SB
334

HOUSE COMMITTEE REPORT

File

(11)
Date Referred: March 8, 1990 FURTHER REFERRALS:

Date of Committee Action: 3/30/90

The FINANCE Committee considered: SB 334(efd am)

SENATE BILL NO. 334(efd am) MEDICAID WAIVERS FOR HOME-BASED SERVICES "An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

RECOMMENDATIONS:

[ ] be replaced with ______ [✓] the same title [ ] a new title

[ ] have attached amendment(s)

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the ______ Committee

ADOPTS: House HESS letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact ______

[ ] zero fiscal note ______

[ ] zero with analysis ______

APPROVES PREVIOUS: (Date/Dept)

2 [✓] fiscal note(s) Dept of Admin 1/22/90 DHSS 1/22/90

[ ] zero fiscal note(s) ______

[ ] zero fn/analysis ______

SIGNING DO PASS:

[signature] Hoffman

[signature] Co-Chair Larson

[signature] Brown

[signature] Koponen

[signature] Ulmer

[signature] Barnes

[signature] Wallis

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[signature] Shultz		✓	
[signature] Phillips		✓	
[signature] Rieger		✓	

[signature] Larson

Co-Chairman's Signature

[signature] Hoffman

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

P.O. BOX V, JUNEAU 99811
(907) 465-3759

LETTER OF INTENT
to SB 334 (efd Am)

It is the intent of this legislation that the Department of Health and Social Services will study the "TEFRA Option" as part of the home and community based services package. A "TEFRA Option" allows the same income deeming standards that apply to an institutionalized child to apply to a similarly disabled child living at home.

Rep. Johnny Ellis, Chair

R/O HFC 3-30-90

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 334 (a)**
PUBLISH DATE: 1/22/90
**REVISED--SEE NOTE BELOW (includes (a)(b)(c)

FISCAL NOTE

REQUEST:

Revision Date: ____
Title: An Act Directing the Department of Health and Social...
Sponsor: Uehling, Fahrenkamp, Duncan
Requestor: Uehling

Agency Affected: Health and Social Services
BRU: Medical Assistance Administration
Administrative Services
Components: Central Administration
Governor's Council on the Handicapped

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	148.8	203.7	210.4			
TRAVEL	10.6	4.9	4.7			
CONTRACTUAL	278.6	217.4	218.9			
SUPPLIES	6.0	6.5	6.5			
EQUIPMENT	22.0	-0-	-0-			
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	466.0	432.5	440.5			

CAPITAL	-0-	-0-	-0-			

REVENUE	-0-	-0-	-0-			

FUNDING: (Thousands of Dollars)

GENERAL FUND	233.0	216.2	220.3			
FEDERAL FUNDS	233.0	216.3	220.2			
OTHER						
TOTAL	466.0	432.5	440.5			

POSITIONS:

FULL-TIME	5	5	5			
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

FY90 Impact-None.
This is the TOTAL Fiscal Note for SB 334; including RSA's with The Older Alaskans Commission and The Governor's Council on the Handicapped and Gifted for their activites. Funding is 50% federal financial participation and 50% state general fund match.

Prepared by: For: Kim Busch
Division: Medical Assistance
Phone: 465-3355
Date: January 22, 1990

Approved by Commissioner: Myra M. Munson
Agency: Department of Health and Social Services
Date: 1/22/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

THIS FISCAL NOTE INCLUDES PREVIOUS FISCAL NOTES (b) and (c). FISCAL NOTE (c) UPDATED AND REPUBLISHED AT REQUEST OF FINANCE COMMITTEE

Detail of Fiscal Note on SB 334
FY91 OPERATING

		Medical Assistance	RSA Governor's Council	RSA Older Alaskans Commission
100	Personal Services			
	.75 PFT Health Planner III (R21)	46.8		
	1.5 PFT Research Analyst III (R18)	80.7		
	.75 PFT Clerk Typist III (R8)	21.3		
	2 PFT Health Planner II (R19)		58.0	58.0
	Sub-Total	148.8	58.0	58.0
200	Travel	10.6	15.4	10.0
300	Contractual			
	Office Space, Risk Management, telephone, etc.	52.6	15.6	29.0
	FOCUS: National Association of State Units on Aging computerized projection of adult functional disabilities based on the 1980 census.	6.0		
	Consultant Fees Including Travel		14.0	6.0
	RSA's			
	Older Alaskans Commission	110.0		
	Governor's Council H & G	110.0		
	Sub-Total	278.6	29.6	35.0
400	Supplies	6.0	1.5	1.5
500	Equipment			
	Microcomputer hardware and software	16.0	4.0	4.0
	Desks, chairs, etc.	6.0	1.5	1.5
	Sub-Total	22.0	5.5	5.5
TOTAL FY91 OPERATING		466.0	110.0	110.0
FUNDING:				
	50% Federal Financial Participation	233.0		
	50% State General Fund Match	233.0		

Detail of Fiscal Note on SB 334
FY92 OPERATING

		Medical Assistance	RSA Governor's Council	RSA Older Alaskans Commission
100	Personal Services			
	1 PFT Health Planner III (R21)	63.6		
	2 PFT Research Analyst III (R18)	110.7		
	1 PFT Clerk Typist III (R8)	29.3		
	2 PFT Health Planner II (R19)		60.0	60.0
	Sub-Total	203.7	60.0	60.0
200	Travel	4.9	5.7	5.7
300	Contractual			
	Office Space, Risk Management, telephone, etc.	54.7	13.5	13.5
	RSA			
	Older Alaskans Commission	82.0		
	Governor's Council H & G	80.7		
	Sub-Total	217.4	13.5	13.5
400	Supplies	6.5	1.5	1.5
TOTAL FY92 OPERATING		432.5	80.7	80.7

FUNDING:

50% Federal Financial Participation	216.3
50% State General Fund Match	216.2

Detail of Fiscal Note on SB 334
FY93 OPERATING

	Medical Assistance	RSA Governor's Council	RSA Older Alaskans Commission
100 Personal Services			
1 PFT Health Planner III (R21)	66.2		
2 PFT Research Analyst III (R18)	114.4		
1 PFT Clerk Typist III (R8)	29.8		
2 PFT Health Planner II (R19)		61.7	61.7
Sub-Total	210.4	61.7	61.7
200 Travel	4.7	4.4	4.4
300 Contractual			
Office Space, Risk Management, telephone, etc.	56.8	13.5	13.5
RSA			
Older Alaskans Commission	81.1		
Governor's Council H & G	81.1		
Sub-Total	218.9	13.5	13.5
400 Supplies	6.5	1.5	1.5
TOTAL FY93 OPERATING	440.5	81.1	81.1

FUNDING:

50% Federal Financial Participation	220.2
50% State General Fund Match	220.3

STATE OF ALASKA R/O HFC 3-30-90
1990 LEGISLATIVE SESSION

Bill Version: SB 334 (am)(c)
Publish Date: 1/22/90

REVISED

FISCAL NOTE

REQUEST:

Revision Date: January 19, 1990
Title: Directing DHSS to seek permission, options, waivers under Medicaid Program
Sponsor: Uehling, Fahrenkamp, and Duncan
Requestor: Uehling

Agency Affected: Administration
BRU: Older Alaskans Commission
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	58.0	60.0	61.7	0	0	0
TRAVEL	10.0	6.5	6.2	0	0	0
CONTRACTUAL	35.0	14.0	11.6	0	0	0
SUPPLIES	1.5	1.5	1.5	0	0	0
EQUIPMENT	5.5	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	110.0	82.0	81.0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER I/A (RSA)	110.0	82.0	81.0	0	0	0
TOTAL	110.0	82.0	81.0	0	0	0

POSITIONS:

	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
FULL-TIME	1	1	1	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

IMPORTANT NOTE: All amounts on this fiscal note are already included in the fiscal note from the Department of Health and Social Services.

Prepared by: Connie J. Sine Frances B. Toland Phone: 465-3250
Division: Older Alaskans Commission Date: 01/19/90

Approved by Commissioner: Frank S. Baxter for Date: 1/19/90
Agency: Department of Administration

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

4/15D1/011103-0

Rev: 11/89

1/22/90 REVISED
(Letter attached)

Department of Administration
Older Alaskans Commission
Draft Revision 1/19/90

Detail of Fiscal Note on SB 334

FY 91

		Amount
100	Personal Services 1 PFT Health Planner II (Range 19) Juneau	$ 58,027
200	Travel Includes as one-time expenses: One 2-week visit to a Medicaid Home Care Waiver State to study state and local operations (2.0), a Medicaid expert's travel to Alaska to consult for 5 days (2.0).	10,000
300	Contractual Services Includes as one-time expenses: Public seminar on Home Care Options for all disabled groups covered by SB 334 (9.0), printing of report from OAC (6.0,) and Medicaid expert/consultants (6.0)	35,000
400	Supplies	1,500
500	Equipment Includes as one-time expenses: Computer, desk, etc.	5,5C0
	FY 91 TOTAL:	$110,027

Amended: 1/25/90 6-1564J
Introduced: 1/8/90
Referred: Health, Education and Social
Services and Finance

BY SEN. UEHLING, Fahrenkamp, Duncan, Sturgulewski, Faiks, Halford, Rodey, Jones, Eliason, Zharoff, Pourchot

1 IN THE SENATE

2 SENATE BILL NO. 334(efd am)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act directing the Department of Health and Social
7 Services to seek permission to use options and re-
8 ceive waivers under the Medicaid program for the cost
9 of home or community-based services for develop-
10 mentally delayed children, developmentally disabled
11 persons, disabled adults, and older Alaskans; direct-
12 ing other agencies to assist in that process; and
13 providing for an effective date."

