CHOICE Pilot Report to Legislature

Family and Social Services Administration

March 2016

Public Law 145-2014 established a pilot program to test new eligibility requirements for the State CHOICE program. The Division of Aging is required to submit reports to the legislative council that include an analysis on the areas participating in the program and whether implementation of the program has affected the admission of individuals to comprehensive care beds in nursing facilities in the area. This is the first report, due March 15, 2016.

Summary

Community and Home Options to Institutional Care for the Elderly and Disabled (popularly referred to as "CHOICE") is a 100% state funded program that provides long term services and supports (LTSS) to individuals at risk of institutionalization who are not eligible for Medicaid. P.L. 145-2014 established a pilot program in four Area Agencies on Aging (AAAs) to demonstrate that, by updating eligibility requirements and assessment protocols, publicly funded services could be braided around informal and community supports to reduce the risk of institutionalization. Financial eligibility criteria were also changed to increase personal financial accountability for CHOICE recipients. The CHOICE pilot began in January 2015. The pilot was implemented in four of the area agencies on aging.

Most significantly, to date the pilot areas have demonstrated that the needs-based approach with options counseling is a model that can reduce average CHOICE expenditures. Other results from the pilot have been mixed. Waitlists have been reduced, although much of that was due to administrative activity not related to the pilot. There has been a small increase in the number of individuals served with CHOICE dollars who contribute financially. It is unclear at this point in the pilot whether or not this approach can impact the risk of institutionalization among program participants.

Background

CHOICE began in 1984 to provide services to individuals who would otherwise need to reside in a nursing facility before Medicaid waivers were prevalent. Medicaid has since become the largest payer long term services and supports in Indiana. P.L. 145-2014 seeks to update the role of CHOICE as a preventive program.

This pilot is based on the experience of two AAAs that used other funding to implement a model called "Community Living", focused on eliminating waitlists and increasing the number of people served with limited service dollars. Leaders of both agencies had local data indicating their programs had reduced the risk of institutionalization.

The initial bill proposed wholesale changes to the eligibility criteria for CHOICE, but was passed as a pilot after concerns were expressed that the expanded number of potentially eligible recipients would actually create growth in waitlists as an unintended consequence. The pilot will conclude June 30, 2017

The CHOICE program began in January 2015. The pilot was implemented in four area agencies on aging (AAAs). All sixteen AAAs were asked to provide an assessment of their interest and possible readiness to participate in the pilot. Agencies were then chosen on the basis of that assessment as well as their geographic and demographic diversity.

CHOICE 2.0 Pilot AAAs:

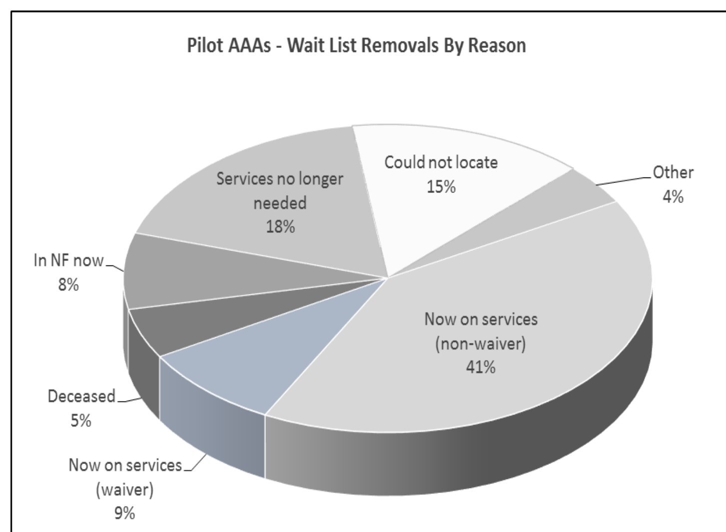
Pilot Agency	Counties Served
AAA 1 - Northwest Indiana Community Action Corporation	Lake, Jasper, Newton, Porter, Pulaski, and Starke
AAA 4 - Area IV Agency on Aging & Community Action Programs, Inc.	Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren and White
AAA 13 – Generations Vincennes University Statewide Services	Daviess, Dubois, Greene, Knox, Martin, and Pike
AAA 14 - LifeSpan Resources, Inc.	Clark, Floyd, Harrison, and Scott

Traditional CHOICE eligibility requires impairments of two or more activities of daily living (ADL's). In the pilot, individuals can be eligible for CHOICE with one or no ADL impairments if there are indications that a targeted intervention will address a risk of institutionalization.

Financially, the pilot updated the consideration of assets as well as income in the calculation of cost share. The asset limit for the pilot areas was reduced to $250,000 while it remained at $500,000 in the non-pilot areas. Assessment of CHOICE clients in the pilot areas is completed using a "needs-based" assessment instrument rather than a traditional eligibility-based screening process.

The legislation identified options counseling/case management as a service that can impact the risk of institutionalization. In the pilot AAAs, previous limits on how much of their CHOICE allocation can be spent on case management have been removed. Total allocation of CHOICE dollars did not change. Each pilot agency had to manage that change against the service dollars they already had committed to existing CHOICE participants in ongoing service plans.

Pilot Results through 2015:



A great deal of discussion during the legislative process for the pilot concerned expectations for reductions in waitlists for CHOICE services. All pilot areas experienced a reduction in their CHOICE waitlists. Areas 1 and 13 indicated that waitlist reduction was largely the result of administrative waitlist "clean up" activities unrelated to the pilot. Area 14 reported that, while they had eliminated their wait list by June of 2015, by October of 2015 they

were again experiencing a wait list for services. At least two of the pilots are now reporting growth in their wait lists numbers over the past couple of months.

