



U.S. Department of Health and Human Services

An Examination of Issues Related to How Home and Community-Based Services Programs Operate Within Fixed Budgets and to the Administrative Linkages Between Eligibility Determination, Needs Assessment and Care Planning Functions

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PART I

INTRODUCTION

This paper reports the findings of an exploratory study to document and analyze selected best practices related to state-administered home and community-based services (HCBS) programs. What the programs look like and how they work provided the context for examining two interrelated areas of policy interest:

1. How states organize and deliver a range of home and community-based services (HCBS) within fixed budgets, what mechanisms they use to manage program resources, and how they deal with actual or projected budget shortfalls in relation to demand for service; and
2. how eligibility determination, needs assessment, care planning and service authorization functions are structured and linked to one another administratively.

HCBS programs in Arkansas, Illinois, Indiana, Maine and North Dakota were selected for review. These

particular states were identified as examples of HCBS programs reflecting somewhat different approaches to organizing, managing and delivering home and community-based long-term care services to their target populations -- primarily older people, but in some cases also younger persons with physical disabilities.¹

Since older people represent the largest proportion of the population of persons with significant disabilities (70% of the Administration's proposed HCBS program's target population was estimated to be persons 65 and older), the statewide programs included in the project were chosen from among HCBS programs managed by state units on aging. In addition to being statewide, the selected programs offer a range of community-based services, have a significant resource base relative to their target population, and have a well-defined assessment and care management system in place.

Two of the states -- Indiana and North Dakota -- offer their home care services within a single administrative structure to both older and younger persons with disabilities. In Maine, in addition to managing the aging waiver and the state-funded home care program, Area Agencies on Aging (AAAs) administer a modest amount of state program resources to provide services to persons with physical disabilities who are under age 60. The Arkansas and Illinois programs that were examined serve older adults exclusively.

Arkansas and Illinois also provide particularly relevant contrasts with respect to one of the policy issues that framed the project. While Arkansas relies heavily on fixed federal, state and local budget resources to support its HCBS program, it also has access to an additional, essentially open-ended source of funding for personal care, available as an optional service in its Medicaid state plan. In Illinois, the HCBS program, funded by both state general funds and Medicaid waiver resources, operates as a statewide entitlement.

[Exhibit A](#) provides selected demographic characteristics of the study states. [Exhibit B](#) lists the HCBS programs examined in each state, their funding sources, and their current operating budgets.

Site visits to the five states took place over a two-month period during August and September, 1994. On-site interviews were conducted with staff from the state aging and Medicaid agencies and other relevant senior level policymakers and administrators at the state level, and with program administrators and operations staff at the substate service delivery level. Information from on-site data collection was supplemented by document reviews and telephone discussions.

EXHIBIT A. Selected Demographic Characteristics of Project States

State	Total Population	Population 65 and Older			"Severely Disabled" ¹	
		Number	Percent	Rank	18-64	65 & Older
Arkansas	2,399,000	358,000	14.9	6	9,156	27,931
Illinois	11,631,000	1,464,000	12.6	28	38,096	92,400
Indiana	5,662,000	717,000	10.4	27	17,843	44,918

Maine	1,235,000	163,000	13.3	17	3,901	11,266
North Dakota	636,000	91,000	14.2	8	2,130	6,126

Source: *Infrastructure of Home and Community Based Services for the Functionally Impaired Elderly: State Source Book*, Administration on Aging, U.S. Department of Health and Human Services, 1994.

1. Severe disability for adults 18 through 64 is defined as persons requiring assistance with at least three of five ADLs, as well as those with severe chronic mental illness or Alzheimer's Disease. Persons 65 and older with severe disabilities include those requiring assistance with at least three of five ADLs or those with a similar level of cognitive or mental impairment.

EXHIBIT B. Selected HCBS Programs

State	HCBS Programs	Funding Sources	Current Year Funding (in millions)
Arkansas	ElderChoices	Medicaid Waiver	\$15.0
	Home Care Services Program	Title III, SSBG, USDA, State Revenues	14.2
	Medicaid Personal Care and Targeted Care Management	Medicaid State Plan	52.7* (Total: \$81.9)
Illinois	Community Care Program	State Revenues, Medicaid Waiver	\$105.0
	Waiver Programs: - Aged & Disabled - Medically-Fragile Children - ICF/MR	Medicaid Waiver	\$11.5 0.8 23.6
Indiana	- ICF/MR (OBRA) - Autism		7.7 1.5
	CHOICE Program	State Revenues	24.5
	Other Home Care Services	Title III, SSBG, USDA, State Revenues	20.5 (Total: \$90.1)
Maine	HCBS Waiver Services for the Elderly	Medicaid Waiver	\$8.8
	Home-Based Care Program	State Revenues	6.3
	Medicaid Personal Care, Targeted Care Management, Adult Day Care & Private Duty Nursing	Medicaid State Plan	4.4* (Total: \$19.5)

	Waiver Services for the Elderly and Disabled	Medicaid Waiver	\$1.5
North Dakota	Service Payments for the Elderly and Disabled	State Revenues	3.2
	Expanded Service Payments for the Elderly and Disabled	State Revenues	0.8 (Total: \$5.5)

* Amount is for the last fiscal year, and includes all Medicaid recipients.

A site visit discussion guide was developed to gather information relating to the two principal areas of policy interest. Responses then were organized into the following topic headings, which provide the structure for the individual state case study reports as well as the summary of principal project findings:²

- Program elements and funding sources for selected HCBS programs;
- process for establishing HCBS budgets;
- principal issues affecting HCBS program financing;
- program operations at the state and local levels, including eligibility requirements and eligibility determination procedures, care planning and on-going care management, and available services and types of service providers;
- control mechanisms used to keep program spending within budget;
- self-identified problems with the programs and attempted solutions;
- perception of HCBS programs as mechanisms for reducing nursing home costs; and
- state officials' opinions regarding their ability to manage a HCBS program within a fixed budget.

BACKGROUND AND PROJECT RATIONALE

Even before the Administration's Health Security Act was officially introduced, the debate regarding details of its health care and insurance reform proposals dominated the domestic political and media landscapes. Less attention and, particularly noticeable within the relevant Congressional committees, less controversy were focused on its proposals for a new, federally-legislated HCBS program. Except for special interest groups who felt that the needs of their particular constituencies were not being addressed adequately, there appeared to be no major opposition to the substantive elements of the HCBS proposals.

For example, there seemed to be general acceptance of such notions as using functional measures to determine eligibility, allowing a great deal of flexibility for states to determine what HCBS benefits they would offer, and not using age as a basis for program eligibility. What was much more at issue -- not only in the Congress, but within the Administration and also in states across the country -- was the question of financing levels for the new program.

There were several schools of thought. The President's plan called for an annual \$38 billion "capped

entitlement" when the program was fully phased in, calculated and apportioned to each state by means of a generous formula and with higher match rates than those of Medicaid. The Administration was confident that the numbers derived from its calculations were adequate to cover the costs of providing home and community-based services to the population targeted for the new program, even building in a safety factor to add further assurance that state allocations would be sufficient. On the other hand, many in the Congress were concerned that the bottom line figure was too high, regardless of how soundly-based it was vis-a-vis the numbers and needs of the program's proposed target population.

From the states, a different set of financing issues surfaced. Among some state-level policy analysts and program administrators, especially those accustomed to managing budgets and making decisions and recommendations in the context of Medicaid's open-ended entitlement benefits, there was considerable opposition. For them, the idea of an annual fixed maximum dollar amount to cover what they believed were uncertain program costs seemed particularly onerous. "if you are going to cap our dollars, give us a way to cap our program" was how one of the more vocal state officials framed the concern.

On the other hand, many other state officials and local program staff, while they too stated their preference for open-ended program funding, viewed the potential of a new federally-supported, state-administered HCBS program with great enthusiasm. This latter group was comprised mainly, though not entirely, of people accustomed to working with formula grant programs and block grants, i.e., having a fixed amount of money to serve particular categories of individuals in order to accomplish specific goals.

For most of 1994, the debate regarding health care reform was wide-ranging and frequently heated, generating so much controversy that Congress was not able to coalesce around any of the various versions that were introduced during its legislative session. One matter was made clear during the process: Open-ended entitlement funding to states for **any** new federal social program was not at all likely to be politically feasible, at least for the foreseeable future.

Even though the 103rd Congress did not produce any long-term care legislation, the importance of creating well-designed home and community-based services systems to meet the long-term care needs of the current and growing population of older and younger persons with disabilities, continues unabated. Seeking to better understand the dynamics of how existing HCBS programs are operating within the limitations of a fixed budget environment continues to be a useful activity. It is hoped that findings from this exploratory study will be instructive and prove useful to both federal and state policymakers as they consider how best to proceed with their efforts to encourage and support effective HCBS policies and programs.

SUMMARY OF PROJECT FINDINGS

I. Program Elements and Funding Sources for Selected HCBS

Programs

1. Resource Bases: Medicaid and Other Funding

Although HCBS programs in all five states were originally begun with non-Medicaid funds, Medicaid now plays an integral role in their financing -- ranging from a low of 27% in waiver funds for North Dakota's "Home and Community-Based Services Program for Elderly and Disabled" to 83% in combined waiver and Medicaid state plan resources in Arkansas.³

In four of the five states -- Illinois, Indiana, Maine and North Dakota -- state HCBS program resources plus at least one Medicaid waiver designated to serving the same populations are combined to form a coordinated home and community-based service delivery system and funding nucleus operated through a single administrative structure. In Indiana and North Dakota, the coordinated program serves older people and younger persons with physical disabilities. In Illinois and Maine, the programs that are included in the project focused exclusively (in Illinois) and primarily (in Maine) on people 60 and older. In Arkansas, the state's waiver program is directed to persons 65 and older and is administratively separated from its elderly home care services program, which relies on a combination of state revenues and federal formula grants to pay for services to the state's 60 and older population needing home care services.

In two states, Medicaid state plans include personal care and targeted care management as optional services. In Arkansas last year, Medicaid payments for personal care amounted to more than \$52 million. Estimates are that at least 75%, or about \$40 million, was paid out to seven of the state's eight Area Agencies on Aging (AAAs) in their role as certified providers of personal care services. Medicaid payments for targeted care management on the other hand, which also is provided primarily by AAAs to non-waiver clients who are Medicaid-eligible, were only about \$400,000 last year.⁴

In Maine, Medicaid reimburses AAAs for targeted care management for Medicaid-eligible clients receiving state-funded home-based care services. However, AAAs have no special access to personal care, nor to adult day care and private duty nursing services, which are also included in the Medicaid state plan. No funding breakout by service currently is available, but last fiscal year's Medicaid payments for the four services for all eligible population groups totalled \$4.4 million.

With the exception of Indiana, which has waiting lists for all but its OBRA waiver, the remaining four states appear to have a larger number of approved waiver slots than they are likely to need in order to serve their current and projected caseloads -- at least for the near term. This might suggest that at relatively high levels of disability, estimates of the numbers of people who are eligible and who are likely, or able, to take advantage of the availability of waiver services may be on the high side. (See also the discussion of time lags in the next section, which relates to applicants' ability to utilize waiver services.)

Other significant resources used to varying degrees for HCBS programs include the Social Services Block Grant (SSBG), Older Americans Act Title III programs, U.S. Department of Agriculture (USDA) Commodity Foods program for home-delivered meals, federal and state grants, and contributions and

local resources.

Only Arkansas and Indiana have administratively connected SSBG and Title III services into their broader HCBS program framework, so that HCBS care managers can authorize the delivery of SSBG- and Title III-funded services. In the other states, the care managers have to rely on their ability to broker services over which they have no authority and for which their clients have no special priority status.

2. Cost-Sharing

All the state programs except those in Arkansas include client cost-sharing provisions which, beyond various protected amounts, can reach 100% of the costs of services provided. Although the total amounts collected are relatively low -- ranging from less than 1% to no more than 5% of the program budget -- the general belief is that cost-sharing serves the added function of raising awareness of service costs as a way to encourage a "prudent purchaser" perspective among clients.

II. Process for Establishing Program Budgets

State agencies administering the HCBS programs develop budgets, usually based on a target set of figures generated by their state's budget office. As a rule, agency staff work within these limits, using program experience, growth projections and anticipated policy changes to arrive at a budget, or series of budgets, to cover HCBS program expenditures. Because of fiscal constraints, these budgets often reflect "least harm" scenarios. After passing through various layers of internal review, the proposed HCBS program budgets are ultimately included in the Governor's budget submission to the state legislature, where the external political process takes over. At this point, advocates for HCBS programs attempt to influence budget decisions in their favor but, given the fiscal climate, not with as much success as they have had in the past.

III. Principal Issues Affecting HCBS Program Financing

Severe budget pressures due to the economic downturn of recent years continue to be felt by all of the states. While they would like to see their programs grow, the states' fiscal situations are such that level funding often is considered a victory!

All of the state agencies administering the HCBS programs -- including Illinois, whose Community Care Program has the unique status of being an entitlement -- feel vulnerable to fiscal pressures. Even in Arkansas, with its very significant Medicaid personal care entitlement, financing for HCBS is not nearly as stable as the state and service delivery level staff would like it to be. A referendum to repeal a state tax dedicated to generating the state match for Medicaid was defeated in the last election, but the outcome was not at all certain prior to the vote.

As a consequence of state budget constraints, it would seem reasonable to assume that HCBS programs would place considerable emphasis on seeking out and serving Medicaid-eligible clients, using available

waiver resources that can generate federal match payments. This seems to be a priority in Illinois and Indiana. How much, and how permanently, such an orientation will alter their programs' targeting strategies (as well as other features of the programs themselves) is not clear.

IV. Program Operations at the State and Local Levels

1. Administrative Structure

While all of the HCBS programs are administered at the state level by state units on aging, only two of the four states that have Area Agencies on Aging have given them responsibility for both the state-funded and waiver programs. In Maine, AAAs manage the major portion of the state-funded home-based care program and the Medicaid waiver for older people, and authorize and arrange for the delivery of HCBS to eligible clients. However, Maine also has two waivers specifically to serve persons with physical disabilities -- one limited to persons age 18 through 64 and the other for adults age 18 and older. Each of these waivers is being managed by a different statewide administrative entity.

In Indiana, AAAs have administrative responsibility for the state's aged and physically disabled and medically-fragile children's waivers, working directly with clients and authorizing and arranging for waiver or other needed HCBS services. For clients eligible for one of the state's three MR/DD waivers, AAA care managers also may work with eligible clients directly or, at a minimum, participate with regional MR/DD staff from the state's Bureau of Developmental Disabilities to develop appropriate care plans. However, in either instance, AAAs retain sign-off authority for all waivers as well as other HCBS resources.

In Arkansas, AAAs are responsible for administering the state's home care support program for persons 60 and older, which is funded by a combination of state and federal formula grant resources. In addition, seven of the state's eight AAAs are also major direct providers of Medicaid waiver and Medicaid and state-funded personal care services. The state's waiver program for people age 65 and older, however, is administered directly by the state aging agency, with outstationed state employees responsible for conducting assessments and developing plans of care.

In Illinois, the HCBS program is administered at the substate level by a number of different types of community service agencies on a contract basis; the state's Area Agencies on Aging have only limited coordinating and supporting roles vis-a-vis the HCBS program. North Dakota, which does not have AAAs, relies on generic care managers located in the state's county-based social services system to perform assessments and arrange for and monitor waiver and non-waiver service delivery to eligible clients of all ages.

2. Eligibility Requirements

- a. **Age.** In North Dakota and Indiana, the HCBS programs examined are available to persons of all ages, whereas Arkansas and Illinois limit their services to people 60 and older. In Maine, the

situation is less clear cut. Waiver services provided through its AAA structure are targeted to older adults, but its state-funded home-based care program -- though targeted primarily to older adults -- has a small set-aside for younger persons as well.

- b. **Functional Measures.** In conjunction with defined age limits for specific programs, measures of functional impairment are universal determinants of eligibility for HCB services. Four of the five states require the use of a single assessment instrument, designed to measure a range of functional impairment levels, irrespective of funding stream. Arkansas, on the other hand, requires a brief, structured instrument for its waiver program but only suggests an assessment instrument -- different from the one used for the waiver -- for its home care services program.⁵ Based on the functional assessment, which also generally includes questions relating to cognitive capacity, several decisions can be made: Does the applicant fit within the minimum/maximum levels set for participation and, if so, for which of the available program/funding streams?

In terms of functional eligibility for waiver services, Maine, Indiana and Illinois use a minimum of three ADL limitations requiring total or significant assistance; Arkansas and North Dakota require a minimum of two ADLs for determining eligibility for waiver services. Illinois and Indiana apply the same three ADL minimum for both waiver and non-waiver program eligibility. Maine's state-funded home care program uses the same assessment instrument but applies less stringent functional eligibility criteria for services. North Dakota's major state-supported HCBS program actually requires a more severe level of functional impairment -- a minimum of four ADLs or five IADLs -- to be determined eligible for home care services. In Arkansas, functional eligibility for its home care support program is very loosely defined.