14 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

15 * Section 1. FINDINGS; INTENT. (a) The legislature finds that chil-
16 dren and adults who are experiencing disabling conditions have individual
17 and changing needs that can be best addressed by having available to them a
18 mix of services, including home and community-based services and institu-
19 tional care. The historical focus of the Medicaid program has been on
20 providing services in institutional settings for adults who need outside
21 assistance in daily living and for children who need developmental help.
22 Therefore, some persons whose needs could be met outside of institutions
23 have, nevertheless, become institutionalized so that they could receive
24 services through the Medicaid program. Other persons in need have received
25 no services until their conditions deteriorated to the point where they met
26 the Medicaid criteria for institutionalization. Nursing facilities, hos-
27 pitals, and intermediate care facilities for the mentally retarded should
28 remain readily available for those whose needs require that kind of set-
29 ting, but the availability of home and community-based services should also
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1 be expanded so that, when possible, persons could be deinstitutionalized,
2 avoid institutionalization, or avoid becoming at risk of institutionaliza-
3 tion and be assisted to live on their own, with their families, or in group
4 settings that allow semi-independent living in their own communities.
5 Furthermore, home and community-based services can help persons whose
6 disabling conditions might never require institutional care, but whose
7 lives could be more comfortable and more productive if the services were
8 provided.

9 (b) It is the legislature's intent in enacting this Act to require
10 the Department of Health and Social Services to seek approval from the
11 federal government to use some Medicaid program money to broaden the range
12 of home and community-based services that are available for appropriate
13 groups of developmentally delayed children, developmentally disabled per-
14 sons, disabled adults, and older Alaskans, who could benefit from them,
15 especially those who would otherwise require Medicaid program money for
16 more costly institutionalization. The choice of which waivers and options
17 would be applied for and which population groups should be served would be
18 made by the department after priorities are recommended by the Governor's
19 Council for the Handicapped and Gifted and the Older Alaskans Commission.
20 Through budget oversight, legislative hearings, and other legislative
21 action, the legislature would give specific budgetary authority and policy
22 directives to the department to guide it when it applies for the options
23 and waivers.

24 * Sec. 2. PRELIMINARY RESEARCH. (a) The Governor's Council for the
25 Handicapped and Gifted and the Older Alaskans Commission shall, in consul-
26 tation with other appropriate public and private agencies, conduct re-
27 search, compile statistics, and prepare information and documents that
28 would be useful to the Department of Health and Social Services in deter-
29 mining necessary services, optimal service delivery areas and methods, and

1 the appropriate groups of developmentally delayed children, developmentally
2 disabled persons, disabled adults, and older Alaskans, for which the de-
3 partment may apply for home and community-based options and waivers under
4 42 U.S.C. 1396n and other federal laws relating to the Medicaid program.
5 (b) By June 1, 1991, the Governor's Council for the Handicapped and
6 Gifted and the Older Alaskans Commission shall submit written reports to
7 the legislature and the Department of Health and Social Services document-
8 ing their recommendations for the scope and substance of the options and
9 waivers that the department may apply for under this Act, including their
10 recommended priorities for which specific populations should be served.
11 * Sec. 3. PRELIMINARY DETERMINATIONS; FISCAL ANALYSIS OF PROPOSED
12 PROGRAM CHANGES. (a) Based on the written reports, including the priority
13 designations, received under sec. 2(b) of this Act, the Department of
14 Health and Social Services shall make a preliminary determination of which
15 options and waivers it plans to apply for. The department shall, by
16 January 15, 1992, submit to the legislature a report estimating the fiscal
17 effect of implementing the particular options and waivers for which it
18 plans to seek approval from the federal government under this Act. The
19 report must include for each population group for which approval for an
20 option or waiver will be sought
21 (1) a description of the group and its geographical distribu-
22 tion, including the number of persons to be served in each geographical
23 area;
24 (2) the specific types of services to be provided under the
25 option or waiver;
26 (3) the cost to the state of implementing the option or waiver,
27 including administrative costs, the cost of services to be provided under
28 the options or waivers, and other affected Medicaid program costs; the
29 report must specifically address whether use of the option or waiver will

result in the provision of services to a newly eligible population not previously receiving Medicaid services; and

(4) the cost to the state of serving the group and other affected Medicaid program costs if the option or waiver is not approved and implemented, including administrative costs and the costs of services that would be provided in the existing health care delivery system without using the option or waiver.

(b) During the process of developing the applications that would be submitted to the federal government for its approval under this Act, reliable information should become available to substantiate the costs of implementing home and community-based options and waivers. The legislature acknowledges that reliable information on this subject is not currently available, although long-term cost avoidance is likely because home and community-based services will help slow the rate of growth in the need for construction of additional nursing home beds and help persons avoid institutionalization. Therefore, it is the legislature's intent that fiscal notes prepared for this Act should reflect only the costs of researching, writing, negotiating, and obtaining approval of the applications to the federal government and the costs of preparing the fiscal analysis required under (a) of this section. Estimates of program implementation costs, including the costs of services, should be made only after comprehensive data is available.

* Sec. 4. FINAL DETERMINATION; APPLICATIONS FOR OPTIONS AND WAIVERS. (a) After legislative review during the Second Session of the Seventeenth Alaska State Legislature, and before September 15, 1992, the Department of Health and Social Services shall apply to the Secretary of Health and Human Services for permission to use home and community-based options and waivers that may be approved under 42 U.S.C. 1396n(c) - (d) and other federal laws for developmentally delayed children, developmentally disabled persons,

disabled adults, and older Alaskans, especially those for whom the department determines that but for the provision of the services the persons would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded, the cost of which could be reimbursed under the federal Medicaid program. When determining which options and waivers it will apply for under this subsection, the department shall consider the priorities recommended by the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission and the specific budgetary authority and policy directives set by the legislature.

(b) In its process of seeking permission to use options and receive waivers under (a) of this section, the Department of Health and Social Services may seek to provide all appropriate services allowed by federal law that are consistent with the needs of the population groups for which the department intends to provide services under the options and waivers.

(c) While preparing applications required under (a) of this section, the Department of Health and Social Services shall consult with the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission. In addition, 60 days before submitting applications to the Secretary of Health and Human Services, the department shall deliver a copy of the proposed applications to the council and the commission for their review and comment. The department shall consider comments made by the council and commission and amend the applications as considered appropriate by the department before submitting them to the Secretary of Health and Human Services.

(d) The Department of Health and Social Services may submit more than one application under this section if more than one group of persons could be effectively served by home or community-based options or waivers consistent with (a) of this section and the requirements of 42 U.S.C. 1396n(c) -

(d) and other federal laws.

* Sec. 5. INTERAGENCY COORDINATION. The Governor's Council for the Handicapped and Gifted, the Older Alaskans Commission, and the Department of Health and Social Services shall enter into an interagency agreement for carrying out this Act. The agreement must provide that

(1) the Department of Health and Social Services is recognized as the lead agency responsible for applying to the federal government for the use of options and waivers described in this Act; and

(2) all three agencies will cooperate with each other in providing requested nonconfidential information that would assist the agencies in fulfilling their duties under this Act.

* Sec. 6. DEFINITIONS. In this Act

(1) "developmentally delayed children" means children who are eligible for Medicaid under federal regulations and need early intervention services because they

(A) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; or self-help skills;

(B) have a diagnosed physical or mental condition that is likely to result in developmental delay described in (A) of this paragraph; or

(C) are at risk of having substantial developmental delays as described in (A) of this paragraph if early intervention services ar not provided;

(2) "developmentally disabled person" means a person who is eligible for Medicaid under federal regulations and has a severe, chronic disability that

(A) is attributable to a mental or physical impairment or

combination of mental and physical impairments;

(B) is manifested before the person attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated;

(3) "disabled adult" means a person 18 years of age or older who is eligible for Medicaid under federal regulations and is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months;

(4) "older Alaskans" has the meaning given in AS 47.65.060, except that it includes only older Alaskans who are eligible for Medicaid under federal regulations.

* Sec. 7. This Act takes effect immediately under AS 01.10.070(c).

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

BILL SUMMARY

SB 334

"AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES ... TO SEEK ... WAIVERS UNDER THE MEDICAID PROGRAM"

This bill directs DHSS to apply for federal approval to modify Alaska's medicaid program to allow for home care in place of institutional care.

Alaska's current medicaid program does not provide home care benefits for those patients who qualify for institutional care. This program if adopted will allow Alaskans who qualify for medicaid to choose home care rather than institutional care.

Home care can provide many benefits. The federal program caps the cost of home care so that it cannot exceed the cost of institutional care. In many cases the home care alternative will save the state money. In addition, for certain patients the recovery process is more rapid when the patient is in a home environment, supported by family.

The bill works by requiring DHSS, the Older Alaskans Commission, and the Governor's Council for the Handicapped and Gifted to survey client needs and to coordinate the list of potential home care services. DHSS will then serve as the lead agency to prepare an application to the federal government to modify Alaska's medicaid program to include home care services.

Alaskans who benefit from this legislation include senior citizens, parents of disabled children, disabled adults, and Alaskans experiencing a developmental disability.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-4821 • 3111 ST. #515, ANCHORAGE, AK 99503 (907) 561-7613

POSITION PAPER

SENATE BILL 334

For an Act entitled: "An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

This Act directs the Department of Health and Social Services, the Governor's Council for the Handicapped and Gifted, and the Older Alaskans Commission to enter into an interagency agreement to work toward preparing reports and fiscal analysis to be provided to the Legislature for the purpose of obtaining Medicaid-funding for services and waivers to provide access to home and community based care for the classes of individuals described in the Act's title.

