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LONG-TERM CARE

Elderly Individuals Could Find Significant Variation in the Availability of Medicaid Home and Community Services

Statement of Kathryn G. Allen
Director, Health Care—Medicaid
and Private Health Insurance Issues

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Mr. Chairman and Members of the Committee:

I am pleased to be here today as you continue to explore issues that confront many elderly Americans seeking long-term care services, with today's focus on care options that can allow elderly individuals—as they face declining health and independence—to remain in their homes and communities as long as possible. This Committee has held a series of hearings this year examining the current provision of long-term care and considering the role that the public sector should play in assuring that long-term care needs will be met for the impending surge of the baby boom generation. The availability of home and community-based care is an important aspect of the overall long-term care spectrum.

As the Comptroller General testified before this Committee in March, the aging baby boom generation is anticipated to greatly expand the demand for long-term care services, which could result in spending for long-term care for the elderly nearly quadrupling by 2050.[1] This growing demand for long-term care will exert increased pressure on federal and state budgets since long-term care relies heavily on financing by public payers, particularly Medicaid, which is currently the largest payer for long-term care services. Nursing home care traditionally has accounted for most Medicaid long-term care expenditures, but the high costs of such care and many individuals' preferences to remain in their own homes has led states to expand their Medicaid programs to provide coverage of home and community-based long-term care services.

States have considerable discretion within their Medicaid programs to decide who may be eligible for home and community-based care and what services to cover. Most home and community-based services—including in-home assistance with activities of daily living, such as bathing or eating, or community-based options, such as adult day care or assisted living facilities—are optional elements of state Medicaid programs. Local case managers, who screen Medicaid-eligible individuals to determine what services they qualify for, also often have discretion to customize care plans based on an individual's needs, preferences, and the availability of care services, including unpaid care provided by family members or other informal caregivers.

[1]See U.S. General Accounting Office, *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T (Washington, D.C.: Mar. 21, 2002).

My remarks will summarize findings of a report that we are releasing today that examines four geographically diverse states—Kansas, Louisiana, New York, and Oregon—that varied in their coverage of Medicaid home and community-based services.[2] At your request, we examined how these states' coverage policies affected long-term care services available to elderly individuals needing care. We focused on three specific issues: (1) the extent to which home and community-based services were available for Medicaid-eligible elderly, (2) services that local case managers would offer to two hypothetical elderly individuals based on the levels of unpaid informal care provided by family members, and (3) the extent to which care offered to the same individual with the same level of informal support varied among the selected states.

The cornerstone of our work was the development of vignettes for two hypothetical elderly persons—an 86-year-old woman with debilitating arthritis and a 70-year old man with moderate Alzheimer's disease. For each of these hypothetical individuals, we developed three scenarios where the individuals had varying levels of informal care available from their families and preferred to remain at home as long as possible. We then asked four Medicaid case managers in each of the four states to develop care plans for each scenario.[3]

In summary, we found that a Medicaid-eligible elderly individual with the same disabling conditions, care needs, and availability of informal family support could find significant differences in the type and intensity of home and community-based services that would be offered for his or her care. These differences were due in part to the very nature of long-term care needs—which can involve physical or cognitive disabling conditions—and the lack of a consensus as to what services are needed to compensate for these disabilities and what balance should exist between publicly available and family-provided services. The differences in care plans were also due to decisions that states have made in designing their Medicaid long-term care programs and the resources devoted to them. The case managers we contacted did offer, in general, care plans that relied largely on in-home services rather than other residential care settings. However, there was

[2]U.S. General Accounting Office, *Long-Term Care: Availability of Medicaid Home and Community Services for Elderly Individuals Varies Considerably*, GAO-02-1121 (Washington, D.C.: Sept. 26, 2002).