- c. **Income and Assets.** or waiver services, Indiana and North Dakota use 100% of SSI, and a \$2000 (\$3000 for a couple) asset limit for eligibility. Arkansas and Maine set their maximum income eligibility level at 300% of SSL. Because of the way Illinois operates its program, income is not used as an eligibility criterion for participation.

Except for limited SSBG-funded services administered directly by HCBS agencies in Arkansas and Indiana, and a small state-funded program in North Dakota, none of the major state-funded programs uses income as an eligibility criterion, and only two states consider assets in determining program eligibility. Illinois uses a \$10,000 countable asset limit for participation in its Community Care Program, funded by both waiver and state general revenues, and North Dakota has established an unusually high liquid asset limit of \$50,000.

3. Eligibility Determination Procedures

Illinois uses a single point of entry for determining eligibility and differentiates client status after the fact in order to establish and charge the costs of client services to the appropriate funding stream. Within and across the other four states there are several variations with respect to personnel and procedures for determining eligibility. The differences mainly apply to eligibility rules for Medicaid waivers and for statefunded programs.

Except in Arkansas and Maine where registered nurses are **required** to perform assessments for potential

waiver clients, states use their care managers -- mainly social workers, but also some nurses -- to perform assessments on all applicants, irrespective of funding stream.

In Arkansas, the RNs are state employees, working within the state administrative structure. Assessments for non-waiver clients are performed by care managers in AAAs, which are structurally separated from the administration of the waiver program. In Maine, the RNs who perform assessments and develop preliminary plans for potential waiver clients may be on the staff of the AAA, but are more likely work on a contract basis through the AAA, which then is responsible for care plan implementation and on-going care management functions. Assessments for non-waiver applicants are conducted by AAA care managers.

North Dakota uses generic care managers based in each of the state's county social service offices to conduct assessments of all applicants for its coordinated HCBS program. In Indiana, AAA care managers are responsible for administering an eligibility screen used to determine eligibility for all waiver and non-waiver applicants, except those who are assessed through the MR/DD system. Also in Indiana, frequently in the case of families applying for services under the waiver for medically-fragile children, local AAAs will use an RN -- either on their staff, or through a contract with a home health agency -- to conduct the assessment that will then be used to determine eligibility for waiver services.

An eligibility characteristic of Medicaid waivers also presents a common problem for state HCBS programs: Medicaid approval of financial eligibility status (always) and functional eligibility/level of care determinations (often) tend to be complex and timeconsuming. The time lag for certifying client eligibility for Medicaid waiver services -- except in Illinois where the payment source decision is made after the fact -- too frequently seems to result in losing the potential HCBS client. Especially if the applicant is awaiting hospital discharge and has inadequate financial or informal resources to bridge the time gap, and other public funding is not available, nursing home placement is the most usual outcome upon discharge.

4. Care Planning and On-Going Care Management

All five states have established targets or benchmarks for their HCBS care plans. Arkansas, Indiana and Maine explicitly use a percentage of their nursing home costs; Illinois and North Dakota have set maximum dollar amounts which, while they are keyed to nursing home costs, are not directly stated as percentages.

In Arkansas, the target is 100% of the state's average intermediate care nursing facility costs, and it applies to care plans for waiver services as well as Medicaid personal care services. Care plan costs for the state's Home Care Support Program are self-regulated at the AAA level. In Indiana, the target is 90% of nursing home costs for waiver clients. For its state-funded program, rather than applying a percentage, Indiana calculates and uses the state match for Medicaid nursing home reimbursement as the basis for establishing its care plan benchmarks. Maine, which uses 75% of the average state nursing facility rate, is the only state that applies the percentage as the care plan target for both its waiver and state-funded HCBS programs.

Regardless of the absolute targets or benchmarks that have been established, the average cost of care plans for both waiver and state-funded programs in all of the states actually is considerably lower than the targets. An estimate of the average care plan costs across all states and programs may be as much as two-thirds lower than the average established per person expenditure targets.

Once care plans are in place, on-going care management across all programs is basically the same. Care managers maintain contact with clients on a more or less regular basis, and as-needed. Care plans generally are written for a one year period, but can be modified depending on clients' circumstances.

5. Available Services and Service Providers

All of the states offer basically the same core set of HCB services within their waiver and state-funded HCBS programs. Even in the Illinois Community Care Program, which technically offers only two services, what it calls "homemaker" actually covers a number of in-home service functions -- housekeeping, shopping, meal planning and preparation -- and also personal care tasks such as bathing and grooming, assistance with transferring and range of motion, and medication management.

- a. **Agency Providers.** All five states utilize some type of contracting mechanism or other form of agreement to create a pool of agencies that can be called on to provide services to their HCBS clients. In all but Illinois, providers must be certified by the state if they will be providing waiver services. (In Illinois, the state agency contracts directly with local providers, who compete for contracts on a two-year cycle.) Except for North Dakota, which certifies all providers, state certification is not necessary for providers of state-funded services. In Arkansas, Indiana and Maine, AAAs -- as the designated substate agencies for administering their state's HCBS programs -- are responsible for identifying and establishing agreements with local providers in their geographic areas for delivering non-waiver services.

The level at which provider payment rates are set varies considerably across states and by program within states. Illinois contracts directly with provider agencies and establishes the statewide rates it will pay for service provision. Arkansas and Maine also establish statewide rates, but only for waiver services. Indiana gives its substate administrative units, the Area Agencies on Aging, latitude to negotiate rates with each of their providers for all services. And lastly, North Dakota, which depends primarily on individual contractors for both waiver and state-funded services, sets ceilings but allows its contractor agencies (as well as individuals) to actually set their own rates, as long as they fall within the established ceilings.

- b. **Independent Providers.** Illinois and Maine do not use independent Providers (IPs) for their programs at all, and Arkansas uses them only in their nonwaiver Home Care Support Program. In Indiana, independent contractors -- identified by clients themselves or selected from a "self-declared" registry maintained by AAAs -- are assigned to appropriate non-waiver clients, and monitored by an AAA care manager or a staff person functioning as a care manager from a regional office of the Bureau of Developmental Disabilities. Except under special circumstances, immediate family members are precluded from being paid as individual providers.

North Dakota's service delivery system, as noted above, is largely dependent on individual "qualified service providers" (QSPs) to provide HCBS and assistance to waiver clients and clients of either of the state-funded programs -- all but 10% of the state's QSPs are individual contractors. Irrespective of funding source, clients are offered the option of selecting an individual provider from a list of county residents who have enrolled with the state agency, or identifying an individual they would prefer and who is willing to sign on as a QSP.

V. Control Mechanisms Used to Keep Spending Within Budget

Like most other programs that have limited resources with which to operate (whether this is an absolutely fixed amount or, in the case of most entitlement program environments, an identifiable target figure), all of the state programs have established specific policies that limit program expenditures. They control participation by setting financial limits and functional disability levels. They control costs by limiting the number and types of services they offer, and by establishing cost caps on client care plans, on specific services, and on provider payment rates for services. They use cost-sharing, in part to generate additional program income, but for another, frequently stated, reason as well -- to make program participants more conscious of the costs of the services they are receiving and, as a result, to make them more selective of the types and levels of service they will request. And, as a last resort, states rely on waiting lists.

Another mechanism used by some states is to centralize control, or at least detailed oversight and review, of those program features that entail significant costs. The Illinois program is highly centralized -- the state agency contracts directly with all of the providers in its system, signs off on all vendor payments, and conducts spot checks or 100% reviews, depending on circumstances, of initial care plans and all requests to increase care plan services. The other states also exercise fiscal control and oversight, but to a lesser degree.

In Indiana and North Dakota, the state agency controls the assignment of "slots" -- for waivers in Indiana, and for the state-funded SPED program in North Dakota. Even after eligibility is determined, services cannot be initiated until a program slot has been assigned to the client. (Since the numbers of HCFA-approved waiver slots in Arkansas, Illinois, Maine and North Dakota are in excess of the number assigned, there has not been any attempt to control waiver costs by introducing controls on waiver slots.)

Maine established a capitated system for its state-funded Home-Based Care program, actually contracting for a minimum number of clients who are to be served for the contract amount, with either out-of-pocket payments or reduced budgets as penalties for non-performance. In Indiana, the trade-off for fairly broad eligibility criteria in its state-funded program is a long waiting list.

VI. Self-Identified Problems and Attempted Solutions

In general, the problems raised by state and local program staff were very specific to the way their respective state HCBS program is organized and, therefore, are not particularly generalizable. One

exception, raised in a preceding section, relates to waiver programs and the frequent discontinuity between an individual's need for HCB services and the time it takes to establish eligibility as a precondition of receiving needed services. Because of the importance and likely relevance of this problem to other states, it may be useful to summarize how Arkansas and Maine are trying to resolve it for their state.

What is at issue is that agencies cannot be reimbursed for providing a Medicaid-reimbursable service unless or until the person they provide the service to is determined to be eligible for Medicaid. If the applicant or the state has sufficient resources to bridge the waiting period while the financial and functional eligibility determination decisions are being made, there is no problem. When such resources are not available, the result is that the applicant will be lost to a nursing home or return home from a nursing home or hospital to an unsustainable environment -- undermining a major purpose of the waiver program.

A senior staff person in the Arkansas Division of Aging and Adult Services, with an extensive background in Medicaid, asked the question: "Why is it that nursing homes, but not waiver service providers, can bill and be paid retroactively for days of care for an **applicant** for Medicaid coverage if s/he subsequently is determined to be Medicaid-eligible?" The apparent response from HCFA was that there did not seem to be any reason why they could not do the same.

Based on this argument, Arkansas recently submitted a waiver modification to HCFA requesting that providers be allowed to assume the risk and initiate services, and then be able to bill retroactively if the applicant subsequently is determined to be Medicaid-eligible. Even though DAAS staff do not expect retroactive billing will be utilized in all cases -- either because the applicant's eligibility status is not clear and/or providers are not willing to risk their own resources -- they do believe it will make a bridging option available where none may have existed before.

In Maine, the Medicaid agency has agreed, on a trial basis, to allow registered nurses who are already required to conduct functional eligibility assessments, to make level of care determinations for one of its waivers for physically disabled adults. If it works it will be only a partial answer -- only for those applicants who are already Medicaid-eligible and therefore do not need to establish financial eligibility as well. Nevertheless, this approach should alleviate the time lapse problem, at least in some instances.

A second issue that has surfaced in Maine but is likely to occur in other states as well, relates to the implications for HCBS programs when states begin to narrow eligibility criteria for nursing facility placements. In an attempt to better control nursing home costs, Maine recently tightened its Medicaid level of care determination criteria for nursing home placements, causing a "trickle down" effect on the state's HCBS programs. As a direct result of the new policy, the state's waiver-funded programs -- which use the same eligibility criteria as those used for nursing facility level of care decisions -- are beginning to see people with heavier care needs requesting waiver services. Some of these people might actually be better served, and served more cost efficiently, in a nursing home setting.

Area Agency on Aging staff in Maine who are responsible for nursing home preadmission screening and for administering the state- and waiver-funded services programs, are also reporting the same

phenomenon one level farther down. Persons with significant needs who were qualifying for waiver services prior to the new regulations are now seeking assistance from the state-funded program, which in the past was focused on serving persons with fewer functional needs and, therefore, with lower service costs. The net effect is that AAAs that already have waiting lists for state-funded services are not able to serve people who actually may have a greater need for assistance, without considerable disruption of the existing caseload.

VII. Home and Community-Based Services as Mechanisms for Reducing Nursing Home Costs

In all of the states, the original motivation for initiating home and community-based services programs was to provide an alternative to nursing homes for those people with functional deficits who preferred and were able to remain in their own homes. At the time, concerns regarding nursing home costs were at best a secondary issue. While nursing home costs are now at or close to the top of states' agendas as they seek ways to rein in spiraling Medicaid expenditures, only Maine has a moratorium on nursing home beds and also has made an explicit connection between its home-based care and nursing home programs. A 1993 statute tightens nursing home eligibility, requires pre-screening, limits increases in the bed supply, and supports a diversion strategy that would invest anticipated savings into community-based services.

Indiana has just recently created a state-level task force to begin examining long-term care issues more broadly than simply in terms of nursing home care. In Arkansas, Illinois and North Dakota, the prevailing view seems to be that nursing home care and HCBS programs are parallel, but distinct, service delivery systems. A state official in Arkansas actually suggested that the state's HCBS programs are not appropriate alternatives for Arkansas' more medically-oriented nursing home system.

VIII. State Officials' Opinions Regarding Their Ability to Manage a HCBS Program Within a Fixed Budget

The universal preference for an open-ended entitlement for HCBS was the only common response from all five states. In terms of implementing and managing a HCBS program with a fixed budget, each state responded differently.

In Arkansas, responses of the state Medicaid and aging staff were most divided. Medicaid staff were adamant that no matter what the federal government said, they believed there would not be sufficient federal resources to cover all those who would qualify for services, and it would not be politically tenable for them to close intake. A aging staff, on the other hand, said they would do whatever it took to make a federally-funded HCBS program work.

Illinois aging staff were concerned about the structural and programmatic complexities involved in integrating a fixed budget program into their existing entitlement-based Community Care Program; they hoped there would be sufficient flexibility to allow this to happen so that they would not have to create a

new and separate program.

In Maine, the principal concern was the "fit" between a federally-mandated and funded HCBS program and the state's plan to move in the direction of managed care for Medicaid recipients. While the state intends to begin managed care on the acute care side, it anticipates bringing long-term care in as well.

Indiana and North Dakota staff had similar reactions to the question of their state's ability to manage a significantly broadened HCBS program with a fixed budget. In both states, the general feeling was that they already were operating within a fixed budget environment, and that other state officials who are supportive of their current program are likely to continue to be supportive of any expansion effort.

CONCLUSIONS AND OBSERVATIONS

As noted in the introduction, two interrelated areas of policy interest provided the impetus for conducting this exploratory examination of state-administered home and community-based services programs. One set of questions focused on how the programs are organized to deliver HCBS within fixed budgets, and what mechanisms they use to manage available resources and to respond to projected or actual budget shortfalls. The second set of policy-related questions focused on the administrative and programmatic relationships between eligibility determination, assessment, care planning and service authorization functions.

1. Factors Relating to Operating Within Fixed Budgets

What seems clear is that when there is no other option, states can and do operate their HCBS programs within the resources they have available. Four of the five states that have capped program budgets have developed the mechanisms necessary to manage them so that resources are not over-committed. Even the Illinois Community Care Program (CCP), which by court order is required to operate as an entitlement, includes all but one of the same control mechanisms -- and for the same purpose.

All five states limit participation, using age, types and degrees of functional disability, and income and/or asset levels in various combinations as criteria for eligibility. They also all limit costs by restricting the types of services available, and rely on cost caps -- of care plans, caseloads, and specific services -- as targets for maximum service expenditures. And, with the exception of Arkansas, they use costsharing as a client-directed utilization control mechanism.

Of course, the one critical difference between the Illinois program and the other statewide HCBS programs is that the CCP must provide services to applicants who meet its eligibility requirements. If necessary -- as has been reported to have been the case five or six times in its twelve year history -- the state legislature will appropriate whatever funds are required to carry out the court order. The use of waiting lists, the last fallback of the other states to cap program expenditures, is not an option in Illinois.

States that have more Medicaid waiver slots (and associated earmarked match) than they are using, seem to be more relaxed about bringing eligible clients onto the caseload. Care plan targets for waiver clients are higher, and so too are care plan costs. The explanation offered is that waiver clients require more, and more skilled, care than non-waiver HCBS program clients. (Beyond the scope of the study, but of some interest, would be a comparison of client characteristics and care plan services and costs for waiver and non-waiver programs within the same service delivery structure.)

The state agencies managing the HCBS programs that were examined all have computerized information systems in place to track program expenditures, both by client and by local administering agency. By reviewing actual and projected costs against available resources, state staff are able to make decisions about the status of the program budget(s), assign client "slots" if and when it appears that resources are available to cover needed services, and, when necessary, propose appropriate expenditure-limiting changes so that program budgets are not over-extended. The bottom line is that if there is a bottom line, states and local programs seem to be able to do whatever is necessary to ensure that available funding is not exceeded. When there is no absolute bottom line, they do the best they can.

2. Administrative and Programmatic Relationships Between Eligibility Determination, Assessment, Care Planning and Service Authorization Functions

In general, non-waiver HCBS programs funded primarily by state and other resources have similar administrative and programmatic configurations for client assessment and eligibility determination, care planning and services authorization. Responsibility for managing these functions is vested in several different types of community-based agencies, but all use care managers to carry them out. On the other hand, although the same functions occur within Medicaid home and community-based waiver programs, responsibility for performing the various functions is more fragmented.