The Act establishes guidelines including a timeframe in which the Department must conduct research, analyze recommendations of the Older Alaskan's Commission (OAC) and the Governor's Council for the Handicapped and Gifted (GCHG), prepare a detailed fiscal analysis, and write and submit state plan amendments and waiver requests.

During FY91, the Department's efforts will be directed toward staff training, creation of a project plan, consultation with experts, research in federal and state law and regulations, creation of a data base of potential clients and existing services, and public meetings to obtain information on service needs and expectations.

In FY92 the Department will prepare draft waiver requests, Medicaid State Plan Amendments, and a fiscal note analysis as specified in Section 3 of Senate Bill 334. This will require on-going research and planning including coordination with the Older Alaskan's Commission and the Governor's Council for the Handicapped and Gifted and the Health Care Financing Administration.

In FY93 the Department will finalize waiver requests and state plan amendments that have been funded by the Legislature. These will be sent to the Governor's Council for the Handicapped and Gifted and Older Alaskan's Commission by July 15, 1992. After consideration of any recommendations from the Governor's Council for the Handicapped and Gifted or the Older

POSITION PAPER/Department of Health & Social Services

Alaskan's Commission the Department will submit the waivers and state plan amendments to the Health Care Financing Administration by September 15, 1992. State plan amendments are generally approved within 90 days of submission. Once approval is certain the Department will begin implementation. The average length of time between submission of a waiver request to the Health Care Financing Administration and final approval is approximately 9 months. In FY94 the Department would be implementing the waiver.

Department Position
The federal laws governing the Medicaid Program have been undergoing rapid change and will likely continue to change especially in the area of long-term care. It is critically important for the Department to stay current on the laws affecting Medicaid services and waivers and to assist in positioning the state to take advantage of federal financing opportunities in regard to the classifications of individuals targeted under Senate Bill 334.

SB 334 provides a process by which the DHSS, OAC and Governor's Council can act together to recommend to the Legislature the most appropriate home and community based Medicaid options and waivers. The Department of Health and Social Services supports SB 334.

RECOMMENDED: Kim Busch
Kim Busch
Director
Division of
Medical Assistance

DATE: 1-18-90

APPROVED: Myra M. Munson
Myra M. Munson
Commissioner
Department of Health
and Social Services

DATE: 1-22-90

Older Alaskans Commission

Box C
Juneau, Alaska 99811-0209
907/465-3250

POSITION PAPER
ON SENATE BILL 334

Senate Bill 334, the Home Care Bill, will commit the State to a two year process of planning and applying for federal Medicaid programs to pay for home and community based support services for the elderly, and disabled adults and children who need such services to avoid placement in nursing homes or other institutions.

Alaska is almost the only state that does not now use Medicaid dollars for home care programs for functionally disabled citizens. Many states use a combination of Medicaid "optional services" and a Home Care "Waiver" to complete the continuum of care available to persons with disabilities.

Although institutional care will always be needed for some clients, a range of "home and community care" Medicaid programs can be used by the state to provide less costly and higher quality-of-life alternatives to nursing homes for many people. Home care optional services assist family caregivers to extend the time when a frail senior or other disabled family member can stay at home, or avoid nursing home placement altogether.

Over thirty other states now use Medicaid to augment medical care for the elderly with "social" services to support home or community care. These include services such as adult day care, in-home respite care, hospice care, homemaker and home health service, case management, and adult foster care.

Older Alaskans have very limited or no access to these types of services; only a few of these options are available through OAC services to the elderly, and only in a few towns. What services do exist are fragmented, provided by six different state agencies (or their local contractors), and there is no one entry point to home care, nor any one person who allocates the care resources among those in need or helps to coordinate the different services to make an overall effective care package for the family and client. When a person is 85, frail, ill, and home-bound, dealing with six bureaucracies is an overwhelming burden--perhaps the most important optional Medicaid service Alaska could start would be managed care, or "case management" of home service for the most frail and disabled.

SB 334 authorizes the OAC and the Governor's Council for the Handicapped and Gifted to each conduct a year of research into

the needs of their populations, and by June, 1991 to issue a report recommending the best combination of Medicaid services for the populations each represents.

The Medical Assistance Division of the Department of Health and Social Services is mandated by SB 334 to respond to the OAC and GCHG reports with cost studies and its own recommendations for the 1992 Legislature. If the 1992 Legislature approves the plans, the State would submit applications to the federal Medical agency by late 1992. Services would be phased in, starting in 1993.

SB 334 instructs the three agencies, Medical Assistance, OAC, and the GCHG to coordinate their work through an inter-agency committee. The three agencies are already planning a "team" approach to this multi-year project, and have tried to coordinate their fiscal notes in such a way as to use one-half federal Medicaid dollars to fund the project.

The Older Alaskans Commission strongly endorses SB 334. Alaska must seek all available federal dollars to help fill the serious gaps in Alaska's "continuum" of care for the elderly and disabled. Although the Medicaid programs will not serve all seniors, a base of Medicaid dollars to fund home and community services would free other state resources for similar services to moderate income, at-risk elderly living at home.

Although Alaska earlier made bold initiatives to set up Pioneers' Homes and the Longevity Bonus to assist seniors who wish to stay in the state, Alaska has not kept up with the state-of-the-art in elder (or disabled) care in other states. As a state, Alaska has not yet responded to the strong desire of seniors to stay at home as long as possible--a desire repeated in every senior survey and demonstrated by the current ages of admission to the Pioneers' Homes, where the average age upon entry is over 80.

Many, many Alaskan seniors are looking for a reassurance that home care or community assistance will be there when they need it. In addition to the Older Alaskans Commission endorsement of this bill, the Legislature will find support from the Alaska chapter of the American Association of Retired Persons and the Older Persons Action Group. The OAC is also sure that most local senior groups will support this bill, as the Commission is constantly informed by seniors throughout the state of the pressing need for home and community care.

APPROVED:

Frances B. Ialand for
Peggy Burgin, Chair
Older Alaskans Commission

REVIEWED:

Frank Baxter
Frank Baxter, Commissioner
Department of Administration

Uehling

SECTIONAL ANALYSIS
SENATE BILL 334(efd-am)

The following is a sectional analysis of SB 334, a bill which directs the Department of Health and Social Services to seek approval for certain options and waivers under the federal medicaid program.

In general, the bill requires DHSS to coordinate the application with information obtained from the Older Alaskans Commission and the Governor's Council on Gifted and Handicapped.

The bill was amended on the Senate Floor. The amendment changed the effective date from July 1, 1990 to immediately under AS 01.10.070(c).

Section 1

Subsection (a-b) provides a descriptive basis for mandating a medicaid operated home care program.

Subsection (c) names the Department of Health and Social Services as the lead agency for preparing the federal application after taking into consideration priorities recommended by the Older Alaskans Commission and the Governors Council for the Handicapped and Gifted.

Section 2

Subsection (a) describes preliminary research activities to be conducted by the Governor's Council for the Handicapped and Gifted, and the Older Alaskans Commission.

Subsection (b) sets June 1, 1991 as the deadline for the submission of a written report to DHSS and the Legislature to detail the results of the activities in Subsection (a) above.

Section 3

Subsection (a) directs the Department of Health and Social Services to submit a report to the Legislature by January 15, 1992 which estimates the cost of implementing particular options and waivers for which it plans to seek approval from the federal government under this Act.

Subsection (b) defines the costs to be used by the administration in preparing the fiscal note for this bill as those necessary for the researching, writing, negotiating and obtaining approval of the application to the federal government and the costs of preparing the fiscal analysis under this section.

Section 4 provides for Legislative review of the applications for options and waivers prior to submission by the Department of Health and Social Services. This section also directs DHSS to consult with the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission during the preparation of the applications.

Section 5 requires the Department of Health and Social Services, the Governor's Council for the Handicapped and Gifted, and the Older Alaskans Commission to prepare an interagency agreement for carrying out this Act.

Section 6 sets out the definitions in this Act for "developmentally delayed children", developmentally disabled person", "disabled adult", and "older Alaskans".

Section 7 creates an immediate effective date.