[3]In each state, we selected two case managers in a county with a small town (less than 15,000 people) and two in a county with a large city (at least 250,000 people).

considerable variation in the extent of in-home services offered. For example, for our hypothetical 86-year-old woman with debilitating arthritis, case managers recommended from 4.5 hours per week to 40 hours per week of in-home assistance to supplement the care she received from her daughter who lived with her but who also cared for her own infant grandchild. However, despite coverage for varying types and levels of home and community-based services in all four states' Medicaid programs, two states had waiting lists that would at present preclude the availability of many of these services for elderly individuals seeking them.

Background

Individuals needing long-term care have varying degrees of difficulty in performing some activities of daily living without assistance, such as bathing, dressing, toileting, eating, and moving from one location to another. They may also have trouble with instrumental activities of daily living, which include such tasks as preparing food, housekeeping, and handling finances. They may have a mental impairment, such as Alzheimer's disease, that necessitates supervision to avoid harming themselves or others or need assistance with tasks such as taking medications. Although a physical or mental disability may occur at any age, the older an individual becomes, the more likely it is that a disabling condition will develop or worsen.

Assistance for such needs takes many forms and takes place in varied settings, including care in nursing homes or alternative community-based residential settings such as assisted living facilities. For individuals remaining in their homes, in-home care services or unpaid care from family members or other informal caregivers is most common. Approximately 64 percent of all elderly individuals with a disability relied exclusively on unpaid care from family or other informal caregivers; even among almost totally dependent elderly—those with difficulty performing five activities of daily living—about 41 percent relied entirely on unpaid care.[4]

Medicaid, the joint federal-state health-financing program for low-income individuals, continues to be the largest funding source for long-term care. In 2000, Medicaid paid 46 percent (about $63 billion) of the $137 billion

[4]Calculations based on Korbin Liu et al, *Changes in Home Care Use by Older People with Disabilities: 1982-1994* (Washington, D.C.: AARP, January 2000).

spent on long-term care from all public and private sources.[5] States share responsibility with the federal government for Medicaid, paying on average approximately 43 percent of total Medicaid costs. Within broad federal guidelines, states have considerable flexibility in determining who is eligible and what services to cover in their Medicaid program. Among long-term care services, states are required to cover nursing facilities and home health services for Medicaid beneficiaries. States also may choose to cover additional long-term care services that are not mandatory under federal standards, such as personal care services, private-duty nursing care, and rehabilitative services. For services that a state chooses to cover under its state Medicaid plan as approved by the Centers for Medicare & Medicaid Services (CMS), enrollment for those eligible cannot be limited but benefits may be. For example, states can limit the personal care service benefit through medical necessity requirements and utilization controls.

States may also cover Medicaid home and community-based services (HCBS) through waivers of certain statutory requirements under section 1915(c) of the Social Security Act, thereby receiving greater flexibility in the provision of long-term care services.[6] These waivers permit states to adopt a variety of strategies to control the cost and use of services. For example, states may obtain CMS approval to waive certain provisions of the Medicaid statute, such as the requirement that states make all services available to all eligible individuals statewide. With a waiver, states can target services to individuals on the basis of certain criteria such as disease, age, or geographic location. Further, states may limit the number of persons served to a specified target, requiring additional persons meeting eligibility and need criteria to be put on a waiting list. Limits may also be placed on the costs of services that will be covered by Medicaid. To obtain CMS approval for an HCBS waiver, states must demonstrate that the cost of the services to be provided under a waiver (plus other state Medicaid services) is no more than the cost of institutional care (plus any other Medicaid services provided to institutionalized individuals). These waivers permit states to cover a wide variety of nonmedical and social

[5]Based on our analysis of data from the Centers for Medicare & Medicaid Services, Office of the Actuary and The MEDSTAT Group. These figures include long-term care for all people, regardless of age. Amounts do not include expenditures for nursing home and home health care services provided by hospital-based entities, which are counted generally with other hospital services.

[6]42 U.S.C. §1396n(c) (2000).

services and supports that allow people to remain at home or in the community, including personal care, personal emergency response systems, homemakers' assistance, chore assistance, adult day care, and other services.