While community agency staff assess waiver applicants, and develop and implement care plans, authority to determine eligibility for Medicaid waiver programs rests with the state Medicaid agency. This is universally true for establishing financial eligibility and, with one exception among the waiver programs examined in the project, also true for determining functional eligibility status.

The single exception is Indiana's aged and disabled waiver. There, the locus of authority to determine functional eligibility for Indiana's aged and disabled waiver is located in the community at the care management level. In all other instances, the ultimate authority of the state Medicaid agency holds, even in Illinois where it takes the form of an after-the-fact process and in North Dakota where, at least for level of care decisions, a telephone review of client status usually suffices for the initial authorization to begin arranging for the delivery of waiver services.

Historically, there has been considerable emphasis on separating assessment and care planning functions and decision-making from the potential special interests of agencies which also provide care plan services. Except in Arkansas, where care planning decisions representing tens of millions of dollars for personal care services are made by the same agencies that then actually provide the services that are

authorized in the care plan, this separation does seem to be the rule.

When the question was raised with state agency and AAA staff in Arkansas, the response was that there was no self-serving motivation involved in the care planning decisions that were made. Whatever "profit" margin was built into their rate structure was turned back into the budget to pay for services for persons who needed help but did not meet the state's Medicaid eligibility requirements. Whether or not the care plans are skewed is an empirical question beyond the scope of this study.

In the Medicaid Program, where financial and functional eligibility decisions are made by the state Medicaid agency, applicants are put on hold for Medicaid waiver services, frequently to their detriment. Attempts in several states to reduce the time period may help the situation somewhat. However, it seems that a major review of the issues and recommendations for dealing with the problems would be a worthwhile undertaking.

3. Other Program Features of Policy Interest

When there will be another attempt to legislate a federal home and communitybased services program is difficult to predict. Nevertheless, it may be useful to summarize how several key elements of the Administration's original HCBS proposals would fit with program features of the operating HCBS programs included in the project.

a. Using Functional Impairment Measures for Program Eligibility

The principle of using functional impairment levels as the basis for establishing program eligibility fits very well with how states currently determine client eligibility for program participation. What might be problematic: The congruence between federal and state definitions and applications of specific ADLs and the number that would be required for eligibility (different states have expanded the original list of five ADLS, some considerably); whether and which IADLs might also be considered in making eligibility decisions; and whether and how a federally-mandated assessment instrument can/should substitute for or be incorporated into states' own time-tested assessment tools.

A related issue is the concept of choice of setting and the nursing home diversion strategy of HCB care. Any federal requirements regarding numbers and/or types of ADLS (and IADLs) for HCBS could affect existing state nursing facility eligibility rules and, ultimately, resident mix, as well.

b. Not Using Financial Status as a Basis for Eligibility

None of the state-funded HCBS programs in the study use income as a basis for establishing eligibility, and it is an empirical question to determine how many otherwise eligible applicants are turned away because of the asset limits imposed in the Illinois and North Dakota programs. (An intuitive guess is that the numbers are not so great that some adjustment could not be made.) Of much more likely concern to the states would be how much flexibility they would have to limit

participation.

Both the Administration's and subsequent proposals for a federal HCBS program would have allowed states to specify the services that would be provided (except for the required personal care assistance services), set maximum rates for specific services, cap care plan costs, and use waiting lists. What would not have been allowed is perhaps the most powerful mechanism of all -- cost-sharing up to 100% above a protected amount to cover care plan costs. Without this last type of control as a safety valve, very long waiting lists for HCB services could become politically untenable.

c. Requiring All States to Offer Client-Directed Personal Assistance Services

Most of the state programs in the project do not include client-directed personal assistance services in their benefit packages. However, there does not appear to be any obvious evidence to suggest that such a service should/could not be developed. In this regard, a more detailed examination of North Dakota's use of individual providers -- many of whom are client-identified, and most are client-directed -- might prove useful for developing reasonable policies and workable recruitment, training, and monitoring parameters which could apply to densely populated as well as rural areas.

d. Encouraging States to Consider a Generic Approach to HCB Services Driven by Functional Needs Rather Than Age

Simply by emphasizing functional rather than age-related eligibility criteria in the Administration's HCBS proposals, states may be encouraged to pursue economies of scale that can result from taking a more generic approach to HCBS delivery. This is especially true for HCBS for younger adults with physical disabilities in states where there is no service delivery structure beyond the Medicaid system currently in place. A generic non-age-related approach may be more problematic in states where there are well-established service delivery systems, e.g., for older people and the MR/DD population. Political bridges may need to be built, but North Dakota and Indiana have created generic HCBS systems that combine the aged and adult physically disabled populations, and with apparently satisfactory results.

e. Assuring that Eligibility Rules and Procedures Do Not Hinder Attaining Program Goals

Although this issue was discussed above, it bears repeating. HCBS program staff expressed strong feelings about the time it takes to establish Medicaid eligibility and the negative impact these time lags have on their ability to assist people who want and are able to continue living in the community. Since community-based long-term care services and Medicaid waivers were designed primarily for such individuals, the staff frustration seems justified. Too frequently, a person has to be placed into a nursing home before the eligibility decisions are made. To be effective as a nursing home diversion strategy and also to truly offer clients a choice of long-term care settings, a program's eligibility rules and procedures must be able to accommodate the need for fast track eligibility decisions.

In conclusion, it appears that the major features of the Home and Community-Based Services Program included in the Administration's Health Security Act are compatible -- allowing for some adjustments --

with the existing home and community-based long-term care services programs included in this study.

PART II. STATE HOME AND COMMUNITY-BASED SERVICES PROGRAM DESCRIPTIONS

ARKANSAS

I. What are the Program Elements and Funding Sources for the State's Home and Community-Based Services System?

A. Principal Program Elements and Funding Sources

Three program elements join together to make up Arkansas' home and community-based services system for older people: An "ElderChoices" Medicaid waiver program; the Medicaid state plan personal care option; and an Area Agency on Aging-administered "Home Care Support Program" (HCSP), which combines several federal and state funding sources.

The ElderChoices waiver program, first implemented in July, 1991, has a projected budget of about \$15 million for the current fiscal year to provide a range of community-based long-term care services to persons 65 and older who meet the financial and medical/functional eligibility criteria for participation. The program currently is serving about 3100 clients, a number anticipated to increase to an active client census of 4250 by the end of this fiscal year. (State agency staff report that the waiver program could be at full capacity, utilizing all 9100 of its approved slots, by the end of state fiscal year 1996.) Although the state Medicaid agency has ultimate authority over the waiver, the Division of Aging and Adult Services has administrative responsibility to manage and operate the program at the service delivery level.

The second program element, Medicaid-reimbursed personal care services, complements the ElderChoices program. Since 1978, Arkansas has included the Medicaid personal care option in its state plan as a cost-efficient way to expand the availability of home care services for all Medicaid recipients who need personal care.

A budget estimate for Medicaid personal care services for the current year is not available. However, Medicaid payments last year -- at a federal/state match ratio of 75:25 -- were \$52.7 million, to provide personal care to 16,560 clients. Since three out of four recipients of Medicaid personal care services in the state are 65 and older, it might be reasonable to extrapolate that perhaps three out of four personal care dollars expended -- or somewhere around \$46 million (including \$6 million for ElderChoices clients) -- was for personal care services delivered to older adults.

The two principal providers certified to deliver Medicaid-reimbursable personal care services in Arkansas are Area Agencies on Aging (AAAs) and county health departments. Together they deliver about 90% of all Medicaid personal care benefits in the state.⁶

The third program element in the Arkansas system is the community-based Home Care Support Program (HCSP), which provides a range of non-institutional home care services to people 60 and older who meet the program's broad eligibility requirements. The HCSP is funded by a combination of federal and state resources, managed by the Division of Aging and Adult Services (DAAS) and administered at the substate level by the Area Agency on Aging network. The HCSP budget for the current fiscal year totals \$14.2 million, of which \$5.65 million is from Title III of the Older Americans Act; \$2.25 million is from the Social Services Block Grant (SSBG); and \$6.22 million is from state revenues, including a dedicated state cigarette tax.

Together, ElderChoices, the Medicaid personal care option, and the Home Care Services Program form a linked system that this year will be providing services totalling perhaps as much as \$87 to \$97 million for in-home and community-based services to Arkansas' older population.⁷

B. Other Home and Community-Based Services Resources

One additional resource is "targeted care management" (TCM), another optional service under the Medicaid state plan. Despite its apparent potential as a resource for home and community-based care, Medicaid payments for targeted care management last year is estimated to have been only \$400,000.

TCM is available for Medicaid recipients 60 and older who have limited functional capacity requiring the coordination of multiple services, or who are at risk of abuse, neglect or exploitation. Currently, Area Agencies on Aging are the major TCM providers. However, county health departments, which are already certified as Medicaid vendors, have recently begun expressing interest in offering targeted care management to their Medicaid-eligible clients as well.

Arkansas does not have a cost-sharing provisions for its home-based care programs.

II. HOW ARE THE PROGRAM BUDGETS ESTABLISHED?

Like state agencies in other states, Arkansas'aging and Medicaid agencies prepare budget proposals for state general revenues based on analyses of their programs'experiences and growth projections. (Resources from formula-derived grant programs as well as dedicated state revenues are pre-determined.) After this exercise, however, the budget process itself takes over, and politics become the primary basis for deciding how the state budget will be constructed.

III. WHAT ARE THE PRINCIPAL ISSUES AFFECTING PROGRAM FINANCING?

Like many rural states with a relatively low average per capita income, Arkansas has had a difficult time producing the revenues it needs to operate essential state services and continue to support its human services system, including its longstanding commitment to home and community-based services for the state's older population. Several years ago, as a way of generating additional state match for Medicaid dollars, it instituted a "provider tax" -- as did a number of other states -- only to have it subsequently declared illegal by HCFA.

To compensate, the state legislature placed a small wholesale tax on soft drinks, with the proceeds to be used specifically for state Medicaid match. Although a statewide referendum mounted by the soft drink industry to repeal the "soda pop" tax was voted down in the 1994 election by a margin of 54% to 46%, the referendum underscores advocates' concerns regarding the instability of funding for home care services generally, and Medicaid personal care services in particular. As evidence of their concern, they pointed to the fact that the referendum received considerable support from cigarette manufacturers, whose motivation could very well have been a belief that if the soda pop tax could be voted down, they could do the same with the dedicated cigarette tax -- which now funds transportation and home-delivered meals services for the state's older population.

The bottom line is that while smaller federal and state funding sources may or may not experience cutbacks, the very significant Medicaid-funded elements of the state's home and community-based services program seem to be especially vulnerable. In a situation where state Medicaid match dollars frequently tend to be difficult to find, optional state plan services -- even if they are viewed very positively -- are likely to be put on the table, at least for discussion. Given this review process, they become more susceptible to being cut back or, if the budget situation is serious enough, eliminated entirely.

IV. HOW ARE THE HOME AND COMMUNITY-BASED SERVICES PROGRAMS ADMINISTERED AT THE STATE AND SUBSTATE LEVELS?

As noted, the structure for organizing home and community-based services in Arkansas is comprised of three interrelated service programs. Two of them, ElderChoices and the Personal Care Option, while both

funded by Medicaid, are operationally differentiated and also have some different administrative and program eligibility requirements. The third, the Home Care Services Program, while managed by the same state agency (DAAS) as ElderChoices, is operated by yet a different service delivery mechanism at the substate level. Also, the HCSP is actually a composite comprised of multiple funding sources, which -- while they mainly share common, programmatic and client eligibility criteria -- still have a few requirements unique to particular funding streams.

A. Eligibility Requirements

- a. **ElderChoices.** In order to be eligible for ElderChoices, an applicant must be at least 65 years of age; have an income no greater than 300% of SSI with no more than \$2000 (\$3000 for a couple) in countable assets; and have medical care and/or functional support needs requiring an intermediate level of care that could only be provided in a nursing facility setting if home care services were not available.

Arkansas uses informed "professional judgment" rather than numeric scoring to grade the severity of an applicant's condition and circumstances in order to establish medical necessity for nursing home care. Among the factors taken into account are the need for regular nursing care, supervision and/or monitoring for medical conditions, in conjunction with the need for assistance with two or more ADL functions, i.e., eating, transferring, walking, toileting, bathing and grooming.

- b. **Optional Personal Care Services.** Eligibility for Medicaid personal care services requires that an individual be a categorically-needy Medicaid recipient and have at least two ADL impairments that significantly limit their capacity to function independently.
- c. **Home Care Services Program.** In general terms, eligibility criteria for the HCSP are fairly broadly defined. A person must be at least 60 years of age, be frail and unable to independently perform normal daily tasks, and live alone and/or not have a significant support system to provide needed assistance. In addition, for services supported by Older Americans Act Title III resources, the individual also must exhibit a "social" need, e.g., have a low income, be isolated, and/or be a member of a minority group. For SSBG services and state-funded personal care services, eligibility requirements make the low income measure explicit -- recipients of these services cannot have incomes in excess of 200% of SSI.

B. Eligibility Determination Procedures

- a. **ElderChoices.** Registered nurses, employed by DAAS and deployed around the state in regional offices of the Department of Human Services, are responsible for assessing needs and developing care plans for the ElderChoices program. If an individual is 65 or older, and either is a Medicaid recipient or appears likely to meet ElderChoices'waiver eligibility criteria, s/he is usually referred to an ElderChoices nurse for an assessment. Referrals come from a variety of sources, e.g., AAAs, hospitals, physicians, social service and health departments, and senior centers.

As soon as possible after a referral, the RN makes arrangements with the applicant to conduct an

assessment of needs, using a standardized instrument. Then the assessment form, which also includes a plan of care and a physician's sign-off, is forwarded for a level of care determination to the state Office of Long Term Care, within the Office of Medical Services, the state Medicaid agency. If the applicant is not yet financially qualified, the nurse care manager will try to assist in facilitating the application to determine eligibility, since it too is necessary for Medicaid reimbursement. Unfortunately, all of this takes a great deal of time, including a not infrequent time lapse between referrals and client assessments.⁸

- b. **Optional Personal Care Services.** To be eligible for personal care benefits under the Medicaid state plan, a person must first meet the income and age and/or disability criteria for general Medicaid eligibility. This part of the process is performed by staff of the state Medicaid agency, and is based on information contained in the Medicaid application and supporting documents. For Medicaid recipients who may need personal care, certified personal care service providers are authorized to assess specific needs and develop a plan of care based on the information collected during the required assessment process.

In Arkansas, this means that in most cases either the relevant Area Agency on Aging or county health department, as certified providers, will assign a staff person to conduct the assessment, develop the plan of care and, after obtaining a physician's signature, provide the care that is authorized. As long as the prescribed hours are within the state cap, no further authorization is required. Even though clients have the freedom to choose any certified provider s/he prefers, for the time being at least, their choices are limited basically to either the AAA or the health department; and it is reasonably certain that whichever agency does the assessment will also be the agency that delivers the service.

- c. **Home Care Services Program.** Area Agency on Aging care managers are responsible for doing intake and developing a services plan for non-Medicaid clients in need of home care services. Other than for state-funded personal care -- which requires the same standardized assessment, care plan and physician sign-off as the optional personal care benefit -- how AAAs go about determining client need and arranging for services under the HCSP is much more loosely-structured than in either of the other two programs.

C. Care Planning and On-Going Care Management

Although on-going care management is essentially the same in the three programs, each has somewhat different policies and procedures for care planning. For ElderChoices, care plans are developed by registered nurses in conjunction with conducting a standardized assessment. Individual client care plan costs are capped at 100% of Medicaid's average ICF payment, \$1636/month, which can be annualized to accommodate periods of heavier care needs. Even with the inclusion of Medicaid personal care in the cost calculation, ElderChoices care plan costs this fiscal year are averaging only about \$500/month.

For Medicaid personal care services, as noted above, the required plan of care is prepared by the provider agency. In accordance with the Medicaid agency's current policy, the maximum amount of service that can be authorized without its prior approval is 72 hours per month. Although AAAs (and county health departments) are required to adhere to this policy, it is unclear whether residential care facilities, which

also are certified to provide Medicaid personal care, are also expected to operate within the cap.⁹

Care planning for the Home Care Services Program is done by AAA care managers in conjunction with intake and assessment. While the DAAS has developed several forms that can be used to collect information and maintain client records, they are not required. As long as AAAs adhere to DAAS policies for the various funding streams that comprise and support the HCSP, they have considerable latitude to specify how the services they make available will be organized and delivered.

