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Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

August 1994

MEDICAID LONG-TERM CARE

Successful State Efforts to Expand Home Services While Limiting Costs

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GAO

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Health, Education, and
Human Services Division

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The Honorable John D. Dingell
Chairman, Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Nearly one-third of the nation's Medicaid expenditures are now spent on long-term care, which amounted to about $42 billion in 1993.[1] Both federal and state governments continue to devote an increasing share of their budget resources to Medicaid long-term care expenditures. These budget pressures coupled with a growing elderly population have induced the federal and state governments to seek new approaches to restraining long-term care expenditures.

Care in institutional settings—primarily nursing facilities—constitutes about 85 percent of Medicaid expenditures for long-term care. Shifting long-term care from nursing facilities and other institutional settings to less expensive home and community-based settings continues to be a major thrust of cost-containment efforts. States are testing new approaches to ensure that the use of less expensive home and community care translates into budget savings and control over total long-term care spending.

You asked us to review states' experience in expanding government-funded home and community-based services. We focused our review on three states that have made substantial attempts to do so—Oregon, Washington, and Wisconsin. Our analysis centered on determining (1) how far the three states had gone in shifting their long-term care to home and community-based settings, (2) what controls they had in place to manage the growth of home and community-based programs, and (3) what impact the shifts and controls have had on the ability to deliver long-term care services.

[1]Long-term care includes an array of health, personal care, and social and supportive services. The services are delivered to individuals who are at least partly unable to care for themselves because of disabilities or impairments resulting from a chronic illness, injury, or other condition. This report focuses on long-term care services for persons aged 65 and older and persons with physical disabilities.

Results in Brief

Oregon, Washington, and Wisconsin have expanded home and community-based long-term care in part as a strategy to help control rapidly increasing Medicaid expenditures for institutional care. Since the early 1980s, the three states have developed Medicaid and state-funded home and community-based care programs that have allowed them to serve more beneficiaries overall and to serve a larger proportion of them at home and in the community. For example, long-term care programs for the aged and persons with physical disabilities in Oregon grew from about 15,300 beneficiaries in 1983 to almost 24,000 in 1993; during that time, Medicaid nursing facility use declined slightly while the proportion of beneficiaries using home and community-based care grew from 49 percent to 68 percent of the total.

Even as they expanded home and community-based programs, the three states have restricted how large most of the programs can grow. Some of these restrictions come from the federal government, which approves capacity limits on programs operated as Medicaid home and community-based service waivers. Other restrictions result from constrained state budgets. Because the demand for home and community-based services can exceed budget allocations, state agencies that administer the programs must determine which persons should be served within the limited program treatment capacity and dollars available. Thus controls on growth in home and community-based programs, which federal and state governments view as necessary to managing program expenditures, have at times limited access to services. This has resulted in waiting lists for some programs, particularly the state-funded programs.

Despite deliberate limits on program size, one impact of the shift to home and community-based care is that the three states have been able to provide services to more people with the dollars available. This is because home and community-based care is generally less expensive per person than institutional care, although the gap between the two narrows when other government expenditures for home and community-based recipients—such as Supplemental Security Income (SSI) payments—are added to Medicaid costs. Home and community-based services have helped control growth in overall long-term care expenditures by providing an important alternative to nursing facility care, thus helping states exercise greater control over nursing facility capacity and use. While the total number of nursing facility beds operated in the United States increased by 20.5 percent between 1982 and 1992, the combined number of beds in Oregon, Washington, and Wisconsin declined 1.3 percent. These

three states have accommodated all or most of the growth in their total long-term care programs in home and community-based care.

Background

Part of the national debate on health care reform has focused on expanding long-term care in recipients' homes and in community-based settings, including a proposal by the administration to create a new home care program supported by $38 billion per year in federal funds when fully implemented. Home and community-based care is seen as generally less expensive than nursing facility and other institutional care. Additionally, many who need long-term care would prefer to receive it at home or in the community. However, concern has also been raised that greater availability of such services might create rapid growth in the number of people seeking to use them, making it difficult to control total spending.

Medicaid is a joint federal/state program that pays medical expenditures for more than 31 million low-income beneficiaries. Those who receive long-term care under Medicaid, numbering about 8 million individuals, include the elderly, persons with physical disabilities, and persons with developmental disabilities.[2] This report focuses on services for individuals 65 years of age and older and persons with physical disabilities, because these are the largest groups of long-term care users, and because persons with developmental disabilities generally rely on different programs and service providers.

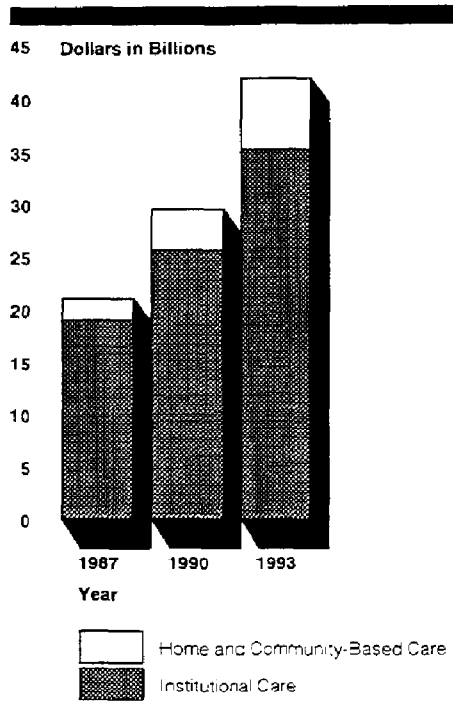
For many years, Medicaid has paid for beneficiaries' long-term care in institutional settings such as nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR). Most states did not provide significant Medicaid home and community-based long-term care services until after 1981, when the Congress specifically provided the option of Medicaid waivers to allow greater flexibility in developing alternatives to institutional care.[3] Figure 1 shows the growth in Medicaid institutional and home and community-based expenditures in recent years. The Congress' action was based in part on the theory that providing certain kinds of nonmedical social services (such as housekeeping, personal care, and

[2]Persons with physical disabilities include persons of all ages who cannot function independently because of a disease or injury. For example, they may be paralyzed or have a brain injury or a debilitating medical problem such as multiple sclerosis. Most persons with developmental disabilities have mental retardation, but the term also encompasses those who have substantial disabilities from cerebral palsy, epilepsy, or other conditions. Many persons with physical or developmental disabilities are relatively young.

[3]See appendix I for a discussion of the Medicaid home and community-based waiver program. Appendix I also provides background data on long-term care in the United States. Appendixes II, III, and IV describe long-term care services in Oregon, Washington, and Wisconsin, respectively.

adult day care) in residential or community settings can delay or eliminate the need for more expensive care in nursing facilities.

Figure 1: Medicaid Long-Term Care Expenditures for Home and Community-Based and Institutional Care: 1987, 1990, and 1993



Note: Home and community-based care includes expenditures for personal care, home health, and waiver services. Institutional care includes expenditures for nursing facilities and ICFs/MR.

Source: SysteMetrics.MEDSTAT, using data from HCFA-64.

All states now provide at least some home and community-based services in their Medicaid programs. Many states choose to offer some of these services on a nonwaiver basis—that is, the services are available as part of the regular Medicaid program. This approach is basic to most of the services offered under Medicaid, including long-term care in institutional settings. Since the early 1980s, however, much of the innovation at the state level has been in Medicaid waiver programs. The 1981 changes made by the Congress authorize the Secretary of Health and Human Services through the Health Care Financing Administration (HCFA), the federal agency in charge of Medicaid, to approve exceptions or waivers to

Medicaid program rules.[4] These waivers allow the states to offer packages of services, including nonmedical services, that may not be covered by the states' regular Medicaid programs. Moreover, states may choose to provide specific services only to defined groups, instead of to all eligible beneficiaries, as would be required under Medicaid absent a waiver. As of May 1994, states operated 195 approved waiver programs and had applications pending for 34 more. The importance of these waivers in controlling the size of home and community-based programs is discussed on page 11. A number of states also provide home and community-based services funded by state general revenues.

As states began using waivers to develop home and community-based programs during the 1980s, concerns surfaced about the potential effects of such programs on Medicaid costs. These concerns were grounded in research showing that while such programs were less costly on a per-person basis, they generally raised health care costs overall because limited reductions in institutional use were more than offset by increased demand for and use of home and community-based care. The research suggested that home and community-based care programs often did not substitute for nursing facility care, but instead served beneficiaries who might not necessarily have entered nursing facilities. The desirability of home and community-based services has been said to create a "woodwork effect," attracting new service users who "come out of the woodwork."

Home and community-based waiver programs have evolved over time. In the early years, states were optimistic about waivers as a means to provide alternatives to institutional long-term care, but they built the programs slowly because of their inexperience with home and community-based services. The early waiver programs tended to have narrow eligibility guidelines and restrictive service programs, and were available in limited geographic areas within the states. By the mid-1980s, as states became more experienced and confident of their ability to manage the programs, they applied for more and larger waivers. Because of concerns about program costs, however, HCFA made efforts from about 1983 through 1992 to restrain program size. In recent years HCFA has become more flexible, and a more cooperative relationship has developed between HCFA and the states.

The states we selected for our work reflect the evolution of the waiver program. Oregon, Washington, and Wisconsin were early to apply for

[4]These waiver programs were authorized by the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35).

home and community-based service waivers, which permitted a targeted, controlled approach to service delivery. Over time their waivers expanded and evolved to conform with federal requirements and state program and budget needs.

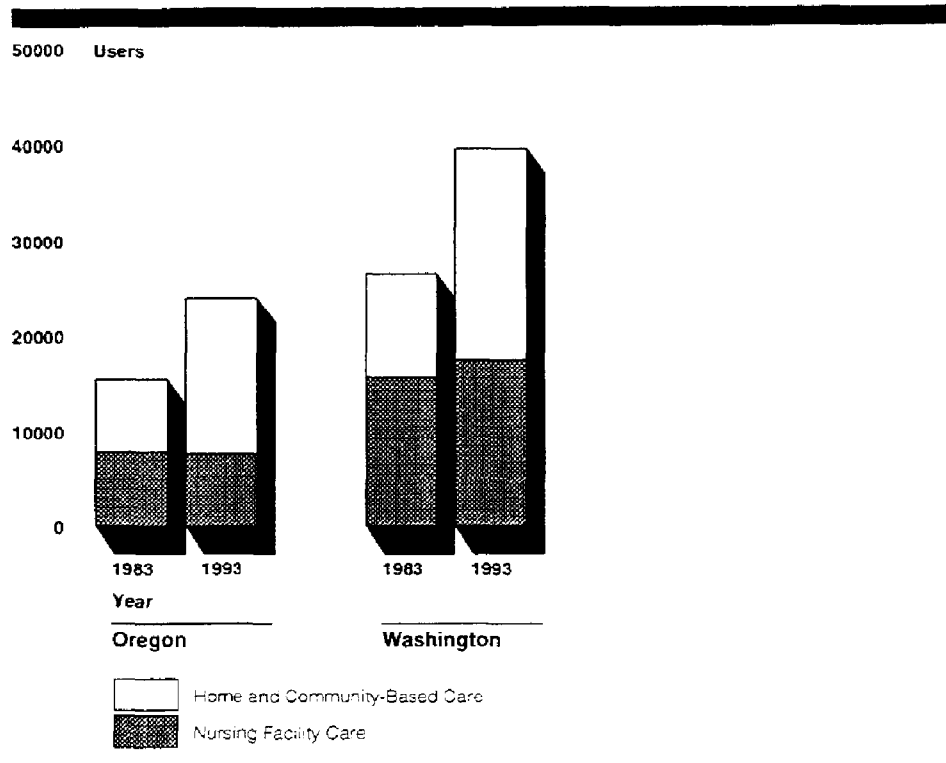
We focused our work on Oregon, Washington, and Wisconsin mainly because (1) the three states have made substantial efforts to develop home and community-based care programs and (2) state Medicaid specialists indicated that the three states' programs could provide examples of mechanisms for managing program growth.

States Have Expanded Home and Community-Based Care Programs

Oregon, Washington, and Wisconsin have expanded their home and community-based care programs since the early 1980s as part of efforts to control institutional long-term care expenditures and respond to consumer preferences for alternatives to institutional care. Growth in the number of beneficiaries who received home and community-based care in 1983 and 1993 is shown in figure 2 for Oregon and Washington.[5]

[5]Wisconsin is not included in the figure because comparable data were not available.

Figure 2: Aged and Physically Disabled Users of Nursing Facility and Home and Community-Based Care in Oregon and Washington, 1983 and 1993



Sources: Senior and Disabled Services Division, Oregon Department of Human Resources; and Aging and Adult Services Administration, Washington Department of Social and Health Services.

Although they faced very different situations in terms of nursing facility bed supply—and their bed supplies remain quite different—the three states have used their expanded capacity for home and community-based services to help justify limiting the supply and use of nursing facility beds.[6] This has been accomplished through the certificate of need process[7] and

[6]From 1982 to 1992, the ratio of licensed nursing facility beds per 1,000 persons aged 65 and older remained constant nationwide at 53.1 beds per 1,000. Over that decade, ratios declined in Wisconsin from 89.0 to 74.5 beds per 1,000, but remained well above the national average. In Oregon, ratios declined from 47.2 to 36.0 beds per 1,000 and in Washington, from 59.3 to 48.7.

[7]The National Health Planning and Resources Development Act of 1974 (P.L. 93-641), among other things, required state agencies to administer so-called certificate of need programs as a means of containing health care costs and preventing unnecessary duplication of health services. Under these programs, nursing facilities and other providers were required to obtain a certificate of need before they could expand facilities. Certificate of need commonly was used to control the expansion of nursing facility bed supply and associated costs. After sections of the law were repealed effective 1987, some states discontinued or modified their programs.

other restrictions on adding beds. The three states have taken different approaches to structuring the administration of their long-term care programs and delivering services. All offer multiple home and community-based programs for the aged and persons with physical disabilities, including Medicaid waiver and state-funded programs; but eligibility for the programs and the specific services they provide are different in each state. There are differences, moreover, in the extent to which the states emphasize in-home services relative to services provided in a variety of alternative living arrangements, such as adult foster homes and assisted living facilities. Table 1 provides a summary of key characteristics in the three states.