Medicare—the federal health financing program covering nearly 40 million Americans who are aged 65 or older, disabled, or have end-stage renal disease—primarily covers acute care, but it also pays for limited post-acute stays in skilled nursing facilities and home health care. Medicare spending accounted for 14 percent (about $19 billion) of total long-term care expenditures in 2000. A new home health prospective payment system was implemented in October 2000 that would allow a higher number of home health visits per user than under the previous interim payment system while also providing incentives to reward efficiency and control use of services. The number of home health visits declined from about 29 visits per episode immediately prior to the prospective payment system being implemented to 22 visits per episode during the first half of 2001.[7] Most of the decline was in home health aide visits.

Selected States Varied in Expenditures for and Design of Medicaid Home and Community Services

The four states we reviewed allocated different proportions of Medicaid long-term care expenditures for the elderly to federally required long-term care services, such as nursing facilities and home health, and to state optional home and community-based care, such as in-home personal support, adult day care, and care in alternate residential care settings. As the following examples illustrate, the states also differed in how they designed their home and community-based services, influencing the extent to which these services were available to elderly individuals with disabilities.

- New York spent $2,463 per person aged 65 or older in 1999 on Medicaid long-term care services for the elderly—much higher than the national average of $996.[8] While nursing home care represented 68 percent of New

[7]U.S. General Accounting Office, *Medicare Home Health Care: Payments to Home Health Agencies Are Considerably Higher Than Costs*, GAO-02-663 (Washington, D.C.: May 6, 2002).

[8]Medicaid expenditures for long-term care services for the elderly include nursing facilities, home health, personal support, and other care (which includes adult day care and alternate residential settings). We calculated a per capita cost based on the state or national population aged 65 or older and adjusted Medicaid expenditures for a state's health care costs in relation to the national average health care costs for 1997 to 1999 to at least partially account for geographic cost differences.

York's expenditures, New York also spent more than the national average on state optional long-term care services, such as personal support services. Because most home and community-based services in New York were covered as part of the state Medicaid plan, these services were largely available to all eligible Medicaid beneficiaries needing them without caps on the numbers of individuals served.

- Louisiana spent $1,012 per person aged 65 or older, slightly higher than the national average of $996. Nursing home care accounted for 93 percent of Louisiana's expenditures, higher than the national average of 81 percent. Most home and community-based services available in Louisiana for the elderly and disabled were offered under HCBS waivers, and the state capped the dollar amount available per day for services and limited the number of recipients. For example, Louisiana's waiver that covered in-personal care and other services had a $35 per day limit at the time of our work and served approximately 1,500 people in July 2002 with a waiting list of 5,000 people.[9]
- Kansas spent $935 per person aged 65 or older, slightly less than the national average. Most home and community-based services, including in-home care, adult day care, and respite services, were offered under HCBS waivers. As of June 2002, 6,300 Kansans were receiving these HCBS waiver services. However, the HCBS waiver services were not currently available to new recipients because Kansas initiated a waiting list for these services in April 2002, and 290 people were on the waiting list as of June 2002.
- Oregon spent $604 on Medicaid long-term care services per elderly individual and, in contrast to the other states, spent a lower proportion on nursing facilities and a larger portion on other long-term care services such as care in alternative residential settings. Oregon had HCBS waivers that cover in-home care, environmental modifications to homes, adult day care, and respite care. Oregon's waiver services did not have a waiting list and were available to elderly and disabled clients based on functional need, serving about 12,000 elderly and disabled individuals as of June 2002.

Appendix I summarizes the home and community-based services available in the four states through their state Medicaid plans or HCBS waivers and whether the state had a waiting list for HCBS waiver services.

[9]This HCBS waiver also covers environmental modifications to the home (such as wheelchair ramps) and personal emergency response systems. The dollar cap on services provided through this waiver increased as of September 1, 2002 to $55 per day.