All clients receiving services from any one of the three programs are followed by care management staff, although some more closely than others. For ElderChoices, RN care managers are required to maintain contact with clients on a regularly-scheduled basis, and reassessments must be completed and a new plan of care developed as circumstances change, or no less frequently than once a year. For Medicaid personal care services, clients' plans of care must be reviewed every 60 days, or when there has been a change in circumstances. Ongoing care management for HCSP clients varies in intensity and frequency, depending on the particular circumstances of individual clients, but care managers attempt to maintain a schedule of monthly contacts and bimonthly home visits.

D. Available Services and Service Providers

[Exhibit C](#) displays the home and community-based services available through ElderChoices, the Home Care Services Program, and the Medicaid state plan. While there is some overlap, the broadest range of services is available through the HCSP. In keeping with its philosophy, the HCSP services listing includes "emergency assistance" and "other services," which give AAA care managers considerable flexibility to be responsive to client needs that do not fit into one of the specified service categories.

For the Home Care Services Program, AAAs can identify and contract with providers, including individual contractors who are not family members and who they deem to be appropriate to deliver services to AAA clients. However, providers of the eight ElderChoices waiver services must be certified by the Division of Aging and Adult Services, as well as be approved by the state Medicaid agency as qualified Medicaid vendors. In addition, an authorized provider for Medicaid personal care and targeted care management must be licensed by the state -- either as an all-encompassing home health agency or as a limited provider of personal care services. Arkansas does not utilize independent contractors for Medicaid-reimbursable services.

Area Agencies on Aging, instrumental in getting the personal care option included in the state's Medicaid plan more than a decade ago and in providing the personal care workers needed to deliver the service, continue to be the primary providers of Medicaid-reimbursable personal care services. As a result, Medicare/Medicaid-certified private home health agencies focused their attention on Medicare and other Medicaid-related services, but not personal care. AAAs, together with county health departments, had essentially put a lock on the personal care market.

EXHIBIT C. Available Services in Arkansas

Services	ElderChoices Waiver	Home Care Services Program	Medicaid Services ¹
Targeted Care Management			X
Homemaker	X	X	
Chore	X	X	
Personal Care		X	X
Home-Delivered Meals	X	X	
Adult Day Care	X	X	
Adult Day Health Care	X		
Respite	X	X	
Adult Foster Care	X		
Personal Emergency Response System	X	X	
Health Promotion		X	
Home Repair/Modification/ Maintenance		X	
Emergency Assistance		X	
Other Services (as Approved)		X	

V. WHAT BUDGET CONTROL MECHANISMS ARE USED TO ENSURE THAT PROGRAM SPENDING REMAINS WITHIN BUDGET LIMITS?

Budget control mechanisms also vary by program. For the HCSP, the budget is self-controlling. AAAs develop service plans that identify how much of what resources will be dedicated to what services, using funds they receive from DAAS through a grant mechanism. Expenditures are then reviewed against projections, and adjustments are made as needed; but there is no opportunity to overspend.

For ElderChoices, the active client census is far below the number of approved slots and available budget, so the only significant budget control issue is whether care plan expenditures are within maximum cost caps. A computerized data base for ElderChoices allows DAAS staff to track clients' status, services and costs. For Medicaid's optional personal care and targeted care management services, the Medicaid agency depends on its MMIS -- as it does for all its benefits -- to track client and expenditure data.

VI. WHAT, IF ANY, ASPECTS OR FEATURES OF THE PROGRAMS HAVE BEEN PROBLEMATIC, AND WHAT KINDS OF SOLUTIONS ARE BEING TRIED OR CONSIDERED TO REMEDY THE PROBLEMS?

One major problem that surfaced in Arkansas -- and may well be universal and of significant impact in every state administering a 2176 waiver -- relates to the time it takes to process applications for Medicaid eligibility and/or to receive responses to requests for level of care determinations. For individuals being discharged from a hospital or nursing home, the system, almost by definition, does not work. In many instances where services included in a cost-effective plan of care would be sufficient to maintain a person in his or her own home, by the time the ElderChoices nurse is informed about the financial eligibility and/or level of care determination decision(s), the person has either died or entered (or chose to remain in) a nursing home.

The DAAS is taking several steps to attempt to remedy this serious problem. First, it is in the process of amending the Medicaid waiver to allow retroactive reimbursement if a service plan is activated prior to receiving confirmation of an applicant's financial eligibility and/or level of need determination. While this places the provider at risk, in at least some instances it is almost certain that the approvals will be forthcoming, and a number of providers already are using stop-gap resources to bridge the time period until approval is given to initiate the plan of care.

A second change being undertaken by DAAS is to underwrite the salaries of Medicaid income eligibility workers so that they can be outstationed in AAA offices to expedite at least the financial eligibility determinations necessary for participating in Medicaid.

Another time-related problem has at least been alleviated for the short-term with the recent increase of DAAS registered nurses available to conduct assessments, develop plans of care and perform the other functions associated with effective care management. But there could still be a continuing problem, given the projected increases in the ElderChoices active caseload. State government employee slots, especially in a limited budget environment, are difficult to acquire. It is not clear whether the DAAS has examined the staffing and, by extension, service implications of retaining the ElderChoices program within its operational aegis, when it may continue to have great difficulty -- or even be unsuccessful -- in expanding staff slots to adequately accommodate a significantly increased ElderChoices caseload.

A final issue relates to the potential for conflict of interest when personal careproviders are also in the position of authorizing the services they are providing. In Arkansas, this is a particularly important issue, since essentially all of its Medicaid personal care services are delivered within this framework. If a federal program were initiated which required the separation of services authorization from service provision, Arkansas Area Agencies on Aging and county health departments would face a serious problem as would the DAAS, the Medicaid agency, and the recipients of Medicaid services across the state.

VII. TO WHAT EXTENT ARE HOME AND COMMUNITY-BASED SERVICES PERCEIVED AS MECHANISMS FOR REDUCING NURSING HOME COSTS?

Although DAAS continues to try and make the case for viewing home and community-based services programs as less costly alternatives to nursing home care, it has also begun to emphasize the intrinsic value of giving people the option to choose which type of care setting they would prefer. One DAAS staff person suggested that the latter argument might actually be the more successful one anyway, because it was far less likely to enflame nursing home owners, who would be formidable foes should home-based care be perceived as a threat to their business interests.

With respect to Medicaid, it would appear from even a brief discussion with several Medicaid agency staff that they do not see community-based care as offering a valid alternative for individuals who need more medically-oriented care -- particularly ElderChoices clients who, by definition, must meet nursing facility level of need requirements. Given this view, it is not surprising that the state's nursing home bed supply is above the national average and continues to expand. Between 1983 and 1993, the ratio of nursing facility beds per 1000 persons 65 and older increased from 62.5 to 67.1.^{[10](#)}

VIII. HOW DO STATE OFFICIALS EVALUATE THEIR ABILITY TO MANAGE A HOME AND COMMUNITY-BASED CARE PROGRAM WITHIN A FIXED, AS OPPOSED TO OPEN-ENDED ENTITLEMENT, BUDGET?

Arkansas represents what seems to be the general tenor of opinion in a number of states across the country regarding a federally-mandated home and community-based services program with a fixed budget. The Division of Aging and Adult Services and AAA staff say they would welcome it -- even though they obviously would prefer an open-ended budget -- and "deal with anything they would have to deal with" if the program would support the expansion of community care services in the state.

In contrast, state Medicaid agency staff were adamantly opposed to capped funding. Their position was quite clear: (1) No matter what the federal government said, they believe there would not be sufficient money in the budget to appropriately serve the number of people who would be eligible; and (2) even if the program allowed them the flexibility to close intake, it would not be possible for them to do so because of the political power wielded by vested interests.

ILLINOIS

I. WHAT ARE THE PROGRAM ELEMENTS AND FUNDING SOURCES FOR THE STATE'S COMMUNITY CARE PROGRAM?

A. Principal Program Elements and Funding Sources

Illinois' "Community Care Program" (CCP), one of the earlier statewide home and community-based care programs in the country, provides homemaker and adult day care services to persons 60 and older, irrespective of income. Since it began in the late 1970's, the program has gone through several iterations. In terms of how it is financed, the most significant change resulted from a 1982 court order, following a law suit challenging the long waiting lists that the CCP had at the time. The effect of the court ruling was to change the nature of the CCP from a limited grant program to a statewide entitlement program, supported in part by a Medicaid waiver but mainly by state general revenues.

The Community Care Program is administered at the substate level by 62 "case coordination units" (CCUs) that serve as the single point of entry for CCP services. Both structurally and administratively, the CCP functions as a unified service delivery system, with no distinctions regarding who is eligible to receive services or how the program works. For the current fiscal year, the state appropriation for CCP services is \$105 million. The Medicaid waiver, with a federal/state match ratio of 50:50, has a projected budget of slightly more than \$60 million to cover about 19,000 approved slots.

Last year, CCP expenditures totalling \$100 million served an average caseload of 28,000 clients/month -- about one-third of whom were covered under the Medicaid waiver. Unfortunately, because no distinction is made between Medicaid and non-Medicaid clients at the service delivery level, and even at the state level in terms of program management, no figures are readily available until the end of each fiscal year to show the actual distribution of CCP expenditures across the two funding sources. However, past experience suggests that the budget distribution more or less mirrors the distribution of program recipients by their eligibility status, and since client needs are not weighted more heavily on the Medicaid side, it can be assumed that about one-third of CCP expenditures are likely to be covered by the Medicaid waiver

and the remaining two-thirds by state general revenues.¹¹

B. Other Home and Community-Based Services Resources

Older Americans Act Title III resources, administered at the substate level by 13 Area Agencies on Aging (AAAs), are used primarily to provide services to older people who do not meet the level of need and/or assets criteria for the CCP.¹² CCP clients have no priority status vis-a-vis these services, which are provided on an as-needed and as-available basis, particularly home-delivered meals and transportation. Social Services Block Grant funds, administered by the state's Department of Public Aid, are negligible with respect to supporting community-based services for older people.

The CCP has a cost-sharing provision which it applies to all program clients. The amount of participant responsibility is derived by using a combination of clients' non-exempt income minus a protected amount (100% of poverty) and a complex formula that includes a "client fixed fee share" for each unit of service, the number people in the family receiving CCP services, and the intensity of need. Once determined, client copayments -- which can equal 100% of costs -- are paid directly to providers, who then bill the state agency if there is any balance due for services rendered. Cost-sharing actually generates very little revenue -- less than 3% of program costs -- which suggests that even though program eligibility is not income-related, CCP clients are of relatively low income.

II. HOW IS THE BUDGET ESTABLISHED FOR THE PROGRAM?

Because the Community Care Program functions as an entitlement, the budget process operates quite differently than it would under the more usual state appropriations scenario. Budget figures are developed initially for each budget cycle by the state agency that manages the CCP, the Illinois Department on Aging (IDoA). IDoA staff prepare detailed explanations and justifications to back up the proposed numbers, which are based on the program's history, growth factors and anticipated policy changes for the coming year. There is always considerable pressure on the IDoA to come up with its best projection of how much state money the program will need for the fiscal year, to reduce the likelihood that it will have to go back to the state legislature for a supplemental appropriation.

Advocacy groups in Illinois also play a role in the state budget-making process. In the early stages they are given an opportunity to meet with Bureau of the Budget staff to make their case in support of the Community Care Program and the various aspects of its budget, and subsequently, they try to make their case again during legislative budget hearings. Historically, however, state fiscal constraints have left little room to be responsive, even to what may seem to be justifiable requests.

III. WHAT ARE THE PRINCIPAL ISSUES AFFECTING PROGRAM FINANCING?

As noted above, the fact that the CCP is an entitlement program is the principal issue affecting its financing and budgeting process. As long as CCP continues to operate under the 1982 court order, the state legislature will continue to appropriate whatever resources are necessary to fund the program. One effect of this is that the state has a special interest in increasing the proportion of CCP clients on Medicaid. Since it pays only 50% of the service dollars for Medicaid waiver clients, CCU care managers are expected to encourage applicants who might possibly meet Medicaid eligibility requirements to apply for Medicaid status. However, at least for the time being, individuals who are potentially eligible for Medicaid but choose not to apply are not denied CCP services, as long as they meet the functional need and asset requirements.

IV. HOW IS THE PROGRAM ADMINISTERED AT THE STATE AND SUBSTATE LEVELS?

The Community Care Program is managed at the state level by the Illinois Department on Aging (IDoA), and at the community level by 62 "care coordination units" (CCUs), which are housed in a number of different types of community agencies, e.g., county health departments, home health, family and social service agencies and multi-purpose senior centers.¹³

CCU agencies are under contract with the IDoA to provide assessment and care management services to CCP applicants and eligible clients. In addition to these activities, CCUs also are responsible for conducting pre-admission screening for Medicaid recipients and other applicants for nursing home placement who are likely to spend down to Medicaid eligibility within 60 days. Because the same instrument is used for determining the need for nursing home and CCP services, CCU care managers are well-positioned to offer community-based service alternatives to nursing home applicants who may still retain some desire -- and capacity -- to remain in their own homes.

A. Eligibility Requirements

Eligibility criteria for the CCP are straightforward: Applicants must be at least 60 years of age and certified to have non-exempt assets not exceeding \$10,000. Income is not an eligibility criterion. Applicants also must demonstrate an appropriate level of need for CCP services according to a standardized assessment instrument, referred to as the "Determination of Need" (DON). The DON includes measures of both cognitive and functional status and takes into account available physical and

environmental supports provided by family, friends, and others in the community in order to determine net need.

Both ADLs and IADLs are addressed in the DON and, interestingly, are given the same weight in the judgments that are made about an applicant's functional capacity and extent of need. ADL functions included are: eating, bathing, grooming, dressing, transferring and incontinence; IADL functions are: telephoning, meal preparation, capable of being left alone, managing money, taking care of routine and special health needs, going outside the home and doing laundry and housework. In addition, the DON includes the mini-mental status scale as a measure of cognitive impairment.

DON functional scores are based on two sets of four point scales. One set scores level of limitation for each ADL and IADL function, ranging from none or only minor impairment to total inability to perform a particular function independently. The other set scores level of need for assistance, from none to extensive. Taken together, the two scores reflect net functional need. Additional points reflecting the measure of cognitive impairment are then added to the two score total; an applicant whose total is above the established minimum cutoff is considered eligible for the CCP.

B. Eligibility Determination Procedures

CCU care managers receive applicant referrals from a variety of sources and follow up by arranging an appointment to administer the DON and financial information forms. Except under special circumstances, usually when an applicant is hospitalized or in a nursing facility at the time of the assessment, the CCP requires that a CCU care manager conduct a home visit in conjunction with performing the assessment.

Eligibility for CCP services is determined at the service delivery level. Since the total DON score determines whether an applicant will meet the functional requirements for eligibility for CCP services, the functional eligibility determination procedure is effectively finished once the DON instrument is completed. Financial information and related documents also are collected at the time of the assessment, and as long as the applicant's countable assets are within the allowed \$10,000, CCP services can be initiated.

C. Care Planning and On-Going Care Management

The DON score not only determines whether an applicant is eligible for CCP services, but also sets maximum CCP payments for care plan costs, based on his or her net level of need score. According to the standardized payment scale, CCP responsibility for care plan costs can range from \$1 to \$1445 per month. (Last year's average monthly care plan cost was \$302.)

One effect of working with a standardized payment scale reflecting relatively narrow ranges of scored need is that for CCP care managers, care planning is a much less complicated matter than in other state programs where there are more service options to consider and a much wider range of care plan dollars to work with. (The IDoA does allow for an "emergency" increase in the amount established by the

standardized payment scale for client care plans, but only for a very limited 15 day period, and only with its approval.) Given these structured limits, CCU care managers nevertheless develop care plans that can be considered adequate to meet client needs, since each one has to be reviewed and signed off on by a physician, registered nurse or other medical practitioner.

D. Available Services and Service Providers

Technically, only two specific services are offered and can be authorized by CCU care managers -- homemaker and adult day care. However, because the activities included are extensive, a broader array of need is covered than would appear to be the case. For example, adult day care includes not only social day care activities, but also rehabilitation and skilled nursing services on an optional basis. And homemaker services include not only housekeeping, shopping, meal planning and preparation, but also assisting with medications, and performing personal care tasks such as bathing and grooming, assistance with transferring and range of motion, etc.

In Illinois, the state agency contracts directly with local providers for CCP services. IDoA uses a six year procurement cycle, which allows them to recompute the contracts of one-third of the providers every two years. Since the state establishes a single, statewide unit rate for each of the two CCP services, criteria for selecting providers are based on factors other than cost, i.e., community knowledge and involvement, offers to provide additional optional services, and previous CCP experience.

