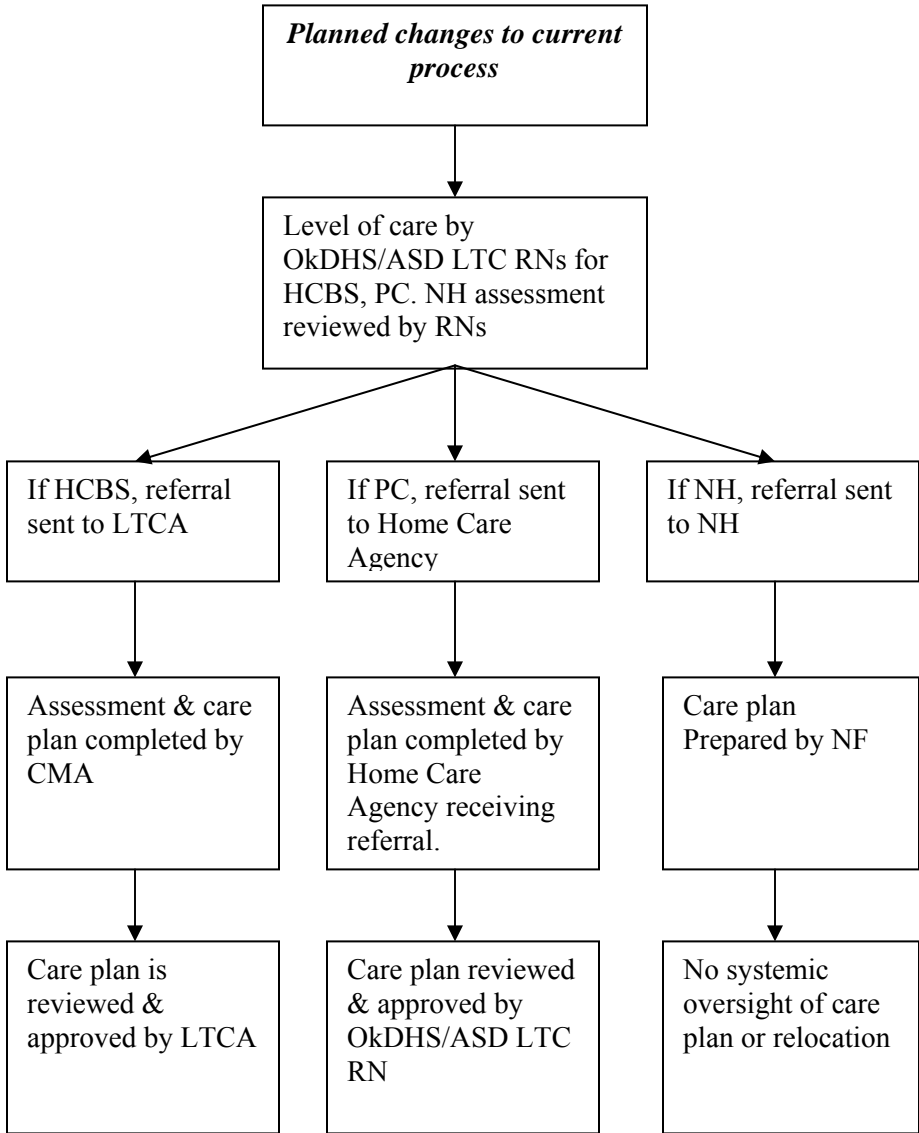


Figure 7a –Oklahoma Access Pathways to Long Term Care



Colorado, Connecticut, Maine, Massachusetts, New Jersey, Oregon, Pennsylvania, Washington and Wisconsin operate Comprehensive Entry Point systems. Options counseling is an important component of the CEP systems in these states.

New Jersey and Washington operate effective nursing home relocation programs and a relocation process was implemented in Massachusetts in 2005. In 1995, the Washington ADSA re-assigned case managers from hospitals to each nursing home in the state to work with residents who are interested in relocating. State officials determined that most people discharged from a hospital needed a short-term rehabilitation stay before they could return home. Each case manager is responsible for working with residents in 2-3 facilities. The caseload ratio is 1:400 for maintenance case management and 1:100 for active relocation.

Case managers, who may be social workers or registered nurses, contact all nursing home residents who have been admitted from a hospital within seven days of admission to the nursing facility to inform them of their right to decide where they will live, discuss their preferences, likely care needs and the supports that are available in the community, and other service options. Individuals admitted from a community setting who are Medicaid beneficiaries, or are likely to become a Medicaid beneficiary within 180 days, receive a preadmission assessment and options counseling. A full comprehensive assessment is completed when the resident expresses an interest in moving to the community. The case manager then develops a transition plan with the consumer.

The Community Choice Counselors in New Jersey are state employees that are cross-trained to do nursing home pre-admission screening, options counseling and transition support. They work with Independent Living Centers to transition people under age 60 who desire peer support. Currently there are 73 clinical staff (12 social workers and 61 registered nurses) who are funded with a federal match of 50% for social workers and 75% for RNs. They are organized into 3 regions, with assignments to specific hospitals and nursing homes in those regions. They follow a specific caseload of "track II" persons who have been screened and determined to need short-term nursing home care but have the potential to return to the community.

New Jersey Community Choice Counselors staff have access to a state-funded transition fund. The state has received approval from CMS to add transition services as a Medicaid waiver service but the service has not yet been implemented. About 40% of people transferred from nursing homes do not need Medicaid waiver services, but some Medicaid beneficiaries do use state plan services. In fiscal year 2004, Community Choice Counselors transferred 498 people. In the past they have transitioned more than 1,000 in a year, but when staffing was frozen, productivity was curtailed and the nursing home census rose. They are currently increasing staffing to achieve prior diversion rates.

New Jersey Community Choice Counselors count only those residents who actively needed transition counseling and support; they provide these services to people regardless of payment source but most are Medicaid beneficiaries or would be within a few months of admission to a nursing home.

In Pennsylvania, the Intra-Governmental Long Term Care Council conducted a system-wide review of access to long term care services. Based on the Council's report, the Governor's Office of Health Care Reform and several state agencies developed Community Choices to address 22 process, information and systemic barriers to home and community based services. Many related to the delays in establishing Medicaid functional and financial eligibility.

- A reduction in the Medicaid financial application from 12 to four pages;
- Self-declaration of income and assets for applicants under the 300% special income level option;
- Presumptive financial eligibility to facilitate access within 24 hours when necessary;
- Exemption for \$6,000 in assets;
- Exemption for burial plots;
- 24/7 access to assessments and eligibility determination;
- Reduction in the functional assessment form from 30 to five pages; and
- Expedited appeal process for denials.

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. About 30 percent of the referrals were made by family members. Hospitals accounted for 19 percent of the referrals. AAA network agencies, nursing facilities, and other service providers accounted for just over 11 percent of the referrals. Seventy four percent were found eligible. About 10 percent were either financially or functionally ineligible. Another 10 percent of the applications are pending at the end of each reporting period. The data indicated that 27 percent of the applicants were diverted from nursing home placement, relocated from a nursing home or were referred by a nursing home. The remaining 67 percent accessed services more quickly. State agencies are adapting existing information systems to determine the impact on nursing home admissions and Medicaid bed days in the demonstration counties.

