

REAL CHOICE PILOT EVALUATION: KEY FINDINGS

Introduction

In 2004, Massachusetts launched the Real Choice Pilot on Flexible Services and Supports (the Pilot). The Pilot is based on the Cash and Counseling model which, as originally implemented in three states, has been shown to improve satisfaction and health outcomes for participants. Building on this model, the Pilot gave participants control in calculating an individual budget with which they then purchased services and goods to meet their community living needs—services and goods not typically covered by Medicaid or Medicare. Each participant had a community liaison or support broker who assisted the participant with budgeting and purchasing and a fiscal intermediary who paid participants' purchases/workers and managed all fiscal and legal employer-related responsibilities on the participants' behalf. Two agencies, a case management agency for elders and an independent living center, were contracted as support brokerage agencies; an independent living center was contracted as the fiscal intermediary; and the contract and implementation oversight was conducted by the University of Massachusetts Medical School's Center for Health Policy and Research (CHPR).

Recognizing that Massachusetts' current provider infrastructure differed from other states and could potentially affect participant outcomes, Massachusetts policy makers and consumer stakeholders overseeing the Pilot requested an evaluation of the Pilot. Specifically, they were interested in experiences of the Pilot that could provide lessons for the design and implementation of this model on a larger scale. They requested that CHPR a) review design issues and implementation barriers, b) make recommendations for future design and implementation, and c) describe any financial impacts of the Pilot on Medicaid utilization¹.

Outreach and Enrollment

The goal of the outreach and enrollment phase was to enroll as diverse as possible a pool of participants to explore how individuals of different target groups were served by this model. Fifteen participants were eventually enrolled in the Pilot, slightly less than the enrollment target of 20 participants. About half of the participants had education above high school. Five participants were 60 or more years of age at the time of writing while about half reported having a mental illness. Most were not currently living with a partner. At the time of enrollment, two of the 15 participants were living in a nursing facility, one was living in a rest home, and another was living in an adult foster care arrangement.

¹ See Appendix I for more details on the overall evaluation scope and methodology.

Based on the experiences of support brokerage agencies' staff who conducted outreach and enrollment, future program implementation should consider doing the following:

- Allow sufficient time for outreach: Given the relative complexity and lack of public awareness of the model, both outreach staff and targeted individuals will need sufficient time to understand the model. Enrollment is likely to be slow, as experienced in the Pilot and the original Cash and Counseling model.
- Develop a variety of accessible outreach materials: Accessible written materials should be sent to individuals who otherwise could not attend in-person outreach events. These materials will help to reach a diversity of individuals, such as non-English speaking individuals or individuals with visual impairments.
- Develop a mechanism to address applicants' questions: Such a mechanism could provide potential applicants with an accurate and more comprehensive understanding of the program (beyond the information in outreach brochures) and therefore aid participants in making informed decisions regarding enrollment. For example, a customer service telephone number or a web-based frequently asked questions could provide additional and possibly more interactive information.

Individual Budgets

Individual budgets within the Pilot were developed using a two-step process. The process began with the participant developing a draft spending plan and budget, with the assistance of the support broker and based on the assessment of needs. Using this process, the 15 participants developed their draft budgets totaling \$303,190. Because this amount exceeded available funding, a second phase was implemented whereby a formula based budget was developed for each participant and compared to the requested budget. If a requested budget was less than the formula budget, the former was approved. If the requested budget exceeded the formula budget, the participant was requested to re-draft their spending plan based on the formula budget.

After this second step, nine participants received their requested budgets; five participants received the formula-based budgets which were lower than their requested budgets; and one participant received a formula-based budget with a one-time supplement. Approved budgets totaled \$257,750, while the average budget was \$17,183 per participant per year.

The first phase of the Pilot budgeting process in which participants developed a draft budget was time-consuming and subject to over and under-estimation. To offset these impacts, future implementation should consider the following for a participant-driven budgeting process:

- Ensure proper training of participants and support brokers: Training participants and support brokers on allowable versus non-allowable

purchases, community resources to meet needs, and differentiating between “needs” versus “wants” will be critical.

The second phase of the Pilot budget process based on formula-based budgets helped to create consistency and objectivity in the budgeting process. However, this process could be strengthened by the following:

- Review standardized process or formula periodically: This will help ensure the formula does not overlook needs or circumstances not captured in the formula and ensure that factors previously overlooked are considered in the future.

Spending Plans

By the end of the first year budget cycle, approximately 62 percent of Pilot budgets were spent. Of this amount, about 60 percent was spent on directly hired workers. Most workers performed tasks such as homemaking, transportation, errands, and personal care. A few participants also hired agency-based workers to provide personal care or case management support. Other supports using the budgets were modifications to home (such as bath handrails or chairs), medical equipment (such as hospital beds), personal care supplies (such as dentures), community integration (such as continuing education classes). In addition, some creative purchases, not covered under Medicaid, were air conditioners for better air quality/comfort, computers for employment training, education and management of self-direction responsibilities, and closed circuit televisions for visual support.

While the Pilot allowed participants to purchase items not traditionally covered by Medicaid, this flexibility also led to questions as to whether a particular item could be purchased using the budget. Given the dynamic nature of spending plans, questions about allowable purchases could arise frequently. To ensure participants can make informed choice regarding the use of their budget, future implementation should consider the following:

- Create a list of examples of allowable and non-allowable purchases: Such a list could provide some guidelines for use of budgets. This list should be available to participants, their support brokers, and the fiscal intermediary to ensure oversight of purchases.