DIVISION OF MEDICAL ASSISTANCE

Prior Year Expenditures

ACCT	CATEGORY OF SERVICE	FY 86 ACTUALS	FY 87 ACTUALS	FY 88 ACTUALS	FY89 YTD ACTUALS	FY90 Authorized
MEDICAID FACILITIES		44,828.1	46,831.6	59,574.1	71,284.7	78,280.5
	MEDICAID HOSPITALS	19,884.2	21,284.8	32,598.0	36,711.4	44,397.4
	MEDICAID NURSING HOMES	24,943.9	25,546.8	26,836.7	34,434.5	33,623.1
	MEDICAID TPL RECOVERY	0.0	0.0	139.4	138.8	260.0
MEDICAID STATE FACILITIES		0.0	0.0	0.0	3,227.6	3,805.1
MEDICAID NON-FACILITY		20,246.2	22,731.3	33,192.3	40,124.7	45,706.3
	MEDICAID PHYSICIAN SERVICES	11,006.0	11,477.4	18,182.4	19,510.7	22,801.9
	MEDICAID OTHER	5,902.8	7,113.3	10,892.1	16,747.5	17,104.4
	MEDICAID EPSDT	3,337.4	4,140.6	4,056.8	3,844.0	5,696.0
	MEDICAID TPL RECOVERY	0.0	0.0	61.0	22.5	104.0
MEDICAID INDIAN HEALTH SERVICE		1,793.8	4,956.0	4,902.5	5,145.9	5,957.7
TOTAL ALL MEDICAID SERVICES		66,868.1	74,518.9	97,668.9	119,782.9	133,749.6
GENERAL RELIEF MEDICAL						
	GRM HOSPITAL	4,617.4	2,396.4	2,974.3	3,098.0	4,069.5
	GRM PHYSICIANS SERVICES	2,119.5	740.4	949.9	1,088.6	1,045.8
	GRM OTHER SERVICES	4,612.0	3,371.2	4,626.7	3,523.1	1,233.7
	GRM TPL RECOVERY	0.0	0.0	6.9	4.1	36.0
TOTAL ALL GRM SERVICES		11,348.9	6,508.0	8,557.8	7,713.8	6,385.0
CATASTROPHIC ILLNESS		513.7	0.0	0.0	0.0	0.0
ALASKA LONGEVITY BONUS H.H.		0.0	19.5	675.3	1,001.3	1,236.6
PERMENANT FUND DIVIDEND H.H.		0.0	353.6	740.4	910.2	1,300.0
TOTAL MEDICAL ASSISTANCE		78,730.7	81,400.0	107,642.4	129,408.2	142,671.2

File: i:\dma\lotus\expend\expend.wk1
06-Jul-89

DIVISION OF MEDICAL ASSISTANCE

Prior Year Expenditures

ACCT	CATEGORY OF SERVICE	FY 86 ACTUALS	FY 87 ACTUALS	FY88 ACTUALS	FY89 YTD ACTUALS	FY90 Authorized
MEDICAID						
	MEDICAID HOSPITALS					
800	Inpatient Hospital	16,295.1	17,619.7	27,275.0	27,898.9	36,700.7
803	Inpatient Psych Hospital				3,594.1	1,942.8
805	Outpatient Hospital	3,412.9	3,438.5	4,995.0	5,022.6	5,624.1
807	Outpatient Surgical Centers	176.2	226.6	328.0	195.8	129.8
	TOTAL M. HOSPITALS	19,884.2	21,284.8	32,598.0	36,711.4	44,397.4
809	PFDBH RSA	0.0	353.6			
811	TPL Recovery Contract			139.4	138.8	260.0
MEDICAID STATE FACILITIES						
802	Inpatient Psych - API				353.2	400.0
890	Harborview ICF/MR				2,619.8	3,405.1
895	Harborview ICF				254.6	0.0
	TOTAL MEDICAID STATE FACILITIES				3,227.6	3,805.1
	MEDICAID PHYSICIAN SERVICES					
815	Physician Services	10,908.4	11,393.7	18,066.2	19,444.5	22,722.0
816	Rural Health Clinics	97.6	83.7	116.2	66.2	79.9
	TOTAL M. PHYSICIAN SERVICES	11,006.0	11,477.4	18,182.4	19,510.7	22,801.9
	MEDICAID OTHER					
820	Other Services	52.8	52.2	82.8	0.0	71.5
821	Speech Language Therapy	84.8	86.3	79.0	43.9	72.7
822	Mental Health Clinics	1,909.7	2,258.5	3,248.1	3,881.5	3,769.6
824	Home Health Care	59.5	87.9	172.5	145.6	231.7
825	Transportation	1,653.0	1,597.8	2,370.5	3,462.5	2,495.8
826	Glasses Non-EPSDT	650.0	606.2	790.7	972.4	849.8
827	Family Planning	135.6	123.6	112.6	52.7	82.7
828	Laboratory & Xray	96.7	90.6	27.5	323.6	235.3
829	Medicaid Pharmacy				1,159.1	3,909.4
830	Hysterectomy	96.5	367.8	183.3	626.8	536.0
831	Abortion	0.0	1.5	3.2	0.0	0.5
832	Sterilization	133.4	352.3	562.1	664.7	558.6
835	Physical Therapy	156.4	167.0	189.3	140.4	146.9
836	Occupational Therapy	51.9	55.7	101.4	335.4	195.8
837	Pros. Devices-Medical Equip	287.1	339.4	529.2	970.2	641.7
838	Part B Buy-In	535.4	517.2	834.9	1,494.4	1,613.1
839	Hearing Services/Equipment			2.6	115.5	77.4
840	Adult Dental	0.0	24.0	581.7	1,035.4	760.6
841	Personal Care	0.0	281.8	616.9	821.5	814.4
842	Chiropratic	0.0	103.5	399.7	424.5	0.0
860	Disability/Blindness Exams			4.1	42.4	36.7
861	Disability Determination RSA				35.0	4.2
	TOTAL M. OTHER SERVICES	5,902.8	7,113.3	10,892.1	16,747.5	17,104.4

	MEDICAID EPSDT					
846	Labratory & X-Ray	0.1			0.0	0.0
850	Other Services	0.5		0.5	1.1	1.4
851	EPSDT RSA	1,336.9	1,342.3	1,370.7	1,370.7	2,781.6
852	EPSDT Dental Care	1,689.3	2,546.6	2,369.5	2,124.0	2,495.3
854	EPSDT Physician	53.9	49.4	52.2	133.3	91.0
855	EPSDT Glasses	0.1			0.0	0.0
857	Therapy	0.0			0.0	0.0
858	Pros. Devices-Medical Equip	0.0			0.0	0.0
859	EPSDT Transportation	256.6	202.3	263.9	214.9	326.7
	TOTAL M. EPSDT	3,337.4	4,140.6	4,056.8	3,844.0	5,696.0
812	TPL Recovery Contract			61.0	22.5	104.0
	MEDICAID NURSING HOMES					
870	Nursing Home Skilled	2,385.2	4,122.5	2,629.4	3,611.5	2,848.2
871	Nursing Home Intermediate	19,788.1	17,572.8	21,012.2	26,478.0	25,810.3
872	Nursing Home Hope ICF MR	2,770.6	3,748.6	3,195.1	4,340.4	3,327.8
875	Nusring Home Interim Payment	0.0	102.9		4.6	1,636.8
	TOTAL M. NURSING HOMES	24,943.9	25,546.8	26,836.7	34,434.5	33,623.1
	MEDICAID INDIAN HEALTH SERVICE					
880	IHS Clinic	126.2	313.7	398.9	245.4	377.1
881	IHS Inpatient	894.0	3,487.2	2,935.9	2,916.4	4,192.0
882	IHS Outpatient	773.6	1,155.1	1,567.7	1,984.1	1,388.6
	TOTAL M. IHS	1,793.8	4,956.0	4,902.5	5,145.9	5,957.7
	TOTAL ALL MEDICAID SERVICES	66,868.1	74,518.9	97,668.9	119,782.9	133,749.6

	GENERAL RELIEF MEDICAL					
	GRM HOSPITAL					
900	Inpatient Hospital	4,009.8	2,218.9	2,929.3	3,094.0	3,889.9
905	Outpatient Hospital	607.6	177.5	45.0	4.0	179.6
	TOTAL GRM HOSPITAL	4,617.4	2,396.4	2,974.3	3,098.0	4,069.5
930	GRM PHYSICIANS SERVICES	2,119.5	740.4	949.9	1,088.6	1,045.8
	GRM OTHER SERVICES					
939	GRM Other Services	10.2		0.1	0.0	0.0
940	Pharmaceuticals XIX	2,327.8	2,544.9	3,781.1	2,658.3	0.0
941	Pharmaceuticals GRM	248.6	84.8	103.2	104.7	142.4
942	Transportation	128.0	66.0	85.0	98.6	85.5
943	Dental Care XIX	671.6	21.2	1.0	0.0	0.0
944	Dental Care GRM	231.7	50.5	23.6	19.7	0.0
945	Other Services	0.0			0.0	0.0
946	Glasses & Hearing Aids	106.3	22.2	0.8	0.0	0.0
947	Pros Device-Medical Equipmen	31.9	8.9	1.2	10.8	0.0
948	Therapy	44.8	11.6	0.1	0.0	0.0
950	Independent Labs	9.0	2.0	3.9	5.1	0.0
951	Nursing Home Care	595.6	268.5	219.4	243.4	519.7
955	Family Planning	9.3	0.5	1.1	0.7	1.4
956	Abortion XIX	167.3	262.8	376.6	325.1	440.3
957	Sterilization (ALL OTHER)	4.6	1.5	12.9	46.4	0.0
958	Abortion GRM	25.3	25.8	16.7	10.3	44.4
	TOTAL GRM OTHER SERVICES	4,612.0	3,371.2	4,626.7	3,523.1	1,233.7
910	TPL Recovery Contract			6.9	4.1	36.0
	TOTAL ALL GRM SERVICES	11,348.9	6,508.0	8,557.8	7,713.8	6,385.0
	CATASTRIPHIC ILLNESS	513.7	0.0	0.0		
	ALASKA LONGEVITY BONUS H.H.	0.0	19.5	675.3	1,001.3	1,236.6
	PERMENANT FUND DIVIDEND HOLD HARMLESS					
809	PFD Hold Harmless Non-Facility			647.1	199.5	567.5
810	PFD Hold Harmless Facilities			93.3	710.7	732.5
	TOTAL PFD HOLD HARMLESS			740.4	910.2	1,300.0
	TOTAL MEDICAL ASSISTANCE	78,730.7	81,400.0	107,642.4	129,408.2	142,671.2

