Home and Community Based Services Reform and Rebalancing Feasibility Analysis

FINAL REPORT

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Submitted to:
Office of the Secretary
Department of Public Welfare
Commonwealth of Pennsylvania

Submitted by:
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Introduction

In July 2005, the Pennsylvania Department of Public Welfare contracted with Thomson Medstat to evaluate long-term living programs in Pennsylvania, with special emphasis on the current structure of the state’s Medicaid home and community-based services (HCBS) waiver programs. The objectives of the project are to assist the Department in identifying problems and recommending solutions on the financing, administration, and delivery of home and community-based supports to persons of all ages with disabilities. This report presents the findings of the evaluation, as well as a series of recommendations regarding the future development of the home and community-based service system in the Commonwealth.

Methods

Medstat gathered information about the state’s HCBS waiver programs from multiple sources. Medstat interviewed management and operational staff from the Department of Public Welfare (DPW), the Department of Aging (PDA), and the Governor’s Office of Health Care Reform (GOHCR). We met with DPW’s advisory council for HCBS, the Stakeholder Planning Team, and had separate interviews with several stakeholder groups selected by DPW. In addition, we interviewed local managers and support coordinators from several Area Agencies on Aging, Attendant Care agencies, and administrative entities and enrollment agencies for the Community Services Program for Persons with Physical Disabilities (CSPPPD). We also reviewed a large number of reports and other written materials about HCBS waivers and analyzed utilization and expenditure data on both HCBS waivers and institutional services in the Commonwealth. We also conducted comparative analyses of long-term living services in Pennsylvania and long-term care programs in other states.

Overview of the Long-Term Living System in Pennsylvania

In order to provide some context for the findings and recommendations in this report, this section provides a brief overview of the long-term living system in Pennsylvania.

First and foremost, the demographics of Pennsylvania’s aged population are fairly unique. These demographics are driving a high level of demand for publicly-financed long-term care services in the state. It is commonly known that in the 2000 census, the percentage of Pennsylvania’s population over the age of 65 was the second highest of all states, next to Florida.\(^1\) What is less well known about the state’s demographics is that the distribution of Pennsylvania’s aged population is highly skewed towards older age cohorts. The Commonwealth has the fourth-highest proportion of residents age 85 and over.\(^2\) Between 2000


and 2004, the over age 85 cohort grew from approximately 278,000 to 313,000 people, an increase of almost 13%, while the state’s overall population grew less than 1% over the same time period. The Pennsylvania State Data Center estimates that by the year 2010, the over 85 age cohort will increase to 365,000 persons, a further increase of 18% from 2004.3 In essence, Pennsylvania is currently experiencing the kinds of demographic changes that other states will not experience for another 10 to 15 years. Given these demographics, the pressures on Medicaid long-term care budgets will be significant over the coming decade.

Second, it is important to understand these demographics when examining nursing home utilization rates in the state. If one simply measures nursing home utilization in terms of use per 1,000 persons over the age of 65, Pennsylvania’s nursing home utilization would appear to be somewhat higher than the national average across all states. However, if one takes into account the age distribution of Pennsylvania’s aged population, institutional utilization rates in Pennsylvania are slightly below the national average. Pennsylvania’s institutionalization rates are also slightly below average for intermediate care facilities for people with mental retardation (ICF/MR).4

The Commonwealth has a long history of offering HCBS as an alternative to institutional placement and has limited the supply of institutional providers. Since the late 1990s, Pennsylvania has made significant investments in expanding the home and community-based service system. HCBS utilization in the Commonwealth is currently above the national average for people with mental retardation. However, HCBS expenditures are below average for older adults and people with physical disabilities, even when considering both Medicaid and state-funded programs.5 Pennsylvania has articulated a policy goal to further rebalance the long-term living system, i.e., to reduce institutionalization and increase access to HCBS.

Third, Pennsylvania is somewhat unique in regard to the number of HCBS waiver programs it currently administers. Medicaid supports are provided primarily through eleven (11) Medicaid HCBS Waiver Programs that serve a variety of target populations. In 2004, Pennsylvania had more waivers than any other state, with the exception of Texas and Florida. The average number of waivers per state in 2004 was 5.7.6 Only Florida, with twelve waivers, has more. In addition, Pennsylvania serves tens of thousands of people through state-funded programs, especially Act 150 Attendant Care and the OPTIONS program. The 11 waiver programs in Pennsylvania are administered by four separate agencies. Seven are administered by the new Office of Long Term Living (OLTL); two by the Office of Mental Retardation (OMR); one by the Office of Child Development (OCD); and one by the Department of Aging (PDA).

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3 Pennsylvania State Data Center, as cited by The Legislative Budget and Finance Committee, Long Term Care for the Elderly in Pennsylvania April 2005.


5 Prouty, et al., 2005; Burwell, Brian, Sredl, Kate, and Eiken, Steve “Medicaid Long Term Care Expenditures in FY 2004” Thomson Medstat: May 11, 2005; and Data regarding OPTIONS, Bridge, and Act 150 Attendant Care programs sent in February 2006 by the Department of Aging and Department of Public Welfare.