V. WHAT BUDGET CONTROL MECHANISMS ARE USED TO ENSURE THAT PROGRAM SPENDING REMAINS WITHIN BUDGET LIMITS?

Even with an entitlement program, in which participation cannot be limited on the basis of income, there are several ways the state can try to limit costs. One obvious method Illinois has used is to narrow the determinants of need and accept only those clients who have significant functional limitations and very limited or no outside supports to provide necessary assistance. Other cost control measures taken by the state include: limiting the services offered by the program, limiting the reimbursement rates, and increasing the client burden for cost-sharing.¹⁴ While cost-sharing does generate some additional resources, it is intended mainly to create a "prudent purchaser" approach in the care planning process.

Beyond these programmatic and administrative methods, IDoA retains very centralized control of the entire cost and payment system for the CCP. State agency staff review and approve initial care plans where costs are in excess of a predetermined target, based on the statewide average care plan cost for the client's DON score. They also conduct centralized reviews of requests to increase care plan services from CCUs with a history of higher than average care plan costs, and review and sign off on all vendor

invoices submitted for payment.

IDoA staff track and compare actual expenditures against projections for each service and for care management costs, and generate monthly reports comparing the two sets of figures. (The CCP budget has three separate line items, one for each of the two services and one for CCU care management.)

After monthly billings are paid for all client services provided during the month, IDoA forwards computer tapes, with relevant client and vendor information, to the state Medicaid agency, the Department of Public Aid (DPA). It is only at this point that the distinction between a Medicaid-eligible client and a non-Medicaid-eligible client is made. The DPA runs the CCP vendor payment tapes against its records of individuals who are Medicaid recipients. This procedure is the sole basis for identifying how many waiver slots have been used, and which specific CCP expenditures are chargeable to the Medicaid waiver. Should there appear to be an overage, in either the use of slots or the budget, the DPA would notify the IDoA so that program adjustments could be made. (This is not likely to be a problem for a while at least, since the number of approved slots is considerably higher and the projected budget figures considerably less than what the CCP program is able to use.)

VI. WHAT, IF ANY, ASPECTS OR FEATURES OF THE PROGRAM HAVE BEEN PROBLEMATIC AND WHAT KINDS OF SOLUTIONS ARE BEING TRIED OR CONSIDERED TO REMEDY THE PROBLEMS?

IDoA has been developing and managing the Community Care Program for more than a decade, with the same state agency leadership involved with the program since its inception. Although the program has gone through a number of iterations over the years, with the exception of the shift from a grant to an entitlement program, the changes have primarily been refinements of what had come before. The one persistent problem is how to project and manage program costs so that the state revenue appropriation is on target -- neither too little, nor too much.

It was estimated that over the past 12 years since the court order, the IDoA had to go to the state legislature for a supplemental appropriation five or six times; and during the same period, underspent its budget about the same number of times. IDoA staff are constantly looking for ways to refine their data and their procedures so that both concerns are lessened, if not completely eliminated.

VII. TO WHAT EXTENT ARE HOME AND

COMMUNITY-BASED SERVICES PERCEIVED AS MECHANISMS FOR REDUCING NURSING HOME COSTS?

Like most states that initiated home-based care programs in the late 1970's and early 1980's, Illinois' original motivation was to offer non-institutional alternatives, primarily for older people who would prefer to remain in their own homes rather than being placed in a nursing home setting. And similar to most if not all of these states today, Illinois is now viewing its Community Care Program as a mechanism for saving money by diverting people from nursing facility care if they can be maintained safely and cost-effectively in a non-institutional community environment.

On the other side, however, Illinois has not made any significant effort to control nursing home bed supply, which has been and continues to be above the national average. Between 1983 and 1993, the number of nursing home beds per 1000 persons 65 and older increased from 68.1 to 70.0.¹⁵ According to state agency staff, despite evidence to the contrary, the prevailing assumption seems to be that market forces and competition will control prices.

VIII. HOW DO STATE OFFICIALS EVALUATE THEIR ABILITY TO MANAGE A HOME AND COMMUNITY-BASED CARE PROGRAM WITHIN A FIXED, AS OPPOSED TO OPEN-ENDED ENTITLEMENT, BUDGET?

Illinois Department on Aging staff would welcome an expansion of the financing base for home and community-based services. However, because of the entitlement nature of the program as it stands, integrating a new federally-supported home and community-based services program with a fixed budget into the state's pre-existing CCP framework would be quite complicated. Even with a considerable amount of flexibility, it would not be easy for the state to reconcile the two contradictory approaches in a programmatically sound and cost-efficient manner.

INDIANA

I. WHAT ARE THE PROGRAM ELEMENTS AND FUNDING SOURCES FOR THE STATE'S IN-HOME SERVICES PROGRAM?

A. Principal Program Elements and Funding Sources

In 1992, Indiana consolidated funding from several, previously separate, programs and created a new statewide "IN-Home Services Program" (IHSP) to provide a "comprehensive, coordinated alternative to institutional placement" for all its citizens, based on need and irrespective of age. The nucleus of the IHSP is the state-funded "Community and Home Options to Institutional Care for the Elderly and Disabled" (CHOICE)¹⁶ and five Medicaid waivers -- one targeted to the aged and disabled, three to the MR/DD population with one specifically for persons with autism, and the fifth to medically-fragile children.

For the current fiscal year, the total federal and state IHSP funding level is projected to be about \$90 million. Of this amount, \$45 million (50%) is the estimated total combined budget for the five waivers;¹⁷ \$24.5 million (27%) in state funds is budgeted for CHOICE. The balance of \$20.5 million (23%) represents combined federal and state funding from SSBG, Title III and USDA meal supplements, and the "Older Hoosiers" programs for home care-related services to assist people who are basically able to care for themselves, but who nevertheless could benefit from some help, and also to supplement waiver and CHOICE services.

In terms of numbers of people served, projections are that CHOICE funding will cover about 5000 non-Medicaid eligible clients, and Title III and SSBG will provide one or more of their services to another 70,000 people. For the same period, all of the waivers combined are projected to serve just under 3000 clients. Following is a breakdown of the budgets and numbers of approved slots for each waiver:

Waiver	Amount Budgeted	Approved Slots ¹
Aged and Disabled	\$11,482,000	2000
Individuals with Autism	1,528,000	55
ICF/MR	23,626,000	700
ICF/MR (OBRA)	7,699,000	178
Medically-Fragile Children	763,000	50

1. These numbers represent HCFA-approved slots; all but the OBRA waiver are currently operating with waiting lists.

B. Other Home and Community-Based Services Resources

As noted above, resources from Title III of the Older Americans Act, the Social Services Block Grant and several smaller state programs -- together totalling about \$20.5 million -- are also a significant element of Indiana's IHSP. These resources fund a range of community-based services for older people and others who are less functionally impaired than waiver or CHOICE clients, but who could nevertheless benefit from some home care services and assistance. They also are used to provide needed, supplemental services that are not covered under a waiver or CHOICE. Although these resources represent the smallest proportion of the IHSP budget, they are expected to be the first dollar expenditures in terms of developing care plans to meet client needs.

The IHSP has a cost-sharing formula for CHOICE-funded services that results in expanding CHOICE resources by about 1%. The formula, which calculates a client's share of the cost of CHOICE services, is designed to protect net income (after Medically-related expenses are deducted) up to 150% of poverty adjusted by family size. The client's share, calculated as a percentage of service costs, gradually increases up to a maximum of 100% when net income exceeds 350% of the adjusted poverty level.

II. HOW ARE THE BUDGETS ESTABLISHED FOR THE IHS PROGRAM?

In preparation for the state budget deliberations that occur during each legislative session, staff from the state agency responsible for managing the IHSP -- the Bureau of Aging and In-Home Services -- work with other administration officials to develop the budget proposals for funding CHOICE and other related state-supported programs. The numbers that are generated are based on the programs' operating experience over the previous year and growth projections for the coming year. Budget proposals and justifications are reviewed, modified as appropriate, and then included in the Governor's budget submission to the legislature.

A Medicaid Waiver Unit within the Bureau of Aging and In-Home Services is instrumental in developing budget figures for each of the Medicaid waivers. Working closely with the state Medicaid agency, staff from the waiver unit are responsible for recommending necessary waiver modifications and preparing the documentation needed to submit to HCFA for approval of the modification requests. Except for the aged and disabled waiver, state match is drawn from the overall state Medicaid match appropriation, which includes Medicaid state plan expenditures as well. (Match for the aged and disabled waiver is taken from the CHOICE appropriation each year.)

III. WHAT ARE THE PRINCIPAL ISSUES AFFECTING PROGRAM FINANCING?

Indiana, like every other state, has been operating in a tight budget mode resulting from the state's economic downturn over the past decade. As a result, the CHOICE budget has remained at level funding since 1991, when it more than doubled at the time it merged with the Medicaid waivers and other federal and state resources into the IHSP. Despite the fact that CHOICE has not received any budget increases since then, an indication of the legislature's and the administration's continued support for the program is that its unspent funds can be carried over to the following year, a policy that does not apply to most other state-funded human service programs.

IV. HOW ARE THE PROGRAMS ADMINISTERED AT THE STATE AND SUBSTATE LEVELS?

Responsibility for overall management of the IN-Home Services Program, including the five waivers, rests with the state Bureau of Aging and In-Home Services (BAIHS), a program unit in the Division of Disability, Aging and Rehabilitative Services of the Indiana Family and Social Services Administration (FSSA). Administrative authority and management specific to the five waivers, including tracking costs and assigning waiver slots as they become available, rests with the previously-mentioned Medicaid Waiver Unit (MWU) within the BAIHS.

At the substate level, Indiana's sixteen Area Agencies on Aging (AAAs) administer all of the various components that together constitute the comprehensive IHSP, with sign-off authority for all Medicaid waiver services included in IHSP care plans. Area Agencies on Aging also have responsibility for conducting pre-admission screening for all nursing home placements for Medicaid eligibles and private pays.¹⁸ AAA care managers are authorized to approve nursing facility placement at the ICF level for both categories of applicants. SNF decisions and all denials are made by the Office of Medicaid Planning and Policy, the state Medicaid agency located within the FSSA.

A. Eligibility Requirements¹⁹

- a. **Waiver Services.** Except for medically-fragile children, eligibility for waiver services require that applicants meet at least ICF level of care criteria, based on the IHSP assessment screen, and have incomes no greater than 100% of SSI.²⁰ To meet the ICF level of care provisions, an individual must have a medical need requiring nursing supervision and three ADL deficits.

But even if an applicant meets the level of care and financial criteria, s/he will not be eligible for any of the waiver slots unless the total Medicaid cost of serving the recipient -- including waiver costs plus any other Medicaid-reimbursable services -- would not exceed the total cost to Medicaid for serving the recipient in an appropriate institutional setting.²¹

- b. **CHOICE Services.** CHOICE-funded services are available to state residents who are 60 years of

age and older or severely and permanently disabled because of a physical and/or mental condition, and who are at risk of institutional placement. Income is not used as an eligibility criterion. However, there is a requirement that if an applicant can meet the Medicaid eligibility criteria but chooses not to, the use of CHOICE funds is prohibited.

B. Eligibility Determination Procedures

Procedures for determining eligibility for all IHSP services are the same, irrespective of funding stream. Care managers use a standardized eligibility screen, which includes questions covering financial circumstances, medical needs, ADL and cognitive deficits, as a basis for determining eligibility for waiver or CHOICE services. The screen also includes questions relating to IADL limitations and informal supports. While the latter are not criteria for establishing eligibility for waiver or CHOICE services, they are used to determine whether the applicant might qualify for services funded by Title III, SSBG or other sources. A standardized assessment form, complementing information from the eligibility screen, is used for care planning purposes.

Based on the functional and financial information generated by the screening instrument, the care manager can make an informed judgment about an applicant's likely eligibility status -- whether s/he qualifies for waiver services or for CHOICE and/or any of the other funding streams that support IHSP services.²² AAA care managers have the authority to approve functional eligibility for waiver services for those applicants who, according to the eligibility screen, meet the state's ICF level of care criteria. However, if the screen indicates that the applicant's needs are at the SNF level, the screening information is forwarded to the Office of Medicaid Policy and Planning (OMPP) for a paper review by staff nurses. With few exceptions, their decision supports the initial judgment of the AAA care manager. If the applicant is not already a Medicaid recipient, an application to establish financial eligibility -- and, therefore, eligibility for waiver services -- must be filed with the state Medicaid agency.

A fairly common exception to the process outlined above relates to the MR/DD population, when someone other than an AAA-based care manager is the immediate contact with the applicant to administer the screen and, if appropriate, the assessment instrument. Applicants for services covered by one of the three MR/DD waivers, who are likely to be known to staff from one of the state's regional offices of the Bureau of Developmental Disabilities Services (BDDS), might prefer to have their applications processed through the BDDS. In these cases, BDDS staff assume responsibility for completing the eligibility screen and assessment information which, in most instances, also will include a "diagnostic and evaluation" review to determine the most appropriate care setting.

In this situation, an AAA care manager is brought in to participate in the process, which might include a joint case conference to arrive at the initial decision regarding eligibility. If it appears that the applicant is both eligible and appropriate for waiver services, the necessary paperwork is forwarded to OMPP for review and approval. Regardless of the details of the eligibility process, however, gaining approval for waiver services does not guarantee that services will be initiated.

Responsibility for tracking and assigning available waiver slots for all five waivers resides with the Medicaid Waiver Unit (MWU). After Medicaid eligibility has been established, the Area Agency on Aging care manager contacts MWU staff to determine whether an appropriate waiver slot is available. If so, services can be initiated in accordance with an approved care plan. If not, the individual is added to a statewide waiting list maintained by the MWU. If there is a need and CHOICE or other resources are available, they are used as a bridge until a waiver slot opens up.

C. Care Planning and On-Going Care Management

Care planning and care plan targets differ as a function of different funding streams, different severity levels and different client groups receiving waiver services. For waiver clients, there is an individual care plan target that cannot exceed 90% of the costs of care in a health care facility setting appropriate to the client's needs, or about \$1800/month. For the last fiscal year, the average care plan cost for Aged and Disabled waiver clients was \$579/month.

For CHOICE-funded services, the state has developed caseload benchmarks as well as maximum targets for individual care plans. As long as a client's care plan stays within the maximum target numbers and the AAA has uncommitted CHOICE funds, care managers can authorize services without approval from the state agency. For CHOICE clients, the care plan target for persons with disabilities under age 60 is a \$736/month averaged over a three month period, but it can go as high as \$5520/quarter for a person who is severely disabled. For clients over age 60, there also are two target levels: \$561/month, or up to \$4209/quarter for an older person who is severely impaired. Last year's monthly CHOICE care plan for both age groups also averaged \$579.

All care plans, regardless of funding stream, must include the signature of a physician, either the client's regular doctor or one who has seen him or her within the last thirty days. The purpose of this policy is that physician sign-off serves as a "health and safety" assurance -- that the client can remain safely and appropriately in the community.

Once a care plan is in place, the assigned care manager monitors the client and the services on a regularly scheduled basis -- irrespective of which funding stream is paying for client services. For quality assurance purposes, AAA supervisory staff as well as state agency staff will conduct home visits with IHSP clients on a random basis.

Just as MR/DD applicants have the option to work through BDDS staff for determining their eligibility for waiver services, they also can choose who they would prefer to have as a care manager -- the Area Agency on Aging care manager, a BDDS staff person, or an independent contractor. Whoever is chosen would be responsible for developing an appropriate care plan that meets client needs and also fits within the IHSP cost guidelines, and providing on-going monitoring and care management services. However, if an IFS staff person or an independent contract care manager is selected, an AAA care manager still must sign off on the care plan, as well as on any subsequent changes to the care plan, in order for the services that are provided under the waiver to be reimbursed by Medicaid.

D. Available Services and Service Providers

In addition to care management, available services include: Homemaker, home health (including nursing care and the various therapies), attendant care and personal assistance, adult day care, respite care, home-delivered meals, transportation, adaptive aids and home repair and modifications. Specialized services keyed to various waivers include: Prevocational services and supported employment, group and/or individual habilitation, behavior management and crisis intervention. [Exhibit D](#) lists all of the services available by funding stream.

Providers of Medicaid waiver services all have to be certified by BAIHS's Medicaid Waiver Unit so that they can become Medicaid vendors and bill the state for the services they provide. On the other hand, providers of CHOICE and other IHSP services do not require state certification, unless the service they are providing has a statutory state certification requirement. Otherwise, Area Agencies on Aging have the authority to negotiate and sign a memorandum of agreement with "any willing provider" who the AAA determines is qualified to provide the service(s).²³

EXHIBIT D. Available Services in Indiana

Services	CHOICE	Aged & Disabled	Autism	ICF/MR	OBRA	Medically-Fragile Children
Care Management	X	X	X		X	X
Homemaker	X	X				
Attendant Care/ Personal Assistance	X	X		X	X	X
Home-Delivered Meals	X	X				
Adult Day Care	X	X		X	X	
Respite	X	X	X	X	X	X
Adaptive Aids/ Assistive Technology	X	X		X	X	
Personal Emergency Response System	X			X	X	
Home Modifications	X	X		X	X	X
Occupational Therapy	X			X	X	
Speech Therapy	X		X	X	X	
Physical Therapy	X			X	X	
Auditory Therapy	X		X			
Supported Employment (Group/ Individual)				X	X	
Habilitation			X	X	X	

Pre-Vocational Services			X	X
Transportation	X		X	
Behavior Management			X	
Crisis Intervention			X	
Home Health	X			
Home Health Supplies	X			
Other Necessary Services	X			

CHOICE clients also can opt to use individual providers, either from a "self-declared" registry maintained in the AAA, or by recommending a person they want as a personal assistant. According to IHSP policy, only immediate family members are precluded from being paid as individual providers, unless unpaid caregiving can be shown to result in financial hardship for the caregiver, and the family member completes a formal training program.