Presumptive eligibility

The Washington Aging and Disability Services Administration (ADSA) developed a presumptive eligibility process for long term care programs for adults with disabilities and elders. Social workers/nurses that conduct assessments and authorize long term care services and the financial eligibility workers are located within ADSA. The policy allows social workers or nurses to authorize delivery of essential services before the full eligibility process is completed. It is used when the case manager has sufficient financial information including a statement or declarations by the individual that lead staff to the reasonable conclusion that the applicant will be financially eligible for Medicaid. The case manager consults with the financial worker, completes an assessment and service plan and authorizes services for 90 days. The individual must submit a formal application for Medicaid within 10 days of the service start date. Individuals sign a fast track agreement that specifies that services are time limited and the applicant must complete an application with ten days and will be liable for the cost of delivered services if they are found ineligible.

Eligibility workers are able to “presume” eligibility and approve Medicaid coverage in a day if it means that a beneficiary can receive services in a residential or community setting instead of a nursing facility.

Since FFP is not available for services delivered if the applicant is not eligible for Medicaid, state funds are used to pay for services in the few instances in which the applicant is found ineligible. State officials believe that the risk is limited compared to the savings realized by serving a person in the community. Washington officials have determined that clients presumed eligible save Medicaid an average of \$1964 a month by authorizing community services for people who would have entered an institution if services were delayed.

Nebraska allows presumptive eligibility for potential waiver clients when the client has signed and submitted a Medicaid application to the Medicaid eligibility staff. To avoid confusion with the federally-approved presumptive eligibility option, Nebraska named its program “Waiver While Waiting.” Financial eligibility is the responsibility of a state agency that is separate from the division responsible for waiver services. However, staff in both divisions has joint access to the data system that is used for Medicaid eligibility and for waiver services authorization, provider enrollment and billing/payment. Service coordinators receive some training on the Medicaid financial eligibility criteria but do not advise applicants.

Service coordinators work closely with the financial eligibility worker to determine when a person may be presumed eligible. After the assessment has been completed and the level of care determined, clients are given a choice of entering a nursing home or receiving waiver services. The service coordinator contacts the Medicaid eligibility staff to determine if the applicant is likely to be Medicaid eligible. To receive services under presumed eligibility, the applicant must agree to complete the application, submit all necessary financial records and meet any cost sharing obligations. Applicants sign a consent form and a notation is made on the consent form indicating that the applicant is presumed eligible until a final Medicaid eligibility decision has been made. When the consent form is approved by the financial eligibility worker, service coordinators may authorize ongoing waiver services and medical transportation services for clients while the application is being processed. Home modifications and assistive technology services may not be presumptively authorized.

The services coordinator maintains regular contact with the Medicaid eligibility staff until a final decision is made. If the client is found ineligible, the services coordinator sends a written notification to the client in writing that services are terminated and offers assistance and referrals to other programs or resources. A ten day notice is not permitted. In the few instances in which applicants were later found ineligible, Social Services Block Funds were used to pay for the services delivered.

Array of services

Background

Consumers have the most choice and the best opportunities to avoid admission to a nursing home or to return to the community, when states offer a full array of in-home, community and

residential service options. Services in assisted living settings are covered in 41 states through HCBS waivers, Medicaid state plan personal care services and state general revenues. Two states have approved waivers that have not yet been implemented and a third state received statutory authority to obtain an HCBS waiver for services in assisted living settings.

Findings

The *ADvantage* waivers covers a broad array of in-home and community services: case management, personal care, skilled nursing, advanced supportive restorative assistance, adult day health care, home delivered meals, respite, comprehensive home care (case management, personal care, skilled nursing, advanced supportive restorative assistance and home respite), personal emergency response, physical therapy, occupational therapy, speech and language therapy, respiratory therapy, specialized equipment and supplies, environmental modifications, hospice, institution transition services (for transition planning only), consumer-directed personal assistance supports and services, and prescription drugs.

Oklahoma also covers personal care services under the Medicaid state plan. “Personal Care is defined as assistance to an individual in carrying out activities of daily living such as bathing, grooming, and toileting, or in carrying out instrumental activities of daily living such as preparing meals and doing laundry to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration (OAC 317:35-15-2).”

Approximately 4,000 persons *ADvantage* participants were receiving personal care services under the Medicaid state plan until July 2004 when all personal care services for waiver participants was transferred to *ADvantage* to reduce fragmentation.

Services in adult family homes and assisted living settings are not covered under the *ADvantage* waiver or under the Medicaid personal care state plan service. State officials expressed reservations about the feasibility of covering services for individuals in assisted living centers because of what was described as limited regulation and oversight by OSDH and insufficient staffing requirements. The licensing regulations allow assisted living centers to serve residents who need assistance with personal care or nursing supervision; intermittent or unscheduled nursing care; medication assistance; and assistance with transfer and/or ambulation.

States with minimum regulations may establish additional requirements for facilities that contract with Medicaid. Although several informants indicated that industry representatives describe their objections to “more regulations” and Medicaid requirements, they are not required to serve Medicaid beneficiaries. Covering assisted living does not always result in large numbers of facilities willing to contract with Medicaid, especially if the rates are perceived to be too low. OHCA’s strategic plan for SFY 2006 included requesting “appropriate funding and making necessary policy and state plan changes in order for assisted living to be a covered Medicaid service.”⁶

Promising practices

Washington and Oregon both offer consumers a comprehensive array of services – institutional, residential and in-home. While most states cover services in residential settings for Medicaid

⁶ -----, Strategic Plan FY 2006. Oklahoma Health Care Authority. November 2004. Page 36. Available at: http://www.ohca.state.ok.us/reports/PDFlib/strategic_plan_2006.pdf

beneficiaries, Washington and Oregon successfully developed adult family homes and assisted living facilities as resources for beneficiaries that do not have caregivers and may have higher needs than other participants without informal supports. Covering services in residential settings has allowed both states to relocate nursing home residents who do not have housing.

Consumer Direction

Background

Consumer direction in long term care includes a variety of approaches that are designed to give older adults and younger persons with disabilities primary control over the services they receive, the providers who supply services, and the manner in which services are delivered. In consumer-driven programs, an individual budget is designed with the consumer during a person-centered planning process, which varies in detail by state. The consumer can then purchase the services he or she needs with much more flexibility than is customary in traditional programs. The consumer may hire a worker—a traditional provider agency, a family member, or a neighbor, depending on the program. Rather than handle the paperwork, consumers almost always choose to have a “fiscal management service” (FMS) handle the paperwork. A state entity, or private companies approved by the state, serves as this “fiscal intermediary” to handle provider payment and withholding on behalf of the consumer. While the consumer selects and trains the personal care worker, a “support broker” or case manager can assist with such tasks as worker recruitment and background checks.