The state does not provide a personal care services benefit under the regular state Medicaid plan, so people must access HCBS services either through waiver programs or through one of the state-funded programs. However, the state’s 11 waiver programs do not offer services to all persons with disabilities who qualify for institutional services. As a result, some people with severe disabilities do not currently qualify for any of the state’s 11 waiver programs. For example, most adults with autism spectrum disorders do not qualify for any of the state’s waivers, unless there is a concomitant diagnosis of mental retardation. As part of the evaluation study, DPW specifically asked Medstat to assess the feasibility of reducing the number of HCBS waivers that are currently in operation in the state as well as to address gaps in eligibility for waiver services.

Each of state’s eleven waivers is briefly described below, along with three state-funded HCBS programs.

**Consolidated Waiver**

Pennsylvania’s oldest waiver is the Consolidated Waiver for people with mental retardation. The Consolidated Waiver started in 1986 when the state combined three waivers that helped the state implement particular lawsuit settlements. The three original waivers served different regions of the state while the Consolidated Waiver serves the entire Commonwealth. All consumers must have a physician’s diagnosis of mental retardation. Most Consolidated Waiver participants receive residential habilitation services, often in group homes with three or fewer people. The Consolidated Waiver also offers a wide range of additional services. Waiver recipients access services through one of 46 county Mental Health and Mental Retardation (MH/MR) programs.

**Person/Family Directed Support Waiver**

The Person/Family Directed Support (P/FDS) Waiver is almost identical to the Consolidated Waiver, except the P/FDS waiver does not offer residential habilitation and has an individual expenditure limit of approximately $21,000. The P/FDS waiver only serves people with mental retardation who live in their own home or their family’s home. One goal of the P/FDS waiver is to encourage people and families to direct their own services, but waiver participants may choose whether to direct their own services or use a provider agency.

**Infants, Toddlers, and Families (ITF) Waiver**

The Infants, Toddlers, and Families (ITF) Waiver provides home-based habilitation for children under age three with a physician’s diagnosis with a developmental disability and a need for ICF/MR level of care. This waiver funds some of the Early Intervention services mandated by Part C the Individuals with Disabilities Education Act. Pennsylvania emphasizes family training so that families can teach their children based on early intervention professionals’ recommendations. This waiver is unique to

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7 Pennsylvania Department of Public Welfare, “Home and Community-Based Services Waiver Profiles” May 2002
8 Prouty, et al., 2005.
Pennsylvania. As of 2004, only one other state had a waiver specifically targeting children under age three.\textsuperscript{10} Nebraska’s waiver only provides case management services and is designed to expand Medicaid access to children under age three with severe disabilities.\textsuperscript{11} In 2005, the Department of Public Welfare transferred ITF Waiver management from the Office of Mental Retardation to the Office of Child Development. Families still access services for their children through County MH/MR Programs.

\textit{OBRA Waiver}

Unlike most states, Pennsylvania has separate service systems for people with mental retardation and people with other developmental disabilities. Pennsylvania’s waiver for people with other developmental disabilities, the OBRA Waiver, started in 1992 to implement federal requirements of 1987 Omnibus Budget Reconciliation Act (OBRA), which mandated that states ensure nursing facility residents with mental illness, mental retardation, and related conditions received appropriate services.\textsuperscript{12} The OBRA Waiver now serves people who never entered nursing facilities as well as former nursing facility residents. In addition to support coordination, the most common services are daily living services (i.e., personal assistance with activities of daily living) and community integration services.\textsuperscript{13} People access the OBRA Waiver through three regional enrollment agencies that assess functional eligibility and provide case management.

\textit{COMMCARE Waiver}

The COMMCARE Waiver provides support coordination, personal assistance, habilitation, community integration, and other supports for people with traumatic brain injuries.\textsuperscript{14} COMMCARE is designed to provide ongoing services after people have received post-acute rehabilitation from private insurance, Medicaid, or the state-funded Head Injury Program. Like OBRA Waiver participants, COMMCARE participants access the waiver through one of three regional enrollment agencies. In addition to the enrollment agencies’ assessment, the local AAA must assess consumers to determine clinical eligibility for nursing facility services.

\textit{Independence Waiver}

The Independence Waiver provides a variety of services for adults with physical disabilities ages 18 to 60. The most common services are daily living services (i.e., personal assistance with activities of daily living), support coordination, and personal emergency response systems.\textsuperscript{15} If a consumer turns age 60,

\textsuperscript{10} Medstat analysis of waiver information from the Centers for Medicare & Medicaid Services Web site in 2005.

\textsuperscript{11} Personal Communication with Mary Jo Iwan, Nebraska Department of Health and Human Services.

\textsuperscript{12} Pennsylvania Department of Public Welfare, 2002.

\textsuperscript{13} CMS Form 372 Report for the COMMCARE Waiver for 2004.

\textsuperscript{14} Pennsylvania Department of Public Welfare, 2002.

\textsuperscript{15} CMS Form 372 Report for the Independence Waiver for 2003.
he or she can move to the PDA Waiver for older adults or choose to remain in the Independence Waiver. Like OBRA and COMMCARE participants, Independence participants access the waiver through one of three regional enrollment agencies. In addition to the enrollment agencies’ assessment, the local AAA must assess consumers to determine clinical eligibility for nursing facility services.