Table 1: Key Characteristics of Long-Term Care Services for the Aged and Persons With Physical Disabilities in Oregon, Washington, and Wisconsin

Characteristic	Oregon	Washington	Wisconsin
Ratio of nursing facility beds per 1,000 persons aged 65 and older[a]	36	49	75
Number of aged and physically disabled beneficiaries			
Home and community-based care	16,330[b]	22,040[b]	Home health and personal care[c]—12,577 Waiver—6,129 COP—5,819
Nursing facility care	7,631	17,428	30,497
Percentage of aged and physically disabled beneficiaries receiving home and community-based services	68	56	NA

NA: data not available.

Note: All of the statistics in the table are for 1993 except for Wisconsin and the population ratios, which are for 1992.

[a]Nationwide, there were 53 nursing facility beds per 1,000 persons aged 65 and older in 1992.

[b]In Oregon and Washington, numbers of beneficiaries using nursing facility and home and community-based programs are reported differently. For nursing facilities, the number of beneficiaries is the average daily census. For home and community-based programs, the number of beneficiaries is the average number of persons served monthly during the year.

[c]Wisconsin beneficiaries generally use more than one home and community-based program at a time. Due to this overlap, the numbers of users reported by the different programs have not been summed. The counts of home health and personal care users include the aged and persons with physical or developmental disabilities. COP is the state-funded Community Options Program.

Oregon

Oregon operates under a policy that considers nursing facilities to be the placements of last resort. Implementation of that policy through certificate of need controls and facility closures has reduced the ratio of nursing facility beds per 1,000 persons 65 and older from 47 in 1982 to 36 in 1992, one of the lowest in the country.

In Oregon, a single agency is responsible for institutional and noninstitutional care programs for the aged and persons with physical disabilities. Oregon covers personal care and home health services in its regular Medicaid program, but most of its home and community-based services are provided through a Medicaid waiver program. There also is a smaller state-funded program for persons who do not qualify for Medicaid. In 1993, 68 percent of the nearly 24,000 beneficiaries receiving Medicaid or state-supported long-term care during an average month were being cared for in home or community-based settings.

The state has actively developed noninstitutional alternative living arrangements for long-term care beneficiaries, with emphasis on adult foster homes and assisted living facilities. Of the aged and persons with physical disabilities who received noninstitutional care in 1993, about 34 percent (more than 5,500 individuals) received it in a setting other than their own homes.

Washington

Washington has a formal policy to deliver long-term care through home and community-based settings whenever possible. In 1989, it established a goal of gradually reducing the ratio of nursing facility beds per 1,000 aged residents from about 54 to 45 by limiting the number of new beds. By 1992, the ratio had dropped to 49 per 1,000 aged residents.

In Washington, a single state agency is responsible for institutional and noninstitutional long-term care services for the aged and persons with physical disabilities. Washington offers a number of home and community-based care programs, including a Medicaid waiver program, a nonwaiver Medicaid personal care program, and two state-funded programs for persons who do not qualify for Medicaid. In 1993, 56 percent of the nearly 39,500 beneficiaries receiving Medicaid or state-supported long-term care during an average month were being cared for in home or community-based settings.

Washington has made some efforts to encourage development of alternative living arrangements, but not to the extent that Oregon has. In

1993, about 15 percent (almost 3,300 individuals) of the aged and persons with physical disabilities who received noninstitutional care received it in a setting other than their homes.

Wisconsin

Wisconsin has expanded home and community-based care programs to help moderate the growth of Medicaid nursing facility use and expenditures. The state also has capped the number of nursing facility beds. As a result, Wisconsin's ratio of nursing facility beds per 1,000 elderly persons, though it remained higher than the U.S. average, declined from 89 in 1982 to 75 in 1992.

Wisconsin's regular Medicaid program provides a substantial amount of home health and personal care services to the aged and persons with physical disabilities. In addition, the state operates a Medicaid waiver program and the state-funded Community Options Program (COP). Wisconsin differs from Oregon and Washington in its administrative structure for long-term care programs. The waiver program and the state-funded program are the responsibility of one division of the Department of Health and Social Services, while the regular Medicaid program and nursing facilities fall in a different division. Services are managed and delivered at the county level.

In 1992, most of Wisconsin's long-term care beneficiaries—a daily average of almost 30,500 individuals—continued to receive services in nursing facilities. An estimated 14,000 individuals, or about one-third of the total, used one or more of the home and community-based care programs.[8] Unlike Oregon and Washington, Wisconsin has not been active in encouraging or developing alternative living arrangements, but has placed more emphasis on in-home services.

Management and Cost Controls Limit Growth in Most Home and Community-Based Programs

Federal waiver rules and state budget constraints limit the overall growth in many of the three states' home and community-based service programs. In addition, the states apply financial eligibility and functional impairment criteria to control beneficiary eligibility for services. Finally, the states use a variety of management techniques to control long-term care program growth and expenditures in both institutional and home and community settings.

[8]It is difficult to estimate the number of individuals using home and community-based services in Wisconsin because individuals generally are served by more than one program and persons with developmental disabilities are included in the data on home health and personal care. This estimated unduplicated count of users is based on data reported in table 1 and appendix table IV.1.

Waiver Rules and State Budgets Constrain Overall Growth

Federal Medicaid waiver rules have been a significant factor in determining how large the three states' home and community-based programs have grown. Under these rules, each waiver is approved to serve a specific unduplicated number of beneficiaries each year, and there is a limit on the amount of federal funds that may be spent under the waiver. These controls are in place to help ensure that waiver programs (1) will not increase overall Medicaid expenditures and (2) will provide home and community-based services only as a substitute for institutional care. Oregon's waiver for the aged is the only waiver nationwide that operates under different rules, which approve an overall expenditure cap on the federal Medicaid contribution to the state's nursing facility and home and community-based care programs combined.

In the mid-1980s, some states were critical of federal waiver rules that constrained expansion of home and community-based care. More recently, however, state budget limitations also have restricted the size of home and community-based programs, including the waivers. In 1989, for example, Wisconsin did not initially apply for the maximum number of waiver beneficiaries that federal rules would allow because of limited state funding. In all three states, home and community-based programs that are exclusively state-funded also face state spending limits that generally cannot be exceeded.

Financial and Functional Impairment Criteria Control Eligibility

Program eligibility criteria provide ways to manage program growth and costs. Individuals must meet Medicaid financial eligibility criteria, which though complex generally require low income and limited assets. State programs also are focused on lower-income individuals and have similar criteria regarding income and assets. In addition, individuals must meet functional impairment criteria to qualify for services under each of the long-term care programs. Eligibility for long-term care based on functional impairment generally is determined by a detailed assessment of each applicant's need for assistance in activities of daily living (such as eating, toileting, and bathing) and other factors, including medical, cognitive, social, and living conditions. In Oregon, Washington, and Wisconsin, these assessments are conducted using instruments and procedures that are standard statewide.

States Use a Variety of Management Techniques

The three states expanded home and community-based care in part to help control rising Medicaid expenditures for institutional services. To that end, they also have used the certificate of need process or other mechanisms to

limit new nursing facility beds, eliminated beds, undertaken preadmission screening of nursing facility applicants, and constrained the annual increases in nursing facility reimbursement rates. In addition, the states have developed various management controls to limit the size and costs of home and community-based programs. The specific controls vary among the three states, but many of them fall into three groups, as follows:

- Provider fee controls and capped individual service budgets. All three states control payments to home and community-based service providers through fee or payment rate schedules. Rates for a particular service may vary according to beneficiary disability levels. The states also impose per-beneficiary limits on hours of service or dollar benefits in the different programs.
- Case management. Case management is an important component of home and community-based service delivery in all three states. Case managers typically assess beneficiary needs, determine financial eligibility, develop and monitor care plans, and authorize services. Officials in Oregon and Washington believe that case management saves money by functioning as a gatekeeper to Medicaid services, but studies have not been done to document the cost-control effects.
- Other mechanisms. Some mechanisms are unique to a particular state. For example, Oregon's Nurse Delegation Act appears to stand out nationally for the extent to which it permits nurses under contract with the state to train and monitor persons who are not licensed health caregivers to provide specific medical services, such as administering certain kinds of medications. Oregon officials said this use of nonprofessional caregivers makes the delivery of home and community-based care less costly. In Washington, on the other hand, the use of unlicensed paid staff is prohibited, and officials believe this increases costs.

States Believe Expanding Home Care Has Increased Access While Controlling Long-Term Care Costs

One result of the shift to home and community-based care in these three states is that the states have been able to serve more beneficiaries with the Medicaid and state dollars they have available. This is because on a per-beneficiary basis, home and community-based care is considerably less expensive than nursing facility care. In Washington, for example, the average monthly expenditure per user for nursing facility care for the aged and persons with physical disabilities averaged $2,023 in 1993, compared with $419 for home and community-based care users (see table 2). Generally, per-user spending for nursing facility care has also been rising faster than for home and community-based care.

Table 2: Average Expenditure Per User for Nursing Facility and Home and Community-Based Care in Oregon, Washington, and Wisconsin

Programs for the aged and persons with physical disabilities	Oregon (monthly expenditure, 1993)	Washington (monthly expenditure, 1993)	Wisconsin (annual expenditure, 1992)[a]
Nursing facility care	$1,657	$2,023	$20,427
Home and community-based care	420	419	Home health & personal care Aged— 5,744 Disabled— 7,017 Waiver—6,371 COP—3,410

[a]Because Wisconsin beneficiaries generally use more than one program, we have not summed the data. The home health and personal care services for the disabled category includes persons with physical and developmental disabilities.

Sources: Senior and Disabled Services Division, Oregon Department of Human Resources; Aging and Adult Services Administration, Washington Department of Social and Health Services; Division of Community Services and Division of Health, Wisconsin Department of Health and Social Services.

Looking at Medicaid and state expenditures only, however, provides a somewhat distorted picture of the difference between spending for institutional and for home and community-based care. Persons who are served at home or in community-based settings may receive other forms of government support that persons in nursing facilities do not receive.[9] For example, in 1993 many beneficiaries of home and community-based care received federal SSI payments of up to $434 per month as general income support. Studies performed in Wisconsin suggest that the net savings in per-person public expenditures associated with home and community-based care amounted to about 16 percent.

Officials in the three states credit expansion of home and community-based services with playing an integral part in controlling increases in long-term care expenditures. A study concluded that Oregon's use of home and community-based services instead of nursing facility care had saved an estimated $227 million between 1981 and 1991 out of a projected direct service expenditure of $1.35 billion for the period. Oregon and Washington officials told us that increased home and community-based services have enabled them to reduce the number of nursing facility beds and place beneficiaries in less costly settings. All three states have succeeded in controlling the number of nursing facility beds. Between 1982 and 1992, the number of licensed nursing facility beds

[9]Individuals entering a nursing facility for a stay of 90 days or less and who maintain an outside residence may receive full SSI payments for up to 3 months. For others, the payment is discontinued except for a small personal allowance of $30 per month plus a supplement in some states.

increased 20.5 percent nationally, while the combined number of beds in Oregon, Washington, and Wisconsin declined 1.3 percent.[10]

Program Cost Controls Result in Not Everyone Being Served

Although home and community-based programs have allowed the three states to offer services to more people, there are indications that the programs' cost controls have at times limited access to services. There are waiting lists for Wisconsin's waiver program, and Washington's waiver program was closed for 8 months in 1992-93 because of limited waiver capacity. Enrollment was limited for some state-funded programs for the aged and persons with physical disabilities in all three states. In Oregon and Washington, local service administrators have taken various approaches to managing this excess demand, ranging from simple first-come, first-served waiting lists for eligible beneficiaries to priority-ranking systems based on assessed beneficiary needs. A Washington official said that eligible waiver applicants have the option of using institutional services when waiver services are not available, but may choose not to do so.

Conclusions

Oregon, Washington, and Wisconsin have expanded their Medicaid home and community-based care programs to better serve residents with long-term care needs, while managing expected growth in demand for long-term care and controlling overall long-term care expenditures. An essential component of this expansion has been the states' ability to control growth and expenditures effectively for these home and community-based care programs. The three states have pursued this objective through the use of Medicaid waivers, which limit enrollment and expenditures, and through additional controls on beneficiary functional eligibility and provider fees. State officials believe that expanding home and community-based care programs has been cost effective because of the savings that result from more stringent controls on the number and use of nursing facility beds.

Agency Comments

We discussed a draft of this report with HCFA officials in the Medicaid Bureau and with Oregon, Washington, and Wisconsin state officials. They

[10]Our analysis of available data from 50 states shows that increased spending for home and community-based care was not always linked to slower growth in the number of nursing facility beds. Some states (for example, Colorado and Michigan) had limited growth in the number of nursing facility beds, but also had relatively low spending for Medicaid home and community-based care. Other states (such as North Carolina and Massachusetts) had greater than average growth in the number of nursing facility beds along with relatively high home and community-based care spending.

generally agreed with the information as presented. We have incorporated their comments where appropriate.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Director of the Office of Management and Budget, the Secretaries of Human Services in each of the three states, and other interested parties. We also will make copies available to others on request.

Please call me at (202) 512-7125 if you or your staff have any questions concerning this report. Other major contributors are listed in appendix V.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director,
Health Policy Issues

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Figures

Abbreviations

AIDS	acquired immunodeficiency syndrome
CAPS	Client Assessment and Planning System
COP	Community Options Program
COPES	Community Options Program Entry System
HCFA	Health Care Financing Administration
ICF/MR	intermediate care facility for the mentally retarded
OBRA	Omnibus Budget Reconciliation Act
SSI	Supplemental Security Income
SSP	state supplemental payments

Medicaid Long-Term Care Services

This appendix describes (1) national and state long-term care services focusing on Medicaid, (2) Medicaid institutional long-term care, (3) the Medicaid home and community-based service waiver program and related policies, (4) nonwaiver Medicaid home care services, and (5) the study's scope and methodology.

National and State Long-Term Care Services

Long-term care, which includes an array of health, personal care, and social and supportive services, is provided to individuals who are at least partially unable to care for themselves because of a disability or impairment resulting from advanced age, a chronic illness, injury, or other conditions. State governments have lead responsibility for public long-term care programs. These programs fund services including institutional services in nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR), and a range of home and community-based services. States have taken a variety of approaches to program administration and service delivery. The states also are responsible for licensing all long-term care facilities, public and private.

Since the early 1980s, home and community-based long-term care has expanded more rapidly than institutional care, reflecting individual preferences and state initiatives. Most long-term care expenditures, however, continue to be for services in nursing facilities and other institutions.