Consumer-directed care is primarily non-medical, with an emphasis on personal care services that require little technical expertise. However, more states are permitting attendants to help with “health maintenance activities,” including medication administration and tube feedings.

The consumer direction trend has its roots in the Independent Living Movement (ILM) that promotes the basic tenets of autonomy and self-determination for people with disabilities of all ages, including older adults. Increasingly, older adults and the organizations that represent them have become proponents of consumer-directed services. AARP surveys document that older adults favor self-directed home care over agency-directed home care, with more than 75% of respondents preferring to have control over the money allotted for these services, and the supervision of aides providing such services.

The trend toward consumer-directed programs is gaining momentum across the country. There are small state-funded consumer directed programs in almost all states. But currently, more than half the states are developing statewide programs under Medicaid to support consumer direction for people with disabilities, including older adults. In 2003, the Centers for Medicare & Medicaid Services funded 12 states to develop “Independence Plus” programs that would allow people on Medicaid to direct more of the personal care services provided in their homes. In 2004, the Robert Wood Johnson funded 11 states to replicate its “Cash & Counseling” project, first launched in 1995 in three states (Arkansas, Florida and New Jersey). Evaluation of the three-state pilot is being conducted by Mathematica. Findings to date document high consumer satisfaction and comparable costs to more traditional, agency-based services. In Arkansas, the flexibility to hire non-agency workers increased access to care. However, the control group that used traditional agency services had lower personal care expenditures because they received only

two-thirds of the authorized care plan and many received no services because of agency worker shortages. The higher personal care expenditures in the “Cash & Counseling” group were offset by lower spending for nursing home care and other Medicaid services within two years of enrollment in the more flexible program.

States are interested in developing cost efficient programs and supporting consumers’ desire for more personal responsibility in arranging services that work for them. They are also aware of the shortage of front-line workers in long-term care, and believe that friends and relatives that are hired to provide personal care will broaden the universe of potential caregivers. States like California, Washington and Oregon adopted this approach decades ago.

Findings

Although Oklahoma was one of the first states to offer personal care through Medicaid, the state is just beginning to provide a consumer-directed option for that service. We provide a brief examination of the national context for consumer direction as a foundation for our recommendations for Oklahoma.

Consumer Direction is a new development in Oklahoma. In 2005, the Consumer-Directed Personal Assistance Services and Supports (CD-PASS) program was included as a service option within the *ADvantage* waiver. Participants who choose this option are the employers of their Personal Service Assistant (PSA). Since the CD-PASS service option is new, enrollment in this voluntary program is limited. These pioneers have to be *ADvantage* beneficiaries for a year before they could apply for the CD-PASS option, and be able to direct his/her own care or use an Authorized Representative. According to the new marketing brochure, consumers work with a Consumer-Directed Agent (CDA), a case manager who is specially trained in consumer-directed services. An Employer Support Services provider assists the Consumer/Employer in preparing for employer role and provides accounting, payroll and IRS fiscal agent functions on behalf of the Consumer/Employer. Enrollment is expected to grow over time.

This option was added after essential consumer direction design elements were developed under a CMS CD-PASS planning grant. LTCA–Oklahoma prepared the grant for OkDHS and administers the grant, which is overseen by the Oklahoma Partnership advisory group. LTCA–Oklahoma also prepared and administers the 2002-2005 CMS Real Choice grant for OkDHS, and is currently requesting a one-year no-cost extension.

Oklahoma’s entrance into the consumer directed personal care arena is a promising beginning and is founded on the Oklahoma Partnership principles of individual empowerment, personal independence, and responsibility. The consumer should have the authority to “choose, direct, and receive services that from the individuals’ perspective are dependable (reliably provided), provided in a respectful way, and individualized to consumer needs and preferences.”

Like states that have preceded Oklahoma, the evolution from a strong provider/agency-based model of long term care to this consumer-directed model is challenging. Provider resistance is the norm and is usually expressed as a concern for the safety of beneficiaries, particularly older adults and those with cognitive disabilities. Discussions with state officials, providers and consumers during our site visit indicate that:

- Medstat provided technical assistance for CMS on the technical details for CMS waiver approval; this is a sound foundation although there will be changes in the next iteration as CMS policy evolves.
- Utilizing newly approved regulations under Section 80-4 of IRS Code, LTCA–Oklahoma is operating as the public IRS fiscal reporting agent and fiscal intermediary for the program and contracts with Acumen to assist the consumer with the employer responsibilities that entail paperwork (budget, payroll, and accounting reports); in Oklahoma this function is known as the Employer Support Services Provider (ESSP) and also includes training and consultant services to help prepare and assist the Consumer/Employer to successfully carry out Employer responsibilities.
- High level state officials expressed concern about CD-PASS creating “false expectations” and liability for consumers’ health and safety.
- Activist consumers on CD-PASS now feel strongly that consumer direction is most critical in rural areas where access to PSAs is very difficult and that accessing services through an agency reduces consumer control.
- The new CD-PASS marketing brochure will be helpful in educating the public and providers about this new option.
- Case management agencies are in the early stages of understanding the fundamental shift from PROVIDER to SUPPORTER.
- The Oklahoma Partnership’s interpretation of the state’s Nurse Practice Act (NPA) is that it does not preclude consumer direction of personal care services in the *ADvantage* Program. Review of the NPA, regulations and Senate Enrolled Act 259 (2005) indicates:
 - There is no formal exemption to the NPA that clearly states consumer-directed PSAs can give medications or perform other health-related tasks, such as suctioning, ostomy care or blood glucose monitoring.
 - SEA 259 does make such provisions for program authorized by OkDHS for community-based care of persons with developmental disabilities.
 - The NPA does permit nurses to delegate to unlicensed assistive personal (with multiple guidelines).

Promising Practices

More than a dozen states that have been designated by CMS as *Independence Plus* states have adopted participant-directed planning and individual budgeting. Minnesota and New Hampshire exemplify two different approaches in their Section 1915(c) waiver programs. Minnesota’s prospective budgeting methodology was developed by using a regression analysis, based on data from Minnesota’s Medicaid Management Information System (MMIS) regarding characteristics

of persons on the waiver and their expenditures. In New Hampshire's retrospective budgeting approach, individuals discuss their needs and a "map" of potential services to explore options and personalized solutions; costs are discussed in relation to the individual service plan with consultation on becoming more creative and resourceful in crafting unique, economical approaches to that plan. No single individual budgeting approach will meet the needs of any given state. CMS affirms states' rights to craft their own approach to participant-centered planning and individual budgeting.

To help consumers handle the paperwork associated with spending their individual budgets, states select vendors to serve as financial intermediaries. The Arkansas Division of Aging and Adult Services' Independent Choices Program developed guides to determine whether vendors were prepared to act as counseling/fiscal agents. These "Counseling/Fiscal Agency (CFA) Initial Readiness, Mid-Year and Annual Review Manuals" include tips on evaluating the staffing and organizational structure and materials to help assess customer service systems.