**Attendant Care Waiver**

The Attendant Care Waiver offers personal attendant services to adults with physical disabilities ages 18 to 60. Attendant care is the only hands-on service available in this waiver. Consumers also receive service coordination and may access personal emergency response system and community transition services. If a consumer turns age 60, he or she can move to the PDA Waiver for older adults or choose to remain in the Attendant Care Waiver.

Consumers access the waiver through one of 15 Attendant Care enrollment agencies that assess functional eligibility and develop initial service plans. The enrollment agencies also provide ongoing service coordination, but consumers can also choose different service coordination agencies. In addition to the enrollment agencies’ assessment, the local AAA must assess the person to determine clinical eligibility for nursing facility services.

**Act 150 Attendant Care (state-funded)**

The Attendant Care Waiver expanded the state-funded Act 150 Attendant Care Program. Act 150 Attendant Care is nearly identical to the Attendant Care Waiver, but Act 150 serves people with higher income or asset levels. Also, Act 150 does not offer community transition services. Act 150 served 2,268 individuals in State Fiscal Year (SFY) 2005.

**Aging Waiver**

The Aging Waiver, also known as the PDA Waiver because it is operated by the Pennsylvania Department of Aging, provides personal assistance services, home delivered meals, extended home health care (beyond Medicaid state plan coverage), specialized medical equipment, and other services to people age 60 and older. People access the PDA waiver through 52 county-based Area Agencies on Aging (AAAs), which perform clinical eligibility assessments.

**OPTIONS Program**

In addition to the Aging Waiver, the Commonwealth’s lottery proceeds are entirely devoted to senior services, including home and community-based services, transportation, and prescription drugs. Lottery profits do not fund the waiver, but continue to fund non-Medicaid services for older adults provided

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17 Ibid.
through the AAAs. People may receive OPTIONS services if their income and assets are too high for Medicaid, or if they do not meet nursing facility clinical eligibility but need services. The OPTIONS program served 96,829 people in SFY 2005, including 17,772 people who met nursing facility clinical criteria. OPTIONS has an individual cost limit of $625 per month.

**Bridge Program**

The other lottery-funded program, the Bridge Program, helps people who are clinically eligible for nursing facility services but have too many assets to qualify for Medicaid. Under this program, consumers pay for half of their home and community-based services and the Commonwealth pays for the other half. This program, which is being phased out, served 965 people in SFY 2005.

**Elwyn Waiver**

The Elwyn Waiver pays assisted living services for deaf or hard of hearing individuals in Delaware County, near Philadelphia. Consumers access services through the Delaware County Area Agency on Aging, which conducts an in-person assessment of clinical eligibility. Elwyn, Incorporated, a major non-profit service provider for deaf and hard of hearing people, owns and operates the only facility that qualifies as a provider for this waiver.

**Michael Dallas Waiver**

The Michael Dallas Waiver provides private duty nursing, respite, attendant care, and other services to people who require technology to sustain life or replace a vital bodily function. People access this waiver through the Office of Medical Assistance Programs, which conducts a paper review of a physician’s certification of waiver eligibility. The local AAA also must assess the person to determine he or she is clinically eligible for nursing facility services.

**AIDS Waiver**

The AIDS Waiver provides nutritional counseling and supplements, homemaker services, and home health (in addition to that available in the Medicaid State Plan) to people with Acquired Immune Deficiency Syndrome (AIDS). People access this waiver through the Office of Medical Assistance Programs, which reviews physician certification of waiver eligibility. Most participants require a nursing facility level of care, and the local AAA must assess the person to determine he or she is clinically eligible for nursing facility services. A few participants qualify at hospital level of care.

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18 Commonwealth of Pennsylvania, 2005-06 Governor’s Executive Budget, February 8, 2005.