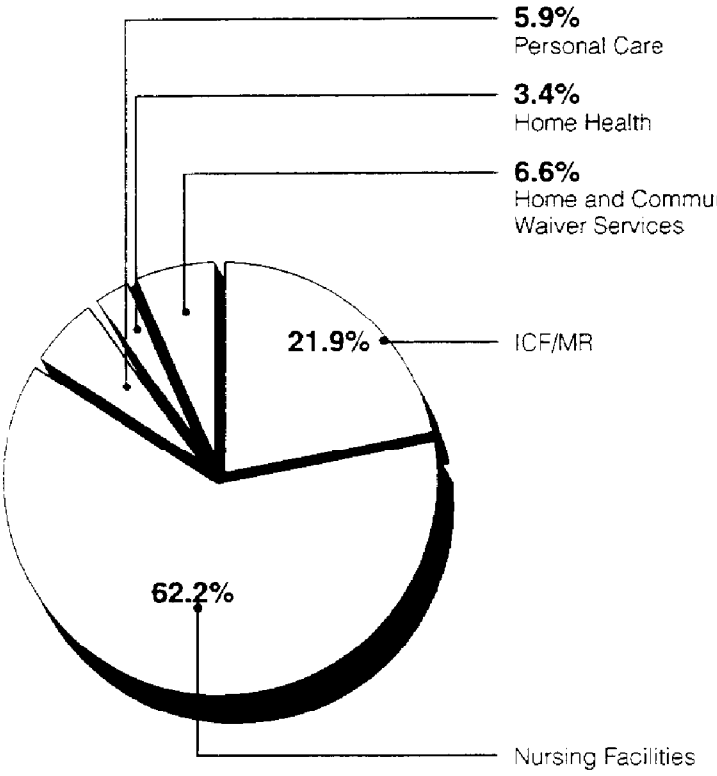
In the United States, expenditures for nursing facility care are financed about equally by Medicaid and private out-of-pocket payments. In fiscal year 1993, the Department of Health and Human Services estimated that Medicaid provided $36.3 billion (48.3 percent) of the $75.2 billion spent on nursing facility care including care in ICFS/MR, while private individuals paid $29.6 billion (39.4 percent) out-of-pocket. The remainder was covered by Medicare (7.6 percent), private insurance (0.1 percent), and other sources. The large proportions paid by Medicaid and individuals out-of-pocket have remained relatively constant since 1980.

Medicaid

Total Medicaid expenditures for all types of long-term care services increased from $33.8 billion in fiscal year 1991 to $38.9 billion in fiscal year 1992 (15.1-percent growth) and to $42.0 billion in fiscal year 1993 (8-percent growth). In fiscal year 1993, Medicaid long-term care expenditures were broken down as follows: nursing facility care, 62.2 percent; ICF/MR care, 21.9 percent; personal care services, 5.9 percent;

home and community-based waivers, 6.6 percent; and home health services, 3.4 percent. Institutional services consumed about 84 percent of Medicaid long-term care expenditures and home and community-based services, the remaining 16 percent. This distribution is shown in figure I.1.

Figure I.1: Medicaid Expenditures for Long-Term Care Services, 1993



Note: Total spending was $42 billion.

Source: SysteMetrics.MEDSTAT, using preliminary data from HCFA-64.

Medicaid Institutional Long-Term Care in the States

Medicaid payments for institutional care far exceed the amount spent on noninstitutional care. As table I.1 shows, funding for institutional care was about $35.3 billion in fiscal year 1993, compared with $6.7 billion for noninstitutional home and community-based care. This pattern has

persisted over time despite the higher growth rate in spending for home and community-based care shown in figure I.2.

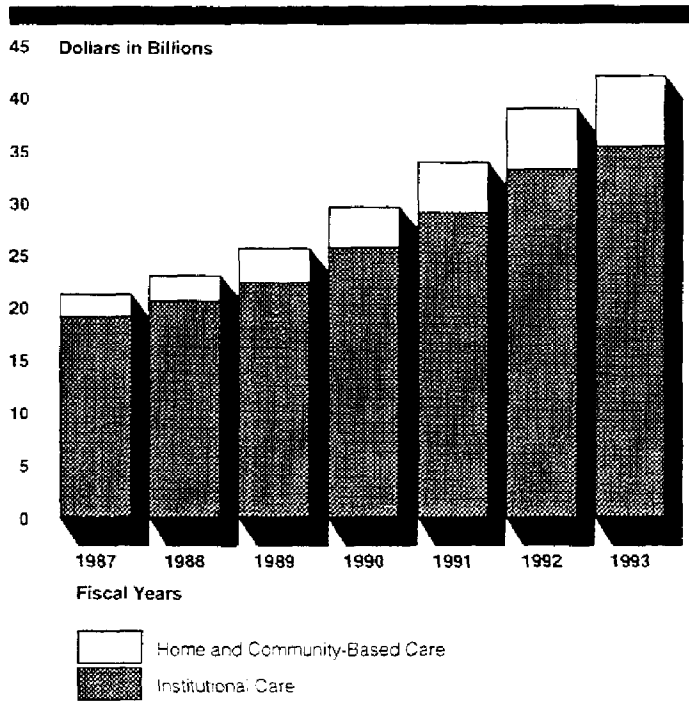
Table I.1: Medicaid Institutional and Home and Community-Based Care Spending

Dollars in millions

	1987	1988	1989	1990	1991	1992	1993
Institutional care	$19,068	$20,532	$22,296	$25,625	$28,994	$33,065	$35,286
Home and community-based care	2,069	2,448	3,257	3,925	4,758	5,761	6,662

Note: Institutional care spending includes expenditures for nursing facilities and ICFs/MR. Home and community-based care includes expenditures for personal care, home health, and waiver services.

Figure I.2: Medicaid Long-Term Care Expenditures for Home and Community-Based and Institutional Care, Fiscal Years 1987-1993



Source: SysteMetrics.MEDSTAT, using preliminary data from HCFA-64.

Nursing Facility Services

Nursing facilities primarily serve the elderly with disabilities (that is, individuals with disabilities who are over 65 and especially those over 85),

but may also serve younger persons with physical disabilities. Nationwide, the number of nursing facility beds grew from about 1.3 million in 1978 to 1.7 million in 1992, while the ratio of beds per 1,000 persons aged 65 and older dropped slightly from 53.4 per 1,000 in 1978 to 53.1 beds per 1,000 in 1992. However, the ratio of beds to 1,000 persons aged 85 and older—the group most likely to require nursing facility services—declined from 610 in 1978 to 502 in 1992. Nursing facility bed ratios vary dramatically from state to state. In 1992, ratios ranged from fewer than 25 beds per 1,000 aged 65 and older in Nevada to nearly 86 in Nebraska.

The Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203) comprehensively revised the statutory authority that applies to nursing homes participating in the Medicaid program. The so-called nursing home reform law eliminated the Medicaid program's previous distinction between skilled nursing facilities and intermediate care facilities, and established a single category called nursing facilities. It strengthened the quality requirements that a nursing facility must meet to participate in Medicaid and specified that nursing facility reimbursement rates must be sufficient to cover the costs of complying with the new nursing facility requirements.

Intermediate Care Facilities for the Mentally Retarded

Although this report focuses on programs for the aged and persons with physical disabilities, the cost of care provided to persons with developmental disabilities constitutes a substantial portion of the Medicaid institutional long-term care budget. Expenditures on ICFS/MR in fiscal year 1993 were $9.2 billion. This amount is 21.9 percent of Medicaid long-term care expenditures and more than the total amount spent for all Medicaid home and community-based care.

Medicaid Home and Community-Based Service Waiver Program

As part of OBRA 1981 (P.L. 97-35), the Congress established the home and community-based service waiver program as section 1915(c) of the Social Security Act to offer an alternative to institutional long-term care services. The provision was one of two in OBRA 1981 that allowed states, with federal approval, greater flexibility in program design as a means of developing cost-effective alternatives for delivering services.[1]

As of May 1994, all states except Arizona—which provides similar services under a separate demonstration program—had initiated Medicaid home

[1]Much of the following description of the waiver program is drawn from Medicaid Source Book: Background Data and Analysis, Congressional Research Service (Jan. 1993).

and community-based waiver programs. The 49 states operate 195 individual waivers with each waiver authorizing services for a specific group needing long-term care, such as the aged, persons with physical disabilities, or persons with developmental disabilities. In 1991, when the Health Care Financing Administration most recently tabulated figures, approximately 73 percent of those served under the waivers were aged and persons with physical disabilities; 21 percent were persons with developmental disabilities; and the remainder were persons with acquired immunodeficiency syndrome (AIDS), disabled children, and others. In terms of spending, however, 31 percent of the nearly $1.7 billion in 1991 waiver expenditures was spent on the aged and persons with physical disabilities, 65 percent was spent on persons with developmental disabilities, and the remaining 4 percent was split among children with disabilities and persons with AIDS or chronic mental illness.

Home and Community-Based Waiver Services

States provide a range of health and social support services under Medicaid home and community-based waivers. Waiver programs for the aged and persons with physical disabilities most often offer case management, homemaker services, adult day care, personal care, and respite services. For persons with developmental disabilities, waiver programs most often provide habilitation services, respite services, and case management. States may also provide other services such as transportation and minor home modifications.

The waiver program permits states to cover (1) services that are beyond the medical and medically related benefits that have been the principal focus of the Medicaid program and (2) individuals whose incomes are above the usual Medicaid eligibility standard, but less than the higher income standard used for nursing facility residents. Under waiver programs, the states may cover a wide variety of medical, nonmedical, social, and supportive services. But services are to be directed to individuals who, "but for the provision of such services ... would require the level of care provided in a hospital, or a nursing facility, or intermediate care facility for the mentally retarded."[2] Descriptions of some of these types of services are presented in table I.2. States have flexibility in deciding which services they will cover in their programs.

[2]Section 1915(c)(1) of the Social Security Act.

Table I.2: Examples of Home and Community-Based Services

Service	Description
Case management	Assists beneficiaries in getting medical, social, educational, and other services.
Personal care	Includes bathing, dressing, ambulation, feeding, grooming, and some household services such as meal preparation and shopping.
Adult day care	Includes personal care and supervision and may include physical, occupational, and speech therapies. Also provides socialization and recreational activities adapted to compensate for any physical or mental impairments.
Respite care	Provides relief to the primary caregiver of a chronically ill or disabled beneficiary. By providing services in the beneficiary's or provider's home, or in other settings, respite care allows the primary caregiver to be absent for a time.
Homemaker	Assists beneficiaries with general household activities and may include cleaning, laundry, meal planning, grocery shopping, meal preparation, transportation to medical services, and bill paying.

In addition, waivers are not required to cover all Medicaid beneficiaries throughout the state—but may be targeted. States have the flexibility to define the geographic areas and target populations, and set financial eligibility levels for any individual waiver. Because of these variations, many states have more than one waiver.

Waiver Approval Process

The statute requires that a waiver shall be approved only if

"under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals [the waiver enrollees] does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures ... for such individuals if the waiver had not been granted."[3]

To implement this portion of the statute, HCFA applies a formula that seeks to keep costs at or below what Medicaid would have spent in the absence of the waivers—a concept known as budget neutrality.[4] Within the targeted group, the formula generally compares the estimated average cost per beneficiary of long-term care services in a state Medicaid program with a home and community-based service waiver and without such a waiver. The formula also sets an annual limit on the unduplicated number

[3]Section 1915(c)(2)(D) of the Social Security Act.

[4]HCFA regulations formalized budget neutrality in a formula published in 1981 and revised in 1985

of beneficiaries who may be served in a waiver program. By multiplying the average cost per beneficiary by the unduplicated number of beneficiaries, an annual budget ceiling is created for the waiver.[5] The most contentious issue surrounding the formula has always been the "cold bed" concept used to determine the number of eligible waiver beneficiaries.

Cold Beds and the Woodwork Effect

Historically, a state has been required to document that it has either an empty or closed institutional bed (cold bed) for each waiver beneficiary. HCFA viewed this policy as a means to control the rate of growth of the Medicaid home and community-based waivers. HCFA's concern was that providing a new home care benefit would bring individuals "out of the woodwork" to use the services.

The waiver formula requires states to estimate the number of persons who would be served in nursing facilities and other institutions in the absence of a waiver. This requirement is intended to ensure that home and community-based services substitute for institutional services rather than supplement them. Institutional capacity is measured as the sum of (1) all current Medicaid-certified beds, by type of facility; (2) all beds that would be added during the life of the waiver; and (3) all beds eliminated as a direct result of the waiver. States with a certificate of need program must document that beds would be added and would be certified in the absence of a waiver. For states without certificate of need, other "convincing evidence" must be provided that nursing facilities would actually be built (in the absence of the waiver). States also had to submit data on occupancy rates and waiting lists for their nursing facilities as evidence of the demand for institutional services and a baseline measure for the effect of waiver services over time.

The cold bed policy has at times been problematic for states that limited nursing facility bed supplies prior to applying for a waiver. Their smaller bed supplies, when incorporated into the formula, have resulted in lower limits on the number of persons allowed to be covered under the waiver. Some states believed the formula punished them for their earlier success in controlling costly institutional care.

In recent years, HCFA has become more flexible in evaluating the evidence required to document actual and potential bed capacity in the absence of a waiver. HCFA and the National Governors' Association have negotiated a

[5]Initially, HCFA disallowed federal Medicaid payments for expenditures exceeding approved waiver limits. However, in 1986 the Congress amended the statute to clarify that HCFA could not disallow payments on that basis.

simplified version of the cost-neutrality formula, and the new formula was published as a final rule on July 25, 1994.[6] The new formula compares average costs with and without the waiver, and eliminates number of beds as a variable altogether. In brief, the cold bed policy no longer exists.

1915(d) Waivers for the Elderly

In OBRA 1987 (P.L. 100-203), the Congress established a new waiver program for persons aged 65 and older. This alternative waiver was developed to give states that had tried to limit their nursing facility bed supply more flexibility to expand home and community-based services. Where the 1915(c) waiver limits the unduplicated number of persons served and sets an overall spending target, the 1915(d) waiver sets only an overall spending limit. For example, under a 1915(c) waiver, if a state shows that it will empty a nursing facility bed costing $24,000 a year, it can serve only one person in the community even if community-based services cost substantially less. Under a 1915(d) waiver, however, when a state empties a bed costing $24,000, it can provide community-based services to as many more people as can be served for that amount.