States that have moved beyond a pilot phase of consumer direction often find resistance from the State Board of Nursing, which claims unlicensed assistive personnel cannot perform "nursing tasks" like medication administration and catheter care. Oregon, Washington, Texas, and Colorado exemplify different approaches to overcoming these obstacles. Some took a "delegation approach" that offers guidelines on how nurses can teach personal care attendants how to perform these types of tasks. Other states "exempt" consumer directed programs from the state's nurse practice acts. All of these states developed explicit policy through statute or regulations.

Quality Management

Background

The purpose of a quality management system is to assure that there are timely and effective methods to detect and resolve individual problems and that, based on ongoing review and analyses of data, opportunities for systems improvement are acted upon and work as intended. While the concept of quality management is quite simple, a successful quality management program requires a complex web of communication, data and systems to come together into a rational decision-making process that takes into account the interests and needs of diverse stakeholders.

Phase I of our review focused on the structure, systems and methods that are in place to assess and improve the quality of the state's home and community based services and supports for older persons and persons with disabilities. Given that many of these services operate under federal waivers and are therefore subject to CMS waiver assurances, the ability of the state to address those assurances was also considered.

In addition to staff at the LTCA-Oklahoma, interviews were held with the Aging Services Division staff who are responsible for quality management, case management agencies, consumers, and OHCA. Each provided perspectives on how the quality management system is structured and working and their own role in that system. There was also heavy reliance on

reviewing documented quality assurance and improvement processes and findings to determine the scope of the quality management function; how information is collected, analyzed and ultimately used; and whether the system is operating as perceived.

There are no explicit standards for how a state must design and operate its quality management system. The ultimate test of quality is found in positive outcomes among service participants. This was not an outcome evaluation but instead relied heavily on a judgment of whether the state has set up the prospective conditions that enhance the likelihood of positive outcomes down the road. With this in mind, we focused on six primary areas:

- Is there clear leadership, authority, and responsibility for quality management?
- Are there generally agreed to measures of quality?
- Are there discovery methods for routinely collecting timely and consistent data on quality measures?
- Are there systems for remediating problems found at the participant and provider level?
- Is there a process for analyzing trends, producing evidence, and identifying and acting on opportunities for systems improvement?
- Is there a meaningful system of engagement with stakeholders in the quality management process?

Each of these issues are addressed in the following sections. Each section begins with a summary statement of CMS expectations. Unlike the other sections of this report where there is a discussion of best practice, we have focused primarily on how closely Oklahoma meets CMS guidelines as the framework for evaluating strengths and weaknesses. Many of the issues facing Oklahoma are peculiar to its organizational structure with few parallels in other states. Following a description of CMS guidelines for each issue, we present our expectations and findings.

Leadership, Authority and Responsibility for Quality Management

Expectations

The CMS Draft Waiver Application (Version 3.2) requires states to delineate the roles and responsibilities of those involved in measuring performance and making improvements. By federal statute, the Medicaid Agency is the entity accountable for compliance with CMS waiver assurances. There is heightened vigilance by CMS these days that Medicaid assume oversight responsibility in an active and meaningful way. When the waiver is not operated by the Medicaid agency, states must specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements and assurances. In addition, roles in quality management must be defined for the operating agency, contracted entities, and local/regional non-state entities as well as any committees or other advisory structures.

Findings

Oklahoma's unique organizational structure diffuses responsibility for quality management

across multiple entities.

Role of Medicaid: Oklahoma's structure establishes a direct line of reporting between the OHCA (the single state Medicaid agency) and OkDHS and between OkDHS and the LTCA-Oklahoma but none directly between the OHCA and LTCA-Oklahoma. We have not reviewed the contents of the letter of understanding between the OHCA and OkDHS to determine specifications relating to quality oversight of the *ADvantage* Program. The contract between OkDHS and the LTCA-Oklahoma clearly references responsibilities of the LTCA-Oklahoma in complying with CMS Waiver Protocols although does not explicitly reference any reporting requirements back to OkDHS and subsequent review of compliance with those provisions by OkDHS and OHCA. (We understood, however, that monthly reports are submitted.) The Health Care Authority contracts with *ADvantage* providers once certified or credentialed by the LTCA-Oklahoma; audits of provider performance under those contracts are conducted by OkDHS.

Role of OkDHS: Since SFY 2002, OkDHS's Aging Services Division conducts audits of provider agencies, including direct service providers and case management agencies. This activity previously was performed by the LTCA. This audit unit currently has 3 full time staff with plans to increase by 2 additional staff. Regulations governing their role were not available for review nor were any protocols for conducting the audits available, with the exception of the audit tool itself.

Role of LTCA-Oklahoma: As specified in its contract with OkDHS, the role of the LTCA-Oklahoma is to administer the *ADvantage* program and assure its compliance with all state and federal requirements, including:

- Certify, recertify and decertify *ADvantage* service providers
- Authorize service plans
- Conduct required prior authorizations
- Conduct provider training
- Research, Intake, Referral and Screening, Information Technology support of waiver management, Complaint/Problem Discovery and Resolution, etc.

The LTCA-Oklahoma submits Monthly Program Narrative reports to OkDHS showing consumer activity, demographics, claims processed and turnaround time on authorized service plans for new consumers.

Role of Case Management Agencies: Agencies are certified by LTCA-Oklahoma based on compliance with standards that include the establishment of a continuous quality improvement plan to address activities related to specific operational standards. As the direct interface with the consumer, case managers are the eyes and ears of the state's quality management system and are relied upon to detect and correct problems and improve program performance. Activities include consumer assessments and reassessments, service planning and implementation, and service monitoring. There are about 30 case management agencies, many with multiple branch offices. Case management agencies must have a continuous quality improvement manager responsible for the required CQI plan and must attend CQI trainings conducted by LTCA-Oklahoma. Historically case managers reported being more active participants in the quality management

process through regular meetings with LTCA-Oklahoma QI staff and occasional strategic planning efforts. They sense a start and stop approach to the LTCA-Oklahoma's efforts and are not aware of the products of their input. They frequently see themselves caught between the conflicting directions of two masters (OkDHS and LTCA-Oklahoma) and sometimes are frustrated by the lack of clear and unambiguous guidance on issues. For example, one case manager described a situation where she did not feel she could provide a safe environment for a client being placed with her agency and received conflicting advice from OkDHS and LTCA-Oklahoma about how she should address the situation.

Role of Comprehensive Home Care provider agencies: Providers offering both home care and case management services must meet specified standards that include the development of a continuous quality plan showing evidence of an internal quality assurance program, the use of consumer surveys, complaint and grievance processes and audits and self-evaluations.