Support Brokerage

During the first year, three agencies served as support brokerage agencies for the Pilot. Among their major responsibilities was the training and supervision of individual support brokers. These individual support brokers, in turn, met with participants at least monthly and assisted them to design and modify their spending plans. Other support broker responsibilities included providing general training on purchasing and reimbursement and community resources that could be purchased with the budget.

Within the Pilot guidelines, each support brokerage agency implemented this role slightly differently from the other. One such guideline was that participants would have an opportunity to select their own individual support brokers. Some participants were instructed to identify a support broker at the time of enrollment while others were offered a limited pool of trained support brokers from whom they interviewed and chose. As a result, individual support brokers represented a diverse spectrum from service coordinators in traditional provider agencies to internal staff of support brokerage agencies to family members or friends.

While choice of individual support broker was conceptually consistent with the philosophy of consumer direction, training and supervision of individual support brokers were more difficult when support brokers were not the support brokerage agency's own staff. This, in turn, compromised support brokers' skills and ability to assist the participants. Because participants' ability to make informed choice rested on adequate information, the ability of the support broker to meet this need for information directly affected participants' ability to self-direct their budget. The support brokerage function could be strengthened by doing the following:

- Design support brokerage elements to be consistent with participant choice and information needs: Program design should ensure that choice of support brokers does not adversely impact the ability of support brokers. Training and supervision of individual support brokers are vital to the program implementation.

Another major factor that affects the implementation of support brokerage is the flexibility of support brokers to provide the type and level of assistance appropriate to different individuals. Support brokers with more direct experience with consumer directed service appeared more likely to offer a level of support consistent with the participant's level of need. As this model is implemented in the future, care should be taken to:

- Train support brokers on consumer direction and foster flexibility of individual support brokers: This flexibility is critical if this model can serve individuals of different levels of needs and disabilities. Specifically, a participant who was clear on whom to hire and what to purchase required less support than one who needed more encouragement and assistance to think of ways to use the budget to meet his/her goals.

Fiscal Intermediary

The main responsibilities of the fiscal intermediary were to process and/or pay participants' workers or purchases, assure participants' compliance with federal and state tax requirements, and provide participants and support brokerage agencies with monthly statements with budget and expenditure information. Because the Pilot served only 15 participants, the fiscal intermediary was not able to take advantage of the economies of scale that might have existed in a larger program. Nevertheless, the fiscal intermediary developed methods of

purchasing for participants and identified the following lessons for future implementation:

- Implement a variety of purchasing methods: Online purchasing, catalog purchasing, use of gift registries, and invoicing allow purchases to be made and paid for, without participants' upfront use of their own resources.
- Provide comprehensive fiscal process training to participants and support brokers: Training is critical to ensure that participants understand the process and documentation necessary in order for purchases to be made or reimbursed and to ensure that workers are paid in a timely manner.
- Automate spending plans: Future implementation should create a mechanism to ensure that changes in spending plans can be easily made *and* be monitored by participants, fiscal intermediary, and support brokerage agency.
- Set clear guidelines for fiscal intermediary on how to address fiscal-related issues: At times, the fiscal intermediary may have questions that will need to be answered before a payment or reimbursement can be made. For example, a fiscal intermediary may be unclear on whether a purchase is consistent with the spending plan or the fiscal intermediary does not have sufficient documentation for payment. Guidelines on what a fiscal intermediary should do should be clear to ensure that fiscal intermediary and support brokerage responsibilities are distinct and separate and to avoid delays in payment/reimbursement for participant purchases.

Financial Implications

To estimate impacts on MassHealth utilization after Real Choice Pilot enrollment, CHPR retrieved MassHealth service claims² for 14 participants. (Although 15 participants enrolled, one participant disenrolled before she used any of her budget). Specifically, claims data were retrieved for the two year period before each participant's enrollment and the six month period after his/her enrollment. We used the data for the six month period after the Pilot enrollment to estimate MassHealth utilization for 12 months after enrollment. Data were retrieved in August 2006 for participants who enrolled in the Pilot between February and October 2005.

The total estimated MassHealth expenditures for the 14 participants during the first year of Pilot enrollment (2005-6) was \$206,595, compared to \$417,251 in 2004-5 and 45 percent lower than the total of \$434,110³ in 2003-4. The decline was largely attributed to decline in nursing facility and hospitalization expenditures of three participants because two succeeded in using their budgets to transition back to the community and one became dually eligible for Medicare and Medicaid after Pilot enrollment. Because these participants have moderate to significant ADL/IADL needs, mental illness, and other physical conditions, the

² Because policy makers were interested in financial implications specifically for the Commonwealth, Medicare data was not retrieved, although eight participants are dual eligibles.

³ All MassHealth expenditures are inflation adjusted to 2005 dollars.

Pilot faces a challenge in maintaining this lower level of MassHealth expenditures in future years.

Despite the encouraging decline in hospitalization and nursing facility expenditures, specific MassHealth-funded long-term supports (that theoretically could be “substituted” by allowable purchases in the Pilot) remained fairly constant through the three-year period. It is possible that MassHealth-funded supports (e.g., home health service, personal care) and durable medical equipment did not decline because participants used their budgets for supports that MassHealth does not cover, i.e., worker-based transportation, non-medical equipment. This also suggests that participants received paid supports in ways that would not have been possible with traditional funding. When reviewed in the aggregate, certain participants that may be of special interest to policy makers experienced a substantial decline in MassHealth expenditures-- participants in adult foster care and nursing facilities.