ALASKA NURSING HOMES CENSUS

AS OF : NOVEMBER 30, 1989

FACILITY	MEDICAID PER DIEM RATE	CERTIFIED CAPACITY: SNF/ICF	CERTIFIED CAPACITY: SWING BEDS	MEDICAID/GRH PLACEMENTS: ICF	MEDICAID/GRH PLACEMENTS: SNF	NON-DMA PLACEMENTS: MEDI-CARE	NON-DMA PLACEMENTS: ** OTHER	TOTAL CENSUS	VACANT BEDS	% OCCUPANCY OF TOTAL BEDS: OVERALL	% OCCUPANCY OF TOTAL BEDS: MEDICAID
CORDOVA HOSPITAL LTC	$282.85	10	4	10	0	n/a	0	10	4	71%	71%
DENALI CENTER (Fairbanks)	161.08	101	0	38	12	8	16	74	27	73%	50%
HERITAGE PLACE (Soldotna)	219.11	45	0	23	0	0	5	28	17	62%	51%
ISLAND VIEW MANOR (Ketchikan)	232.28	46	0	24	1	2	3	30	16	65%	54%
KOTZEBUE SENIOR CITIZEN CARE CTR.	198.08	9	0	5	1	0	0	6	3	67%	67%
KODIAK ISLAND HOSPITAL LTC	211.34	19*	4	17	0	0	2	19	4	83%	74%
MARY CONRAD CENTER (Anchorage)	232.56	66*	0	63	n/a	n/a	2	65	1	98%	95%
OUR LADY OF COMPASSION (Anchorage)	168.80	224	0	128	51	13	24	216	8	96%	80%
PETERSBURG HOSPITAL LTC	251.13	14	4	12	0	0	2	14	4	78%	67%
QUYAANA CARE CENTER (Nome)	222.09	15*	0	14	n/a	n/a	0	14	1	93%	93%
SOURDOUGH PLACE (Valdez)	176.74	16*	0	13	n/a	n/a	3	16	0	100%	81%
SOUTH PENINSULA HOSP. LTC (Homer)	234.77	18	0	14	0	n/a	1	15	3	83%	78%
ST. ANN'S NURSING HOME (Juneau)	195.95	45	0	29	10	0	2	41	4	91%	87%
WESLEYAN NURSING HOME (Seward)	130.72	66	0	44	0	n/a	4	48	18	73%	67%
WRANGELL GENERAL HOSPITAL LTC	262.43	14	4	6	1	0	4	11	7	61%	39%
SWING BEDS (Acute to LTC):											
CENTRAL PEN. HOSPITAL (Soldotna)	177.51	0	4	0	0	0	0	0	4	0%	0%
SEWARD GENERAL HOSPITAL	177.51	0	2	0	0	1	0	1	1	50%	0%
SITKA COMMUNITY HOSPITAL	177.51	0	[illegible]	0	0	0	0	0	2	0%	0%
VALDEZ COMMUNITY HOSPITAL	177.51	0	4	2	0	0	1	3	1	75%	50%
VALLEY HOSPITAL (Palmer)	177.51	0	4	0	0	1	0	1	3	25%	0%
	TOTAL:	740		442	76	25	69	612	126	83%	70%

* - beds certified ICF only.
** - includes VA, private pay, insurance, and other.

Karen Hartz 12/15/89
KAREN HARTZ DATE
DIVISION OF MEDICAL ASSISTANCE—(907) 561-2171

ICF/MR AND IMH CENSUS

AS OF: NOVEMBER 30, 1989

CURRENT OCCUPANCY

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	MEDICAID TOTAL	MEDICAID UNDER 22	MEDICAID OVER 65	NON-MEDICAID	TOTAL CENSUS	VACANT BEDS
ALASKA PSYCHIATRIC INSTITUTE Anchorage	274.28	160	18	14	4	70	88	72
CHARTER NORTH HOSPITAL Anchorage	N/A	60	15	15	0	24	39	21
NORTH STAR HOSPITAL Anchorage	N/A	34	7	7	0	15	22	12

ICF/MR BEDS	PER DIEM RATE	CERTIFIED BEDS	MEDICAID	NON-MEDICAID	TOTAL CENSUS	VACANT BEDS
HARBORVIEW DEVELOPMENTAL CENTER Valdez	302.00	64	59	0	59	5
HOPE COTTAGES Anchorage	261.49	40	40	0	40	0

Karen Martz 12/15/89

KAREN MARTZ DATE

DIVISION OF MEDICAL ASSISTANCE (907) 561-2171

Janet

MEMORANDUM

State of Alaska

TO: Commissioner John M. Andrews
Department of Administration

DATE: February 2, 1989

FILE NO:

THRU: James J. Fox, Deputy Commissioner
Department of Administration

TELEPHONE NO: 465-4400

FROM: Barbara Bathony, Director BB
Division of Pioneers' Benefits
Department of Administration

SUBJECT: Pioneers' Homes Occupancy Report
December 27, 1988 through
January 26, 1989

	Available Beds					Not Available	Total Beds	Occupied Beds				% Occupancy of Available Beds	
	R	R2	N	=	I	V	=	R	R2	N	=	this mo.	last mo.
SIT	45	*	39	84	2	41	127	36	*	35	71	85	87
FBX	56	*	46	102	2	0	104	54	*	46	100	98	99
PMR	18	17	53	88	2	4	94	18	16	53	87	99	97
ANC	113	25	88	226	6	0	232	96	24	88	208	92	92
KTN	19	*	28	47	2	0	49	17	*	28	45	96	96
JUN	20	*	32	52	2	0	54	18	*	31	49	94	96
TOTAL	271	42	286	599	16	45	660	239	40	281	560	93	94

	ADMITTANCES			DISCHARGES			DEATHS			IN-HOUSE TRANSFERS					
	R	R2	N	R	R2	N	R	R2	N	R-R2	R2-R	R-N	N-R	R2-N	N-R2
SIT	0	*	2	0	*	1	1	0	2	*	*	1	1	*	*
FBX	0	*	0	0	*	0	1	*	0	*	*	1	0	*	*
PMR	0	2	3	0	*	0	0	0	4	2	1	0	0	3	*
ANC	1	0	0	0	0	0	0	1	2	0	0	0	0	0	0
KTN	0	*	0	0	*	0	0	*	0	*	*	0	0	*	*
JUN	0	*	0	0	*	0	0	*	1	*	*	1	0	*	*
TOTAL	1	2	5	0	0	1	2	1	9	2	1	3	1	3	0

	Awaiting In-House Transfer						Waiting List			
	R-R2	R2-R	R-N	N-R	R2-N	N-R2	R	R2	N	=
SIT	*	*	0	2	*	*	10	*	4	14
FBX	*	*	14	0	*	*	7	*	18	25
PMR	0	0	0	0	1	0	2	2	29	33
ANC	4	0	2	0	0	0	0	2	53	55
KTN	*	*	0	0	[illegible]	[illegible]	12	*	10	22
JUN	*	*	10	0	*	*	47	*	18	65
TOTAL	4	0	16	2	1	0	78	4	132	214

	Stipend				Infirmary Beds		Residents receiving Nursing	
	R	R2	N	=	Days	Residents	#/residents	#/hours
SIT	2	*	5	7	31	4	37	666
FBX	2	*	17	19	35	2	30	375
PMR	0	0	14	14	0	0	0	0
ANC	1	1	21	23	104	5	79	512
KTN	1	*	8	9	21	2	17	106
JUN	0	*	8	8	21	4	1	16
TOTAL	6	1	73	80	212	17	164	1675

R = Residential care level
R2 = Residential II care level
N = Skilled Nursing level
I = Infirmary Beds
V = Vacant beds due to renovation/construction
* = Not applicable

C/8901

02-001A(Rev. 10/79)

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE

MEDICAL CARE

HUMAN SERVICES RESEARCH INSTITUTE
2336 Massachusetts Avenue
Cambridge, MA 02140
(617) 876-0426

MEDICAID: MEDICAL ASSISTANCE PROGRAM

Purpose

This program (often referred to as "Title 19" because of its authorizing legislation) provides federal financial assistance to states for medical services furnished on behalf of public assistance recipients and, in some states, on behalf of other medically needy persons who, except for income and resources, would be eligible for cash assistance. The federal matching rate varies by state and is determined under a complex formula geared to state per capita personal income. The federal share of program costs ranges from 50% to 80% (new matching rates for federal FY 1989-90 were issued by HCFA on October 27, 1988). The Medicaid program is administered by a state's "single state agency," and the agency must operate under a Medicaid state plan approved by the Secretary of the Department of Health and Human Services and comply with all federal regulations governing aid and medical assistance to the needy.

Eligibility

There are numerous categories of persons who are eligible for Medicaid. Federal law mandates that states must serve some categories of persons. Other categories of persons are eligible for Medicaid at state option and if they are listed in the state Medicaid plan. In some cases, if a state opts to include certain optional categories of persons in their Medicaid plan there are federal requirements that restrict the eligibility of those groups. Overall, the federal Medicaid statute encompasses a wide-range of eligibility options aimed at the extension of Medicaid services to children with severe disabilities who are members of low-income households or who have had financial deeming requirements waivered. Careful review of each state's Medicaid state plan is necessary to determine the range of eligible groups that are covered in a particular state and, consequently, the role Medicaid benefits might play in meeting the needs of such children.

The following pages describe the mandatory and optional eligibility groups.