CQI Committee: This is an internal steering group comprised of staff from the LTCA – Oklahoma responsible for overseeing the quality management program, identifying trends and opportunities for improvement. According to a review of the minutes, the CQI Committee generally meets several times a month and documents actions taken and the need for follow-up. In addition to the above, over the years the LTCA-Oklahoma has established many forums for engaging stakeholders in the quality management process. Among these were a Provider Quality Task Force, Brown Bag sessions, and the *ADvantage* Collaborative. These activities were suspended in early 2004 during a lapse in the contract between LTCA and OkDHS and the loss of key LTCA-Oklahoma staff. LTCA-Oklahoma expects to resume these activities when new staff are hired.

The Adoption of Quality Measures

Expectations

Measures provide focus to a quality management system and set expectations for how a state will evaluate performance. The CMS Quality Framework has been used by many states as the landscape for determining the domains of quality that should be measured. Within the Framework, states are required to focus at a minimum on how well the system is meeting the required waiver assurances relating to level of care, plan of care, qualified providers, and health and welfare.

Findings

The LTCA has done an exceptional job in converting CMS waiver assurances into concrete indicators against which to evaluate conformance. Staff reviewed the LTCA-Oklahoma/AA Performance Measures SFY 2005. These measures are operational in nature and identify the methods, data sources and frequency of reporting for each defined measure. The measures include an evaluation of those aspects of waiver administration which fall under the jurisdiction of the LTCA-Oklahoma. Noticeably absent from the list is a measure of the accuracy and consistency of initial level of care determinations, a basic CMS requirement, but an activity performed outside of LTCA-Oklahoma by OkDHS. Measures of provider qualifications are

similarly weak and are likely to reflect the lack of routine data sources for evaluating network providers in that the provider audit function is conducted by OkDHS. SFY 2005 measures include no indicators for health and safety ... a core area intended to address abuse, neglect and consumer safety.

No measures of provider or consumer satisfaction and/or experience are addressed in the 2004-2005 CQI Plan nor are there definable health outcomes, such as percent of participants with risk factors, use of psychotropic medications, avoidable hospitalizations, falls, or emergency room visits. While secondary to the required CMS evidence of performance, collection of such measures are likely to have more direct impact on the actual care process and, given the data sources within LTCA-Oklahoma's control, very doable.

It did not appear that the selection or use of quality measures was a collaborative process involving OHCA, OkDHS, provider agencies or consumers. Given the operational nature of the measures, this may not be inappropriate. A separate concern was the lack of general awareness outside of LTCA that measures even existed for evaluating performance.

Routine and Timely Discovery Methods

Expectations

Critical to quality management and improvement is the capacity to get timely, consistent and relevant data that allow for prompt detection and resolution of problems at the individual level and an understanding of aggregate performance at the provider, program and systems levels. Discovery spans the process from determining what data will be collected; developing data collection tools and protocols to assure data consistency; storing data in a manner that is easily retrieved and linked with other data sources; and analyzing data so that one can draw conclusions and act accordingly.

Findings

The Waiver Information Management System (WMIS) is a comprehensive decision-support system designed and used by LTCA-Oklahoma to support their administration of the *ADvantage* program including quality management activities. WMIS is a rich reservoir of information on individual consumer demographics, care plans, prior authorizations, provider certifications, medical record reviews, waiting lists, and intake and screening. It also links with the program's record of inquiries and requests (NEXUS) and the state's administrative claims system. Plans are underway to create portals into the NEXUS system to allow participating providers direct input of required reports and access to data and policies. No assessment was made on the accuracy of data contained in WMIS and other data bases.

LTCA-Oklahoma operates a statewide 1-800 number for *ADvantage* Consumer related complaints and inquiries and maintains a database that is categorized by type of issue and includes timeframe for resolution. This system for complaint/inquiry registry and resolution tracking is called Consumer Inquiry Services (CIS). Resolution to issues occurs through immediate agency response, LTCA-Oklahoma intervention, or through collaborative problem resolution processes between LTCA-Oklahoma and the provider agencies. Based on the nature

of the problem, a morbidity and mortality review or root cause analysis may be conducted. With the implementation of web portals, provider agencies will be able to access the NEXUS system and be notified of Consumer related complaints or concerns and enter documentation of actions taken to achieve resolution. This will allow for real time information for the providers agencies and provide LTCA real time knowledge about the status of complaint resolution.

LTCA-Oklahoma adheres to Oklahoma state laws related to reporting known or suspected abuse, neglect, or exploitation. Due to APS interpretation of confidentiality requirements, neither provider agencies nor LTCA-Oklahoma staff have been able to get adequate information about the status of APS involvement with *ADvantage* Consumers or to obtain APS investigation results. Consequently, collaboration between APS and *ADvantage* has been limited.

Our meetings with consumers indicated a general lack of awareness about CIS. Currently Case Managers are responsible for informing consumers about CIS and for providing instructions on how to access CIS using the 1-800 number. To increase awareness of CIS, LTCA-Oklahoma plans to conduct a public awareness campaign that will include providing *ADvantage* consumers with magnets that include LTCA-Oklahoma's name and the appropriate number to call with complaints.

Other data bases, although not maintained by LTCA-Oklahoma, have potential relevance to system wide quality management efforts:

- Comprehensive home care case management agencies, as a condition of certification, are required to conduct chart reviews, administer consumer satisfaction surveys and implement QI projects. There are no standard instruments or protocols for these activities nor are the findings, according to the agencies, routinely shared with or reviewed by the LTCA-Oklahoma.
- Since 2002, OkDHS is responsible for conducting provider quality audits on an annual basis to assure compliance with contract requirements. Recently the data collection tool for these audits was revised to reflect the standards used by LTCA-Oklahoma for provider credentialing although LTCA-Oklahoma staff were not part of that development to assure consistent interpretation of the expectations. Based on a random 3 percent sample of consumers, deficiencies are noted whenever it is believed that the standard is not met; no evidence is identified when standards are thought to be met. Findings are reviewed by the OkDHS Compliance Team who in turn may request a corrective action plan by the provider. At the time of the site visit, findings from these audits were maintained on an individual provider basis. No database was seen of individual or aggregate findings. According to LTCA-Oklahoma staff, findings of audits are shared with them but have not been used because no documentation, instruction or training has been provided to LTCA-Oklahoma staff about the audit measures. Similarly, OkDHS staff were unaware of the LTCA-Oklahoma CQI Plan. It was reported by OkDHS that most deficiencies related to inadequate documentation, lack of training, inconsistencies in reporting and failure of communication with front line workers. Audit unit staff acknowledged the need for training for audit staff on quality management techniques and that there would be benefit to conducting joint training with OkDHS Developmental Disabilities Services Division (DDSD) surveyors, the Office of the Inspector General,

OSDH, OHCA surveyors and the LTCA-Oklahoma.

No statistics were available to determine the number of audits conducted, which providers were audited, or the method for selecting providers for audit. Since case management providers are not regulated by any other state certification or licensure status, verification of conformance with LTCA-Oklahoma's credentialing standards is a critical component of quality oversight within the state.

- The Oklahoma State Department of Health licenses home health agencies but, according to LTCA-Oklahoma staff, licensure requirements do not address standards unique to the *ADvantage* program. We did not meet with OSDH.