Under a 1915(d) waiver, a limit on total Medicaid long-term care expenditures (that is, nursing facility and home and community-based services combined) is agreed on by HCFA and the state. Long-term care spending in a base year is updated annually based on the changes in cost of the services and size of the state's population 65 and older. As long as a state stays within the limit, the mixture of spending on nursing facilities and home and community-based services is left to the state. As with the 1915(c) waivers, states have the flexibility to define the geographic areas and target populations and to set financial eligibility levels. As of January 1994, Oregon was the only state that had sought and operated a 1915(d) waiver program. However, in March 1994 state officials submitted an application to HCFA to drop the 1915(d) waiver and expand the 1915(c) waiver because of expected difficulty in staying within the 1915(d) expenditure limit.[7]

Functionally Disabled Elderly or Frail Elderly Program

In 1990, the Congress enacted a program within Medicaid that allows states to provide a package of home and community-based services to the elderly as a state option. The intent of the legislation was to give states an alternative to the waiver programs. The new program does not require

[6]59 Fed. Reg. 37702.

[7]There is one other type of waiver for home and community-based care. Section 1915(e), enacted in 1988, created waivers for children with AIDS or who were drug dependent at birth.

states to demonstrate budget neutrality as under 1915(c) and 1915(d) waivers. It does, however, cap overall spending at specific amounts each year. Only two states have requested funding under this program, which is authorized only through fiscal year 1995.

Nonwaiver Medicaid Home Care Services

Two home care services are covered under the regular Medicaid program. One is mandatory and one is optional. Use of these services has been growing, along with the use of waiver services, as another alternative to institutional care.

Home Health. Medicaid requires all state programs to make home health services available to certain eligible Medicaid beneficiaries who are entitled to nursing facility services. Home health services generally are provided in an individual's place of residence—not in a hospital or nursing facility. Services must be provided on a physician's orders as part of a written plan of care that is reviewed by a physician every 60 days. Home health services include part-time nursing care, home health aide care, and medical supplies and equipment, and also may include physical therapy, occupational therapy, and speech pathology and audiology services.

Personal Care. Personal care has become an important part of the home and community-based service mix in certain states. While the service can be covered under a waiver, most states have chosen to provide it as a separate optional service, targeting it to persons who meet the states' functional impairment criteria. OBRA 1993 clarified that personal care services are covered at the option of the state and can be authorized for an individual either by a physician as part of a plan of treatment or by others, such as a case manager, in accordance with a service plan.

Scope and Methodology

We focused our work on Oregon, Washington, and Wisconsin mainly because the three states use home and community-based programs to a significant extent. Moreover, federal and state Medicaid specialists indicated that the three states' programs could provide examples of mechanisms for managing program growth.

Our analysis covered state programs that provided long-term care services to individuals who are aged or who have physical disabilities. We conducted extensive interviews with state program administrators and collected documentation, including program enrollment and expenditure data. We spoke with other interested parties, including local officials and

advocates for those served by the programs. We conducted our work between July 1992 and April 1994 in accordance with generally accepted government auditing standards.

Long-Term Care in Oregon

By 1993, 68 percent of the aged and persons with physical disabilities who were beneficiaries of publicly funded long-term care in Oregon were receiving care in their homes or in other community settings, compared with 49 percent in 1983.[1] Increased reliance on home and community-based care has helped the state serve more beneficiaries within the constraints of available funds. Oregon has generally been able to meet the demand for home and community-based services, although its state-funded program has faced capacity limits.

Oregon's Programs for Delivering Long-Term Care

Oregon operates two home and community-based programs for the aged and persons with physical disabilities: a Medicaid waiver program and a state-funded program. These two programs served an average of more than 16,300 persons per month in 1993, compared with about 7,600 in nursing facilities (see table II.1). Annual direct expenditures for the two programs totaled about $82 million, compared with about $152 million for nursing facilities. Additionally, federal Supplemental Security Income (SSI) and state supplemental payments (SSP) totaled about $14 million for eligible beneficiaries of these two home and community-based programs in 1993, according to information supplied by Oregon officials.[2]

[1]All caseload and expenditure data discussed and displayed in tables are state fiscal year data (July through June) unless otherwise noted.

[2]Oregon data show that $14 million in SSI and SSP support represents an average payment of $214 per month or $2,568 per year to about one-third of Oregon's home and community-based care beneficiaries who are aged or have physical disabilities. SSI/SSP may be used to pay for the room and board portion of care in alternative living arrangements, such as adult foster homes or assisted living facilities.

Table II.1: Oregon's Long-Term Care Service Programs for the Aged and Persons With Physical Disabilities, 1993

	Services provided	Average monthly users [a]	State fiscal year 1993 expenditures [b]	Average monthly expenditure per user [c]	Funding source
Institutional care					
Nursing facilities	Nursing and personal care	7,631	$151,714,128	$1,657	Medicaid
Home and community-based care					
Medicaid waiver program: section 1915(c) waiver and section 1915(d) waiver	Personal care and some nursing services	13,053	77,712,002	496	Medicaid
Oregon Project Independence	Personal care, chore, escort, home health, day care, and respite care	3,277	4,501,025	114	State
All home and community-based programs		**16,330**	**$82,213,027**	**$420**	

[a]The average monthly users for nursing facility and home and community-based care programs are reported differently. For nursing facilities, average monthly users is the average daily census. For home and community-based care programs, average monthly users is the average number of persons served monthly during 1993.

[b]Only direct long-term care expenditures are reported for the home and community-based programs; other public expenditures, such as SSI, are not included. Also excluded are expenditures for program administration (including case management services), Older Americans Act services, and Medicaid nonwaiver personal care, home health, and private duty nursing services. Medicaid nonwaiver service expenditures totaled about $4 million in 1993. Expenditure figures do not include $7.2 million in state offsets that are primarily from estate recoveries, according to a state official.

[c]For nursing facility and home and community-based care programs, average monthly expenditure per user has been calculated by dividing the fiscal year expenditure by 12 and dividing that quotient by the average monthly users.

Source: Senior and Disabled Services Division, Oregon Department of Human Resources.

The Medicaid waiver program (in fact, two waivers operated as one program) serves persons who otherwise would qualify for Medicaid-covered care in a nursing facility.[3] The program provides such personal care and home support services as meal preparation, assistance with medications, eating, dressing, bathing and personal hygiene, mobility, money management, transportation, laundry, housekeeping, and shopping. The other program, Oregon Project Independence, is entirely state-funded. It provides similar types of services to persons 60 and older who are at risk of institutionalization but are not receiving services under Medicaid.

[3]Waiver conditions are discussed in a later section on program management and cost controls.

In 1993, about 66 percent of the persons in Oregon's home and community-based programs received services in their own homes. The rest—about 5,500—were in alternative living arrangements such as adult foster homes or assisted living facilities.[4] Oregon has actively promoted the development of such alternatives since the early 1980s. Oregon officials cite continued growth and high rates of private-pay clients as evidence of favorable public attitudes toward such alternatives. In 1993, private-pay clients constituted about 60 percent of adult foster home residents and about 73 percent of assisted living residents.

Oregon has consolidated administrative authority over both institutional and noninstitutional long-term care in a single unit within the state's Department of Human Resources (the Senior and Disabled Services Division), which administers all funding resources and services for aged beneficiaries and persons with physical disabilities. According to state officials, this consolidation has been instrumental in developing a comprehensive long-term care program.

Program Management and Cost Controls

Oregon's management and cost controls fall into three main categories. First, federal waiver rules and state budget limits impose constraints on the overall size and cost of the long-term program. Second, beneficiaries must meet financial eligibility and functional impairment criteria. Third, Oregon has instituted other management controls designed to reduce the proportion of long-term care expenditures for institutional care and to help manage growth in the home and community-based programs.

Key Federal and State Program Constraints

Oregon has received two types of Medicaid waivers. The waiver for persons with physical disabilities is a section 1915(c) waiver that operates under enrollment capacity and expenditure limits approved by HCFA.[5] Oregon's program for aged beneficiaries is the nation's only section 1915(d) waiver, which has an overall expenditure cap but allows flexibility in the number of beneficiaries served. In this waiver, the state can increase enrollment of home and community-based beneficiaries as long as total expenditures for nursing facility and home and community-based services

[4]These alternatives include adult foster homes, which provide a family living environment for up to five eligible residents; residential care facilities, which are group living facilities providing services to six or more eligible persons; and assisted living facilities, which provide a range of services, including access to routine licensed nursing tasks, to six or more persons in individual living units. Medicaid covers only approved services provided in these settings, not room and board.

[5]For a description of how HCFA reviews and approves the waiver capacity and spending limits, see appendix I.

together do not exceed the expenditure cap. The state must assure HCFA, however, that persons who receive home and community-based waiver services would otherwise qualify for Medicaid-supported nursing facility care.[6]

State budgets have been an even more constraining factor in program growth than waiver capacity limits have been, according to Oregon officials. State revenues in Oregon were limited throughout the 1980s, and the state-funded program in particular saw little funding growth. As a result, waiting lists have developed for some services (these waiting lists are discussed later in this appendix).

To supplement available program funding, Oregon has developed one of the nation's most effective estate recovery programs. Oregon law permits the state to recover costs of Medicaid-funded nursing facility or home and community-based services from the estates of beneficiaries aged 65 and older who have died.[7] Recoveries amounted to more than $7 million in 1993.

Financial and Functional Eligibility Criteria

Oregon uses financial eligibility and functional impairment criteria to target services to those most in need of services and at risk of institutionalization. The criteria for each program are summarized in table II.2.

[6]In March 1994, because of concerns that the state might exceed the overall expenditure cap on the 1915(d) waiver program by 1995, Oregon submitted an application to combine its aged and physically disabled beneficiaries in an expanded 1915(c) waiver.

[7]OBRA 1993 (P.L. 103-66) authorized states to recover from the estates of beneficiaries aged 55 and older. In its next legislative session, Oregon is expected to amend its statute to conform.

Table II.2: Oregon's Eligibility Requirements for Long-Term Care Programs

Institutional care
Nursing facility
Medicaid eligibility: Income less than or equal to 300 percent of the federal SSI benefit; nonexempt assets at or below $2,000
Functional impairment: Functional disability within specified categories of the state's functional assessment priority system (currently categories 1-17)
Home and community-based care
Waivers
Medicaid eligibility: Same as for nursing facility
Functional impairment: Same as for nursing facility
Oregon Project Independence
Income eligibility: Individuals not eligible for Medicaid; no assets test; income up to $580 per month; above that, sliding fee schedule
Functional impairment: Individual at risk of institutionalization; same criteria as for nursing facility or waiver

Source: Senior and Disabled Services Division, Oregon Department of Human Resources.

Once a person's financial eligibility has been established, Oregon's primary control mechanism for both institutional and noninstitutional care for the aged and persons with physical disabilities is a detailed functional needs assessment system called the Client Assessment and Planning System (CAPS). A case manager, registered nurse, or social worker uses this standardized approach to measure each applicant's dependency in activities of daily living and to assess the applicant's living situation (for example, availability of family or friends as caregivers). Each applicant receives a functional disability rating on an 18-point scale, with 1 being the most impaired. Table II.3 defines the 18 levels of need and shows how the state's nearly 24,000 beneficiaries were distributed among the levels as of December 1992. About 60 percent of beneficiaries were in levels 1 through 4 (the highest dependency), and 83 percent were in levels 1 through 10.

Table II.3: Oregon's Distribution of Beneficiaries by Level of Functional Disability in the CAPS System, December 1992

		Beneficiaries in each level[a]	
Level	**Description**	**Number**	**Percent**
1	Dependent in mobility, toileting, eating, and cognition	2,586	11.0
2	Dependent in mobility, eating, and cognition	340	1.4
3	Dependent in mobility, or cognition, or eating	11,274	47.5
4	Dependent in toileting	81	0.3
5	Needs substantial assistance with mobility, assistance with toileting, and assistance with eating	838	3.5
6	Needs substantial assistance with mobility and assistance with eating	816	3.4
7	Needs substantial assistance with mobility and assistance with toileting	922	4.0
8	Needs minimal assistance with mobility and assistance with eating and toileting	106	0.5
9	Needs assistance with eating and toileting	38	0.2
10	Needs substantial assistance with mobility	2,744	11.6
11	Needs minimal assistance with mobility and assistance with toileting	170	0.7
12	Needs minimal assistance with mobility and assistance with eating	439	1.9
13	Needs assistance with toileting	67	0.3
14	Needs assistance with eating	242	1.0
15	Needs minimal assistance with mobility	2,165	9.0
16	Dependent in bathing or dressing	96	0.4
17	Needs assistance in bathing and dressing	570	2.4
18	Independent in above levels but requires structured living for supervision for complex medical problems or a complex medication regimen	221	0.9
	Total	**23,715**	**100**

[a]Beneficiaries include those in nursing facilities and home and community-based care programs.

Source: Senior and Disabled Services Division, Oregon Department of Human Resources.

Oregon's Senior and Disabled Services Division uses CAPS in several ways. It uses the individual's functional disability level to help identify service needs and develop care plans, and it also uses CAPS data in the nursing

facility and community-based care rate-setting systems. In addition, if state budget limits make it necessary to curtail eligibility, CAPS rankings help ensure that any beneficiaries who may be dropped from coverage are the ones who would be best able to survive on their own. To date the legislature has chosen to fund services for persons in levels 1 through 17.

Other Management and Cost Controls

Oregon officials believe that, overall, the state's consolidated administrative structure has been the key factor in program management and cost control. In addition, Oregon has other specific controls in place. These controls include preadmission screening of all applicants for nursing facility services (including private-pay applicants) and payment limitations, service limitations, and several other related procedures for home and community-based services.

Preadmission Screening. Oregon conducts preadmission screening of all nursing facility candidates—that is, on private-pay as well as Medicaid-eligible candidates. Case managers encourage nursing facility applicants to consider a variety of home and community-based services. Oregon officials said this combination of screening and case management has played a major part in slowing the rate of Medicaid-eligible persons entering nursing facilities, and this has controlled costs. Another result is that nursing facilities increasingly are being used to care for people who need short-term sub-acute care or rehabilitation services. Oregon's nursing facility residents on average tend to be older and more severely disabled than the average person who receives care in other settings. All beneficiaries, however, are severely enough disabled to be at risk of institutionalization, and there are individuals receiving home and community-based services who are as severely disabled as those in nursing facilities.

Payment and Service Limits. Oregon sets limits on rates paid to home and community-based providers for the aged and persons with physical disabilities, as well as limits on the amounts of service that may be authorized for each beneficiary. Rates vary according to disability levels. For example, for beneficiaries who are aged or have physical disabilities, the maximum monthly service payment in adult foster homes ranges from $254 (for persons needing the lowest level of care) to $747 (for those needing the highest level). The state pays providers of in-home services on

an hourly basis up to a maximum number of hours per month.[8] According to state officials, with few exceptions (such as persons with AIDS with extensive needs), the total cost for home and community-based services for any individual cannot exceed 80 percent of the cost of the comparable level of nursing facility care.