21 CMS Form 372 for the AIDS Waiver for 2003.
Utilization and Expenditure Data on HCBS Waivers in Pennsylvania

Table 1 presents selected utilization and expenditure data for each of the state’s 11 waiver programs. Utilization data for state-funded programs are not included in the table.
<table>
<thead>
<tr>
<th>Waiver</th>
<th>03-04 Unduplicated Recipients</th>
<th>04-05 Unduplicated Recipients</th>
<th>Percent Change</th>
<th>03-04 Expenditures (in 000s)</th>
<th>04-05 Expenditures (in 000s)</th>
<th>Percent Change</th>
<th>04-05 Average Cost per Recipient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consolidated Waiver for Persons with Mental Retardition²</td>
<td>13,885</td>
<td>13,821</td>
<td>-0.5%</td>
<td>$914,783</td>
<td>$920,452</td>
<td>+0.6%</td>
<td>$66,598</td>
</tr>
<tr>
<td>Personal Family Directed Support Waiver²</td>
<td>7,296</td>
<td>7,445</td>
<td>+2.0%</td>
<td>$80,003</td>
<td>$76,842</td>
<td>-4.0%</td>
<td>$10,321</td>
</tr>
<tr>
<td>Infant, Toddlers &amp; Families Waiver²</td>
<td>3,760</td>
<td>2,817</td>
<td>-25.0%</td>
<td>$12,316</td>
<td>$12,118</td>
<td>-1.6%</td>
<td>$4,302</td>
</tr>
<tr>
<td>OBRA Waiver³</td>
<td>563</td>
<td>759</td>
<td>+34.8%</td>
<td>$22,047</td>
<td>$29,971</td>
<td>+35.9%</td>
<td>$39,487</td>
</tr>
<tr>
<td>COMMCARE Waiver³</td>
<td>68</td>
<td>152</td>
<td>+123.5%</td>
<td>$2,587</td>
<td>$6,723</td>
<td>+159.8%</td>
<td>$44,228</td>
</tr>
<tr>
<td>Independence Waiver³</td>
<td>882</td>
<td>1,233</td>
<td>+39.8%</td>
<td>$18,215</td>
<td>$29,401</td>
<td>+61.4%</td>
<td>$23,845</td>
</tr>
<tr>
<td>Attendant Care Waiver³</td>
<td>3,262</td>
<td>3,968</td>
<td>+21.6%</td>
<td>$54,375</td>
<td>$64,843</td>
<td>+19.3%</td>
<td>$16,341</td>
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<tr>
<td>Pennsylvania Department on Aging Waiver⁴</td>
<td>16,023</td>
<td>20,495</td>
<td>+27.9%</td>
<td>$159,676</td>
<td>$235,859</td>
<td>+47.7%</td>
<td>$15,311</td>
</tr>
<tr>
<td>Elwyn Waiver⁵</td>
<td>41</td>
<td>33</td>
<td>-19.5%</td>
<td>$1,202</td>
<td>NA</td>
<td>NA</td>
<td>$29,317</td>
</tr>
<tr>
<td>Michael Dallas Waiver⁵</td>
<td>66</td>
<td>73</td>
<td>+10.6%</td>
<td>$7,433</td>
<td>NA</td>
<td>NA</td>
<td>$112,621</td>
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<tr>
<td>AIDS Waiver⁵</td>
<td>NA</td>
<td>285</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<td>NA</td>
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<tr>
<td>Totals</td>
<td>45,846</td>
<td>51,081</td>
<td>+11.4%</td>
<td>$1,272,795</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Sources:
1. Average expenditures per person data are for 2004-05, except 2003-04 data are used for the Elwyn and Michael Dallas Waivers.
2. Participants and expenditures data provided by DPW Office of Mental Retardation, December 12, 2005.
5. Participants data provided by DPW Office of Medical Assistance Programs (OMAP), October 2005. Expenditures data from CMS Form 372 provided by DPW OMAP.
Findings and Recommendations

1. Misaligned Management Structures

In Medstat’s preliminary evaluation report, submitted in November 2005, we reported that HCBS waiver programs in Pennsylvania were not being managed as efficiently as they should be. Specifically, we stated that resources allocated to the expansion of home and community-based services for persons with severe disabilities were not being utilized in a manner that maximized their cost-effectiveness in reducing the utilization of institutional services.

Many problems in the management of Pennsylvania’s HCBS waiver programs related to underlying structural issues that were not amenable to quick fixes. The management of HCBS waiver programs was highly fragmented across the Department of Public Welfare and the Pennsylvania Department on Aging, and we felt this fragmentation in management responsibilities contributed to diffused accountability for ensuring that budgetary resources allocated to waiver programs were used most cost-effectively. The Office of Medical Assistance Programs (OMAP) retained ultimate budgetary responsibility for all 11 HCBS waiver programs, yet it retained minimal management oversight over the eight HCBS waiver programs administered by OMR, OCD, OSP, and PDA. To improve the cost-effectiveness of HCBS waivers, budgetary and managerial responsibilities needed to be more closely aligned.

For example, a fundamental structural problem applied to the management of the Pennsylvania Department of Aging waiver and the Preadmission Screening Program for all nursing facility admissions. The programmatic goal of both of these programs is to control nursing facility utilization and maintain elderly persons in the community for as long as possible. PDA is responsible for the administration of both the preadmission screening program and the PDA waiver, including decision-making authority over who is eligible to receive nursing facility and waiver services, and what waiver services people receive. However, PDA has no management or budgetary responsibility for nursing facility services, nor does it have ultimate budgetary responsibility for the PDA waiver. We felt that the Commonwealth needed to link management authority and fiscal responsibility in a manner that supported a common purpose and vision for long-term living services.

The fragmentation in management responsibilities for HCBS waiver programs extended to the management of information systems needed to operate HCBS waiver programs efficiently. The Office of Medical Assistance Programs (OMAP) in DPW is the repository for Medicaid claims data from HCBS waiver providers for all 11 HCBS waiver programs. These data are critical for tracking waiver utilization and costs for each waiver program. However, these data were generally unavailable to the lead management agency on a timely basis. When Medstat requested basic information from lead agencies on waiver caseloads, expenditures, and costs per waiver recipient, the lead agencies were not able to provide these data for many of the waiver programs. Data availability has improved in recent months as OMAP has been able to verify the accuracy of claims system data. Conversely, the information systems maintained by PDA with data on the PDA waiver was generally unavailable to DPW. The unavailability of information to program managers operating HCBS waiver programs was remarkable.
The fragmentation in management structures for Pennsylvania’s HCBS waiver programs also extended to the policy and program development process. The Governor’s Office of Health Care Reform is the initiator of many policy initiatives that affect the ongoing development of HCBS waiver programs in Pennsylvania, including the Community Choice program, Aging and Disability Resource Centers, the Money Follows the Person initiative, the Quality Assurance and Improvement initiative, and participation in the Cash and Counseling Demonstration Program. However, the Office of Health Care Reform reported directly to the Governor and had no direct line responsibility for day-to-day management of HCBS waiver programs. Thus, the transition from “policy development” to “program operations” for many of the initiatives started within the Office of Health Care Reform had been cumbersome at best.