All pilot areas reported that the biggest change that they experienced with the pilot was the increase in time spent by staff to assess individuals on a needs basis, rather than determining their eligibility for publicly funded services. However, preliminary data received verbally shows that a significant number of individuals seeking services were actually able to be served simply through the provision of options counseling, sometimes with the addition of a targeted, more limited intervention. These are the most promising results of the pilot to date and this data will be captured going forward.

All pilot areas reported small increases in the number of recipients who participated financially in the cost of their service plans.

One pilot area significantly over spent in CHOICE. Preliminary verbal data received suggests that the change in eligibility requirements has resulted in people with lower acuity levels being served. These individuals, if put on long term services, will stay on longer and with fewer interruptions. However, overspending of CHOICE resources cannot be blamed simply on pilot participation. Each AAA is required to manage the provision of services within their allocation.

Analysis of Impact on Institutionalization

The primary question this report must address per the legislation is whether the pilot has had an impact on numbers of individuals admitted to comprehensive care facilities, i.e. nursing facilities. Table 2 references the number of Medicaid nursing facility residents in January 2015 versus January 2016 and compares any change in pilot regions versus non-pilot regions of the state. However, this is actually a difficult question to address for a few reasons:

1. The timeline may be insufficient to measure this sort of longitudinal change. The more flexible eligibility requirements of the pilot mean that intervention is occurring at earlier stages. A logical extension is that the probable nursing facility admission that is being deferred or avoided is possibly several years into the future. One year into the pilot, it is unlikely that an impact on nursing facility admissions would be seen. Note that enrollment data experiences some lag time so these numbers could increase significantly over the next couple of months for January 2016.

2. As noted in Table 1, the percentage of CHOICE participants seeking preadmission screening for nursing facility admission has been tracked since the start of the pilot. In the pilot planning process the group struggled to determine how to measure the results on institutionalization and ultimately identified preadmission screening activity as a substitute measure. While there is a measureable difference between the pilot areas and the non-pilot areas, we are uncertain that this is a leading indicator of an impact on nursing facility

placements. Individuals being served in the pilot may have a lower level of functional limitations and would be less likely to require a nursing facility admission than those individuals that already have impairments with two or more ADLs.

3. Another reason that measuring the impact of the pilot on nursing facility admission is challenging is that the older population is growing in Indiana as it is throughout the country. Even with any impact that the pilot or any other home and community based program may have, the numbers of nursing facility admissions are not likely to see significant declines. There are simply more people in need of long term care every year. Between 2030 and 2050, large increases are anticipated in the 85+ age group. Those persons over age 85, the "oldest-old," are most likely to be frail and require LTSS. According to 2012 estimates, an estimated 70 percent of persons ages 65 and over will use LTSS, and persons ages 85 and over—the fastest growing segment of the U.S. population—are four times more likely to need LTSS as compared with persons ages 65 to 84.

Conclusion

While early concerns regarding the impact of the eligibility changes on waitlists have been validated, the DA believes some course corrections may help address this. Even with changes, it remains a concern that the need for services outpaced available resources and wait lists will continue to be a feature of the CHOICE program.

The DA believes that the introduction of more consistency across the pilots and clearly defined goals will lead to more person centered practices and increased utilization of the individual's own resources, informal supports and community resources. New eligibility criteria will enhance the identification of individuals at risk. Finding a way to quantify risk and reduction of that risk will be the challenge. Evaluation will occur with the next report, due September 16, 2016.

Table 1: Pilot data first 12 months

Performance Measure	Data Used			Brief Analysis
Nursing facility admission rate in pilot agencies versus non-pilots	Percentage of participants with PAS screenings	Pilots	20.73%	The lower percentage in the pilots would be expected given that the pilots allows more flexibility in eligibility requirements
		Non-pilots	29.64%	
		AAA 1	19.04%	
		AAA 4	28.08%	
		AAA 13	23.33%	
		AAA 14	19.49%	
Reduction of wait lists	% decline in CHOICE wait list numbers since 1/1/15	Pilots	50%	Many wait list removals were part of "clean up" efforts, i.e. they were deceased, in a NF, or had moved, or no longer needed assistance
		Non-pilots	17%	
		AAA 1	65%	
		AAA 4	9%	
		AAA 13	77%	
		AAA 14	28%	
Reduction of time spent on wait lists	Average days from wait list date to start of plan of care	Pilots	329.47	As noted above, wait list removals in some of the pilots was more the result of "clean up" efforts than targeting for assistance
		Non-pilots	371.67	
		AAA 1	118.9	
		AAA 4	277.5	
		AAA 13	447.46	
		AAA 14	336.99	
Increased documentation of the use of informal supports	Percentage of CHOICE plans of care with informal supports identified	Pilots	55.73%	There is extreme variance among the pilots in this area; that largely reflects variance that existed prior to the pilot
		Non-pilots	52.21%	
		AAA 1	68.89%	
		AAA 4	84.78%	
		AAA 13	63.55%	
		AAA 14	3.11%	
Reduction of expenditures per person served	CHOICE monthly expenditures per person served	Pilots	$ 384.96	Again, it would be expected that expenditures would be less with individuals in the pilot who have meet the more flexible eligibility standards
		Non-pilots	$ 429.47	
		AAA 1	$ 359.64	
		AAA 4	$ 503.45	
		AAA 13	$ 345.85	
		AAA 14	$ 401.80	

Table 2: Medicaid Nursing Facility Residents

	January 2015	January 2016	Percentage Change
Pilot AAAs	6,100	5,814	-4.69%
Non-pilot AAAs	21,982	21,151	-3.78%
Statewide	28,082	26,965	-3.98%
AAA 1	2,292	2,252	-1.75%
AAA 4	1,344	1,231	-8.41%
AAA 13	1,143	1,125	-1.57%
AAA 14	1,321	1,206	-8.71%