V. WHAT BUDGET CONTROL MECHANISMS ARE USED TO ENSURE THAT PROGRAM SPENDING REMAINS WITHIN BUDGET LIMITS?

Although the IHSP is broad-based and, in principal, is available to anyone who applies and is determined to need assistance, the bottom line is that it can only offer assistance while it has the resources to do so. Given limited resources, a result of the state's decision to maintain fairly broad eligibility criteria is that it also maintains a relatively long waiting list of eligible clients. The current waiting list for CHOICE services is between 1700 and 1800 people already determined to be eligible to receive CHOICE services.

Undoubtedly, the waiting list would be even longer, if the state did not impose some of the usual mechanisms to control participation, e.g., functional eligibility criteria, cost caps on care plans, and cost-sharing provisions which may serve as a disincentive to participate, especially for higher income individuals.

Except for the waivers, the state agency gives a great deal of latitude to each AAA to keep track of and manage its own finances with respect to CHOICE, Title III, SSBG and other funding streams. Since the amount of money they receive from each of these sources is fixed, it is clearly in their interest not to over-commit or over-spend their allocations. They still submit cost reports to the state agency on a regular basis, which include service and administrative cost data and a comparison of projected and actual spending levels across the different line items of their budget. These are carefully reviewed by state staff to identify any potential problems.

For tracking Medicaid waiver data, the state uses a centralized system. The Medicaid Waiver Unit (MWU) within the Bureau of Aging and In-Home Services is the locus for monitoring care plan expenditures and assigning waiver slots as they become available. All requests for waiver slots are submitted to and retained the MWU until a slot assignment can be made. Since all but the OBRA waiver already have waiting lists, these procedures become particularly relevant for budget management.

To do this well, the state has developed a computerized data system that currently is in place in all but two Area Agencies on Aging. The system is capable of documenting and tracking a multiplicity of program, cost and other budget data related to the IHSP. The state is now in the process of modifying the application to bring on the remaining two AAAs and also to allow the programs to work on notebook computers, so that care managers will actually be able to input data from the field.

VI. WHAT IF ANY ASPECTS OR FEATURES OF THE PROGRAM HAVE BEEN PROBLEMATIC, AND WHAT KINDS OF SOLUTIONS ARE BEING TRIED OR CONSIDERED TO REMEDY THE PROBLEMS?

Because Indiana consolidated its various in-home services programs into a comprehensive and coordinated system fairly recently, it capitalized on being able to examine a number of existing statewide community-based care programs and to take the most appropriate elements to incorporate into its own IN-Home Services Program. Although there are always some "nuts and bolts" that need fine-tuning, the overall judgment is that they are very proud of what they have been able to accomplish.

There were two "challenges" rather than problems that were identified by the state agency. The first was to pursue a unified quality assurance system that could be computerized and applied uniformly across the Area Agency on Aging network, instead of the current practice of having a unique set of QA procedures for each AAA. The second was to continue working on the developing official administrative rules for the CHOICE program that can be inserted into the state's administrative code.

VII. TO WHAT EXTENT ARE HOME AND COMMUNITY-BASED SERVICES PERCEIVED AS MECHANISMS FOR REDUCING NURSING HOME COSTS?

It seems quite clear that a principal motivation of the IN-Home Services Program consolidation effort was to create a broad-based home care services system that could identify those individuals who could be served appropriately but at a lower cost than the cost of nursing home care. The state has put up a not insignificant amount of money, as match for its waivers and for the CHOICE program, to fund its home and community-based services effort.

On the other hand, the state does not have a moratorium on building additional nursing homes or adding more nursing home beds to the existing bed supply, which may explain why in 1993, Indiana had the highest ratio of nursing home beds/1000 people age 65 and older in the country -- 82:1000.²⁵

Recognizing that a more comprehensive approach is needed, the Family and Social Services Administration recently announced the formation of a Task Force to examine the issues and devise a set of proposals for dealing with the whole spectrum of factors that are involved, e.g., the problems related to the over-supply of nursing home beds (to the point where neighboring states are sending people into Indiana for placement), the very limited availability of intermediate types of board and care and other residential, assisted-living type facilities, and expanding community-based services.

VIII. HOW DO STATE OFFICIALS EVALUATE THEIR ABILITY TO MANAGE A HOME AND COMMUNITY-BASED CARE PROGRAM WITHIN A FIXED, AS OPPOSED TO OPEN-ENDED ENTITLEMENT, BUDGET?

State agency on aging staff believe the state is well-positioned for such an effort, since it already has the structure and procedures in place to manage a large, multi-targeted, home and community-based services program. And given the support it has received from the state Medicaid agency for the IHSP's waiver components, staff are confident that Indiana could be a model for the country.

MAINE

I. WHAT ARE THE PROGRAM ELEMENTS AND FUNDING SOURCES FOR THE STATE'S HOME

BASED-CARE AND ELDERLY WAIVER PROGRAMS?

A. Principal Program Elements and Funding Sources

Maine's statewide "Home-Based Care" (HBC) program and its "Home and Community-Based Waiver Services for the Elderly" (WSE) program are both managed by the Bureau of Elder and Adult Services (BEAS) at the state level, and administered jointly through a single point of entry at the substate service delivery level. The waiver program serves eligible adults age 60 and older. HBC, in addition to being targeted to the 60 and older population, also provides assistance to a small number of younger persons with disabilities.²⁵ For this fiscal year, the combined budgets for the state-funded and elderly waiver programs are projected to total just over \$15 million. Assuming that expenditures for aged waiver services will meet budget projections, the ratio of waiver to HBC resources will be 58:42 percent.

In addition, Maine has two statewide Medicaid waivers, targeted to adults with physical disabilities, which also are being managed by the Bureau of Elder and Adult Services. One waiver, administered by a well-established Independent Living Center that emphasizes the use of personal assistants, is targeted to persons 18 and older. The second waiver, limited to adults age 18 through 59 and employing a more traditional approach for care planning and care management, is being administered through a contract recently awarded to a New Hampshire rehabilitation foundation which has established an office in Augusta to administer the waiver program.²⁶

The state-funded HBC Program, established by the legislature in 1980 to help older people remain in their own homes, has developed into a statewide program with a current operating budget of \$6.3 million. HBC provides services to an average of approximately 730 clients each month, all but about 5% of whom are age 60 and older.

The Medicaid waiver for the elderly, initially approved by HCFA in 1985, has a federal/state match ratio of 63:37, and a total projected budget of \$8.8 for this fiscal year. WSE has 1047 approved slots and a current average monthly census of 725 clients statewide, just about the same as the HBC active caseload.

Totally separate from the waiver program, the Medicaid state plan's targeted care management benefit is also an integral funding element in terms of administering the HBC program. The most recent available data indicate that billings to Medicaid for targeted care management services provided to HBC clients who are Medicaid recipients represent about 15% of the program's total care management costs. Within this group are individuals who do not meet the level of care requirements for waiver services but still are determined to need services provided through the HBC program.

B. Other Home and Community-Based Services Resources

Except for home-delivered meals which are provided on an as-needed and as-available basis, HBC and WSE clients have no priority status for Older Americans Act Title III resources. The same is true for several smaller home care-related programs managed by the Bureau of Elder and Adult Services (BEAS). Together totalling about \$1.4 million for the current fiscal year, they include:

- SSBG-funded homemaker services, focusing on eligible adults with significant IADL limitations;
- state-funded services for older people living in congregate housing facilities;
- a state-funded resource to supplement SSBG and Older Americans Act services; and
- a demonstration project to expand respite care and consultation services to family members of individuals with Alzheimer's disease.

In contrast to these relatively small home and community-based care resources, the Medicaid program is significant in terms of the home-based services it makes available to the state's Medicaid population.²⁷ Medicaid optional services included in the state plan, in addition to targeted care management mentioned previously, are personal care, private duty nursing and adult day health care. Medicaid State Plan expenditure figures for fiscal year 1993 include the following:

	NO. CLIENTS	EXPENDITURES ¹
Personal Care	415	\$2,856,969
Private Duty Nursing	175	1,526,373
Adult Day Health Care	12	24,855

1. Personal care and private duty nursing services for waiver clients are not included in these figures. If these services are needed, they are included in their care plans, costed out to be within the waiver cost cap, and charged to the waiver account.

The cost-sharing provisions of both the HBC and WSE programs are also worth noting. Even though cost-sharing often serves more as a mechanism for consumer awareness and informed decision-making than for generating significant extra program resources, contributions do offset expenditures to some extent. The most current estimate is that cost-share income for this fiscal year is averaging about 5% of HBC and WSE total program costs.

In Maine, the actual cost of an individual's care plan is not a factor in calculating participant cost-sharing amounts. Rather, for the HBC program, a complex formula has been developed to derive both income and asset values over protected amounts. Then, each value is multiplied by a pre-determined percentage and the amounts are combined to arrive at a monthly copayment figure. For the WSE program, the formula is much simpler. For a single person, all income over a protected \$767 "living allowance" becomes the assigned copayment amount. For both programs, copayment obligations, once established, become the

first dollars applied to the cost of the care plan. If care plan costs are lower than the cost-share amount, the client pays the full cost; if care plan costs are higher, the program picks up the difference.

II. HOW ARE THE BUDGETS ESTABLISHED FOR THE PROGRAMS?

For each of the programs managed by BEAS, budget numbers are generated by BEAS staff in accordance with a set of marks that have come down from the Governor's Office through the Department of Human Services. State agency staff, over the past decade, have become accustomed to developing what in their judgment are "least harm" budget scenarios to deal with whatever numbers ultimately are included in the state's overall annual budget.

III. WHAT ARE THE PRINCIPAL ISSUES AFFECTING PROGRAM FINANCING AND BUDGETS?

Since the late 1980's, Maine's economy has been experiencing a severe downturn, resulting in significant reductions in the amount of money available to fund human services and other state programs. HBC was one of many programs that fell victim to the state's no growth/budget cutback fiscal policies, though it has not been as seriously compromised as some others. Although some states have considered or actually utilized a dedicated tax to support home-based care, Maine continues to rely on general revenues as the principal source of financial support for HBC and state match for waiver services.

A significant programmatic effect of the state's continuing tight fiscal policy environment within which the programs have been operating is the expectation that more can be done with essentially the same level of resources. For example, on January 1, 1994, the state instituted more stringent criteria for Medicaid level of care determinations for nursing home placements. It also initiated a new pre-admission screening program for all Medicaid recipients and other applicants for Medicaid-funded nursing home care. Management responsibility for pre-admission screening was given to the state's five Area Agencies on Aging -- which also are responsible for administering the HBC and WSE programs at the substate level.

Several AAA staff have suggested that these actions are having a domino effect on both the waiver and HBC programs. Although the process is still in transition, staff from several AAAs believe there has been a noticeable increase in the number of heavier care clients for both HBC and waiver services. Their particular concern is that HBC waiting lists, which are already quite long, will get still longer unless additional resources are found to increase available services.

IV. HOW ARE THE PROGRAMS ADMINISTERED AT THE STATE AND SUBSTATE LEVELS?

Maine's Home-Based Care and waiver programs for the elderly and younger adults with disabilities are administered at the state level by the Bureau of Elder and Adult Services (BEAS) which, with the Bureau of Medical Services (BMS), is located within the Department of Human Services. At the substate level, the state's five Area Agencies on Aging (AAAs) are responsible for administering both the HBC and WSE programs, in addition to their responsibilities for pre-admission screening and serving as the designated agencies for implementing Title III of the Older Americans Act and several smaller, state-funded activities.

Each AAA has a core staff of care managers, primarily social workers but also some nurses, who are responsible for conducting assessments, developing and implementing care plans and assuming on-going care management activities for clients in both the HBC and WSE programs. AAAs have also been adding nurses to their staffs, primarily as consultants, in response to a recent state requirement that only registered nurses are authorized to assess medical and functional needs for waiver services, as well as for nursing home preadmission screening and reassessment. The MED'94 -- a comprehensive eligibility assessment and care planning instrument -- has been developed by the state agency for this purpose.

A. Eligibility Requirements

- a. **Waiver Services.** Waiver services are available to persons 65 and older and to persons with disabilities 60 to 64, whose income does not exceed 300% of SSI (\$1338/month) and who have no more than \$2000 in countable assets. Applicants also must meet the level of care requirements for nursing facility placement. To be determined medically eligible, an applicant must be determined to need:
 1. hands-on nursing care or care provided under the supervision of a registered nurse, usually on a daily basis; or
 2. extensive assistance or total dependence with three of five expanded, "late loss" ADLs (including "bed mobility" and "locomotion" as well as eating, toileting and transferring); or
 3. hands on nursing care or supervision no less frequently than three days per week, or cognition problems that require active intervention on a regular basis, and also limited assistance with two of five expanded ADLs.
- b. **Home-Based Care Services.** The Home-Based Care program uses income and asset levels to determine participant copayments, but not as criteria for determining program eligibility. Functional capacity is the basis for establishing eligibility for HBC services. In order to be determined eligible, an applicant must need "limited" assistance plus hands-on physical assistance with at least three ADLs, or a minimum of two ADLs and one IADL, or one ADL and two IADLs.

B. Eligibility Determination Procedures

The first step in the eligibility determination process is to screen applicants in order to make an initial judgment about their service needs. A second purpose of the screen is to determine whether an applicant is already a Medicaid recipient or appears likely to meet Medicaid's financial eligibility requirements.

If an applicant is found potentially eligible, and if funds are available, s/he is assigned for an in-depth assessment. However, even though the same standardized instrument -- the "Med '94" -- is required by both the HBC and WSE programs, and ongoing care management is essentially the same and is done by the same care managers for both programs, there are also very important differences in addition to the different eligibility criteria described above. Who administers the MED '94 and is responsible for reassessments, where the authority rests for approving eligibility, what services are available, and what the care plan cost targets are, differ across the two programs.

- a. **Waiver Services.** In addition to requiring that the MED'94 eligibility assessment instrument be used to determine functional eligibility as well as to provide the basis for care planning, the state also requires that the assessment be conducted by a registered nurse, either on the staff of the AAA or on a contract basis with the agency. As explained, this requirement is mainly to insure that the assessment reflects sufficient knowledge and skill to make appropriate judgments about the medical condition(s) and medical needs of an applicant.

After the assessment instrument is completed, it is forwarded to the Bureau of Medical Services for a level of care decision that will determine whether the applicant will be certified as medically eligible for waiver services. If the person is not currently a Medicaid recipient, final eligibility determination will also have to wait for a decision regarding financial eligibility from the Bureau of Income Maintenance.

- b. **Home-Based Care Services.** Eligibility determination for Home-Based Care services is considerably different from the procedures required for the WSE program. Care managers, while they also use the MED '94, are not required to be registered nurses. After reviewing the information from the assessment form, the care manager, in conjunction with supervisory staff where necessary, has the authority to determine a client's eligibility for HBC services. As part of the process, care managers also are responsible for assessing the financial status of new clients and establishing what their monthly cost-sharing commitment will be.

C. Care Planning and On-Going Care Management

Following a comprehensive assessment and the necessary decisions to establish client eligibility, either for waiver or HBC services, care managers have the responsibility to develop and implement care plans that are responsive to client need and to care planning guidelines set forth by the state agency.

- a. **Waiver Services.** For waiver clients, the recent requirement that RNs conduct client assessments

has introduced an administrative complexity to the care planning and services authorization process. Although the MED '94 allows space for a care plan, if the RN is not a care manager on the staff of the AAA, other than for nursing treatment needs, s/he is less likely to be familiar with all of the factors and details that go into developing a workable supportive services care plan. As a result, AAAs frequently either send a care manager with the RN to complete the assessment, or a care manager will arrange a visit with the client as soon as eligibility has been established. According to AAA staff interviewed, this was the only way they feel confident that the care plan that was developed would effectively and efficiently meet both client needs and the cost guidelines of the program.