In February 2006, the Governor realigned the management structure for long term living services in the Commonwealth. The new management structure is portrayed in Figure 1. The Governor created a Long Term Living Council comprised of six senior state officials: (1) the Secretary of the Department of Public Welfare; (2) the Budget Secretary; (3) the Secretary of Policy; (4) the Governor’s Deputy Chief of Staff; (5) the Director of the Office of Health Care Reform; and (6) the Secretary of the Department on Aging. The Long Term Living Council currently meets bi-weekly to discuss and coordinate long term living issues across all of state government. Further, the Governor created a new staff position, the Executive Director of the Long Term Living Council, who reports directly to the Council, and who has overall management responsibility for the coordination of long term living policy and operations in the Commonwealth. Reporting directly to the Executive Director of the Long Term Living Council is the Deputy for Long Term Living in the Department of Public Welfare, the Long Term Living Project Director for the Governor’s Office of Health Care Reform, and the Deputy Secretary on Aging with responsibility for managing the PDA waiver.

This new management structure is clearly a significant step designed to address the pre-existing fragmentation in the management of long term living programs across state government, as well as a significant step towards bringing programmatic and budgetary goals and objectives into greater alignment. In our view, it is not only a significant step, it is a positive step. This reorganization in the management of long term living services will hopefully bring greater coordination, communication, and consolidation in the formulation of long term care living policy and in the transformation of policy into program operations. While it is clearly too early to determine whether the reorganization will achieve its intended objectives, it represents a change that directly addresses underlying structural problems that were evident to many stakeholders across the Commonwealth.

2. Decentralized Administration of Waiver Programs

A second structural issue in the management of HCBS waivers, however, relates to the decentralization of HCBS waiver program administration across the state. The culture of the Commonwealth has traditionally been one of fairly decentralized management of human service programs, and that culture carries into the administration of HCBS waivers. While local control over program policies and procedures is compatible with state-funded programs, this is not an option for Medicaid-financed services.
The Centers for Medicare and Medicaid Services (CMS) is making it very clear to the state that it expects HCBS waiver programs to be administered in a uniform manner across all geographic regions. The Office of Mental Retardation is currently in the process of coming into compliance with a CMS mandate to achieve uniformity in service definitions, reimbursement methods, and procurement processes across the state’s 46 County Departments of Mental Health and Mental Retardation. CMS has given Pennsylvania one year to make the necessary changes to the Consolidated Waiver to bring it into compliance with Medicaid program requirements. The deadline established by CMS for the state to demonstrate its compliance is July 1, 2006.

The decentralized administration of waiver services that CMS identified in the Consolidated Waiver also exists in Pennsylvania’s other HCBS waiver programs. As a result, there is considerable inconsistency in the application of waiver program policies across the state. Consumers’ services often depend as much on where they live as they do on the consumer’s needs, strengths, and informal support. Most waivers have no centralized utilization management system to ensure consistency in the development of plans of care and the allocation of waiver program benefits. This places the state at risk of non-compliance with Medicaid laws and regulations. In general, the state needs to strengthen its oversight role of local waiver program operations, as well as its quality monitoring activities. This may require more staff at the state level.
Long Term Living Council

Executive Director

Deputy for LTL DPW

- Bureau of Long Term Care
- Support Units: Budget, Policy Etc.

LTL Project GOHCR

- Support Units: Budget, Policy Etc.

Deputy Secretary Aging

- Bureau of Program Integrity
- Bureau of Home & Community Based Services

Existing Stakeholders Groups
3. **Waiver Program Policies and Procedures**

**Develop Uniform Assessment Process**

Currently, there is no statewide uniform assessment instrument for assessing clinical eligibility for nursing facility and HCBS waiver services. Without a uniform assessment instrument, the state is unable to make reliable comparisons of acuity or the costs of care across community-based and institutional service populations. Specifically, it is difficult to make reliable assessments of whether waiver programs are being effectively targeted to persons who are at significant risk for nursing facility care. A uniform assessment process based on a standardized instrument will enable the state to compare costs across service settings and geographic areas, adjusted for the consumer’s need for services. Data from these assessments will allow the state to be more efficient in its utilization management efforts and to predict cost and outcomes with greater accuracy. The lack of a standardized assessment of need also restricts the state’s ability to equitably distribute waiver resources in all program areas from individual plans of care to provider reimbursement. The state should implement a standardized statewide needs assessment instrument and process. One option is the MDS HC, which is an instrument for persons living in the community, and which can be cross-walked to the MDS+, a federally required assessment instrument for persons living in nursing facilities.