This section was prepared with the assistance of Kathleen Blume of the Health Care Financing Administration; Gary Smith of NASMRPD; and Harriet Fox of Fox Health Policy Consultants

MANDATORY COVERAGE

AFDC Recipients

All persons who are recipients of payments under the Aid to Families with Dependent Children (AFDC) program are automatically eligible for Medicaid benefits (referred to as "categorically" eligible). Generally, the regular AFDC cash assistance program extends eligibility to children under age 18 (or 19 at state option) "where the child is deprived of the support of at least one parent (i.e., at least one parent is dead, disabled, continually absent from the house, or, in some states unemployed)" (Congressional Research Service, 1988) and who have caretakers with very low income. Family composition and financial eligibility standards for AFDC payments vary from state-to-state.

Adopted or foster care children receiving cash assistance under Title IV-E of the Social Security Act are considered to be AFDC recipients for purposes of the Medicaid program and are eligible for benefits.

"Qualified" Pregnant Women and Children

Pregnant women and children up to age 7 (or age 8 at state option) who meet the financial requirements of the state AFDC plan (or would be eligible for AFDC if the state AFDC plan included an unemployed parent program) are required to be covered by the state Medicaid plan. These groups, referred to as "qualified" eligibles, who meet AFDC financial requirements, do not have to meet family composition or "deprivation" requirements. At state OPTION, this coverage can be extended to children up to ages 18 through 21. (These recipients are referred to as Ribicoff children after the Senator who sponsored this legislation).

Poverty Related Pregnant Women and Children

Effective July 1989, all pregnant women and infants (up to age 1) whose family income is up to 100% of the federal poverty level ($9,690/year for a family of three in 1988) are eligible for benefits. Pregnant women are eligible only for pregnancy related Medicaid services and the infants are eligible for all Medicaid services available under the state plan. (This provision will be phased-in through July 1990).

SSI

In all but 13 states, all children (including adopted children) and other aged, blind, and persons with disabilities who receive cash payments under the federal Supplementary Security Income (SSI) program are also eligible for Medicaid. The remaining 13, states referred to as "209(b)" states, may choose to limit Medicaid eligibility to individuals who meet requirements that are more restrictive than those for SSI. The thirteen states are: Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, North Dakota, Ohio, Oklahoma, and Virginia.

When determining whether a child with handicaps is eligible to receive SSI, federal law requires that a certain portion of the family's income be "deemed" available to the child. This excludes many children in low to moderate income households from receiving SSI and Medicaid. However, if a child is institutionalized a full calendar month, the parent's income is not counted in determining SSI eligibility and resultant Medicaid eligibility. As a consequence, federal policies are often criticized as creating a bias toward out-of-home placement rather than supporting families.

OPTIONAL COVERAGE

Children Receiving State Supplements

States may provide supplemented payments to SSI recipients and persons with income in excess of SSI income standards. States have the option to extend Medicaid eligibility to children receiving the Supplemental payment. The income limits to receive a state supplemental payment vary by state.

Medically Needy

This refers to individuals and families who do not meet the financial eligibility limits for AFDC, SSI or state supplement, but who lack the resources to pay for their medical bills (usually because of inadequate private health insurance). In such instances, a individuals must "spend down" income for medical expenses until countable income falls to a level specified by the state. "Medically needy" individuals must satisfy special income and resource limits set in the state's Medicaid plan. Federal regulations require that a state set its medically needy income standards no higher than 133% of its AFDC payment standard. AFDC income limits and "medically needy" income limitations vary by state. In 1987, medically needy levels for a family of four varied from $267 in Tennessee to $1,009 in California. Thirty-six states currently operate medically needy programs. The numbers of persons served by a medically needy program vary widely and are dependent upon the level of the state AFDC payment (Fox & Yoshpe, 1987b).

Foster and Adoptive Children

This includes all foster care and adoptive children who have incomes and resources within certain prescribed limits and, who were placed by the state, but were not eligible for AFDC cash assistance prior to placement.

Pregnant Women and Children

This options includes all pregnant women and infants up to age one, whose family income is under a state established threshold that does not exceed 185% of the federal poverty level, and incrementally on an annual basis to children up to age 8 whose family income does not exceed 100% of the federal poverty level. Additionally, states may: omit testing for assets or resources (i.e. only test for income); use the more relaxed resource tests used by the SSI program; and/or disregard changes in income once a pregnant woman is determined to be eligible. Low income pregnant women and young children are not required to meet the family standards, other categorical criteria, or financial criteria of AFDC. Also, pregnant women and infants with family income above 150 percent (and up to 185%) of the poverty level, can at state option, be charged a monthly premium. This premium cannot exceed 10 percent of their gross income, less child care expense.

Waiver Recipients

States can opt to provide all Medicaid services to all persons with disabilities who meet the SSI disability criteria and who are receiving services through an approved home and community-based waiver or through a model waiver program.

Services covered

All states are required to provide the following Medicaid funded services:

* in and out-patient hospitalization;
* laboratory and X-ray;
* skilled nursing home for persons over age 21;
* home health services for persons over age 21;
* rural health clinic services;
* nurse midwife services in those states where midwifery is licensed or allowed by law;
* family planning;
* physician; and
* early and periodic screening, diagnosis and treatment (EPSDT) for children under age 21 (see below).

A state may also cover a wide variety of up to 32 optional service categories at its discretion, (e.g., preventive and rehabilitative services; home care or nursing care; home and community-based waivers; medical equipment and appliances; private duty nursing; home respiratory care services; and case management). States have wide latitude to limit the "frequency, scope, and duration" of Medicaid-covered services (e.g., by limiting the number of physician visits that will be reimbursed). Services under Medicaid except for home and community-based waivers and targeted case management must meet criteria of a "statewideness and comparability" (meaning that services must be equally available and of equal scope across all groups of Medicaid eligible). In most of these areas the state sets the standards for services. States also have broad flexibility in determining payment rates for covered services. Some states have elected to provide comprehensive and often unlimited coverage for all, or nearly all, of the federally allowed Medicaid services, while other states provide more limited benefits and may exclude extended home care, speech and occupational therapies. Moreover, a state can opt to exclude "medically needy" eligibles from optional Medicaid benefits. If a state offers home care they are required to provide nursing visits, medical equipment and supplies. Cost reimbursement methods (e.g., capitation through prepaid health plans) will affect the amount of reimbursement for care.

Of special interest is the fact that every state must provide EPSDT services to Medicaid eligible children under age 21. The Congressional Research Service (1988) describes this program.

> The EPSDT program is designed to assure the availability and accessibility of required health resources and to help eligible children use them effectively. Under EPSDT, states are required not only to finance services, but also to conduct outreach activities that link Medicaid-eligible children with providers. Each state's Medicaid program must (1) inform all eligible children about EPSDT services, (2) provide screening and diagnostic services, and (3) provide treatment to correct or ameliorate any discovered health problems.
>
> Each state must provide, at a minimum, the following EPSDT services: assessments of health, developmental, and nutritional status; unclothed physical examinations; immunizations appropriate for age and health history; appropriate vision, hearing, and dental services found necessary by the screening....
>
> States are permitted to provide services to children under EPSDT even if they are otherwise not available, or available on a limited basis, to other Medicaid beneficiaries (e.g., vision, hearing, and dental services that may not otherwise be available from that state's Medicaid program). (p. 322)

This enables a state to target an enriched array of services to children without risking financial exposure in the remainder of its program.

The Omnibus Reconciliation Act of 1986 (OBRA '86) also authorized state Medicaid coverage of at-home respiratory care services to ventilator-dependent individuals. Individuals must be medically dependent on a ventilator for life support at least six hours per day, and require inpatient respiratory care for which Medicaid would pay, if home respiratory care services were not available. The coverage permits a state to serve Medicaid eligible ventilator-dependent children at home without having to utilize a "2176" home and community based waiver (see the following).

The myriad of service options a state may elect under federal law as well as the special limitations a state may impose on covered services render it practically impossible to draw general conclusions about coverage, independent of each state's program. A careful review of a state Medicaid plan is required to determine the scope of service coverages and their potential applicability to furnishing home servic[illegible] to children with disabilities.

RECENT LEGISLATIVE CHANGES

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Purpose

TEFRA allows states to amend their Medicaid state plans to provide regular Medicaid services (but not non-medical support services) to *all* children with disabilities under age 19 living at home, who because of SSI income eligibility rules, (i.e., the undeeming of parental income) would be Medicaid eligible only if institutionalized. Relevant statutory provisions are contained in Section 1902(e)(3) of the Social Security Act. "TEFRA 134" coverage represented one outgrowth of the so-called "Katie Beckett" waiver program.

Eligibility

The individual must both meet the usual categorical criteria for disability under the SSI program and must require the level of care provided in a hospital, ICF, ICF/MR, or SNF. The state must ascertain for each child that home care is appropriate, and that the cost of this care does not exceed the cost for institutional care. Unlike the "waiver" program, this state option requires the state to cover *all* children with disabilities who meet the criteria on a statewide basis, whether or not they are institutionalized. The number of children that the amendment will actually affect depends on the restrictiveness of the state's interpretation of requirements of institutional care. States are free to develop their own implementing rules and to discontinue coverage for this group at any time.

Services Provided

Persons made eligible under the TEFRA state plan amendment are eligible for all Medicaid services provided by the state comprehensiveness plan. The amount and types of care available to the children depends on the of the state's Medicaid program and the willingness of states to expand Medicaid options. TEFRA does not provide authorization to furnish alternative or other optional Medicaid services. To offer such services, a state could seek approval for a Medicaid waiver (discussed later in this report). A Medicaid waiver can be operated in conjunction with a TEFRA amendment.