Case Managers Predominately Offered Medicaid In-Home Care Services, but Number of Hours Varied

Most often, the 16 Medicaid case managers we contacted in Kansas, Louisiana, New York, and Oregon offered care plans for our hypothetical individuals that aimed at allowing them to remain in their homes. The number of hours of in-home care that the case managers offered and the types of residential care settings recommended depended in part on the availability of services and the amount of informal family care available. In a few situations, especially when the individual did not live with a family member who could provide additional support, case managers were concerned that the client would not be safe at home and recommended a nursing home or other residential care setting.

The first hypothetical person we presented to care managers was an 86-year-old woman, whom we called "Abby," with debilitating arthritis who is chair bound and whose husband recently died. In most care plans, the case managers offered Abby in-home care. However, the number of offered hours depended on the availability of unpaid informal care from her family and varied among case managers.[10]

- In the first scenario, Abby lives with her daughter who provides most of Abby's care but is overwhelmed by also caring for her own infant grandchild. Case managers offered from 4.5 to 40 hours per week of in-home assistance with activities that she could not do on her own because of her debilitating arthritis, such as bathing, dressing, eating, using the toilet, and transferring from her wheelchair. One case manager recommended adult foster care for Abby under this scenario.
- In the second scenario, Abby lives with her 82-year-old sister who provides most of Abby's care, but the sister has limited strength making her unable to provide all of Abby's care. Case managers offered Abby in-home care, ranging from 6 to 37 hours per week. One case manager also offered Abby 56 hours per week of adult day care.
- In the third scenario, Abby lives alone and her working daughter visits her once each morning to provide care for about 1 hour. The majority of case managers (12 of 16) offered from 12 to 49 hours per week of in-home care to Abby. The other four case managers recommended that she relocate to a nursing home or other residential care setting.

The second hypothetical person was "Brian," a 70-year-old man cognitively impaired with moderate Alzheimer's disease who had just been released

[10]Often, the case managers recommended additional services, such as nursing or other home health care, home-delivered meals, assistive devices for bathtubs such as grab bars or transfer seats, and/or personal emergency response systems.

from a skilled nursing facility after recovering from a broken hip. The case managers usually offered in-home care so that Brian could remain at home if he lived with his wife to provide supervisory care. If he lived alone, most recommended that he move to another residential setting that would provide him with needed supervision.

- In the first scenario, Brian lives with his wife who provides most of his care and she is in fair health. All 16 case managers offered in-home care, ranging from 11 to 35 hours per week. Two case managers also offered adult day care in addition to or instead of in-home care.
- In the second scenario, Brian lives with his wife who provides some of his care and she is in poor health. All but one of the case managers offered in-home care, ranging from 6 to 35 hours per week. One case manager recommended that Brian move to a residential care facility.
- In the third scenario, Brian lives alone because his wife has recently died. Concerned about his safety living at home alone or unable to provide a sufficient number of hours of in-home supervision, 13 of the case managers recommended that Brian move to a nursing home or alternate residential care setting. Two of the three care managers who had Brian remain at home offered around-the-clock in-home care—168 hours per week.

Table 1 summarizes the care plans developed for Abby and Brian by the 16 case managers we contacted.

Table 1: Number of Care Plans that Recommended that the Individual Remain at Home or Move to a Different Residential Setting

Amount of informal care available	Number of plans in which the individual remains at home	Range in hours per week of in-home care if individual remains at home	Number of plans in which the individual moves to a residential care setting
Abby (86-year old chair-bound woman with debilitating arthritis)			
Scenario 1: Abby lives with her daughter (who also cares for infant grandchild)	15	4.5 to 40[a]	1
Scenario 2: Abby lives with her sister (who has limited strength)	16	6 to 37[b]	0
Scenario 3: Abby lives alone (her daughter visits once a day)	12	12 to 49	4
Brian (70-year-old man with moderate Alzheimer's disease)			
Scenario 1: Brian lives with his wife (who is in fair health)	16	11 to 35	0
Scenario 2: Brian lives with his wife (who is in poor health)	15	6 to 35	1
Scenario 3: Brian lives alone	3	35 to 168	13

Note: Some care plans also offered additional services, such as nursing or other home health care, home-delivered meals, assistive devices such as a bathtub lift, and/or personal emergency response systems.