Although the maximum monthly cost for an individual waiver client's care plan cannot exceed 75% of nursing home costs (\$2385/month), the average caseload cost cap target for services is less, because AAA care management costs are also included within an overall caseload cost cap. But even with this reduction, monthly care plans for waiver clients are averaging far less than the maximum on a statewide basis. For the first ten months of the fiscal year ending June 30, 1994, the average services reimbursement/client/month was \$683.

- b. **HBC Services.** For HBC clients, the care manager who conducted the assessment is likely to be the same person who also follows through with developing the care plan, using capitation guidelines that were contractually agreed to by each AAA and BEAS at the beginning of the fiscal year.

After a person is determined to be eligible, the care manager develops and then implements the care plan, brokering some services and authorizing others. The current capitation agreement commits each AAA to serving an established minimum number of clients at an aggregate average total caseload cost per client of \$450/month, exclusive of care management costs. (As is the case with WSE care plans, the maximum of 75% of nursing home costs -- \$2385/month -- applies to individual HBC clients as well.) For the last six months of the fiscal year ending June 30, 1994, the actual average care plan **service** cost/client/month was \$447.

Both HBC and WSE client care plans are reviewed and discussed by a multi-disciplinary team comprised of AAA staff, providers and other interested parties. For WSE clients, care plans also are submitted to the state Bureau of Medical Services for review prior to being implemented. Once the care plan is in place, care managers monitor HBC clients on an as-needed basis; WSE clients must be seen at least once in a three month period, and all clients are reassessed no less frequently than every six months. Care managers conduct reassessments of HBC clients; registered nurses are required to reassess WSE clients. For monitoring purposes, quality review teams -- which include state agency staff -- review client care plans on a randomly selected basis.

D. Available Services and Service Providers

[Exhibit E](#) displays the complement of services available from each of the two community-based care programs. While there is considerable overlap, the HBC program package does offer several additional

services, including two that are somewhat innovative. "Consumer payment subsidies" and payments for "other goods and services" allow care managers the flexibility to arrange for necessary assistance beyond what is specifically included on the list of approved services.

Because AAAs have been in business doing care management in their areas for almost two decades, they have longstanding relationships with most if not all of their providers. While provider rate caps are established at the state level, AAAs are responsible for negotiating individual provider rates within the cap and managing the billing and payment process, usually depending on quarterly cash allocations received from BEAS.

EXHIBIT E. Available Services in Maine

Services	Home-Based Care	Waiver Services for the Elderly
Care Management	X	X
Homemaker	X	X
Personal Care	X	X
Home Health	X	X
Adult Day Health Care	X	X
Transportation	X	X
Personal Emergency Response System	X	X
Mental Health	X	X
Family Assistance	X	
Companion	X	
Chore	X	
Respite	X	
Home Modifications	X	
Consumer Payment Subsidies	X	
Other Goods and Services	X	

AAA care managers, when appropriate, will include personal care assistants (PCAs) in care plans, but not as independent providers. In addition to using an agency based in Augusta that recruits and trains PCAs for placement statewide, some AAAs also arrange for PCAs from local agencies.

V. WHAT BUDGET CONTROL MECHANISMS ARE USED TO ENSURE THAT PROGRAM SPENDING

REMAINS WITHIN BUDGET LIMITS?

Maine uses fairly standard policies and procedures as mechanisms to control and track program costs. It limits participation by setting eligibility criteria; it limits the types and amounts of services that are available; and it uses cost-sharing very effectively as a disincentive for higher income people to participate in the program.

For client and caseload management and tracking, each AAA has a computerized system that allows them to record and synthesize client and care plan information and to compare-estimated cost projections with actual expenditures. A similar MIS system is used at the state level, not only to track individual AAA client and budget data, but also to compile aggregated information about each of the programs it administers. Because the approved number of WSE slots is considerably higher than the number of clients currently being served by the program, tracking costs relate more to assuring that individual care plans are both appropriate and cost-efficient than to concerns about exceeding the total available waiver budget.

For the HBC program, the state agency has developed a capitation-type contract arrangement that makes maintaining control of the HBC budget of particular interest to AAAs at the service delivery level. According to the terms of the contract, which specifies a budget amount to serve a minimum number of clients, each AAA assumes the risk if either the minimum number of clients is not met, or the maximum average annualized cost/client is exceeded. In the case of overspending, the AAA has to pick up the difference from any unrestricted resources it has available. If an AAA spends up to the limit available but does not meet the client numbers, their HBC allocation for the following year is reduced by the difference between what they did spend and what they would have spent, given the number of clients they actually served. The downside of this approach is that several of the more cautious AAAs have considerably underspent their target allocations in order to be certain they are not penalized for overspending.

VI. WHAT IF ANY ASPECTS OR FEATURES OF THE PROGRAMS HAVE BEEN PROBLEMATIC, AND WHAT KINDS OF SOLUTIONS ARE BEING TRIED OR CONSIDERED TO REMEDY THE PROBLEMS?

Several program features have been identified as problems, especially at the service delivery level. In principle, there is considerable support for a strategy to divert people from nursing homes into community care settings, provided that the community settings are available and appropriate to meet client needs. However, Area Agency on Aging staff have expressed some concern that the recent introduction of the MED '94, a significantly more medically-oriented eligibility assessment instrument intended as a vehicle for implementing such a strategy, is premature. They have suggested that current resources are not

sufficient to pay the higher costs for heavier care clients who are no longer eligible for waiver services, and that there has been insufficient time to establish appropriate alternative settings, e.g., board and care arrangements, for people who might be best served in a sheltered environment rather than in their own individual households.

A second, related issue raised by AAA staff was the state requirement that nurses administer the MED '94 to potential waiver clients. Again, although in principle AAA staff have no objection, they are concerned about the added costs of the additional staff time of care managers to fill in necessary information for effective care planning.

A final issue that was raised, by both AAA and state agency staff, relates to the time lag that too frequently occurs between the assessment of WSE applicants and approval of their financial and/or level of need eligibility status. In some instances, AAAs have been able to initiate emergency services on an interim basis, either from their HBC budget or other sources, e.g., their unrestricted funds, from Medicare through a certified home health agency, United Way, etc. However, when resources are not available, potential clients often fall between the cracks and end up in a hospital or in a position where home-based care may no longer be sufficient to safely meet their needs.

To respond to this concern, the Bureau of Medical Services and the Bureau of Elder and Adult Services have agreed, on a trial basis, to allow level of need determinations to be made by the nurses who are conducting assessments for one of the two waivers for persons with physical disabilities. Both BEAS and BMS staff have suggested that if the experiment works, they will consider expanding the authority to the other waiver programs.

VII. TO WHAT EXTENT ARE HOME AND COMMUNITY-BASED SERVICES PERCEIVED AS MECHANISMS FOR REDUCING NURSING HOME COSTS?

In Maine the initial motivation for establishing a home-based care program was the idea that people should have an alternative to nursing home placement. Subsequently, however, this value has been joined by another pressing incentive at the state level, i.e., to develop and implement a diversion strategy that expands community care options in order to reduce, or at least limit, the growth of nursing home beds and associated costs to the state's Medicaid program.²⁸ A 1993 law made this strategy very explicit. Its major features included the following:

- tightening medical eligibility criteria for nursing home admissions and requiring a pre-admission screening assessment for Medicaid recipients and other applicants who may become Medicaid

eligible within six months;

- restricting nursing home interests from increasing the bed supply without legislative approval and actually projecting that the diversion strategy will result in the elimination of 800 nursing home beds across the state; and
- investing the anticipated savings from the diversion strategy to support additional community-based services, alternative living arrangements, etc.

Some of these measures are reflected in actions that are already underway in terms of both the HBC and the WSE programs.

VIII. HOW DO STATE OFFICIALS EVALUATE THEIR ABILITY TO MANAGE A HOME AND COMMUNITY-BASED CARE PROGRAM WITHIN A FIXED, AS OPPOSED TO OPEN-ENDED ENTITLEMENT, BUDGET?

Maine has just received notification that it has been awarded a three year grant from HCFA to design and begin implementation of a managed care system that would focus initially on Medicaid acute care services, but then be extended to include long-term care services as well. One state staff person expressed concern about whether a federally-supported home and community-based services program could provide enough flexibility to fit into a managed care framework. If so, this person believed there would not be a problem implementing it, with either a fixed or open-ended budget.

NORTH DAKOTA

I. WHAT ARE THE PROGRAM ELEMENTS AND FUNDING SOURCES FOR THE STATE'S HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR THE ELDERLY AND DISABLED?

A. Principal Program Elements and Funding Sources

North Dakota's statewide "Home and Community-Based Services Program for the Elderly and Disabled" (HCBSP) offers a range of non-institutional long-term care services and assistance to eligible older people as well as younger adults and children living in the community who have severe functional impairments not caused by mental illness or mental retardation.²⁹ Administered through a single point of entry -- a generic care management system located at the county level -- the program has three principal funding streams that define three distinct, but structurally and administratively consolidated, program elements.

For the current fiscal year, total funding for the HCBSP is close to \$5.5 million, the major portion of which is for the "Service Payments for the Elderly and Disabled" (SPED) component of the program. Until January, 1994, when counties began matching state funds at 5%, SPED was fully state-funded. From a modest \$450,000 state appropriation in 1983, its level of funding has increased to \$3.15 million for this year, representing 57% of the HCBSP primary resource base. SPED's monthly census averages 1200 clients, about 40 percent of whom are under age 60.

The Medicaid waiver for aged and disabled, with a federal/state match ratio of 69:31, is the second principal source of HCBSP funding. Also approved initially in 1983, waiver services together with SPED form the nucleus of the statewide program. Combined funding for HCBSP waiver services this year is \$1.5 million, representing 28% of HCBSP resources. Although 420 slots have been approved, approximately 300 waiver clients are currently being served each month.

The third component, referred to as "Expanded SPED" (E/SPED), is a new, and considerably smaller, element of the state's HCBSP. E/SPED started serving clients only in September, 1994, at an annualized funding level of \$780,000, or 14% of projected HCBSP resources for the fiscal year. Like SPED, it is state funded. However, in contrast to its well-established partner, E/SPED is targeted primarily to adults with low incomes who may require some limited ADL assistance, but whose primary need is for help with IADLs and/or supervision at home or in a more structured environment, i.e., adult foster care. Since at the time of the site visit, E/SPED had only been operating for a few weeks, further references to it will be made only where information was available.³⁰

B. Other Home and Community-Based Services Resources

Social Services Block Grant (SSBG) funds, about \$2.4 million annually, are allocated directly by the Department of Human Services to North Dakota's 52 County Social Services Boards. Among the services most often available are county-employed homemakers, home health aides and drivers to provide in-home and personal care, and medical and other necessary transportation. Although the primary recipients of SSBG services are county residents who need help but do not meet either the financial and/or functional eligibility requirements for HCBSP-funded services, the SSBG does serve as an important resource for the program -- particularly for providing services to SPED-eligible clients who are waiting for slot assignments.

Title III services funds are managed primarily by local senior centers to provide outreach, information and referral, home-delivered meals, companion visiting, and other services. While coordination is encouraged

by the state, and care managers help broker Title III services for HCBSP clients, they have no special priority status for Older Americans Act resources. Of the \$10 million the state has available in Title III dollars, none is dedicated directly to the HCBSP, and only a small proportion is thought to be accessed for HCBSP clients.

One additional financial resource of some significance to the HCBSP is its costsharing provisions. For SPED clients with incomes in excess of the established protected amounts, fees are graduated from 10% to 100% of HCBSP-authorized care plan costs. For example, the 10% to 100% fee would apply to a single person with an income ranging from \$641 to \$1279/month, and to a two-person family income from \$857 to \$1713/month. Cost-share amounts are deducted from the state's monthly payments to providers; clients are responsible for paying the balance directly.

II. HOW IS THE BUDGET ESTABLISHED FOR THE HCBSP?

During each biennial session of the legislature, the Governor's budget forms the basis for hearings and, ultimately, legislative decisions regarding what the state budget will look like for the following two years. In the case of the HCBSP, budget numbers are generated by its state-level administering agency, the Aging Services Division (ASD). ASD develops the budget for each of the program elements, including the Medicaid waiver, based on the overall program's operating experience over the previous two years and projected demographic trends. While incorporating a realistic reflection of need, the process also is politically realistic.

The ASD budget proposals are then reviewed by its parent Department of Human Services and, ultimately, by the Governor's staff. This process culminates with a budget document that is submitted to the state legislature. Historically at least, both the Governors and the legislatures have protected and supported the HCBSP. It has not necessarily gotten the full amount requested initially by the ASD, but it also has never been seriously threatened by severe budget cuts.

III. WHAT ARE THE PRINCIPAL ISSUES AFFECTING THE FINANCING OF THE HOME AND COMMUNITY-BASED SERVICES PROGRAM FOR THE ELDERLY AND DISABLED?

North Dakota recognized fairly early on the importance of community-based service alternatives for people needing long-term assistance and care. So much so that when, in 1983, the state legislature appropriated general revenues to provide match for its first Medicaid waiver for aged and disabled persons, it also provided state funds for SPED, which was not income-related. Since then, for each biennial cycle the HCBSP budget has either been increased or remained at current levels, while other human services program budgets were being cut.³¹

IV. HOW IS THE HCBSP ADMINISTERED AT THE STATE AND SUBSTATE LEVELS?

The North Dakota HCBS Program for the Elderly and Disabled is administered at the state level by the Department of Human Services Aging Services Division (ASD), and at the substate level through 52 County Social Services Boards (CSSBs).³² Generic, county-employed social workers are the entry point for potential clients into the consolidated program. Functioning as HCBSP care managers, they conduct assessments using a common "Multi-Dimensional Assessment" instrument, develop and initiate care plans based on the comprehensive assessment, and provide on-going care management for all HCBSP clients, irrespective of the particular funding stream that pays for the services provided. Counties bill the ASD on a fee-for-service basis for the functions their care managers perform.

A. Eligibility Requirements

While the emphasis of the HCBSP is on providing assistance to people with functional impairments, specific eligibility criteria vary across its three current primary components.

- a. **Waiver Services.** Medicaid waiver services are targeted to low-income individuals 65 and older and younger adults who are classified as disabled according to SSDI criteria. The financial eligibility cut-off is 100% of SSI. To meet the state's criteria for nursing facility level of care, an individual must need medically-related care that requires hands-on nursing and supervision or, in terms of ADL limitations, require "human assistance" with at least two of four ADLs (transferring, toileting, eating and bathing) for at least 60% of the time it takes to perform the specific ADL task.
- b. **SPED Services.** There are no age or income requirements for SPED services and, although there is an asset limit, it is very generous -- a maximum of \$50,000 in countable liquid assets. SPED's functional eligibility criteria, however, are very stringent. Persons 18 years of age and older must be determined to have impairments in a minimum of four ADILS or five IADLs, which are expected to last for at least three months. Persons under the age of 18 must be certified for nursing home care by the state's utilization review organization, which uses the same criteria it applies to Medicaid recipients.
- c. **E/SPED Services.** E/SPED, the newly-instituted HCBSP component, has yet another set of financial and functional eligibility criteria. Although it is supported solely by state funds and

financial eligibility does not have to be determined by the state Medicaid agency, E/SPED applicants still must meet the same income and asset requirements as Medicaid waiver clients. With respect to functional capacity, eligibility focuses on adults who are capable of basic self-care (i.e., not severely ADL-impaired), but who are seriously limited in three of four specified IADLs and/or who need a supervised and structured environment.

B. Eligibility Determination Procedures

- a. **Waiver Services.** Since the number of waiver slots that have been allocated is (and has been) considerably less than the number approved by the Health Care Financing Administration (HCFA), a nursing facility level of care determination is currently the only prerequisite to initiating HCBS waiver services for applicants who already are Medicaid recipients. Based on the comprehensive assessment, if the applicant appears to meet the level of care criteria, the care manager will contact the state's utilization review contractor for authorization. More often than not, this contact is by telephone and the decision, usually approval, is also given verbally. (In these instances, the necessary paperwork is taken care of subsequently.)

If the applicant is not yet on Medicaid -- the necessary precondition for requesting a level of care determination -- the care manager will help complete the appropriate financial forms and materials. Financial eligibility for Medicaid is determined by an Eligibility Specialist from the state Medicaid agency, the Medical Services Division of the Department of Human Services.

Although the Medicaid financial eligibility determination process is, by its nature, cumbersome, it appears that the process, at least in North Dakota, can be expedited somewhat when it is important to do so. Also, except in rare circumstances, SPED or SSBG resources have been sufficient to initiate and pay for needed services until the approvals are made official.

- b. **SPED Services.** For SPED applicants, care managers technically are empowered to make eligibility determination decisions based on information from the assessment instrument. Operationally, however -- in contrast to Medicaid waiver clients -- even when an applicant meets SPED functional and financial (asset level) criteria, care managers cannot activate a care plan and authorize services until they request and receive approval for a SPED "slot." These approvals come from the state Aging Services Division.