State Participation

As of 1988, only 22 states have amended their state Medicaid plans to add the TEFRA-134 coverage option. The reluctance of the majority of states to select this eligibility option reflects wariness concerning the costs of adding a new entitled service population (Allan Bergman, UCPA, personal communication).

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85)

This act added a new section to the Social Security Act under which states were authorized to cover targeted case management as an optional service under their Medicaid plan. Case management is defined as services that will assist eligible individuals "in gaining access to needed medical, social, educational, and other services." Once such services are approved for coverage in a state's plan, federal financial participation in the cost of targeted case management services is made available at the state's regular federal assistance percentage. Case management can be targeted to specific populations without having to meet Medicaid "statewideness" or comparability provisions. The group may be identified by age, type or degree of disability, illness or condition "or other identifiable characteristic or combination thereof."

Medicare Catastrophic Coverage Act of 1988

The Congressional Research Service (1988) reports:

> The Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) provides that state Medicaid plans which impose day limits on payments for inpatient hospital services must establish exceptions to those limits for medically necessary inpatient services for infants (up to age 1) in hospitals which serve a disproportionate share of low-income patients,... These changes have the practical effect of increasing compensation for the treatment of premature infants, infants with acquired immunodeficiency syndrome (AIDs), and other disabled infants in hospitals located in states with Medicaid programs that impose durational limits. (p. 330)

Omnibus Budget Reconciliation Act of 1988 (OBRA 1988)

As of January 1988, all residents of federally funded nursing homes who have mental retardation or developmental disabilities must be screened to determine if they require 24 hour nursing care. By 1990 alternative appropriate arrangements must be made for residents who do not require such care. States must also screen all new admissions by January 1989 and cannot admit an individual to a nursing home unless s/he has been determined to require the level of care provided by the nursing home (Bergman, 1988c).

MEDICAID: WAIVER PROGRAMS

HOME AND COMMUNITY BASED WAIVER

Purpose

This program (sometimes referred to as "2176 waivers" based on its authorizing statute) enables states to finance a variety of home and community based, non-medical support services not usually covered by Medicaid for recipients who would otherwise need more costly institutional care. Unlike service options available within the state Medicaid plan, coverage of home and community-based (HCB) services under the waiver requires the submission of a special application to HCFA. Once approved, waivers are effective for a three year period and can be renewed for a five year period. In its application, a state must designate which types of services it wishes to cover, how the services are to be covered, the target populations for the services, eligibility requirements, and other assurances. There is no limit on the number of waivers that can be granted to a state. The federal share of the program ranges from 50% to 80% depending on the state federal Medicaid assistance percentage.

Eligibility

The Task Force on Technology Dependent Children (1987) provides the following discussion:

> Eligibility is limited to Medicaid recipients who, in the absence of HCB services, would require long term care in a hospital, skilled nursing facility, or ICF/MR. States may restrict eligibility for waiver participation to recipients residing in certain geographic areas in the state; to individuals being deinstitutionalized; or to particular individuals for whom the Medicaid cost of providing HCB services is less than the cost of providing institutional care. States may expand income eligibility for the target population in two ways: 1) by not deeming a certain portion of the family's income to be available to the individual receiving care at home; or 2) by raising the Medicaid income limit to a level equal to three times the maximum payment made to an individual under the SSI program... [This is referred to as the "300%" rule.] Individuals becoming eligible under this higher income standard are required to contribute to the cost of their care. (Task Force, 1987, p.102)

Substantial portions of this section were prepared by Gary Smith of the National Association of State Mental Retardation Program Directors.

The "300% rule" may be used for persons who, because of excess income, are not eligible for SSI; would be eligible for Medicaid if institutionalized; and will receive the HCB services. A state may employ the 300% rule (or a variation thereof) only to the extent it applies a similar standard to determine eligibility for institutionally-based services, (i.e. income levels for waiver services can be no more generous than for institutional services). The SSI payment for a couple in June 1989 is $553 per month. The 300% rule therefore allows eligibility for a couple with income up to $1,659 per month.

Unlike a TEFRA state Medicaid plan amendment, a waiver (both the 2176 "regular" waiver and the "model" waiver described next) permits a state to limit the waiver of the deeming of a portion of a family's income to a discrete population.

Services provided

States may provide services under the Home and Community Based Waiver that are otherwise not covered by Medicaid, such as homemaker, respite care, personal care services, minor home modifications, non-medical transportation, emergency response systems, family consultation, habilitation and supported employment programs, as well as augmented regular Medicaid services, (i.e., beyond the extent, scope, and duration of the states Medicaid services) such as hourly shift nursing, personal care, medical supplies, durable medical equipment, and other services as approved. Under a waiver, a state may relax limits established for regular state plan services when such services are furnished to a waiver recipient; a state is not required to meet medicaid "statewideness" or "comparability" requirements; and a state may authorize Medicaid services it does not cover under the state plan. Where it can be shown to be cost effective, the waiver may also be used to pay for an individual's private insurance premiums. Recent amendments to the waiver include employment related services and supported employment as allowable HCB services.

Restrictions on Waiver Programs

In adopting Section (1915)(c) of the Social Security Act, Congress mandated that a state must demonstrate that the average annual per capita costs of HCB waiver services would not exceed the average costs of institutional services (e.g., ICF/MR, hospital, or nursing home payments) that would otherwise be furnished to waiver recipients. In its implementing regulations for Section 1915(c), the Health Care Financing Administration (HCFA) promulgated a complex formula, designed to assure that a state's proposed HCB waiver program was cost-effective. The essence of this formula is that, in order to gain HCFA's approval of its HCB waiver application, a state must demonstrate that spending on long-term care services (HCB waiver and institutional services) while a waiver is in effect will not exceed expenditures that would have occurred in the absence of a waiver program.

HCFA provisions permit a state to develop waivers specific to individuals with specific conditions and gauge cost-effectiveness against the costs of institutional services furnished to this subset of clients. Hence, in targeting waiver services to

ventilator dependent children the costs of furnishing hospital-based services to such children may be employed rather than the average costs of all hospital services.

In practice, HCFA requires that a state demonstrate that: (a) not only will long-term care per capita expenditures under a waiver not exceed those projected to occur in the absence of offering waiver services, but also that (b) the number of persons receiving long-term care services in a state will be no greater as a result of offering waiver services. HCFA's waiver request/renewal process includes considerable negotiation concerning projected long-term care caseloads. In the end, the projected caseload constitutes a "cap" on a state's utilization of long-term care services on behalf of the target population. If, with a waiver, a state failed to effect a reduction in long term hospitalization, HCFA would question the effectiveness of the program.

As a consequence, the HCB waiver program is an anomaly among Medicaid-reimbursable services. Whereas for other services, a state may not overtly limit provision of services to a fixed number of recipients, a state must do so in its HCB waiver program. Consequently, an HCB waiver program is not immediately expandable due to increased recipient demand. Federal review criteria also place a large premium on the deactivation of state institutional beds in order to expand waiver services. Finally, the HCFA formula itself creates a substantial financial disincentive to offering lower cost services to waiver recipients. The waiver formula does not permit states to realize the savings of offering lower cost services and then to offer these savings to new persons. Therefore states tend to develop waivers for relatively higher cost services, thereby obtaining more federal dollars, rather than opting to offer the less expensive in-home services. This a key factor behind explaining why in-home services typically do not command a significant share of HCB waiver spending in most states.

State Participation

Presently 39 states operate HCFA-approved HCB waiver programs targeted to serving persons with developmental disabilities. The scope and range of services offered under these programs varies enormously. As a consequence, determining whether services are available under a state's waiver program that could play a role in meeting the needs of children at home requires an examination of the particular state's waiver program provision.

MODEL WAIVERS

Purpose

The so-called "Model Waiver" option was developed by HCFA to create a streamlined process for a state to offer home and community-based services (under Section 1915(c) of the Social Security Act) to a relatively small number of individuals. This program was intended to replace the case-by-case waiver requests that emerged as an outgrowth of the "Katie Beckett" case which allowed states to redeploy Medicaid funds for inpatient services to the support of in-home services. However, the "Model Waiver" program establishes no special opportunities to initiate home services for children with severe disabilities apart from generalized statutory authority governing the home and community-based waiver program. Structurally, there is no substantive difference between the model and the "2176" waiver program. The chief distinguishing characteristic of "Model Waiver" programs has been their size and the types of services/individuals states typically target. The model waiver represents an opportunity for a state to more discretely target waiver services to a participating client subpopulations (e.g., ventilator dependent children living at home). and the model waiver is generally oriented to serving children living at home. Until the passage of OBRA-87 in December, 1987, HCFA restricted the size of Model Waiver programs to no more than 50 individuals. Under OBRA-87, Model Waivers serving up to 200 individuals are now permitted. A state may propose to operate two or more model waiver programs and may operate a model waiver in addition to or in lieu of a regular section 2176 waiver. If a state already has a 2176 waiver, the model waiver application form permits the state to avoid repeating some material in its request.

Eligibility

Model Waiver eligibility criteria parallel those employed for the 2176 home and community-based waiver program. HCFA encourages a state to utilize the Model Waiver mechanism when it is seeking to cover a relatively small number of individuals. In addition, where coverage of children living at home is desired, HCFA also encourages (but does not mandate) that a state consider concurrently applying for a waiver of the "deeming" of parental income as a means of broadening eligibility for Model Waiver services. A state, however, may apply for a waiver of "deeming" when it is seeking HCFA approval of a "regular" HCB waiver program application.