[a]In two care plans, case managers recommended that the daughter become licensed for a relative foster home and receive a payment that she could use to hire in-home or respite care for an unspecified number of hours. In addition, one care plan offered 8 hours per week of adult day care rather than in-home care.

[b]In one care plan, the case manager recommended that the sister become licensed for a relative foster home and receive a payment that she could use to hire in-home or respite care for an unspecified number of hours.

Source: GAO interviews with case managers in Kansas, Louisiana, New York, and Oregon.

In some situations, two case managers in the same locality offered notably different care plans. For example, across the eight localities where we interviewed case managers, when Abby lived alone, four case managers offered in-home care while their local counterpart recommended a nursing home or alternative residential setting. The local case managers offering differing recommendations for in-home or residential care also occurred three times when Brian lived alone and once each when Abby lived with her daughter and when Brian lived with his wife who was in poor health. Also, in a few cases, both case managers in the same locality offered in-home care but significantly different numbers of hours. For example, one case manager offered 42 hours per week of in-home care for Abby when she lived alone while another case manager in the same locality offered 15 hours per week of in-home care for this scenario.

Case Managers in Some States Offered More In-Home Care, Alternative Residential Settings, or Other Supplemental Services

The home and community-based care that case managers offered to our hypothetical individuals sometimes differed due to state policies or practices that shaped the availability of their Medicaid-covered services. These included waiting lists for HCBS waiver services in Kansas and Louisiana, Louisiana's daily dollar cap on in-home care, and Kansas's state review policies for higher-cost care plans. Also, case managers in Oregon recommended alternative residential care settings other than nursing homes, and case managers in Louisiana and New York typically considered Medicare home health care when determining the number of hours of Medicaid in-home care to offer.

Neither of our hypothetical individuals would be able to immediately receive HCBS waiver services in Kansas and Louisiana due to a waiting list. As a result, they would often have fewer services offered to them—only those available through other state or federal programs such as those available under the Older Americans Act[11]—until Medicaid HCBS waiver services became available. Alternatively, they could enter a nursing home. The average length of time individuals wait for Medicaid waiver services was not known in either state. However, one case manager in Louisiana estimated that elderly persons for whom he had developed care plans had spent about a year on the waiting list before receiving services. In Kansas, as of July no one had yet come off the waiting list that was instituted in April 2002.

When case managers developed care plans based on HCBS-waiver services for our hypothetical individuals, the number of hours of in-home care offered by case managers could be as much as 168 hours per week in New York and Oregon but were at most 24.5 hours per week in Kansas and 37 hours per week in Louisiana. Case managers in Louisiana also tended to change the amount of in-home help offered little even as the hypothetical scenarios changed. This may have been because they were trying to offer as many hours as they could under the cost limit even in the scenario with the most family support available. (See table 2.)

[11]Funding from the Older Americans Act provides for supportive in-home and community-based services, including such services as nutrition, transportation, senior centers, health promotion, and homemaker services. 42 U.S.C. §§3001-3058ee (2000).