Nurse Practice Act. Oregon's Nurse Practice Act appears to stand out nationally for the extent to which it permits state contract nurses to train and monitor nonlicensed persons (usually relatives or adult foster care resident managers) to provide eligible beneficiaries with specific medical and support services, such as administering certain kinds of medications. Oregon officials said the law has been instrumental in controlling costs because of the expense that would otherwise be involved in paying professional nurses to provide such services.

Case Management. Case management is an important component of Oregon's long-term care delivery model. Oregon's programs rely on local case managers (who may be employed by the state, county, or local Area Agency on Aging) to assess client service needs, determine financial eligibility, develop and monitor care plans, and authorize services. Although studies have not been done to document the cost-containment effects of case management in Oregon, officials believe case managers save money by functioning as Medicaid service gatekeepers. In particular, as noted above, case managers control expenditures by encouraging beneficiaries to select less costly home and community-based services rather than nursing facility care.

Oregon's Experience in Expanding Home and Community-Based Programs and Containing Costs

Oregon's shift to greater reliance on home and community-based services, which are less costly per person, has allowed the state to serve more beneficiaries with available dollars. The state has been able to provide waiver services to all Medicaid-eligible applicants who are aged or have physical disabilities, but limited funding has meant that not all non-Medicaid applicants eligible for the state-funded program have been served.

[8]For in-home services, hours of service that the state will provide are adjusted if beneficiaries receive unpaid care from family members or friends. An Oregon official estimated that if the unpaid care were not available, the state's costs to provide care would rise by 25 percent. Oregon also supports family members and other informal caregivers by providing education, information, and respite care, and in some cases, the state will approve payments to family caregivers.

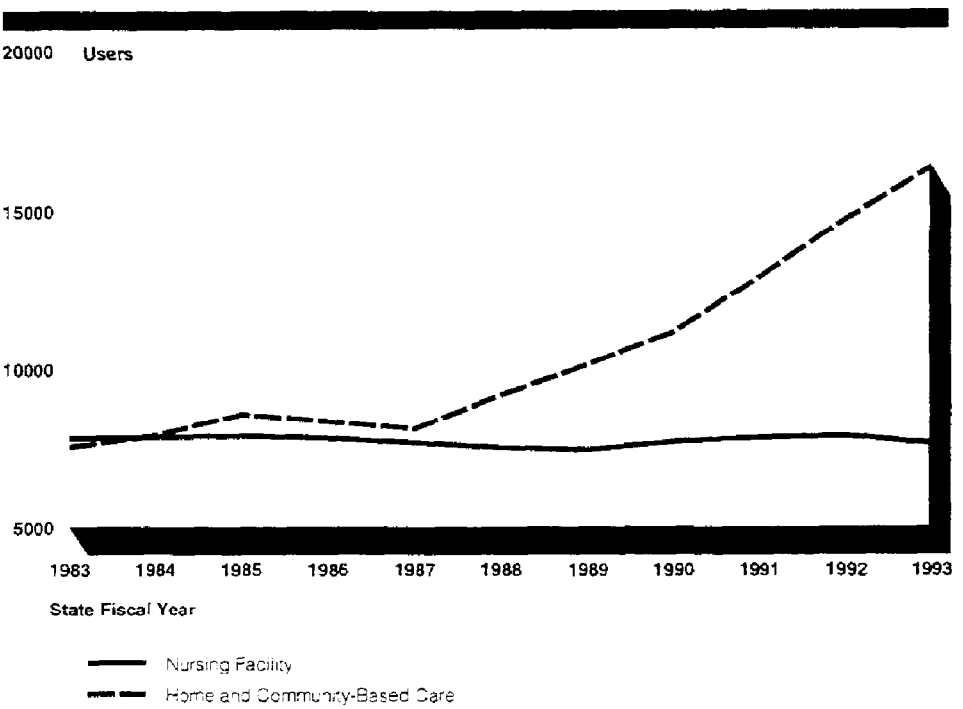
Program Growth Has Been Accommodated in Home and Community-Based Care

From 1983 through 1993, Oregon's annual expenditures for long-term care for the aged almost tripled, from $79 million to about $234 million—an average increase of 11.4 percent each year. The number of individuals served by Oregon's Medicaid and state-funded programs grew somewhat more rapidly than the state's aged population. Between 1982 and 1992, total beneficiaries who were aged or had physical disabilities increased by about 38 percent, compared with a 27-percent increase in the state population 65 and older.[9]

All of the growth in Oregon's aged and physically disabled beneficiary population has been accommodated in home and community-based care. The average number of beneficiaries using nursing facility care dropped from 7,812 persons per month in 1983 to 7,631 in 1993 (see fig. II.1). Over that same period, users of home and community-based care more than doubled, from an average 7,522 to 16,330 per month. As a result, 68 percent of beneficiaries who were aged or had physical disabilities were served at home or in the community in 1993 (compared with 49 percent in 1983), and 32 percent were in nursing facilities.

[9]The most recent year for which Oregon general population figures, by age, are available, is 1992.

Figure II.1: Oregon's Average Monthly Users for Nursing Facility and Home and Community-Based Care, 1983-1993



Notes: Nursing facility data are reported as average daily census.

Home and community-based care data for the Medicaid waivers and Oregon Project Independence are reported as average number of persons served per month.

Source: Senior and Disabled Services Division, Oregon Department of Human Resources.

Expenditures for home and community-based services as a percentage of total long-term care for the aged and persons with physical disabilities increased from 16 percent in 1983 to 35 percent in 1993, but expenditures for nursing facility care continued to consume the largest share of the funding. The 32 percent of beneficiaries in nursing facilities accounted for 65 percent of total expenditures.

Increased Reliance on Home and Community-Based Care Has Helped Control Overall Expenditures

Oregon officials attributed much of their success in controlling nursing facility capacity and use to the statewide availability of home and community-based services, including alternative living arrangements such as adult foster homes and assisted living facilities.

In the early 1980s, Oregon's certificate of need program set a target for adequate nursing facility bed capacity at a ratio of 35 to 45 beds per 1,000 persons aged 65 and older. This policy has contributed to a decline in the ratio of nursing facility beds from almost 47 beds per 1,000 in 1982 to 36 in 1992, one of the lowest in the nation. Oregon also is one of two states that has reduced the actual number of nursing facility beds, from 15,146 in 1982 to 14,758 in 1992.

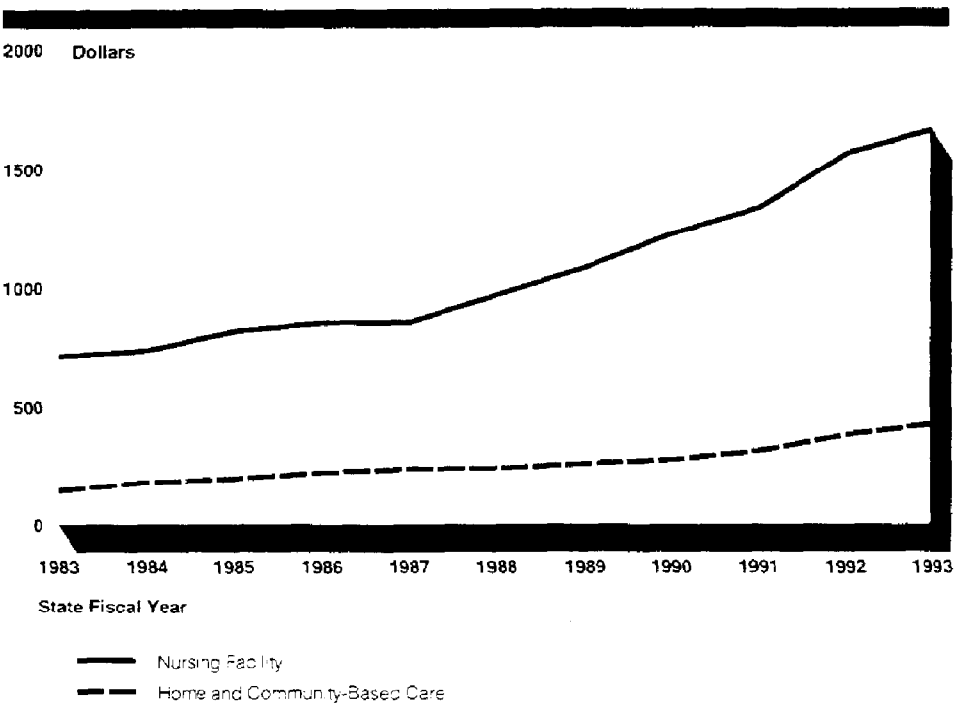
By serving a larger share of beneficiaries in home and community-based care, the state has been able to serve more beneficiaries overall within a given budget than would have been possible using more costly nursing facilities. A state study concluded that the use of home and community-based services instead of nursing facility care for the aged and persons with physical disabilities had saved an estimated $227 million between 1981 and 1991 because actual expenditures were $1.12 billion instead of a projected $1.35 billion.[10]

As figure II.2 illustrates, the average monthly expenditure per user for nursing facility care is substantially higher than for home and community-based care. In 1993, the average monthly expenditure per user for nursing facility care was nearly $1,657, compared with $420 for home and community-based care.[11] The rate of increase in average monthly expenditure per user has been about the same for the two types of care.

[10]The estimate was based on assumptions that (1) long-term care programs had continued to grow at the same rate as the state's population aged 75 and older and (2) the state continued providing nursing facility services in 1991 to the same proportion of people who were served in nursing facilities in 1979. Expenditures and estimated savings were direct program expenditures, not including other public payments such as SSI and SSP.

[11]Using the estimates discussed earlier, adding SSI and SSP support to the amounts for home and community-based care would increase the monthly per-user amount over the total 16,330 users by about $71.

Figure II.2: Oregon's Average Monthly Expenditure Per User for Nursing Facility and Home and Community-Based Care, 1983-1993



Notes: Home and community-based care includes Medicaid-funded 1915(c) and (d) waivers and state-funded Oregon Project Independence.

Average monthly expenditure per user was calculated by dividing fiscal year expenditures by 12 and dividing that quotient by average monthly users.

Source: Senior and Disabled Services Division, Oregon Department of Human Resources.

Oregon officials believe that when acceptable alternatives to nursing facility care are available and people are made aware of them, many of those who need long-term care—whether they are private-pay or Medicaid beneficiaries—will choose home and community-based alternatives. They cite as evidence the majority of private-pay residents in adult foster homes and assisted living facilities, and an independent review of those programs in 1990.[12] The review found that individuals in adult foster homes valued flexibility and a homelike setting.

[12]Rosalie A. Kane, et al., Meshing Services with Housing: Lessons from Adult Foster Care and Assisted Living in Oregon, Division of Health Services Research & Policy, School of Public Health (Minneapolis: University of Minnesota, May 1990).

Controls on Home and Community Services Have Limited Access for Some Applicants

To date, the state has been able to serve all of the applicants who are aged or have physical disabilities who have met financial and functional eligibility criteria for the Medicaid waiver programs.[13] The state-funded program for the aged, however, has faced capacity limits. State funding for this program was reduced in 1991 and 1993, and as a result local offices had to deny services, raise client fees, or keep waiting lists.

[13]Officials said if a need to limit services were identified, legislative approval would be sought for discontinuing services to beneficiaries in the lowest priority (least severe) functional disability levels. During the 1993 legislative session, for example, the legislature considered but rejected an option to restrict eligibility for waiver services to individuals in priority levels 1 through 16 (instead of 1 through 17).

Long-Term Care in Washington

By 1993, more than half of the nearly 39,500 aged and physically disabled beneficiaries of publicly funded long-term care in Washington were receiving care in noninstitutional settings.[1] While the number of persons in institutional and noninstitutional programs combined has grown over the past decade, the increased reliance on lower-cost home and community-based services has helped control growth in overall expenditures. A variety of federal and state controls limit growth in Washington's home and community-based programs, however, and access to some services has been limited at times.

Washington's Programs for Delivering Long-Term Care

Washington has four home and community-based care programs for the aged and persons with physical disabilities. These programs served an average of about 22,000 persons per month in 1993,[2] compared with about 17,400 in the nursing facility program (see table III.1). Direct expenditures for the home and community-based programs totaled about $111 million for the year, compared with about $423 million for nursing facility services. We estimate that Washington's home and community-based beneficiaries may receive an additional $27 million in SSI and SSP support.[3]

[1]Expenditure and utilization figures are for Washington state fiscal years, July through June.

[2]About 2,400 (11 percent) of those using home and community-based services in 1993 were persons with developmental disabilities.

[3]Washington officials estimated that 39 percent of persons in these four home and community-based programs received SSI and SSP support. As of December 1993, the average SSI/SSP amount for persons aged 65 and older in Washington was about $257 per month ($3,084 per year). The estimate of $27 million is based on the assumption that 39 percent of those in home and community-based programs receive $3,084 per year in SSI/SSP support.

Table III.1: Washington's Long-Term Care Service Programs for the Aged and Persons With Physical Disabilities, 1993

	Services provided	Average monthly users [a]	State fiscal year 1993 expenditures [b]	Average monthly expenditure per user [c]	Funding sources
Institutional care					
Nursing facilities	Personal care and services provided by licensed nursing personnel	17,428	$423,122,025	$2,023	Medicaid
Home and community-based care					
Community Options Program Entry System (COPES)	Personal care, related household tasks, case management, supervision	4,840	47,330,320	815	Medicaid (waiver)
Medicaid Personal Care	Personal care, related household tasks	7,823	33,606,968	358	Medicaid (nonwaiver)
Chore Services	Personal care, household tasks	8,656	27,563,967	265	State
Adult Residential Care	Personal care, supervision	721	2,240,595	259	State
All home and community-based programs		**22,040**	**$110,741,850**	**$419**	

[a]The average monthly users for nursing facility and home and community-based care programs are reported differently. For nursing facilities, average monthly users is the average daily census. For home and community-based care programs, average monthly users is the average number of persons served monthly during 1993.

[b]Only direct long-term care expenditures are reported for the home and community-based programs; other public expenditures, such as SSI, are not included. Also excluded are expenditures for program administration, Older Americans Act services, and a number of small special programs. Expenditures for the four programs above represented about 80 percent of total home and community-based service expenditures in 1993.

[c]For nursing facility and home and community-based care programs, average monthly expenditure per user was calculated by dividing the fiscal year expenditure by 12 and dividing that quotient by the average monthly users.

Source: Aging and Adult Services Administration, Washington Department of Social and Health Services.