**Streamline the Eligibility Process for Applicants at Most Risk of Institutional Services**

The expedited waiver intake process available under the Community Choice initiative has made community-based services a viable alternative to nursing facility placement for persons who are at the point of hospital discharge or who are at imminent risk for nursing home placement due to an emergency situation such as the sudden loss of a primary caregiver. Interviews with field staff and hospital representatives indicated that without an expedited intake process, often the only placement option for persons discharged from hospitals is nursing facility care.

The expedited waiver intake process used in Community Choice should be expanded statewide and be limited to persons at immediate risk of institutionalization or who already reside in a nursing facility. Deleting “applicant in jeopardy” from the criteria for a Priority One designation can accomplish targeting the expedited process to those most at risk. The remaining Priority One criteria would be:

- Consumers at risk of nursing facility placement
- Consumers who have lost their caregiver and have no informal supports
- Consumers who are about to lose or have lost their housing

This expansion should be supported by an outreach effort directed to hospital discharge planners, nursing facility social workers, and persons residing in nursing homes.
Prioritize Waiver Services for Persons Most At Risk

In concert with the previous recommendation, we recommend that the state enhance the targeting of new waiver slots or slots that become available through turnover to persons at the highest risk of nursing home placement and to persons already residing in nursing homes. The prioritization of waiver services will be even more critical should the state decide to limit the expansion of selected waiver programs in the 2006-2007 fiscal year due to budgetary constraints. This targeting can be accomplished by amending waivers to designate slots to those persons already living in a nursing home or at high risk of nursing home placement.

We further recommend that Pennsylvania develop a system for prioritizing waiver slots for persons residing in nursing homes in coordination with a Money Follows the Person Rebalancing Demonstration Program grant. Under Section 6071 of the Deficit Reduction Act of 2005, Congress authorized $1.75 billion dollars for a Money Follows the Person Rebalancing Demonstration Program. The program allows states to receive a higher rate of Federal Financial Participation (FFP) for persons discharged from nursing homes to community settings under the Demonstration Program. For Pennsylvania, this means that HCBS waiver services provided to Demonstration participants would have an FFP rate of 77.53%, as compared to the usual FFP rate for Pennsylvania of 55.05% for Medicaid-covered services. Participation in the Demonstration Program could thus result in considerable Medicaid program savings for the state.

The Centers for Medicare & Medicaid Services will select states to participate in the Money Follows the Person Demonstration Program through a competitive grant process. The first round of grants for the Demonstration Program will be awarded to selected states in 2007.

Develop Residential Service Components in Waiver Programs

Most waiver programs in Pennsylvania do not have a residential service component that provides a 24-hour secure environment, personal care, transportation, and other services reimbursed on a per diem basis. Only the Elwyn and Consolidated waivers have a residential service component reimbursed on a per diem basis. The OBRA and COMMCARE waivers allow waiver services to be delivered in group living settings, but the services have to be billed individually which is inefficient and limits access to needed services. This service gap is particularly important for persons who are eligible for nursing facility services, but who do not require the intensity of nursing care and supervision provided in a nursing home setting. States which have made significant progress in rebalancing their long term care systems have all developed a continuum of 24-hour residential alternatives for persons who require some level of care and supervision on a 24-hour basis.

There are a number of contributing factors as to why Pennsylvania lacks residential services that are a viable alternative to nursing facilities including state statutes, licensing regulations, state monitoring practices, and stakeholder resistance. The state should establish a licensure category that allows assisted living facilities to

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22 The higher match rate for persons participating in the Money Follows the Person Rebalancing Demonstration program is only available for the first 12 months of community placement.
serve persons who meet NF criteria. The state should also amend its waivers to provide waiver services in a domiciliary home environment for people who need a less intensive residential option. The state should bundle the services delivered in residential settings so that they can be reimbursed on a per diem basis. While the PDA Waiver currently allows waiver services to be delivered in domiciliary homes, services must be billed individually. This creates the same disincentives as services delivered in group settings under the OBRA and COMMERCARE waivers.

Provide Increased Continuity in Case Management Services

Pennsylvania’s HCBS waivers do not pay for case management services or support coordination when waiver participants experience short-term hospital or nursing facility stays. Case management is often critical to ensure the continuity of community based services when those consumers are ready to return to community life. These case management services are reimbursable under Medicaid. Federal Medicaid guidelines allow the Commonwealth to claim FFP for services to assist persons in a hospital or nursing facility with discharge. Federal funds for discharge planning are available for up to six months prior to actual discharge. Since Pennsylvania pays for PDA Waiver case management as an administrative activity, Medicaid can reimburse the AAA regardless of whether or not the consumer returns to the community. Since service coordination is a service in the OSP waivers, the consumer must return to the community for the waiver service to be reimbursable. The state should adopt policies and procedures that provide continuity of case management and support coordination services when waiver recipients are admitted to a hospital or to a nursing home for a short-term stay.

Separate Case Management Services from Direct Service Provision

Case managers and support coordinators have a dual responsibility. First, they serve as a consumer advocate and facilitator. Second, they are responsible for maintaining cost-effective care plans and to ensure that public resources are efficiently utilized across the full population of waiver program recipients.