Table 2: Range in Amount of In-Home Care Offered to Individuals, by State

	In-home care offered (hours per week)			
Amount of informal care available	**Kansas**	**Louisiana**	**New York**	**Oregon**
Abby (86-year old chair-bound woman with debilitating arthritis)				
Scenario 1: Abby lives with her daughter (who also cares for infant grandchild)	5 to 22	28 to 37	4.5 to 40	7[a]
Scenario 2: Abby lives with her sister (who has limited strength)	6 to 14	24.5 to 37	15 to 35	9 to 16
Scenario 3: Abby lives alone (her daughter visits once per day)	12 to 24.5	24.5 to 35	42 to 49	15 to 42
Brian (70-year-old man with moderate Alzheimer's disease)				
Scenario 1: Brian lives with his wife (who is in fair health)	11 to 14.75	21 to 35	11 to 20	16 to 25
Scenario 2: Brian lives with his wife (who is in poor health)	14 to 21	21 to 28	6 to 35	22 to 29
Scenario 3: Brian lives alone	N/A[b]	N/A[b]	168[c]	35 to 168

[a]Only one case manager offered in-home care for this scenario. Two other Oregon case managers recommended that Abby stay at home, and the family caregiver become licensed for a relative foster home and receive a payment that she could use to hire in-home or respite care for an unspecified number of hours.

[b]All four case managers recommended care in a residential care setting such as a nursing home or assisted living facility.

[c]Only one case manager offered in-home care for this scenario. The other New York case managers recommended a residential care setting.

Source: GAO interviews with case managers in Kansas, Louisiana, New York, and Oregon.

Two states' caps or other practices may have limited the amount of Medicaid-covered in-home care that their case managers offered. For example, case managers in Louisiana tended to offer as many hours of care as they could offer under the state's $35 per day cost limit.[12] Therefore, as the amount of informal care changed in the different scenarios, the hours of in-home help offered in Louisiana did not change as much as they did in the other states. In Kansas, case managers often offered fewer hours of in-home care than were offered in other states, which may have been in part influenced by Kansas's supervisory review whereby more costly care plans were more extensively reviewed than lower cost care plans. A Kansas case manager also told us that offering fewer hours of care may reflect the case managers' sensitivity to the state's waiting list for HCBS services and an effort to serve more clients by keeping the cost per person low. In contrast, case managers in New York

[12]The cap was increased from $35 per day to $55 per day as of September 1, 2002. Also, the cap includes the cost of in-home care as well as a case management fee. According to a state official, Louisiana's daily cap for in-home HCBS waiver services reflects the state's budget constraints as well as the need to be cost-effective relative to nursing home care.

and Oregon did not have similar cost restrictions in offering in-home hours, with one case manager in each state offering as much as 24-hour-a-day care.

When recommending that our hypothetical individuals could better be cared for in a residential care setting, case managers offered alternatives to nursing homes to varying degrees across the states. Case managers in Louisiana recommended nursing home care in three of the four care plans in which care in another residence was recommended for Abby or Brian. In contrast, case managers in Oregon never recommended nursing home care for our hypothetical individuals. Instead, case managers in Oregon exclusively recommended either adult foster care or an assisted living facility in the five care plans recommending care in another residence. It was also noteworthy that two case managers in Oregon recommended that either Abby or Brian obtain care in other residential care settings in a scenario when she or he lived with a family member, expressing concern that continuing to provide care to Abby or Brian would be detrimental to the family. Case managers in Kansas, Louisiana, and New York only recommended out-of-home placement for Abby or Brian in scenarios when they lived alone.

State differences also were evident in how case managers used adult day care to supplement in-home or other care. For example, across all care plans the case managers developed for Abby and Brian (24 care plans in each state), adult day care was offered four times in New York and Oregon and three times in Kansas. However, none of the care plans developed by case managers in Louisiana included adult day care because it was in a separate HCBS waiver, and individuals could not receive services through two different waivers.[13]

Case managers in New York and Louisiana also often considered the effect that the availability of Medicare home health services could have on Medicaid-covered in-home care. For example, one New York case manager noted that she would maximize the use of Medicare home health before using Medicaid home health or other services. Several of the case managers in New York included the amount of Medicare home health care available in their care plans, and these services offset some of the Medicaid services that would otherwise be offered. In Louisiana, where

[13]The Louisiana adult day care waiver served approximately 525 people with a waiting list of 201 people as of July 2002.

case managers faced a dollar cap on the amount of Medicaid in-home care hours they could provide, two case managers told us that they would include the additional care available under Medicare's home health benefit in their care plans, thereby increasing the number of total hours of care that Abby or Brian would have by 2 hours per week. While six Kansas and Oregon case managers also mentioned that they would refer Abby or Brian to a physician or visiting nurse to be assessed potentially for Medicare home health, they did not specifically include the availability of Medicare home health in the number of hours of care provided by their care plans.