All four home and community-based programs provide personal care services to assist beneficiaries with activities of daily living; but they differ in their funding sources and the amount of services they provide. Some individuals may qualify for more than one program, but they receive services through only one. The state's objective is to provide beneficiaries the most suitable services at the lowest cost. Placement in a program is

based on such factors as the individual's need for services and the availability of support from family and friends.

The Community Options Program Entry System (COPES), a Medicaid waiver program established in 1983, serves low-income persons who do not receive cash payments and who have income and resources below specified limits. The nonwaiver Medicaid Personal Care program is limited to persons who receive federally assisted income maintenance payments or would be eligible to receive payments if they applied.[4] In 1994, the state began to make these two programs more comparable by increasing the amount of services and provider payments under Medicaid Personal Care. This change was intended to help reserve COPES enrollment capacity, which is limited, for beneficiaries with higher incomes.

Chore Services, the larger of the two state-funded programs, serves persons at risk of institutionalization but not eligible for Medicaid. Recipients must meet state income and assets standards (described later in this appendix). Adult Residential Care is a small program that covers individuals in adult family homes and congregate care facilities who are not eligible for Medicaid.[5]

In 1993, 85 percent of the aged and persons with physical disabilities in these four programs received services in their own homes. The remaining 15 percent (about 3,300 persons) received care in alternative living arrangements such as adult family homes or assisted living facilities. The state encourages private sector development of these living arrangements.[6]

The Aging and Adult Services Administration within the Department of Social and Health Services is responsible for administering the four home and community-based programs and the Medicaid nursing facility benefit. As in Oregon, state officials in Washington believe consolidated authority over both institutional and noninstitutional care has helped the state expand home and community-based services while controlling institutional care.

[4]Income eligibility for Medicaid Personal Care, at or below 100 percent of federal SSI plus the state supplemental payment, is lower than for Medicaid COPES waiver or nursing facility services at 300 percent of SSI.

[5]Adult family homes are private homes that provide homelike settings for up to six people. Congregate care facilities (also referred to as boarding homes or group homes) provide services for 3 or more persons but generally serve from 12 to 200 persons.

[6]In the 1993-1995 budget biennium, for example, funding was provided for another 850 assisted living units.

Program Management and Cost Controls

Management and cost controls fall into three main categories. First, federal waiver rules and state budget limits impose constraints on the overall size and costs of Washington's long-term care programs. Second, beneficiaries must meet financial eligibility and functional impairment criteria. Third, the state has established other management controls to reduce institutional expenditures and manage growth in home and community-based programs.

Key Federal and State Program Constraints

Washington's Medicaid waiver program for the aged and persons with physical disabilities is restricted by federally approved enrollment and expenditure limits, and indirectly by the availability of state funds.[7] Enrollment capacity for the COPES waiver has grown from 1,540 in 1983 to 7,192 in 1993. COPES was closed to new applicants from November 1992 through June 1993, however, because of concerns about exceeding the enrollment limit of 6,724 then in effect.

Growth in Washington's Medicaid and state-funded home and community-based care programs has also been limited by the availability of state funding. In 1993, despite a HCFA-authorized increase in the COPES enrollment limit to 7,192 in April, the state did not reopen the waiver program until funds became available with the new state fiscal year in July. Limited state funding also has restricted new admissions to the Chore Services program since late 1993.

Financial Eligibility and Functional Impairment Criteria

Washington uses financial eligibility and functional impairment criteria to target services to those most in need of services and at risk of entering a nursing facility. The criteria for each program are summarized in table III.2.

[7]See appendix I for a discussion of HCFA criteria and procedures for establishing the federal limits.

Table III.2: Washington's Eligibility Requirements for Long-Term Care Programs

Institutional care
Nursing facility
Medicaid eligibility: Income less than or equal to 300 percent of the federal SSI benefit; nonexempt assets at or below $2,000
Functional impairment: Requires individually planned treatment and services ordered by a physician and directed daily by a registered nurse
Home and community-based care
COPES Waiver
Medicaid eligibility: Same as for nursing facility
Functional impairment: Requires nursing facility level of care and likely to be institutionalized within 30 days; requires assistance with two or more personal care tasks
Medicaid Personal Care
Medicaid eligibility: Income less than or equal to 100 percent of SSI plus SSP; nonexempt assets at or below $2,000
Functional impairment: Requires help with at least one personal care task because of a medical condition
State-Funded Chore Services
Income eligibility: Income less than or equal to 30 percent of the state median income; nonexempt assets at or below $10,000 for one person or $15,000 for two; reduced services if income exceeds 30 percent of the state median income
Functional impairment: (1) Is at risk of institutionalization, (2) needs help with at least one personal care task, and (3) has no one available to help
Adult Residential Care
Income eligibility: Determined by local staff (SSI or general assistance eligible)
Functional impairment: Needs help with at least one personal care task

Source: Aging and Adult Services Administration, Washington Department of Social and Health Services.

All applicants for Medicaid nursing facility care and Medicaid or state-supported home and community-based care must undergo a comprehensive assessment of their functional abilities. The state uses the comprehensive assessment to (1) identify the applicant's needs in six areas (see table III.3) and (2) evaluate the degree of need based on levels of assistance required and the availability of family and friends to provide some services.

Table III.3: Factors Considered in Washington's Comprehensive Assessment

Assessment category	Critical information for each category
General information	Marital status, source of referral, housing arrangement, condition of housing, and the applicant's reason for seeking services
Health status	Current diagnosis (physical and mental health); pertinent medical and mental health history; bladder and bowel control; medications, frequency of use, and if applicant needs help with taking it; speech, sight, and hearing; and treatments or therapies and the source
Psychological, cognitive, and social status	Problems with memory, hallucinations, depression, anxiety, wandering, a danger to self or others Applicant's ability to supervise a caregiver Whether the applicant has a primary caregiver (unpaid or privately paid) and caregiver's ability and willingness to continue the care Summary of social contacts, family relationships, and other personal history
Functional abilities and supports	Assessed for 16 activities of daily living and instrumental activities of daily living: eating, toileting, ambulation, transfer, positioning, specialized body care, personal hygiene, dressing, bathing, self-medication, travel to medical services, essential shopping, meal preparation, laundry, housework, and wood supply
Income and resources	Inventory of resources Assessed for Medicaid eligibility
Additional factors	Factors indicating institutional care may be appropriate, such as client is 75 or older, lives alone, needs help with multiple medications, needs moderate to total assistance with personal care, is incontinent, lacks adequate family or social support Other services available to the applicant Additional pertinent information from such people as family members or professional caretakers

Source: Aging and Adult Services Administration, Washington Department of Social and Health Services.

Other Management and Cost Controls

Other key management and cost controls for home and community-based programs include payment and service limitations and case management.

Payment and Service Limits. These limits are of several kinds. One is a maximum monthly payment limit per beneficiary. For example, in the COPES waiver program, the maximum per-beneficiary payment was set at $1,061 per month in 1993. A second kind of limit is the number of hours of service a beneficiary may receive. In the Chore Services program, an individual whose income is at or below 30 percent of the state median income may receive up to 116 hours of service per month (those with incomes above the limit receive fewer state-paid hours). Limits on per-beneficiary service hours are coupled with a third kind of limit, maximum hourly or daily provider payment rates. These vary by type of service and provider, with contract agencies paid higher rates than individual providers.[8]

State officials cited another consideration relating to provider payments—regulations governing the practice of nursing in Washington, which they say tend to counteract their efforts to control costs. The regulations prohibit unlicensed paid staff from administering medications and certain treatments to people who receive home and community-based services. According to state officials, the required use of professional providers increases the costs of service delivery.

Case Management. Washington requires case management for all beneficiaries receiving home and community-based services under the COPES Medicaid waiver and selectively in other instances. Case management is generally targeted to beneficiaries who have multiple needs, are unable to provide for themselves, and do not have adequate assistance from family or friends. Washington officials believe case management helps control costs by authorizing and monitoring services, and by ensuring that beneficiaries receive the support services they need to stay out of institutions. No studies have been conducted to specifically measure case management's effect as a cost control.

[8]The state believes agency providers offer a higher level of care because they hire and train their caregivers, while individual providers are hired by beneficiaries. Although the state pays lower rates for individual providers, it also pays their Social Security and unemployment taxes.

Washington's Experience in Expanding Home and Community-Based Programs and Containing Costs

Over the past decade, Washington's officials believe increasing reliance on home and community-based care for the aged and persons with physical disabilities has helped control the rate of growth in overall long-term care expenditures while allowing the state to serve more beneficiaries. By expanding home and community-based care, which is less expensive per person than institutional care, and by controlling growth in the capacity and use of nursing facilities, Washington has been able to serve more people with available dollars than could have been served under a program that relied more heavily on institutional care. Both the federal Medicaid program and state controls on growth of home and community-based services, however, have limited access to services at times.

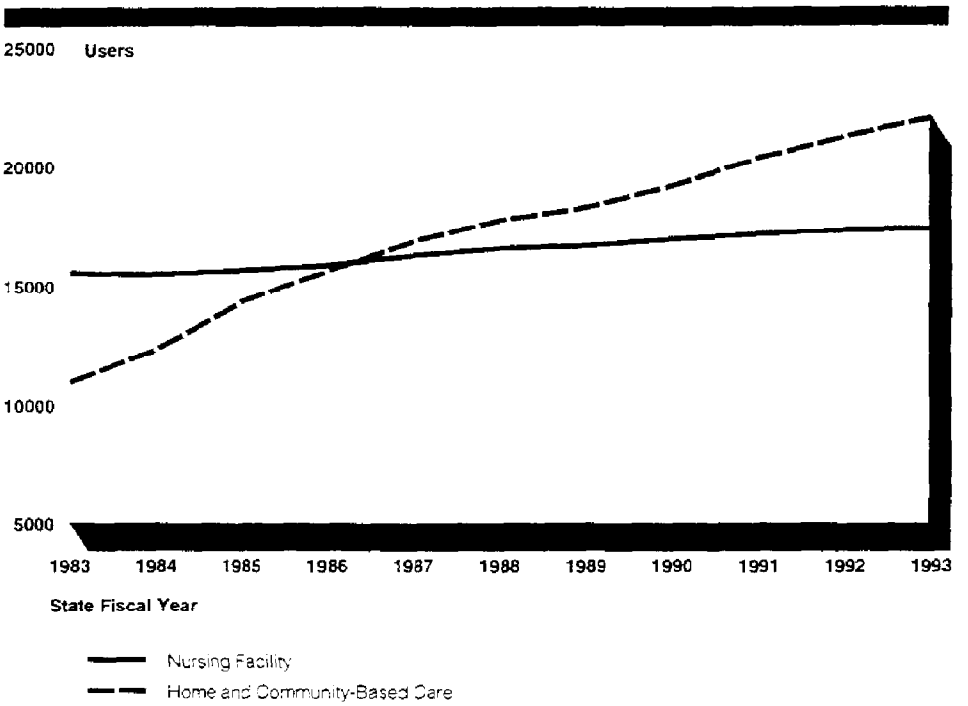
Most Program Growth Has Occurred in Home and Community-Based Care

From 1983 through 1993, Washington's expenditures for long-term care programs for the aged and physically disabled (programs included in table III.1) grew from $173 million to $534 million—an increase that averaged almost 12 percent per year. The number of individuals using these long-term care services has grown more rapidly than the aged population. Between 1982 and 1992,[9] the number of persons receiving Medicaid and state-funded long-term care increased 48 percent, while the state's population aged 65 and older—the group at greatest risk of needing long-term care—increased 30 percent.

Almost all (85 percent) of the growth in the number of Washington's service users who are aged or have physical disabilities has been accommodated in home and community-based care. In 1993, home and community-based programs covered 56 percent of the nearly 39,500 beneficiaries served each month, compared with 41 percent in 1983. Over the decade, the number of beneficiaries using home and community-based services doubled, from an average 10,900 to about 22,000 per month (see fig. III.1). By contrast, the number of Medicaid nursing facility beneficiaries increased only 12 percent (from about 15,500 to 17,400 per month), a rate lower than the growth rate of the aged population.

[9]The most recent year for which general Washington population figures, by age, are available is 1992.

Figure III.1: Washington's Average Monthly Users for Nursing Facility and Home and Community-Based Care, 1983-1993



Notes: Nursing facility data are reported as average daily census.

Home and community-based care data for the COPES waiver, Medicaid Personal Care, Chore Services, and Adult Residential Care programs are reported as average number of persons served per month.

Source: Aging and Adult Services Administration, Washington Department of Social and Health Services.

Expenditures for home and community-based services for the aged and persons with physical disabilities, as a percentage of total long-term care expenditures, increased from about 15 percent in 1983 to almost 21 percent in 1993; but nursing facility services continued to consume the largest share of funding. As a result, the 44 percent of the beneficiaries who were in nursing facilities in 1993 accounted for 79 percent of total expenditures, while only 21 percent of service funds were spent on the 56 percent of beneficiaries who were served at home and in the community.