Systems to Remediate Individual Consumer and Provider Issues

Expectations

Safeguarding the health and welfare of individual participants is a major responsibility in community home and community service programs. Given the vulnerable nature of participants and the lack of direct supervision in the home during the care process, it is essential that adequate protections are in place to provide a rapid response when things do not go as intended. The ability to remediate requires having knowledge that a problem exists (see routine and timely discovery) and assuring that information gets to someone who can act on it in a timely, decisive and appropriate manner.

There are principally four streams through which time-sensitive information comes to the attention of program administrators. First, as previously discussed, is the Consumer Inquiry System that offers a 1-800 call line that can be used by anyone with a problem. According to protocols maintained by LTCA-Oklahoma, complaints are assigned to the appropriate staff person for resolution and required follow-up. It was not possible to determine the nature of the problems requiring remediation or the overall effectiveness of this system given the lack of specific measures to track outcomes.

A second data source for remediation is the OkDHS provider audit. Our understanding is that no provider has ever been de-certified once approved to participate in the network. Data were not available on the number of deficiencies issued and/or the nature and follow up on required corrective action plans.

The third feeder into the state's remediation activity are queries, questions and issues raised by provider agencies, especially case managers. LTCA-Oklahoma operates a secured email system to provide technical support related to compliance with contractual requirements and assistance with unique consumer service delivery issues. Consumer related issues are forwarded to Consumer Inquiry Services and emails requiring more involvement than can be handled by email are forwarded to the appropriate LTCA-Oklahoma staff. LTCA-Oklahoma is able to provide timely responses to providers through the email helpdesk system and LTCA-Oklahoma is potentially able to discover trends related to systemic problems as well as provider training needs, although no formal system to aggregate and review problems by type from the Provider

Question email system currently exists. We learned from case managers that they did not always know to whom an issue should be addressed and that oftentimes their issues were left unresolved. For example, several case managers noted that there was unclear guidance governing when a person could not be safely served in the home. Often they looked to LTCA-Oklahoma to intercede on such issues or, at the very least, help trouble shoot with them.

The fourth source of data for remediation is the risk screening tool used in the development of the plan of care that allows the case manager and clinical review team to pay close attention to those most at risk.

The remediation section of the LTCA-Oklahoma CQI Plan addresses the issue in only a cursory way and describes the activity in a retrospective rather than “real time” manner. While the quality management system should always review the effectiveness of its remediation activities after the fact, there must first be attention given to how issues are initially resolved.

Producing and Acting on Evidence to Improve Systems Performance

Expectations

Evidence presents not only what is happening but tries to distill information into meaningful reports for decision-making. Evidence has become the new buzz word for CMS which now will require states to demonstrate that it is in substantial compliance with waiver assurances or that there is a plan to produce such evidence. Thus, it is no longer sufficient to indicate that the state reviews care plans to determine that they adequately reflect consumer needs. Future waiver reviews will require states to show the findings of these reviews and how a state plans to address any inadequacies that may have been uncovered.

Findings

Earlier sections addressed the impressive use of quality measures by the LTCA-Oklahoma in monitoring its performance. We were particularly impressed by evidence produced as part of the state’s response to CMS in early 2005 and as part of the 2003-2004 CQI plan. No reports were reviewed showing evidence for 2005 year to date.

Reports showed a concerted effort to produce the facts as they are and not to “sugar coat” or downplay unfavorable results. While the evidence was straightforward and useful, the process for how decisions were made to act on the findings was less clear.

Meaningful Engagement of Stakeholders in the Quality Management Process

Expectations

Quality management is a technique but quality improvement is a collective process that requires the support of consumers, workers, agencies, case managers, and policymakers. States struggle to find meaningful ways to engage all sectors into the quality management function. No ideal models have emerged. As a general rule of thumb, people should be brought into the process when the perspectives and skills they offer can enlighten the outcome. Bringing people into the process requires accommodations, time-consuming arrangements and patience. It lengthens

discussion and complicates decision-making. It can also backfire when opinions are not taken into account or participants become frustrated by bureaucratic practices. But it can also work with proper leadership, facilitation, skills training, and a humbling mindset that policymakers do not always know what is right or good. In the end, the engagement of stakeholders is what holds the system accountable.

As currently practiced, LTCA-Oklahoma's quality management function seems highly professional, well documented and researched. It uses the techniques and advancements of the field and applies them to the home and community based setting with impressive skill. LTCA-Oklahoma is doing an incredible job in establishing, refining and improving systems, practices and program features to assess and protect quality. The challenge, however, is that the reach of LTCA-Oklahoma only goes so far and it cannot fix all problems. The quality management system seems to falter when it intersects with the roles and responsibilities of OkDHS, case managers, other providers and consumers. The quality management "tent" is very circumscribed within LTCA-Oklahoma and does not routinely embrace this broader community of stakeholders. People may be brought in to resolve particular issues but lack participation in a regular forum for discussion and decision-making. We noted that past efforts to involve providers and case managers were suspended due to the lapse in the contract and staff turnover.

Section II - Recommendations

As stated in Section I, the components of a comprehensive long term care system include: a well defined philosophy of care; consolidation of responsibilities in a single agency; appropriation of Medicaid funds for long term care services in a single line item; the availability of multiple financing sources; streamlined access through comprehensive entry points; streamlined/expedited processes for determining medical and financial eligibility; a comprehensive array of service options (in-home, consumer-directed care, community, residential and institutional); and the availability of nursing home relocation services. Table 3 compares several components of a comprehensive system in Oklahoma, Oregon and Washington.

Table 3: Comparison of comprehensive system components			
Variable	Oklahoma	Oregon	Washington
NF bed supply/1000 65+	69.3	27.5	31.9
Percent Medicaid HCBS spending	20.7%	55.0%	49.6%
Consolidated organization		●	●
Philosophy		●	●
Comprehensive entry point		●	●
Single, flexible appropriation		●	●
Full array of services		●	●
Extensive consumer direction		●	●
Presumptive eligibility	Planned	●	●
Options counseling		●	●
Nursing home transition	Planned		●

Organization

Oklahoma has a unique structure for organizing long-term care policy, budget, and accountability. With some changes, the state can build on its strengths to improve efficiency and accountability. The roles and responsibilities of each agency should be considered in relation to a strategic plan for long term care which would review the role of each component of the long term care system, including all the state agencies, to develop the most efficient, effective and accountable organizational structure.

Full consolidation of long term care functions is the preferred model for organizing long term care functions. In Oklahoma it would mean shifting all functions from OkDHS and OSDH to OHCA. As an option to full consolidation, we recommend that responsibility for managing long term care funding and programs for older adults and individuals with physical disabilities (state plan personal care services and *ADvantage* services) be transferred to OHCA. We recommend that OHCA continue the contract with LTCA to serve as the Administrative Agent. LTCA-Oklahoma has the capacity and expertise to fulfill its responsibilities as the waiver Administrative Agent and the state should build on this expertise.

