

Aging Services key informants' discussion summaries from 2017-18 by LuMarie Polivka-West, MSP

Major changes in the aging services network over the past five years with the takeover by Managed Care of Medicaid nursing home and home/community based services.

Intake: Phone initial assessment by the Area Agency on Aging, which operates as the Aging and Disability Resource Center, with intake responsibilities. The process begins when a client calls the Elder Helpline to request an assessment. The client will be called back by a counselor, up to three times. If the client does not answer, a letter is sent but no other follow up. During the phone assessment, the client, or their caregiver, are not instructed on what the questions mean or how the questions are ranked or scored for the total score for service eligibility. The Florida Department of Elder Affairs Form 701S, Screening Form, required by rule 58-A-1.010, FAC, is a six page assessment and is used to determine if the person could be Medicaid eligible (total income/assets). This is important information for if the person is potentially eligible for Medicaid and the application is not submitted, they are not considered for any other services such as Community Care for the Elderly (CCE) or Home Care for the Elderly (HCE) funded services. The phone assessments are completed annually as long as the client remains on the waiting list. If there is no response, after three attempts, the client is taken off of all waiting lists. Case managers with lead agencies have reported that a number of clients, active in congregate sites or in contact with the local agency, have been taken off all waiting lists because the assessment counselor "lost contact" with them.

Prior to the SMMC implementation, the lead agencies' case managers were responsible for the initial assessment of the individual. They had the option for an in person assessment if the client seemed to be struggling through the phone assessment. The lack of this in person option is a problem because the frail elder on the phone may not understand the questions being asked or they may overestimate their ability to complete tasks, leading to an incorrect score/assessment. Furthermore, some frail elders may not have phones or computer access.

Key informants questioned why the screening assessment does not assign any weight to the person having memory loss or dementia nor whether the person was in a rehab center or a nursing home in the last year. It was noted that a potential client with a caregiver will receive a higher weighting than a person without a caregiver. The question "Do you need assistance for food?" is also not included in the weighting, but the nutritional screen is to be completed for persons who respond "yes." It was pointed out by a case manager key informant that the scoring process means that a person with full dementia and living alone in the community with no food, could be assigned a low level of "2" if they respond to all of the questions related to skills in such a way as not needing much help. Without an onsite assessment, the phone assessor may not be able to realize the problems.

Next Step: The completed screening form is submitted to the Department of Elder Affairs Client Information and Registration Tracking System (CIRTS). Individuals are advised to apply for Medicaid if the screening finds they meet the income and assets' levels.

CARES is assigned the individuals who may meet the level of care for nursing home placement.

Choice Counselors are available by phone or face to face appointment for sign up with a managed care provider after the person becomes Medicaid eligible, they meet the nursing home level of care or a slot

for home and community based services becomes available and the person is at the top of the wait list for services.

Concerns raised by the key informants include: the individual has the responsibility to collect and submit all of the necessary forms and information for application to the Medicaid program. Before the SMMC program, the aging network case manager would assist with the application process and would be available to answer questions and provide guidance through the process with CARES and links to services.

Medicaid eligibility problems are multifaceted for aging service providers and for the clients. If a client does not have a proactive caregiver and they have memory problems, the Medicaid application or the reapplication may never be submitted in a timely manner with services then terminated if they have been initiated at all. There is a presumptive eligibility period of 60 days when services may begin, but if the eligibility does not go through the provider will not be paid by the managed care organization. The major barrier is that the MCO does not inform the aging service provider when eligibility has either terminated or not been approved within 60 days.

Previously, the aging services case manager was aware of each step of the process. Now with case management handled by the MCOs and home and community based services provided by some of the aging services providers, the eligibility information is not shared until the provider is informed they will not be reimbursed. The client is removed from services and the whole process has to begin again with the screening assessment, level of care, Medicaid eligibility and wait list assignment.