Increased Reliance on Home and Community-Based Care Has Helped Control Overall Expenditures

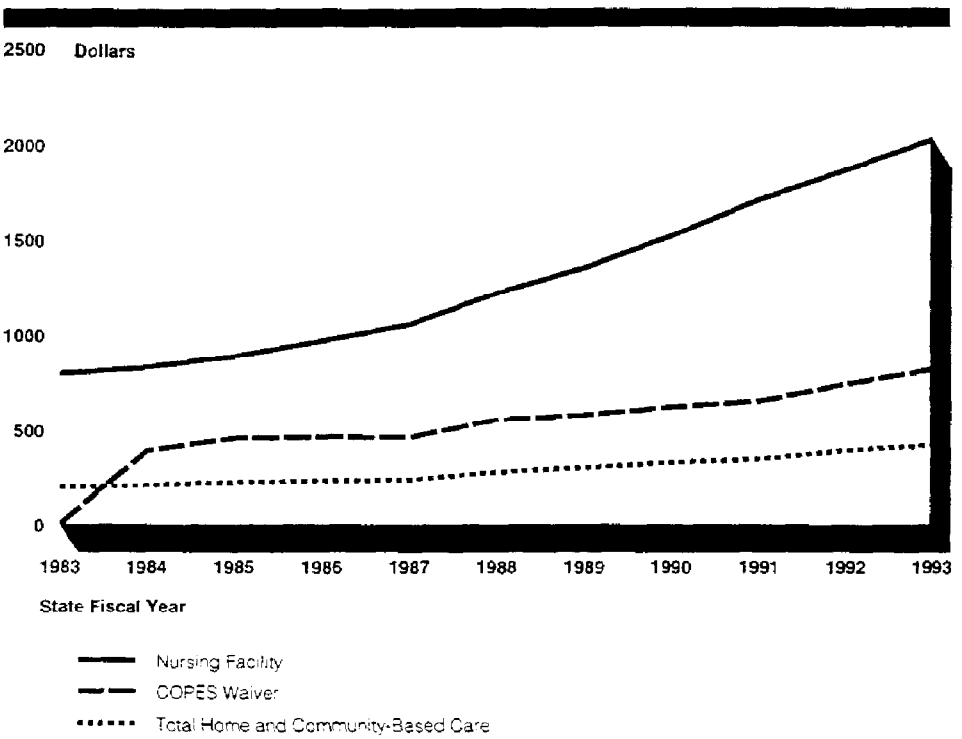
Expansion of home and community-based services has played an integral part in the state's ability to control expenditures for the aged and persons with physical disabilities, according to officials. Home and community-based programs have provided beneficiaries with choices other than nursing facility care and, by counting as available long-term care capacity, have reduced the need for additional nursing facility beds. Moreover, officials said the Medicaid home and community-based waiver program enabled them to convince the Governor and legislature to take steps to reduce the nursing facility bed supply, helping to slow increases in the use of more costly nursing facility services.[10]

Washington established a goal in 1989 to reduce the number of nursing facility beds per 1,000 persons aged 65 and older from 53.7 beds to 45 beds. This goal is incorporated in the state's certificate of need process for planning statewide nursing facility services. By 1992, the ratio of nursing facility beds stood at 48.7 per 1,000 persons 65 and older.

As figure III.2 illustrates, the average monthly expenditure per user for nursing facility care is substantially higher and has increased more rapidly than for home and community-based care. Between 1983 and 1993, the average monthly expenditure per nursing facility user increased from $793 to $2,023. State officials attributed the rise primarily to the nursing facility reimbursement system and cited an internal study done in 1991 that showed similar dependency levels in nursing facility and COPES waiver beneficiaries. By contrast, the average monthly expenditure for all home and community-based care users and for Medicaid COPES waiver users alone increased more slowly.

[10]In 1993, the Adult and Aging Services Administration was authorized to accelerate the reduction of nursing facility beds by closing about 750 beds, statewide, over the 1993-95 budget biennium.

Figure III.2: Washington's Average Monthly Expenditure Per User for Nursing Facility, COPES Waiver, and Total Home and Community-Based Care, 1983-1993



Notes: Total home and community-based care includes the COPES waiver, Medicaid Personal Care, Chore Services, and Adult Residential Care programs.

Average monthly expenditure per user was calculated by dividing fiscal year expenditures by 12 and dividing that quotient by average monthly users.

Source: Aging and Adult Services Administration, Washington Department of Social and Health Services.

Controls on Home and Community-Based Care Have Limited Access for Some Applicants

By managing the growth of waiver and state-funded programs, Washington has been able to expand those programs without exceeding approved federal waiver capacity or state budget limits. However, these controls have had an impact on access to services by persons who meet program eligibility criteria, as shown in the following examples.

When the COPES waiver program was closed for 8 months in 1992 and 1993 because of concerns about exceeding the enrollment limit, some eligible applicants may not have received needed services. Officials said that COPES applicants eligible for the Medicaid Personal Care or Chore Services programs were diverted to those programs, and nursing facility beds also

were available. Because the state did not maintain COPES waiting lists, officials were unable to estimate the number of persons turned away or to determine if those who were turned away received services from other programs. The Washington Senior Citizens Lobby told us they received complaints from eligible applicants who had been turned away from COPES during the period, but they could not estimate the number of persons affected.

As a result of reduced state funding for the Chore Services program, there were waiting lists for that program in January 1994. Program officials said they were operating under a general policy of not enrolling a new applicant until four beneficiaries had left the program. However, the state established criteria that prioritized applicants on the waiting list by their functional needs. Individuals seeking relocation from nursing facilities also had priority for Chore Services.

Long-Term Care in Wisconsin

Although it began the 1980s with one of the nation's highest ratios of nursing facility beds to elderly population, Wisconsin has been able to constrain Medicaid nursing facility utilization and moderate growth in expenditures, while serving more long-term care beneficiaries with home and community-based care. Home and community-based care programs continue to grow, but demand for the services has exceeded program capacity in Wisconsin, resulting in lengthy waiting lists.

Wisconsin's Programs for Delivering Long-Term Care

Wisconsin provides home and community-based long-term care services for the aged and persons with physical disabilities through Medicaid home health and personal care services, a Medicaid waiver program, and the state-funded Community Options Program (COP).

Through these programs, Wisconsin served approximately 14,000 users in 1992,[1] compared with an average daily census of 30,497 Medicaid-funded beneficiaries in nursing facilities. About 12,500 received Medicaid home health and personal care services,[2] while the Medicaid waiver program and COP each served about 6,000 aged or persons with physical disabilities. An exact count of the unduplicated number of users was not available at the time data were requested. Direct service expenditures for the home and community-based programs totaled $141 million in 1992, compared with expenditures of $623 million for nursing facilities.[3] Table IV.1 summarizes Wisconsin's long-term care programs for the aged and persons with physical disabilities.

[1]This figure is an estimated unduplicated count of beneficiaries and is not the sum of all home and community-based program users in table IV.1 because many beneficiaries use more than one program at a time. Expenditures by program do not overlap. Expenditure and utilization figures are for the calendar year when discussing nursing facilities, COP, and the Medicaid waiver program, and for the federal fiscal year when discussing regular Medicaid services such as home health and personal care.

[2]The data on users and expenditures for Medicaid home health and personal care include services provided to persons with developmental disabilities. Because of data limitations, it is not possible to separate the two populations.

[3]Persons receiving services through the home and community-based programs generally may receive additional public support, such as SSI payments. For example, Wisconsin officials report that in 1991, on average, persons receiving services through their Medicaid waiver for the aged and persons with physical disabilities also received $118 per month ($1,416 per year) in SSI payments.

Table IV.1: Wisconsin's Long-Term Care Service Programs for the Aged and Persons With Physical Disabilities, 1992

	Services provided	Annual users[a]	Expenditures[b]	Average annual expenditure per user[c]	Funding source
Institutional care					
Nursing facilities[d]	Nursing and personal care	30,497	$622,956,017	$20,427	Medicaid
Home and community-based care					
Medicaid personal care and home health services	Personal care, home health	Aged—5,098 Disabled[e]—7,479	29,280,950 52,480,453[e]	5,744 7,017[e]	Medicaid
Medicaid waiver program: section 1915(c) waiver	Supportive home care, respite care, chore, and supervision services	6,129	39,047,710[f]	6,371	Medicaid
Community Options Program	Any necessary service	5,819	19,841,247	3,410	State

[a]For nursing facilities, annual users is the average Medicaid daily census. For home and community-based care programs, annual users is the total number of persons receiving services during the year.

[b]The most recent data available for all programs were for 1992. Nursing facility, COP, and Medicaid waiver data are reported by calendar year, while Medicaid home health and personal care data are reported by federal fiscal year.

[c]Average annual expenditure per user has been calculated by dividing 1992 expenditures by the annual users.

[d]State officials reported that in 1992, approximately 850 persons with developmental disabilities received services in nursing facilities.

[e]The figure incluces persons with developmental disabilities.

[f]Waiver data include expenditures for program administration (including case management services). State officials report that program administration expenditures are approximately 7 percent of total expenditures. COP data include expenditures for administration and case management.

Source: Division of Community Services and Division of Health, Wisconsin Department of Health and Social Services.

In Wisconsin, home and community-based long-term care is built around the Medicaid program. In general, eligibility for any of Wisconsin's state-supported home and community-based services is restricted to those eligible for Medicaid or those who would be eligible for Medicaid nursing facility services. Furthermore, when building a package of services, case managers are required to provide services through the regular Medicaid program and the Medicaid waivers before relying on services from the

state-funded COP. If a beneficiary requires services that cannot be provided through Medicaid, then COP services are utilized. All of these programs provide basic personal care services to assist beneficiaries with activities of daily living such as dressing and eating, but they differ in the range of benefits available.

With expenditures of $81.8 million for the aged and persons with disabilities in 1992, Wisconsin's Medicaid nonwaiver home health and personal care services provided a substantial share of the state's home and community-based services.[4] In fact, because eligibility for COP and the waivers is primarily restricted to those eligible for Medicaid, many people enrolled in these programs also receive Medicaid home care services. State officials estimate that $24.3 million of the total $91.5 million home health and personal care expenditures for 1992 (about 27 percent) was provided in services to the elderly and persons with physical disabilities who were also receiving Medicaid waiver services.

Wisconsin operates two programs under its waiver for the aged and persons with physical disabilities. The programs provide home and community-based care to persons at risk of entering nursing facilities. One program also has a small component to relocate people from nursing facilities to the community.[5] The services available through these programs are the same, but they have different limits on average per-person monthly expenditures. Although eligibility for waiver services is restricted to those who are financially eligible for Medicaid, waiver recipients must also either have been receiving services in an institutional setting or have been at risk for Medicaid-funded institutionalization. In addition, waiver capacity must be available.

COP was authorized in 1981 and implemented in 1982. It provides home and community-based care to the elderly, persons with physical and developmental disabilities, and others who need long-term care, including persons with a serious mental illness or Alzheimer's disease. Because it is funded almost entirely through state general revenues, there are very few restrictions on the types of services that can be provided. Any necessary service is allowed, with a few exceptions pertaining to the purchase of land, buildings, or the funding of institutional care.

[4]Data include expenditures for persons with developmental disabilities; total Medicaid expenditures for home health and personal care services were $91.5 million in 1992. The difference between $91.5 million and $81.8 million is accounted for by services to other Medicaid recipients.

[5]Initially, this program was aimed primarily at relocating nursing facility residents to community services and allowed higher monthly expenditures. Currently, it operates mainly to divert potential nursing facility residents

As noted, many people receive services from more than one of these programs. In fact, case workers deliberately enroll beneficiaries in multiple programs to provide a comprehensive package of services. For example, regular Medicaid and even the Medicaid waiver have service gaps that can be filled with services funded by the state's COP. A state official reported that in 1992, about 32 percent of the aged and persons with physical disabilities receiving waiver services also received COP services, and about 58 percent of them also received Medicaid home health or personal care services.

Wisconsin officials estimate that about 92 percent of the aged and persons with physical disabilities who receive services through COP and the waiver program live in their own homes or the homes of relatives. The remaining 8 percent live in alternative living arrangements: 6 percent in community-based residential facilities (three beds or more), 1 percent in adult family homes (one to two beds), and 1 percent in supervised apartments. Wisconsin has not made an effort to develop and encourage alternative living arrangements for the aged and persons with physical disabilities to the extent that Oregon and Washington have.

Although responsibility for Wisconsin's most important long-term care programs is consolidated within the Department of Health and Social Services, management of individual programs is divided among different divisions within the department. For example, Wisconsin's Medicaid waiver and the state-funded COP are managed by one division, while the regular Medicaid program and the state's nursing homes are managed by another division. Furthermore, while overall policy decisions about these programs are made by the state, management of service delivery is subcontracted to Wisconsin's 72 county governments.

Program Management and Cost Controls

Wisconsin controls expenditures for home and community-based long-term care through (1) federal waiver rules and state budget limits that constrain the overall size and cost of the programs, (2) financial and functional eligibility criteria for program participation, and (3) other management controls such as requiring case management and prior authorization for services.

Key Federal and State Program Constraints

Wisconsin's Medicaid waiver program for the aged and persons with physical disabilities is restricted by federally approved enrollment and expenditure limits and by state budget constraints. As explained in

appendix I, HCFA approves a maximum allowable enrollment and associated expenditures for each waiver based on the state's application. While the HCFA formula would have allowed 7,822 aged and physically disabled beneficiaries to be served each year from 1989 through 1992, Wisconsin initially applied to serve only 4,730 individuals and later submitted three amendments to obtain approval to serve the full number of beneficiaries by 1992. Wisconsin officials explained that they did not originally request a waiver program as large as they could justify under HCFA's formula because of the need to control state spending. Thus, the state budget has been a more significant constraint on the waiver's use than have HCFA rules.

Because COP is financed almost entirely with state funds, the program is not subject to federal limits on enrollment. However, the state provides funding for a specific program capacity, and this funding is allocated among Wisconsin's county governments. While each county receives an annual COP budget based on a designated number of beneficiaries, counties are free to serve more or fewer persons as long as total spending remains within the budget. Counties also are given some discretion in allocating funds among the elderly and persons with physical or developmental disabilities. However, the state sets annual quotas for each of these groups.

Financial Eligibility and Functional Impairment Criteria

Wisconsin relies on financial eligibility and functional impairment criteria to control long-term care costs while targeting services to those most in need of care. The program criteria are summarized in table IV.2.

Table IV.2: Eligibility Requirements for Long-Term Care Programs in Wisconsin

Institutional care
Nursing facility
Medicaid eligibility: Income less than or equal to 300 percent of the federal SSI benefit; nonexempt assets at or below $2,000
Functional impairment: Meets specified level of care criteria, generally requires care provided in a nursing facility
Home and community-based care
Medicaid waivers
Medicaid eligibility: Same as for nursing facility
Functional impairment: At risk of institutionalization and qualifies for level of care reimbursable by Medicaid (care provided in a skilled nursing facility or intermediate care facility level 1 or 2)
Medicaid Personal Care/Home Health
Medicaid eligibility: Income less than or equal to 100 percent of SSI plus SSP; nonexempt assets at or below $2,000; and physician order
Functional impairment: Impaired in at least one activity of daily living or in need of skilled nursing or therapy services, as determined by an assessment form completed by the provider and by physician order
State-funded COP
Current financial eligibility for Medicaid: Income less than or equal to 100 percent of SSI; nonexempt assets at or below $2,000; or expected eligibility within 6 months of spend-down at a nursing home
Functional impairment: At risk of institutionalization and qualifies for level of care reimbursable by Medicaid (generally care provided in a skilled nursing facility or intermediate care facility level 1 or 2), plus special eligibility criteria for people with Alzheimer's disease

Source: Division of Community Services and Division of Health, Wisconsin Department of Health and Social Services.