In several waiver programs, including all waivers managed by the Office of Social Programs, many case managers work for the same organizations that provide the services that case managers authorize. This program structure can result in care plans that are not as cost-efficient or consumer-focused as they might otherwise be. In addition, the new CMS 1915(c) waiver format strongly discourages this type of arrangement and requires that the state justify why case management and direct delivery are not provided by separate entities. We recommend separating the support coordination function from service provider agencies. Exceptions may be necessary in areas with low participation and low provider supply.

4. HCBS Waiver Consolidation and Target Population Changes

Consolidation of HCBS Waiver Programs

The state should consider the consolidation of several existing 1915(c) waivers into one waiver. Specifically, the state should consider the creation of a single waiver program for all persons under age 60 with physical
disabilities who are clinically eligible for nursing facility services. This new waiver would consolidate the Independence, Attendant Care, and Michael Dallas waivers. This combined waiver should include a continuum of residential care alternatives, as previously discussed. The Elwyn waiver could be added to the combined waiver after the state resolves the issues with the residential service options.

This waiver would be available to all persons under age 60 who meet nursing facility criteria regardless of diagnosis. This criterion would provide access to community-based services for certain individuals who currently do not qualify for any waiver programs. For example, special justification is currently required on the OBRA Waiver Eligibility Worksheet and on a similar instrument for the Independence Waiver for people who have both a physical disability and a serious mental illness. This additional requirement creates a barrier for dual diagnosed people who may especially need waiver services to avoid institutionalization. A single waiver would be easier to administer and provide a consistent and equitable service delivery system to a wider variety of consumers.

While many consumers in the HIV/AIDS Waiver also meet nursing facility clinical criteria, we recommend that this waiver continue as a separate waiver. Most HIV/AIDS waivers exist as a vehicle to expand Medicaid eligibility criteria specifically for persons with HIV/AIDS, and to provide some unique services that are not available through the regular state Medicaid plan. For example, Pennsylvania’s HIV/AIDS Waiver is the only waiver to provide nutritional supplements.

Changes to HCBS Waiver Programs Populations

We do not recommend any further consolidation of waivers, but suggest Pennsylvania consider broadening two waivers to serve people with disabilities who currently cannot access waiver services.

Eligibility for COMMCARE should be expanded to persons with acquired brain injury. Like people with a traumatic brain injury, people with acquired brain injury often need specialized services from providers with knowledge about brain injuries. We recommend that COMMCARE continue as a separate waiver because of the specialized knowledge needed to manage this population and its unique provider base. People with acquired brain injuries currently served in the Independence and OBRA Waivers could move to the COMMCARE waiver to receive these specialized services. Both provider and consumer representatives recommended that group living settings in the COMCARE waiver should be limited to six or fewer consumers. They report that having eight consumers in one residence makes it very difficult to work with residents with complex behavioral issues. A six-person setting was suggested as a compromise between funding realities and the benefits that from smaller settings. We recommend that the settings be reduced to six or fewer residents and that reimbursement for services in these settings should be based on a per diem payment rate that bundles the services these facilities provide.

The OBRA waiver should be broadened to cover all persons with related conditions. This waiver would serve people with developmental disabilities who do not qualify for other waivers, including adults with autism.

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spectrum disorders. It should continue to use Intermediate Care Facility for Other Related Conditions (ICF/ORC) as the institutional status for eligibility. Those who have a co-occurring condition of mental retardation could choose between the Consolidated Waiver, the Person/Family Directed Services Waiver, and the OBRA waiver.

Waivers for which Consolidation or Population Changes are not Recommended

We do not recommend any changes to the target populations of four waivers. Pennsylvania is already making significant structural changes to the two waivers administered by OMR, the Consolidated Waiver and the Person/Family Directed Supports Waiver, to address previously-described compliance issues raised by CMS. We do not recommend further changes until these waivers meet Medicaid requirements. We did not consider changes to the Infants, Toddlers, and Families Waiver because it serves a unique population of children under age 3. The early intervention focus of this waiver is not a good fit with the other waivers, which primarily serve adults.

We recommend that, for the time being, the PDA Waiver continue as a separate waiver for older adults. This waiver is similar to the large, state-funded OPTIONS Program, and coordination among these programs is important to ensure both programs best fulfill their goal of helping older adults live in the community. If Pennsylvania combined the PDA Waiver with waivers for younger adults, it would either 1) separate administration of OPTIONS and the PDA Waiver, which would reduce coordination among these programs; or 2) consolidate the PDA Waiver and OPTIONS with other programs. The latter would create a program where more than 90% of consumers each year were age 60 or older. This program may not serve working-age adults with disabilities as well as a program focused on that population.

5. Feasibility of Section 1115 Independence Plus Waiver

The Department of Public Welfare requested that Medstat consider the feasibility of the state applying for a §1115 Independence Plus demonstration project as part of its evaluation of home and community-based services in Pennsylvania.