A less effective option to consolidation would formalize the collaboration among state agencies by creating an Inter-Agency Long Term Care Council or Policy Committee.

Philosophy

Oklahoma should include a philosophy and mission statement in statute and regulation.

Once established, the statement would be a useful guide to developing a strategic long term care plan, and decisions concerning the organization, financing and policy.

Improving the balance between community and institutional services - Financing

Budgets for nursing home and ADvantage services should be linked to one another. Policy options that support the continued reduction in Medicaid nursing home bed days and expansion of ADvantage waiver services should be developed. Ideally, long term care funds would be appropriated in a single line item, allocated to nursing home, state plan personal care and home and community based services as needed and tracked to ensure that spending remained within the budgeted amounts.

“Money follows the person” is a second option. Under this approach, the funds are appropriated in separate line item and the nursing home appropriation is used to pay for waiver services for Medicaid beneficiaries who relocate to the community and enroll in the ADvantage program. Claims for waiver services can be paid directly from the nursing home account for participants who relocate to the community or funds can be transferred periodically to the ADvantage appropriation.

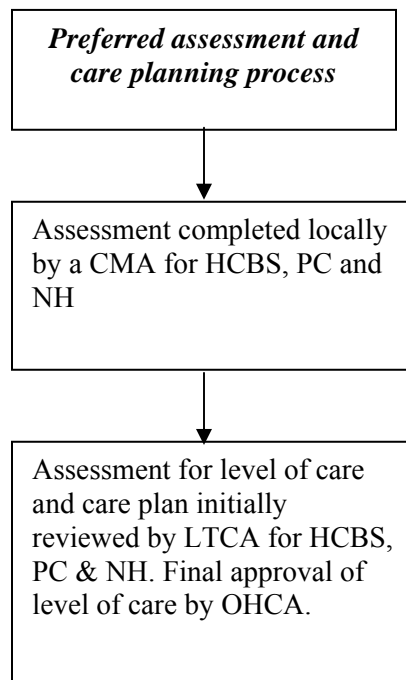
Whichever option is adopted, OHCA should establish goals for balance and establish measures and benchmarks to track progress toward the goals. We recommend using total days paid by Medicaid and the percent of beneficiaries served in institutional and community settings, should be tracked monthly. The interventions should be tracked and reviewed monthly to determine whether there are barriers to reaching the goals and interventions that will facilitate achieving the goals.

Streamlining access to services for consumers - Comprehensive entry points

We recommend that Oklahoma adopt a goal to reduce fragmentation by consolidating access functions currently performed by multiple agencies, increase the visibility of a single access point and create a system that provides seamless access to consumers and families based on their eligibility and preferences through a modified CEP system. See figure 7b. Ideally, the assessment, functional or medical eligibility determination and service authorization functions would be performed by independent case management agencies. Because of Oklahoma’s unique structure, we suggest the following:

- LTCA–Oklahoma become the primary agency for information, assistance, preliminary screening and referral.
- LTCA-Oklahoma would contract with Case Management Agencies (CMAs) that do not also provide waiver services to provide options counseling for all Medicaid beneficiaries seeking admission to a nursing home from the community and applicants for ADvantage services and state plan personal care services. (An assessment and options counseling would be provided to Medicaid nursing home applicants prior to admission.)
- CMAs would complete and forward an assessment to LTCA-Oklahoma.
- LTCA-Oklahoma would review the assessment and make a preliminary medical level of care determination.
- The assessment and recommendation would be submitted electronically to OHCA for a final determination.
- When the level of care is approved, OHCA would notify LTCA electronically. LTCA would notify the CMA and approve the plan of care.
- The CMA would implement, monitor and reassess the plan as needed.

Figure 7b – Oklahoma Access Pathways to Long Term Care



Information, screening and options counseling are important for Medicaid eligible long term care applicants and private pay individuals who would spend their resources and qualify for Medicaid within six months of admission to a nursing home. The LTCA-Oklahoma intake and screening service can be expanded to include information about all long term care service options, a

preliminary eligibility screen and eligibility review for all Medicaid Long Term Care applicants statewide.

Since it is likely to receive requests for information from individuals and families who are not eligible for publicly subsidized services, LTCA-Oklahoma should consider developing a service program for private pay individuals whose income or resources exceed the Medicaid financial eligibility standards.

OkDHS/ASD has 135 LTC positions for RNs and Area Nurses that now perform assessments and other activities depending on the program or service sought by the consumer. These positions would not be needed if the assessment and level of care determination functions were transferred to CMAs, LTCA-Oklahoma and OHCA. The OkDHS LTC RN role could be re-engineered to focus on one or more activities. First, discussions with key informants noted that more work can be done to improve quality assurance and quality improvement activities (described below), develop additional community and residential resources, and identify and assist nursing home residents who are able to relocate to the community. An external, independent audit function would be appropriately maintained in OkDHS after program responsibility is transferred to OHCA and would benefit from additional capacity to expand the scope of the activities and the number of audits conducted for CMAs and provider agencies.

Second, OkDHS RNs could be assigned to nursing homes to identify and support residents who are interested in relocating to the community, develop an appropriate housing arrangement, develop and implement a preliminary service plan and refer the individual case management agency for ongoing case management. Services would be paid for from the amount that was being spent on nursing home care. Co-locating RNs with CMAs would improve collaboration and coordination between RNs who are familiar with the needs of residents and case managers who would be responsible for arranging and coordinating the services needed to support the person in the community. Goals for contacting and relocating residents should be established. Barriers to relocation should be identified, tracked and reported to policy makers to develop strategies to reduce the barriers.

Third, resource developers will be needed to expand the array of services to include residential options – assisted living centers and adult family homes. OkDHS RNs could be trained to develop these resources. These staff could also develop resources to fill other service gaps.

Fourth, many individuals are admitted to a nursing home from hospitals for short term rehabilitative stays covered by Medicare. Other may be admitted as private pay residents. OkDHS RNs or CMA case managers should be assigned to interview and assess residents who convert from Medicare to Medicaid or who are likely to convert from private pay to Medicaid within six months.

Streamlining access to Medicaid

We support plans to implement a pilot program to presume financial eligibility for Medicaid for individuals who are at risk of admission to a nursing home and are likely to be eligible when the

full Medicaid financial application is completed and reviewed. OHCA and OkDHS should identify the core indicators that would allow eligibility staff to presume eligibility, allow self-declaration of income and assets, require the completion of a full Medicaid application within 30 days and have the applicant sign a form agreeing to reimburse the state for the cost of services delivered if they are later found ineligible.

Array of services

State policy officials should examine the array of services available and the circumstances that lead *ADvantage* participants and others to enter a nursing home. Gaps in the service array should be identified and strategies to fill the gaps, either through the addition of specific services to the *ADvantage* waiver or the development of provider capacity to deliver covered services should be developed.

Special attention should be given to the lack of coverage for services in residential settings that would offer more choice to participants who live alone, do not have informal supports and need access to assistance during nights and weekends. Planning for an affordable assisted living pilot program has begun under the Real Choice Systems Change grant.