For the most part, COP restricts participation to those who are eligible for Medicaid. However, some persons with incomes above the Medicaid eligibility level may use cost-sharing to receive COP services. For example, persons who would be eligible for Medicaid through spending nearly all of their resources within 6 months of entering a nursing facility may receive services through COP if they pay part of the cost of those services. According to program rules, persons who are unlikely to become eligible for Medicaid may receive COP services if they pay the entire cost of those services. However, state officials explained that this rarely happens

because county boards are generally not willing to hire the additional staff to provide care on a fee-for-service basis.

County staff determine functional eligibility for COP using uniform statewide criteria and screening instruments. Once eligibility is established, local officials assess each beneficiary's condition, preferences, and abilities, and prepare a care plan. The state requires each county to develop an assessment procedure that addresses two areas: (1) the person's functional abilities and disabilities, including physical health, activities of daily living, emotional and cognitive functioning, communication, capacity for self-care, and social participation; and (2) the home and community-based services necessary for the person to live in the community. Functional assessments may be provided free of charge to anyone (including private-pay applicants) who is a candidate for or current resident of a nursing facility or ICF/MR, or has mental illness or Alzheimer's disease.

Other Management and Cost Controls

Wisconsin has imposed average per-beneficiary expenditure limits on home and community-based programs, requires prior authorization for some services, and uses case management to control use of long-term care.

Payment and Service Limits. Wisconsin's waiver program and COP impose financial limits on average per-beneficiary service expenditures. For example, under state requirements, average COP expenditures per person are limited to the state's share (currently 40 percent) of the amount that would be paid under the Medicaid program had the COP beneficiaries been residents of nursing facilities. In 1994, that limit was $880 per month per participant. This is a limit on average spending, however; individual COP beneficiaries may be funded at essentially any cost.[6]

Similarly, the waiver restricts average per-beneficiary expenditures, although the cost of services for any individual client is not constrained. The average payment limit is based on the approved federal Medicaid contribution to the waiver and state funding. The limit varies from a low of $23.40 per day ($712 per month) for participants in the program that helps the elderly and persons with physical disabilities stay in the community, to

[6]The state limit on average COP expenditures is much lower than the average nursing home expenditure because COP is not designed to pay the full cost of care for any beneficiary. Regular Medicaid services are intended to be used first, with COP filling in the gaps. When all public expenditures from COP, regular Medicaid, and other sources are added together, the expenditure per person averages 80 to 90 percent of the cost of nursing home care.

a high of $39.98 per day ($1,215 per month) for the program that was created to relocate or divert individuals from nursing facilities into the community.

Prior Authorization for Medicaid services. As a means of controlling expenditures for Medicaid home health and personal care services, Wisconsin requires providers, who may be county employees or home health agencies, to receive authorization from the state before approving care plans that include home health services. A state official explained that after home health expenditures began to grow at annual rates as high as 40 percent between 1987 and 1991, the state began enforcing more vigorously the requirement for prior authorization. As a result of this and other changes, home health expenditures declined from $73 million in 1992 to $49 million in 1993.

Case Management. Case management is required for all clients receiving services through COP or the waiver. County-based case managers prepare a care plan for each potential recipient of home and community-based services. If the beneficiary is not eligible for COP or the waiver, the care plan is used to offer advice about other programs that may be available to provide needed services.

Wisconsin's Experience in Expanding Home and Community-Based Programs and Containing Costs

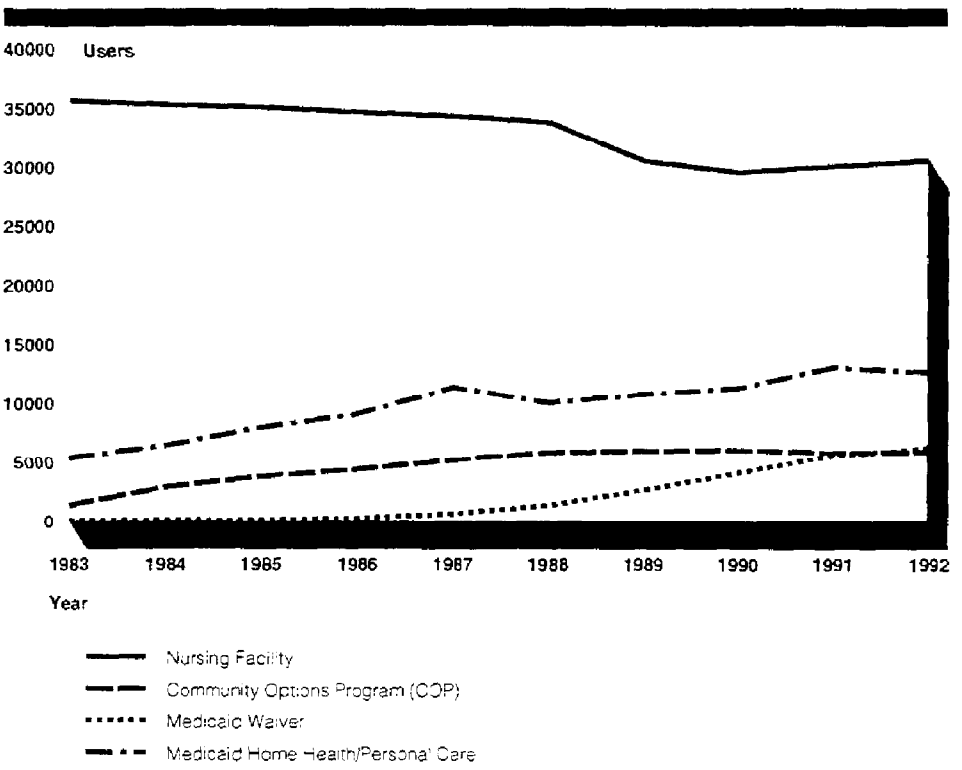
By expanding home and community-based care, which generally is less expensive per person than institutional care, and by capping the number of nursing facility beds, Wisconsin has been able to constrain nursing facility utilization and moderate the rate of growth in expenditures. In this way, Wisconsin has been able to serve more long-term care beneficiaries with available dollars. However, expansion of home and community-based programs has been limited by federal Medicaid waiver rules and state budget constraints. As a result, lengthy waiting lists have developed for all of Wisconsin's home and community-based programs.

Program Growth Has Been Accommodated in Home and Community-Based Care

Although Wisconsin has experienced limited growth in the total number of long-term care beneficiaries, there has been significant substitution of home and community-based services for nursing facility care. From 1983 to 1992, the number of Medicaid beneficiaries in Wisconsin's nursing facilities dropped from an average daily census of 35,587 to 30,497. Because of growth in the home and community-based care programs, however, the total number of individuals using long-term care services has increased modestly. As shown in figure IV.1, the number of aged and

persons with physical disabilities who received home and community-based care through COP grew from 1,284 in 1983 to 5,819 in 1992. Similarly, waiver beneficiaries increased from 61 in 1985, the first year of operation, to 6,129 in 1992; and while 5,283 persons received Medicaid home health or personal care services in 1983, 12,577 persons received those services in 1992.[7]

Figure IV.1: Wisconsin's Users of Nursing Facility and Home and Community-Based Care, 1983-1992



Notes: The most recent available data were for 1992. Nursing facility data and Medicaid waiver data are reported by calendar year. COP data are reported by state fiscal year (July 1 to June 30), and Medicaid home health and personal care services data are reported by federal fiscal year.

Nursing facility data are reported as average daily census. COP, Medicaid waiver, and Medicaid services data are reported as the number of individuals served each year. Any individual may receive services through more than one program.

Source: Division of Community Services and Division of Health, Wisconsin Department of Health and Social Services.

[7]Data on beneficiaries of home health and personal care services include the aged and persons with physical or developmental disabilities, and are not limited only to individuals at risk of institutionalization. For example, this figure includes children with physical or developmental disabilities receiving services at home through a special program known as the Katie Beckett program. In May 1994, 2,569 children participated in this program.

Wisconsin's expenditures for home and community-based services as a percentage of total long-term care expenditures increased from 2 percent in 1983 to 18 percent in 1992, but nursing facility care continued to dominate long-term care programs.

Expanding Home and Community-Based Care Has Helped Moderate Overall Expenditures

Wisconsin officials believe that by expanding home and community-based programs while controlling growth in the number of nursing facility beds, they have been able to control growth in overall long-term care expenditures. In 1981, Wisconsin put a moratorium on new nursing facility beds and later converted it to a cap (allowing the replacement of current beds but no new ones) that is still in effect today. State officials explained that the legislature simultaneously enacted COP in 1981 as a companion to the original moratorium on nursing facility beds. In fact, funding for COP in the first few years was tied directly to the amount that would have been required had nursing facility beds been added and filled with Medicaid beneficiaries. Wisconsin had 89 nursing facility beds per 1,000 persons 65 and older in 1982 and 75 beds per 1,000 in 1992.

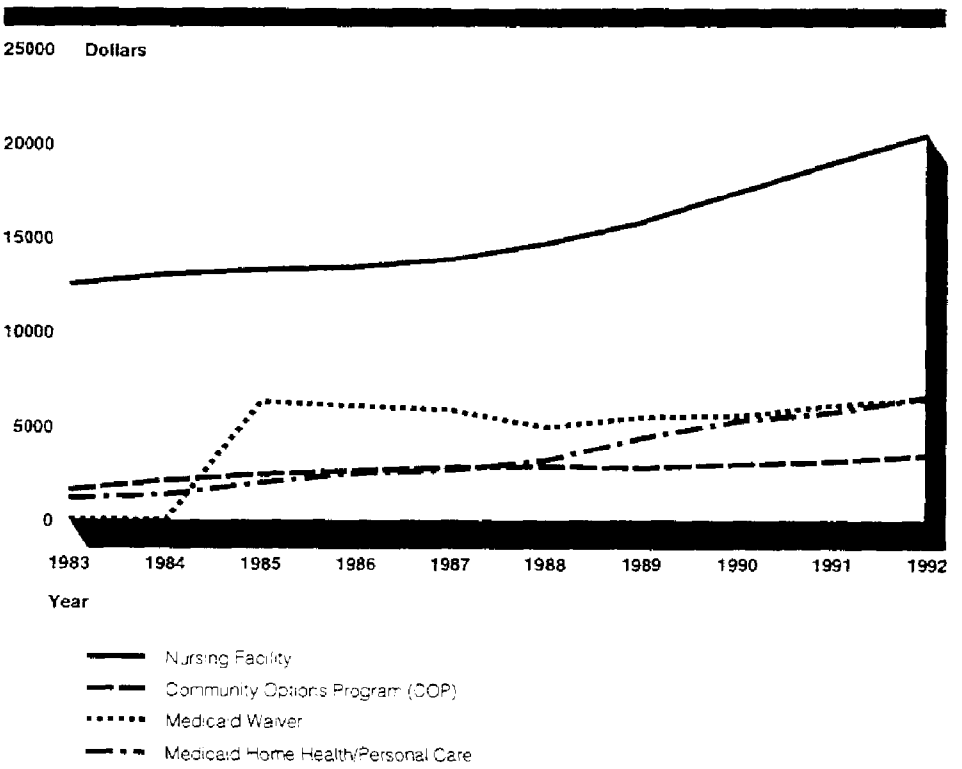
Wisconsin has further limited nursing facility capacity by lowering the overall state cap on beds as nursing facility beds have been delicensed. Beds are delicensed when they are closed by a facility and the beds are not relocated to another facility or added to the state pool for future relocation. State requirements allow adding capacity to treat one waiver beneficiary for each bed delicensed in a public nursing facility and for roughly every two beds delicensed in a private nursing facility. This is true if funding is available and the approved HCFA ceiling on waiver capacity has not been exceeded. Approximately 1,342 beds have been closed voluntarily by nursing facilities since 1985 and converted to capacity for Medicaid waiver beneficiaries.

As a result of these capacity controls, nursing facility utilization has declined in Wisconsin during the past decade, dropping from an average daily Medicaid census of 35,587 in 1983 to 30,497 in 1992. During the same period, Medicaid nursing facility expenditures have continued to rise at an average rate of 3.9 percent per year. This rate of increase is low compared to other states'; nationwide, nursing facility expenditures grew 11.5 percent a year from 1987 to 1993. Wisconsin's Medicaid expenditures for nursing facilities were $443 million in 1983 and $623 million in 1992.

As shown in figure IV.2, the average annual expenditure per-user for nursing facility care is substantially higher than the per user expenditure

for home and community-based care. Between 1983 and 1992, the average annual expenditure per user for nursing facility care increased from $12,445 to $20,427. During the same years, the average annual per-user expenditure for COP increased from $1,582 to $3,410, while per-user expenditure for the waiver increased from $6,249 in 1985 to $6,371 in 1992. Per-user expenditures for Medicaid home health and personal care services combined were $1,149 in 1983 and had increased to $6,501 by 1992.

Figure IV.2: Wisconsin's Average Annual Expenditure Per User for Nursing Facility and Home and Community-Based Care, 1983-1992



Notes: The most recent available data were for 1992. Nursing facility data and Medicaid waiver data are reported by calendar year, while COP data are reported by state fiscal year (July 1 to June 30). Medicaid home health and personal care service data are reported by federal fiscal year and include expenditures for the aged and persons with physical and developmental disabilities.

Average annual expenditure per user has been calculated by dividing 1992 expenditures by annual users. Any individual may receive services through more than one program.

Source: Division of Community Service and Division of Health, Wisconsin Department of Health and Social Services.

Several reviews of COP and the waiver performed by Wisconsin's Department of Health and Social Services and others suggest that the state's home and community-based programs result in per-person total public savings of about 16 percent, compared with the cost of institutional care. The department's studies included expenditures for home and community-based beneficiaries by the Medicaid waiver, Medicaid acute care, COP, SSI, and others.

Controls on Home and Community-Based Care Have Limited Access for Some Applicants

While Wisconsin has controlled the growth of its Medicaid waiver program and COP, the demand for these services has resulted in a substantial number of eligible beneficiaries being placed on waiting lists. For example, while COP and the waiver for elderly and persons with physical disabilities each served about 6,000 persons in 1992, an additional estimated 3,660 persons were waiting for services.

A 1994 state study of the state-funded COP waiting list in Dane County described a typical waiting list participant as an older, unmarried, white female who lived in her own home or with relatives. She was on SSI or Medicaid and required a level of care equivalent to those of persons in nursing facilities. Most people waiting for services described their interim care plans as relying on family and friends for support. The elderly persons surveyed had been on the waiting list from 3 months to 4-1/2 years, with the median wait being nearly 14 months.

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Health Care Reform: Supplemental and Long-Term Care Insurance (GAO/T-HRD-94-58, Nov. 9, 1993).

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Medicaid Estate Planning (GAO/HRD-93-29R, July 20, 1993).

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