One example was discussed of a blind, elderly man with chronic health problems and no available in home caregiver whose Medicaid redetermination for eligibility was not followed through and he was supposed to be terminated from all services. The local aging services provider arranged for other funding sources outside of the SMMC program as a stop gap because he knew this client from many years of services in the community, but general revenue could not be used either because a person who is eligible for Medicaid may not be served with general revenue (GR) services through CCE or HCE.

Case management was previously the responsibility of the local elder care agency and clients were visited in their homes or in nursing homes or ALFs quarterly with monthly phone calls. The MCOs took over the case management responsibility and their process is primarily by phone and is conducted by nurses rather than social workers. The aging services case manager key informants reported that they still get phone calls asking for assistance from clients who are now served through the MCOs. The clients report they are unable to reach the MCO case managers or they don't know who they are or they aren't helpful. One comment was that the system is "brutal" for clients with a fractured process that lacks "human caring assistance." One of the major reasons for the client calls has been with reductions of services in the care plans. MCOs have tight criteria for services such as 8 hours for a day of adult day care which leaves no time for the caregiver to transport the client to and from the center while the caregiver is at work for 8 hours. A concern is that with MCO case management being handled by nurses, the medical needs are primary with minimal assessment of other client needs.

Meals On Wheels vs. frozen meals concerns: The Older Americans Act funded "meals on wheels" are still being provided by volunteers in many areas of Florida. There has been no increase in years so the number served has been reduced as the prices of food increase. The MCOs offer an option of frozen meals shipped from Orlando from "Food with Care" or 14 days of fresh meals packaged and shipped by

“Mom’s Meals” from Ohio for Medicaid clients in the SMMC program. The two shipped options are presented as giving more menu options for the client. The lack of a volunteer’s visit on a daily basis with a meal on wheels is not a concern to the MCOs.

The key informants reported there are many Level 4 and 5’s awaiting services. We discussed how a person coming in through Adult Protective Services could move to the top of the wait list but it was acknowledged as a tool that sometimes just has to be used to get someone services who is in desperate need. The poor funding of the state’s public guardianship program was noted as another problem. An elderly, frail person in need of a guardian with no caregiver is a person at risk, it was noted.

In order for a person in the community to be able to go into a nursing home, two ALFs have to deny admission for the person. This is difficult in a community with limited ALF Medicaid beds.

Conclusions:

The overall impression is of a Medicaid LTC system that has become much more difficult to access and navigate and less person centered by far than the previous Aging Network based model. There are now two systems where there used to be one with the wait list for services continuing to increase for home and community based services and strict parameters on nursing home placement.

The screening intake system on the phone by the Area Agency on Aging is different from the way the previous system worked with the option of an in home assessment if necessary. Concerns are with some clients being assigned a low level on the waiting list because of misinformation reported by the client who may have memory problems or may overestimate their abilities. The screening form does not include a weighting for a person with dementia in determining the level.

The case management system for the Medicaid Managed Care clients in the nursing homes and in the community is primarily via phone not face to face. Care managers’ frequent turnover is reportedly a concern as well.

The case managers serving the CCE/HCE and other General Revenue and OAA funded client services are separate. This used to be a comprehensive system of intake and case management that was seamless prior to SMMC implementation.

Long term clients receiving community based Medicaid funded services still contact the aging services case managers for assistance because they report they are unable to reach their assigned case manager with the MCO or they don’t know who they are because of turnover. Other reasons include a reduction in their service plan for what they report on necessary services and/or a loss of Medicaid eligibility without the client’s knowledge of what to do. Key informants have assisted some of these clients in reporting complaints to the Agency for Health Care Administration but they in turn are passed on to the MCOs to handle.

Aging service providers are not informed when a Medicaid client’s eligibility lapses or needs to be recertified until services that have continued to be provided are not reimbursed.

If a client is not able to complete their Medicaid eligibility renewal within the 60 days allowed time, the provider is not reimbursed for services provided during the 60 day period. The community providers are not notified of the “SIXTY” day status nor are the clients assisted with the eligibility redetermination process for Medicaid by the MCO case manager.