ADvantage beneficiaries who enter a nursing home should be reviewed to determine the reasons for their admission and whether services in residential settings would avoid admissions.

Nursing home transition services should be expanded to cover one time costs associated with establishing a residence in the community.

To provide additional resources for people who are at risk but do not meet the medical level of care criteria for the *ADvantage* program, OCHA might consider modifying the definition of state plan personal care services to allow services to be provided in residential settings.

Consumer direction

States that are leading the way in providing consumers more non-institutional choices for long term care and support consider consumer direction an essential option that is growing in importance. A growing body of policy-relevant research indicates that permitting consumers to have more control over purchasing personal care and other supportive services leads to more efficient resource utilization and reduced nursing home placements. Consumers are more satisfied, non-traditional workers are recruited into the labor force, and families report less burden.

Oklahoma has a successful consumer direction pilot. To expand and sustain this momentum, we recommend that:

- The LTCA-Oklahoma should focus first on raising the comfort level of state officials, provider agencies, and consumers (of all ages) on the consumer direction principles and early implementation of CD-PASS.

- Consumers should continue to be engaged through the Oklahoma Partnership in statewide social marketing messages.
- Invite providers and state agency leaders from states that have been implementing consumer direction for 20, 10, and 5 years to meetings with state agencies and regional forums to describe their experience.
- Provide more formal training for case managers to become Consumer-Directed Agents (CDAs) or support brokers, because many will not be able to make this transition quickly or easily. Case managers would also benefit from “experiential” training,” which brings the case manager into the lived experience of persons with disabilities to help them better understand daily community living needs. Policy and program staff would benefit from joining CMS technical assistance calls on the methods used by other states—and lessons learned—in retraining case managers.
- As LTCA-Oklahoma/Acumen retains the IRS Fiscal Agent function, the state could move toward a model that has other agencies like Independent Living Centers and current independent case management agencies provide training support and consultation for consumers in the consumer-directed program.
- The Oklahoma Partnership advisory groups should continually identify and address any barriers for consumers to be able to direct their personal service assistants to administer medication if needed and perform health maintenance activities like suctioning and other daily, ongoing care tasks that must be performed to support the consumer in the home environment.

Quality management

Responsibility for quality management is clearly focused at the LTCA-Oklahoma with generally weak engagement at the upper and lower tiers of the system. There is no evidence of an active Medicaid role as envisioned by CMS. Nor are there opportunities for case managers, providers and consumers to become active participants in the quality management process. Each sector of the system, including the LTCA-Oklahoma, seems to have responsibility for specific components of quality assurance with no one entity assuming a leadership role to facilitate a collective review of and action on quality issues. To overcome this stovepipe approach to the organization of the quality management function, we recommend that:

- A three-way letter of understanding be negotiated among OHCA, OkDHS and LTCA outlining roles and responsibilities for oversight and administration of the *ADvantage* program.
- An internal work group be established including representatives from OHCA, OkDHS and LTCA-Oklahoma to serve as the filter through which quality-related issues, policies, instruments, data and findings are routinely vetted and acted upon.
- Resume regular forums for input and engagement by case managers.
- Design learning collaboratives or other mechanisms to bring policymakers, case managers, providers and consumers together to work together on quality improvement priorities.

LTCA-Oklahoma has done impressive work in using quality indicators to assess the performance of the HCBS system. There are 3 areas suggested for improvement:

- Develop, track and integrate into QI activities measures related to health and welfare, provider qualifications and level of care.
- Consider expanding measures beyond the assurances to capture more consumer and outcome oriented indicators.
- Engage consumers and providers in the selection of additional measures beyond the assurances.

There are several areas where the quality oversight system is weak.

- The provider audits conducted by OkDHS lack structure, standardization and documentation. There is no protocol for conducting reviews, following up on corrective action, or disseminating findings. There is also no evidence of formal reviewer training programs or evaluation of inter-reviewer reliability.
- Required provider CQI plans (e.g., chart reviews) should be standardized so that information can be collected, compared and used for quality management purposes at the system level.
- Consideration should be given to establishing a mandatory incident reporting system.
- No standardized surveys of consumers and direct care workers are conducted.
- No standardized definition of high risk consumers, description of the risk assessment process, monitoring of high risk consumers or of risk intervention were identified.

It did not always seem clear who is responsible for remediating a situation. As the first line of contact with consumers, case managers and their agencies should be able to resolve most issues. On issues of policy and its interpretation, there is a more direct role for the LTCA-Oklahoma to play. Discussion with the case managers indicated that oftentimes they have similar problems but each are unaware of how it may have been resolved for the other. Documenting and sharing case examples may help to reduce inconsistencies and the need for clarification by LTCA-Oklahoma or OkDHS.

- Systems should be put into place that provides unambiguous guidelines for when a deficiency is warranted and, once resolved, to provide more vigilant oversight.
- Cases of abuse and neglect are the absolute fundamental situations requiring remediation. We did not see reference to concrete policies for reporting such cases and working together with OkDHS Adult Protective Services (APS) in following up on reported cases.

There are a lot of improvement activities from past years but not a sense of whether or how priorities were established. We propose that criteria and processes for setting priorities be established that include the participation of OkDHS and OHCA.

Nursing home supply table

Nursing home bed supply per 1,000 age 65+					
State	Population 65+	Beds/1000	State	Population 65+	Beds/1000
AL	597,959	44.3	MT	126,549	58.8
AK	41,887	17.1	NE	231,803	68.1
AR	381,106	61.6	NV	262,079	19.4
AZ	732,071	22.0	NH	156,672	49.4
CA	3,822,957	32.4	NJ	1,126,141	45.0
CO	450,971	44.0	NM	229,474	31.2
CT	473,693	63.9	NY	2,492,816	48.6
DE	108,961	39.6	NC	1,032,249	41.4
FL	2,927,583	28.0	ND	93,171	70.1
GA	847,082	47.3	OH	1,524,916	60.5
HI	172,008	23.4	OK	464,440	69.3
ID	158,696	39.5	OR	459,821	27.5
IL	1,520,629	64.7	PA	1,896,503	47.0
IN	772,010	62.2	RI	150,587	57.1
IA	433,139	76.9	SC	520,392	34.1
KS	354,579	68.4	SD	109,493	65.8
KY	519,327	49.0	TN	738,053	50.1
LA	527,644	71.2	TX	2,216,610	51.8
ME	189,751	38.9	UT	207,711	36.1
MD	634,743	45.9	VT	80,672	42.6
MA	854,343	59.4	VA	846,921	36.5
MI	1,246,595	37.8	WA	703,145	31.9
MN	615,179	60.4	WV	278,354	39.5
MS	352,867	51.8	WI	715,568	55.6
MO	765,692	65.7	WY	61,113	50.1

Source: Census Bureau Population Projections July 2004 and CMS nursing home supply data December 2004 compiled by the American Health Care Association.