The concept of Independence Plus waivers has evolved considerably at CMS since 2002. Initially, Independence Plus waivers were conceived as stand-alone waivers (either §1915(c) or §1115 waivers) that would provide home and community-based services through consumer-directed care models. Over time, it has been recognized that many states already employ consumer-directed care models within their §1915(c) waiver programs (as does Pennsylvania) and that states do not wish to provide consumer-directed services under a separate waiver authority from their mainstream §1915(c) waiver programs. Thus, the concept of Independence Plus has evolved to one of a “designation” for consumer-directed care programs that meet certain criteria considered “best practices” by CMS. In the new §1915(c) waiver application that took effect on January 1, 2006, these criteria are spelled out, and states, in their renewals of §1915(c) waivers can elect

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23 A twenty-four person pilot in the Philadelphia area currently serves people with autism spectrum disorders. Pennsylvania may want to make statewide services different from the pilot program to reflect lessons learned.
to apply for the “Independence Plus” designation, or not. The lack of an Independence Plus designation does
not mean that the state does not provide community-based services through consumer-directed care models,
only that its program design does not meet the established CMS criteria.

The §1115 waiver authority allows the Secretary of HHS to waive virtually any Medicaid regulation as long as
it consistent with the overall objectives of the Medicaid program. A small number of states operate what are
called “§1115 Independence Plus Waivers” since the focus of the waivers has been to waive Medicaid
program regulations in a manner that allows the state to provide consumer-directed services in ways that are
not permitted under the mainstream Medicaid program. These states include the three original Cash and
Counseling Demonstration states of Arkansas, Florida and New Jersey, the Independent Choices states of
Colorado and Oregon, and more recently, California and Vermont.

Table 2 provides a summary of the differences between providing consumer-directed services under a
§1915(c) waiver authority and under a §1115 waiver authority. The §1115 waiver authority allows the state
broader leeway in the design of consumer-directed programs, such as allowing participants to manage their
own cash benefit or combining diverse populations under one waiver. However, the §1115 authority also
imposes additional requirements on states, such as a strict budget neutrality test (the demonstration may cost
no more than would otherwise be expended and that the state is at risk for any additional expenditures) and
mandatory participation in a CMS-approved evaluation study. The §1915(c) authority requires only that the
waiver costs be no more than the cost of institutionalization (on an aggregate basis) and an evaluation of the
program is not required.

In our conversations with waiver program participants in Pennsylvania, we did not hear a call for broadening
the parameters by which consumer-directed care services are provided in the state. Rather, consumers
were most vocal in expressing their concern that current approaches for providing consumer-directed services
in Pennsylvania be preserved in any future iteration of HCBS waiver programs. There was far greater
concern that what had been achieved in Pennsylvania might be lost, than there was a call for new consumer-
directed care models not currently available.

Thus, we see no need for the state to move forward with the development of a Section 1115 Independence
Plus waiver application. However, as various HCBS waiver programs come up for renewal, the state should
consider, at that time, the advantages and disadvantages of seeking the “Independence Plus” designation
available under the 1915(c) waiver authority, and, if so, make the requisite changes in its waiver programs to
achieve that designation.
### Table 2

**§1915(c) Waivers versus §1115 Demonstrations**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Section 1915(c) HCBS Waiver Authority</th>
<th>Section 1115 Demonstration Authority</th>
</tr>
</thead>
</table>
| **Requirements that may be Waived** | Statewideness  
Comparability of services  
Community income and resource rules for the medically needy | The Secretary may waive any regulation, if it is likely to assist in promoting the objectives of the Medicaid law [42 CFR §1396(a)(10)(A)(ii)(VI)] |
| **Cash Allowance** | Participant does NOT manage the cash allowance directly | Participant MAY manage the cash allowance directly |
| **Hiring Legally Responsible Individuals (Spouse, parents of minor children, legal guardians)** | States May NOT hire legally responsible individuals. CMS may allow for exceptional circumstances. | States MAY hire legally responsible individuals. |
| **Provider Agreements** | Provider Agreements MUST be executed (delegation to a provider agency IS permitted). | MAY BE WAIVED |
| **Direct Payment to Providers** | Direct Payment by the Medicaid agency (or eligible entity) to providers is REQUIRED (delegation to provider agency IS permitted). | MAY BE WAIVED |
| **Payment for Services** | Services may NOT be reimbursed prior to delivery. | Services MAY be reimbursed prior to delivery. |
| **Level of Care** | Individuals meeting institutional level of care ONLY | Medical need MAY vary (e.g., include State Plan population – Personal Care) |
| **Combining Populations** | Combining populations is LIMITED TO:  
1) Aged/Disabled  
2) Mentally Retarded or Developmentally Disabled  
3) Mentally Ill  
4) Any subgroup thereof | States MAY combine populations or include new or expanded populations |
| **Review Process** | Application/Amendment MUST be Approved by CMS. Readiness review Site visit by CMS is NOT mandatory | Application/Amendment MUST be approved by an External Federal Review Team. Readiness review site visit by CMS IS mandatory |
| **Length of Approval** | Waivers are approved for 3 years and renewed 5-year increments. | Demonstrations are approved for 5 years and renewed in 5-year increments. |
| **Financial Reporting** | Waiver must be COST NEUTRAL (waiver costs compared to institutional costs – may be individual or aggregate). | Demonstration must be BUDGET NEUTRAL over the life of the project, and may cost no more than existing programs without the demonstration. Calculations based on Per Member/Per Month. |
| **Program Evaluation** | NOT required | Program evaluation IS required. However, randomization is not mandated. |