Concluding Observations

States have found that offering home and community-based services through their Medicaid programs can help low-income elderly individuals with disabilities remain in their homes or communities when they otherwise would be likely to go to a nursing home. States differed, however, in how they designed their Medicaid programs to offer home and community-based long-term care options for elderly individuals and the level of resources they devoted to these services. As a result, as demonstrated by the care plans developed by case managers for our hypothetical elderly individuals in four states, the same individual with certain identified disabilities and needs would often receive different types and intensity of home and community-based care for his or her long-term care needs across states and even within the same community. These differences often stemmed from case managers' attempts to leverage the availability of both publicly-financed long-term care services as well as the informal care and support provided to individuals by their own family members.

Mr. Chairman, this completes my prepared statement. I would be happy to respond to any questions you or other Members of the Committee may have at this time.

Contacts and Acknowledgments

For future contacts regarding this testimony, please call Kathryn G. Allen at (202) 512-7118 or John E. Dicken at (202) 512-7043. Other individuals who made key contributions include JoAnne R. Bailey, Romy Gelb, and Miryam Frieder.

Appendix I: Medicaid-Covered Home and Community-Based Services in Kansas, Louisiana, New York, and Oregon

Kansas, Louisiana, New York, and Oregon each offered home and community-based services through their state Medicaid plans or HCBS waivers. Kansas and Louisiana had waiting lists that generally made these services unavailable to new clients. Table 3 summarizes the home and community-based services available in the four states we reviewed and whether the states had a waiting list for HCBS waiver services.

Table 3: Medicaid Home and Community-Based Long-Term Care Services for Elderly in Four States

Home and community-based services (includes services offered in state plans and through waivers)	**Kansas**	**Louisiana**	**New York**	**Oregon**
In-home help with daily activities				
Personal care, providing hands-on assistance with activities of daily living such as eating, bathing, dressing, using the toilet, and grooming	❍	❍	●	●
Household support, providing assistance with instrumental activities of daily living, such as housekeeping and meal preparation	❍	❍	●	●
Home-delivered meals			●	●
Standby assistance during day or night	❍	❍		●
Adaptive items or changes to facilitate independence, mobility, or safety				
Environmental modifications, such as wheelchair ramp, or assistive devices or technology, such as bathtub lift or shower seat	❍	❍	●	●
Personal emergency response system	❍	❍	●	●
In-home medical care or counseling				
Periodic nursing evaluation	❍	●	●	●
Home health services/medical equipment assistance	●	●	●	●
Nutritional counseling			●	
Case management	●	❍	●	●
Help outside of home				
Adult day care	❍	❍	●	●
Help provided in community residential settings, such as assisted living facility, adult foster care, boarding home	❍		●	●
Transportation		●[a]	●	●
Moving assistance			●	
Care for Caregiver				
Respite care in-home or out of home	❍		●	●

● Available services

❍ State had a waiting list for these services as of June 2002

Note: Services are only included in the table if the state Medicaid plan or HCBS waivers cover these services specifically for the elderly and/or disabled. In some cases, other services (such as respite care or transportation) may not be specifically included in the state plan or the waiver but could be provided indirectly through personal care attendants or other support services that are covered.

[a]In Louisiana, the HCBS waiver covers transportation to medical appointments only.

Source: GAO interviews with state Medicaid officials and review of state Web sites, 2002.