In general, a slot is approved if, at the time of the request, actual and projected total SPED expenditures appear to be within its available budget. If not, clients are placed on a waiting list until a slot opens up (usually within a few weeks to a month). A computerized system is in place to track initial care plan costs, care plan changes and SPED client terminations, so that accurate budget balances can be maintained and slot assignments can be made in a timely manner.

C. Care Planning and On-Going Care Management

Care plans are developed by HCBS care managers according to client needs and the care plan cost cap

guidelines for either waiver or SPED services, depending on client status. Other than the cost cap differential, care planning requirements are the same for both categories of clients. In either case, care managers follow state guidelines that include maximum unit rates and, for some services, e.g., homemaker, respite, and family home care, maximum daily or monthly total costs.

Even though the average monthly care plan target for SPED clients is \$700, care plans currently in effect are averaging between \$250 and \$275 per month. For waiver clients, the average monthly care plan target jumps to \$1160; and actual waiver care plan costs are averaging about \$500/month. One possible explanation for the cost differences between SPED and waiver care plans may be the result of a differential use of individual as opposed to agency providers. Agency rates for the same types of service can be as much as one-third higher than those of individual service providers.

Once a care plan is in place, a care manager monitors the client and the services on a regularly scheduled basis -- irrespective of which program component the client is being served under -- and is always available if client circumstances change. For monitoring and quality assurance purposes, face-to-face contact with clients is required to occur no less frequently than every three months; and full reassessments are required annually. Staff from ASD also make home visits to clients across the state on a spot check basis.

D. Available Services and Service Providers

[Exhibit F](#) displays the HCBSP's complement of basic services which, while funded by different funding streams, is available to clients irrespective of their eligibility status. SPED services are essentially the same as those covered by the waiver. The single exception is "family home care," which provides a limited, taxable payment of up to \$400/month to encourage families to keep a family member at home. And only SPED's non-medical transportation and adult day care services are not available to E/SPED clients. For care planning and service authorization purposes, state guidelines have established some services as mutually exclusive and others as complementary to one another. For example, family home care and adult foster care are inclusive, 24hour services, so that only respite care (and, under certain circumstances, transportation) would be considered appropriate, and homemaker, chore or home health aide services would not be authorized. Also, SPED clients under age 19 are eligible to receive only family home care and respite services.

EXHIBIT F. Available Services in North Dakota

Services	SPED	Aged/Disabled Medicaid Waiver	Expanded SPED
Care Management	X	X	X
Homemaker	X	X	X
Chore	X	X	X
Personal/Attendant Care	X	X	X
Home Health Aide	X	X	X

Respite	X	X	X
Adult Foster Care	X	X	X
Case Management	X	X	X
Adult Day Care	X	X	
Non-Medical Transportation	X	X	
Family Home Care	X		X
Family Caregiver Training		X	
Environmental Modification		X	
Special Equipment		X	X
Adaptive Assessment			

North Dakota's HCBSP relies very heavily on individual "Qualified Service Providers" (QSPs) as the primary providers of service, as much because of their flexible availability as for their lower rates for providing personal assistance and related services. Of approximately 950 QSPs across the state, only 100 are agencies; the remainder are individuals who have applied to and received approval from the Aging Services Division to provide assistance in accordance with the HCBSP plan of care.

Both individual and agency QSPs establish their own rates for HCBSP services, on the basis of the state agency's assumption that this encourages free market competition. Care managers, when they develop care plans, identify needed services in terms of time-measured units and a maximum dollar value that can be paid for those services. To the extent possible, the care plan is developed with the client, who is encouraged to select his or her own provider(s) from a list of QSPs, which also includes the individual's or agency's particular skills and unit rates. Clients can also suggest someone not on the list. When this happens, the person must submit an application to the ASD to enroll as a QSP. Once enrolled, the QSP can become a Medicaid provider simply by filling out the appropriate forms.

V. WHAT BUDGET CONTROL MECHANISMS ARE USED TO ENSURE THAT HCBSP SPENDING REMAINS WITHIN BUDGET LIMITS?

Like most other programs that have only a certain amount of money within which to operate, the HCBSP has specific policies that establish limits on program costs. Participation is controlled by setting financial and functional disability levels; it offers a limited number of specified services; and it establishes cost caps on client care plans, specific services and even on reimbursement rates for specific services. Also like many other programs, the SPED component includes a participant cost-sharing provision, to generate income, but perhaps even more importantly, to encourage recipients to be more cost-conscious and

selective of the types and levels of service they request.

Cost control functions associated with care planning are performed by the county-based care managers on a case-by-case basis. Tracking program expenditures is a centralized function that occurs at the state level, in the Aging Services Division.

For the Medicaid waiver element of the program, the state has not had to exercise any special cost controls, beyond the standard ones listed. Although ASD tracks waiver slots and provider/vendor payments, to date the program has not come even close to filling the 420 HCFA-approved slots or using the allocated state funds available to draw down Medicaid match. (Interestingly, no one suggested the possibility of amending the waiver to reduce the number of slots and shift the match appropriation to SPED or E/SPED, or to return it to the state general revenue pool.)

Controlling the SPED component budget is a somewhat different matter. As described previously, even after an applicant meets the functional and asset requirements for SPED and an appropriate care plan is developed, services cannot begin until he or she is assigned a SPED slot. The process for determining the number of slots that will be available over a specified budget period is fairly straightforward.

After the Aging Service Division receives the approved SPED budget for the next biennium, ASD staff, using historical program data, establish the number of "slots" they project the two-year budget will cover. They then use a computerized system to track care plan costs and changes, including terminations, in order to maintain an up-to-date accounting of SPED expenditures and a current budget balance. This system allows for more or less constant adjustments in the number of available slots that can be assigned.³³

Occasionally, there may be a delay, usually lasting two weeks to a month or so, before a SPED-eligible client is assigned a slot. When this occurs, the care manager will attempt to access SSBG, Title III or other appropriate, if limited, services as a bridge until a slot becomes available. Because of a relatively rapid turnover in SPED clients -- most frequently due to death or placement in a nursing facility -- there has only been one time in SPED's eleven year history when it was necessary to institute a waiting list for more than a few months.

Self-set QSP rates in North Dakota also have an effect on program costs. Rather than using a contract mechanism to line up service providers, the state will enroll individuals or agencies that meet a set of established competency requirements. Once enrolled, QSPs can set their own hourly rates, as long as they do not exceed the rate ceilings set by the state agency. (The hourly rate ceiling for provider agencies is somewhat higher than that for individual QSPs, \$12.84 vs. \$9.40.)

ASD staff suggest that market forces and, in North Dakota at least, an individual's sense of responsibility are effective in keeping costs down. When a care plan is developed, care managers set a maximum cost for care, depending on the level of client needs for specific categories of service, tempered of course by client eligibility status. QSPs set their rates in order to be competitive. A client who selects a low-cost

QSP could, in theory, obtain more units of service and still remain within the maximum. But in fact it seems that clients do not use more service just because the rate is lower, and so the cost per client tends to be lower than the set ceiling.

VI. WHAT IF ANY ASPECTS OR FEATURES OF THE HCBSP HAVE BEEN PROBLEMATIC, AND WHAT KINDS OF SOLUTIONS ARE BEING TRIED OR CONSIDERED TO REMEDY THE PROBLEMS?

State agency officials, not only from the ASD, but also from other Divisions as well as the Executive Office of the Department of Human Services, expressed considerable satisfaction with the way the program was operating. When asked, they could not identify any particular feature(s) of the HCBSP that were seriously problematic.

VII. TO WHAT EXTENT ARE HOME AND COMMUNITY-BASED SERVICES PERCEIVED AS MECHANISMS FOR REDUCING NURSING HOME COSTS?

Consumer choice and independence are highly valued in North Dakota. In contrast to many other states that began developing community care options at about the same time, and certainly subsequently, there is some evidence to suggest that the state's motivation was and continues to acknowledge and be supportive of these values, rather than to be driven by budget pressures. On the other hand, several other factors may come into play as well.

In a number of communities across the state, nursing facilities are the largest employers. With one of the higher ratios of nursing home beds per thousand 65 and older population (75:1 000),³⁴ a prominent state official suggested that the local and state economic and political impacts of a bed-use reduction strategy might well be worse than the burden of the state match needed to draw down Medicaid dollars for nursing home care.

Also, the nursing home industry -- still referred to by many in the state as the "long-term care" industry -- is an extremely powerful lobby. An example is North Dakota's status as one of only two states in the

country that has a nursing home rate equalization law, requiring state Medicaid and private pay rates to be the same. The net effect of this policy is that the state has less control over Medicaid payments for nursing home care and, as a result, may be paying more per Medicaid day than it otherwise might.

General consensus among state-level staff from the aging and Medicaid agencies, as well as executive branch administrators within the Department of Human Services, is that home care and nursing home care are considered as parallel, but separate and distinct, systems. It may be simply a matter of the politics of appeasement, but it seems that as long as the HCBSP does not appear to threaten the nursing home industry, it will continue to grow, albeit slowly, and nursing homes will continue to be big business as well.

VIII. HOW DO STATE OFFICIALS EVALUATE THEIR ABILITY TO MANAGE A HCBSP WITHIN A FIXED, AS OPPOSED TO OPEN-ENDED ENTITLEMENT, BUDGET?

The North Dakota HCBSP, designed and administered by the Aging Services Division, already operates within a fixed budget. The Medical Services Division, which administers the Medicaid entitlement program, is supportive of ASD's role. Naturally, everyone would prefer an open-ended source of funding, but the state seems well-prepared to manage within a capped budget if that were the only way it could get additional resources for home and community-based services.

NOTES

1. Because of the limited, exploratory nature of this study, state programs designed to offer services to meet the special needs of persons with mental retardation and other developmental disabilities (MR/DD), are not included. The one exception is Indiana, which has a single administrative structure for managing all five of the state's current Medicaid waivers, three of which relate to the MR/DD population.
2. A draft of each state-specific report was made available to the respective state aging agency. The final case studies incorporate comments received from all five states.
3. These percentages need to be viewed with some caution, because while earmarked state and federal grant revenues tend to be fully expended each fiscal year, the Medicaid budget is only a projection, based on estimates of the number of approved slots that will be filled and the total of their associated care plan costs. Except for Indiana, which currently has waiting lists for all but its

OBRA waiver, budget projections for waiver services are likely to be significantly skewed on the high side.

4. In addition to being direct service providers and performing targeted care management functions for Medicaid-eligible clients, AAAs also are responsible for managing the state home care services program.
5. In Maine, Indiana and Illinois, the same instrument used for their HCBS programs is also used for nursing home pre-admission screening. Neither Arkansas nor North Dakota has pre-admission screening tied into their HCBS programs.
6. An estimated \$40 million of last year's \$52.7 million in Medicaid payments for personal care in Arkansas went to seven of the state's eight Area Agencies on Aging. The eighth AAA, in Southwest Arkansas, is one of two that originally had been responsible for assessment and care management functions in a demonstration project that separated these activities from service provision. At the conclusion of the demonstration, the AAA decided to retain the separation and to continue contracting out for direct service provision.
7. This amount represents the current year's budget totals for the HCSP and ElderChoices programs, a steady-state \$6 million for Medicaid personal care for ElderChoices clients, and an arbitrary 0% and 10% inflation/growth increase from the last fiscal year's estimated Medicaid personal care costs for clients age 65 and older.
8. Since the site visit in September, the DAAS has added 12 nurses to its staff, increasing the number of RNs in the field by 60%, from 17 to 29. While the time lapse for level of care and financial eligibility decisions still exists at the state level, state agency staff report that the length of time between referral and completion of an assessment has been reduced considerably.
9. A recent proposal to reduce the maximum allowable hours for Medicaid personal care from 72 to 46 hours/month -- the actual average number of hours/month being written for Medicaid personal care services -- has been put on hold at least until the start of the next fiscal year, apparently due to pressure from various personal care providers across the state.
10. Harrington, Charlene, **et al**, "Variations and Trends in Licensed Nursing Home Capacity In the States, 1983-1993," University of California, San Francisco, December, 1994.
11. State funds are used to pay the operating costs for the entire Community Care Program, including services provided to Medicaid recipients. On a monthly basis, the state Medicaid agency runs CCP expenditures against its Medicaid eligibility roles to identify those program costs that can be charged against the waiver and submitted for FFP. Federal match, when it is received, is then returned to the general treasury.
12. Most AAAs actually contract with the same CCU agencies as the CCP to provide assessment and care management services to Title III clients, but the two are administered totally separate from one another, except perhaps for applicant referrals from one program to the other.
13. In Illinois, Area Agencies on Aging play only a nominal role in relation to the state's home and community-based long-term care services program, performing somewhat loosely defined coordinating and supporting roles vis-a-vis the CCP.
14. Officially, clients are to be terminated from the program if they have not paid their fees for more than two months. In fact, however, it is much more likely that some arrangement -- usually among the provider, the client and the care manager -- will be worked out at the local level before such a drastic action takes place.

15. Harrington, C. **et al, op. cit.**
16. The state requires that a minimum of 20% of the CHOICE appropriation must be earmarked for persons with disabilities who are under age 60. Although the actual percentage varies, some areas of the state report that CHOICE resources for the under 60 population are running as high as 30 to 40 percent.
17. The current Indiana federal/state Medicaid match ratio is 63:37.
18. Indiana Medicaid rules penalize private pays who refuse pre-admission screening by requiring them to forfeit Medicaid coverage for a period of one year from their date of admission to a nursing facility.
19. Since eligibility criteria for Title III and SSBG are loosely-defined in the IHSP -- for Title III, age 60 and older with no income limits, and for SSBG, no specified age limitations, but incomes limited to less than 150% of poverty -- these will not be discussed in detail.
20. Functional eligibility for the medically-fragile children's waiver is based on SNF or hospital level care; and for financial eligibility, the income cutoff is 300% of poverty. Also, for determining financial eligibility for the MR/DD, autism and medically-fragile children's waivers, parents' income is disregarded.
21. Other Medicaid services, which are available under the state plan, might include home health services (home health aides, skilled nursing and the various therapies) and medical transportation.
22. Financial data are used initially only to suggest whether an applicant might be Medicaid-eligible. If this appears to be the case, care managers will work to develop an appropriate care plan, but also strongly urge (but they cannot require) the applicant to apply for Medicaid eligibility status.
23. Memoranda of agreement are open-ended contracts used to retain flexibility with respect to client referrals. The agreement only establishes the type(s) of service that will be provided, how it/they will be provided, and at what rate and how payment will be made. There is no commitment on the part of the AAA to guarantee how many clients will be referred or how many units of service will be utilized.
24. Harrington, C. **et al, op. cit.**
25. Since the HBC program was first legislated, 20% of the budget has been earmarked for individuals with physical disabilities who were under age 60 and for adult protective services. To meet legislative intent, BEAS allocates a proportion of the 20% of each year's HBC budget to an Independent Living Center (ILC) that also administers one of the state's waivers for the physically disabled, and the balance to AAAs for services for clients under age 60 who are disabled, and for protective services. Among the relatively few clients under age 60 who are served by AAAs are those referred by the ILC because they require a more traditional care management model to assist in meeting their service needs.
26. Since both waiver programs are currently administered and operating not only totally separately from one another but also from the elderly waiver, they will not be discussed in any further detail.
27. Although the Medicaid figures are not broken out by age, the data is still instructive in terms of noting the spectrum of home and community-based services currently being utilized across the state.
28. Even though Maine's nursing home bed supply dropped from 61.9/1000 persons 65 and older in 1983 to 59.5 in 1993, the ratio still exceed the national average. Harrington, C., **et al, op. cit.**
29. The state also has an MR/DD waiver, with a separate assessment, care management and services

structure, for its eligible MR/DD population. MR/DD care managers, however, do tap into the HCBSP on an as-needed basis to access more traditional in-home services, e.g., homemaker, in addition to the MR/DD services offered through their own program. HCBSP services provided to MR/DD clients are paid by the MR/DD waiver.

30. North Dakota recently received approval from the HCFA for a new Medicaid waiver to cover services for people with traumatic brain injury (TBI), which will be incorporated as still another component of the HCBSP. At this time, however, there is insufficient information to describe how it will be coordinated with other HCBS Program elements.
31. The state legislature mandated that as of January 1, 1994, each county contribute a 5% match for its SPED allocation, which allowed the program to remain at level funding while reducing the state share from 100% to 95%.
32. North Dakota is one of eight states approved by the Administration on Aging as a “single planning and service area.” Eight Regional Aging Services Coordinators perform various statutory and administrative functions related to the Older Americans Act, but have no official management responsibilities for the HCBSP.
33. North Dakota does not have a statewide computerized MIS system. Countybased care managers send documentation to ASD staff for entry into the state-level computerized network.)
34. Harrington, C., **et al, op. cit.**