Services Provided

While a state may propose to include an array of medical and non-medical services in a Model Waiver program application, HCFA guidelines urge states to restrict Model Waiver programs to a limited set of services. As with a "regular"

This section was largely prepared by Gary Smith of the National Association of State Mental Retardation Program Directors.

waiver program, a state may propose to cover medical services not otherwise furnished under its state Medicaid plan and to augment the extent, scope and services available under the state plan.

Other Notes

In most instances, states have employed the Model Waiver program to extend Medicaid coverage to relatively discrete, low-incidence target populations. Since utilization of home and community-based services is capped, some states have found the Model Waiver program to be a preferable alternative in covering home care services for children with severe disabilities to opting to add TEFRA 134 coverage under the state Medicaid plan. Like "regular" waiver programs, however, the Model Waiver program cannot be viewed as a means of achieving broad-based Medicaid coverage of non-institutional services. A "model" waiver may be appropriate in the case where the services a state wishes to furnish vary markedly from those that would be furnished under its regular waiver or if the institutional costs that would be incurred in the absence of a waiver are differentially higher than settings such as an ICF/MR.

WAIVER PROGRAM FOR "BOARDER BABIES"

The Congressional Research Services reports (1988):

> The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) establishes a new waiver program targeted at "boarder babies," children who are infected with the acquired immunodeficiency syndrome virus (AIDS) virus or who are drug dependent at birth and who may remain in hospitals indefinitely because of problems in finding an alternative placement. The new 1915(e) waivers will allow states to provide services to such children, as well as to any children with AIDS, who (i) are under age 5, (ii) are receiving or are expected to receive federally funded adoption or foster care assistance, and (iii) would be likely, in the absence of waivered services, to require the level of care provided by a hospital or nursing facility. Covered services could include nursing care, physicians services, respite care, prescription drugs, medical devices and supplies, transportation, and any other service requested by the state and approved by the Secretary.
>
> As with other home and community-based services waivers, the state is required to provide assurances that the health and safety of waiver participants will be protected, that there will be financial accountability for program funds, and that the projected per capita cost of the program will not exceed the costs that the Medicaid program would have incurred for the same individuals in the absence of a waiver. (p. 343)

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE

The First Three Years

of the

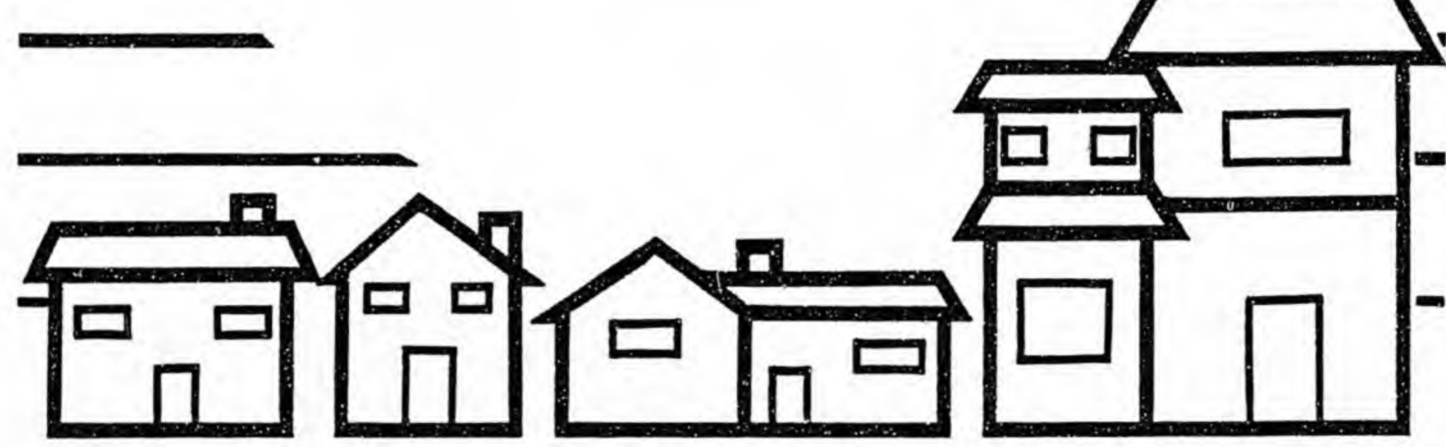
New Jersey

Community Care Program

for the

Elderly and Disabled

(CCPED)



LOOKING BACK
LOOKING AHEAD

The First Three Years of the

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED (CCPED)

(October 1, 1983 through September 30, 1986)

STATE OF NEW JERSEY
THOMAS H. KEAN, *Governor*

DEPARTMENT OF HUMAN SERVICES
DREW ALTMAN, *Commissioner*

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
THOMAS M. RUSSO, *Director*

ACKNOWLEDGEMENTS

We wish to thank the County Boards of Social Services/County Welfare Agencies, Medicaid District Offices, Case Management Sites, and providers for their dedication and commitment to serving elderly and disabled individuals under the Community Care Program for the Elderly and Disabled. This report could not have been produced without their input and assistance, and CCPED would not be an alternative to institutional care without their enthusiastic support of the program.

The report was prepared by staff from the Division of Medical Assistance and Health Services' Office of Home Care Programs, which provides centralized administration of CCPED. Carol H. Kurland is the administrator of this program.

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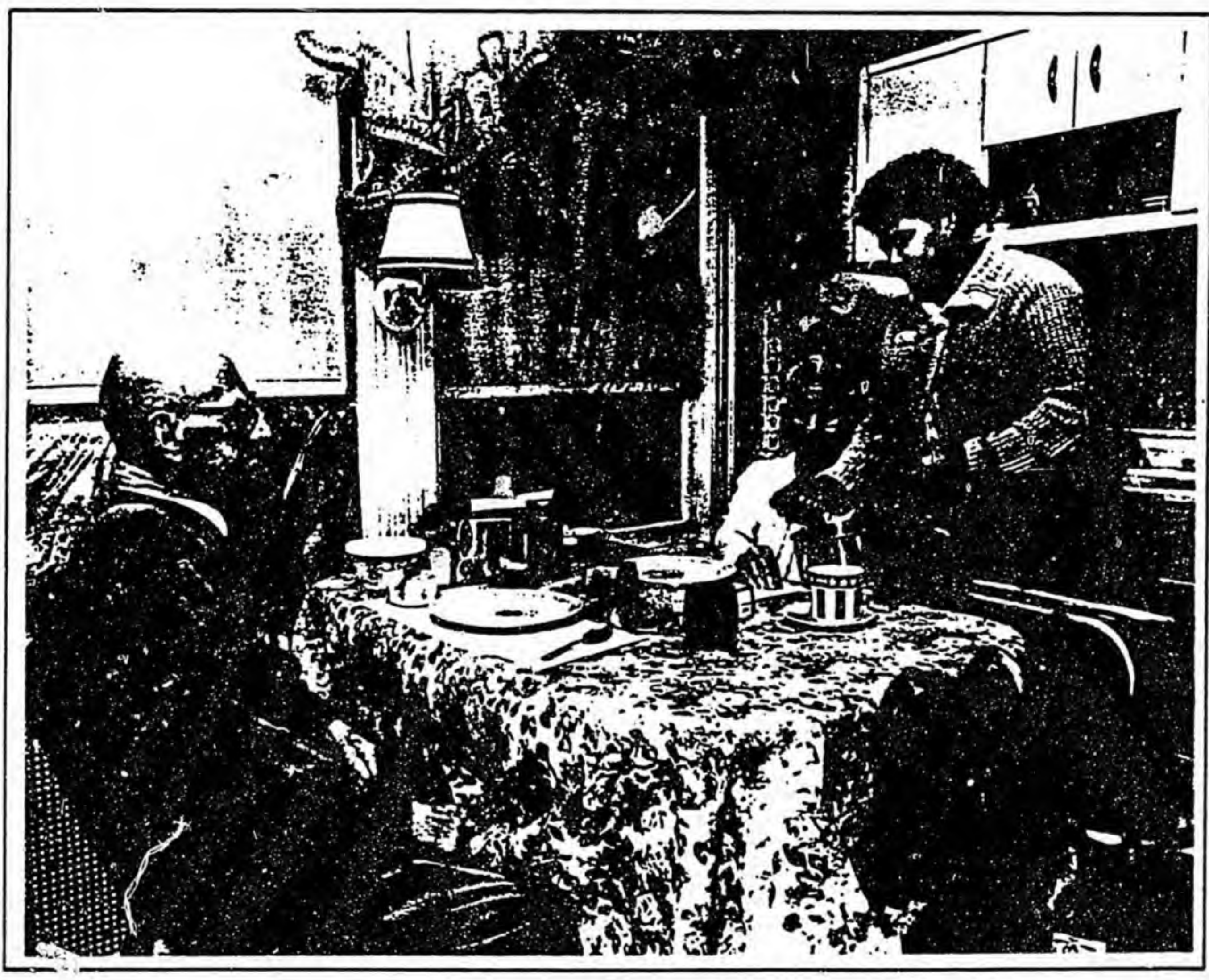
INTRODUCTION

The Community Care Program for the Elderly and Disabled (CCPED) is in its fifth year of operation. With the combined efforts of County Boards of Social Service/County Welfare Agencies, Medicaid District Offices, Case Management Sites, service providers, families, other support persons, and other committed individuals in government, CCPED has served more than 5,000 elderly and disabled individuals in New Jersey since October 1, 1983.

The intent of this report is to look back at the first three years of CCPED to see how the program has evolved, identifying its strengths and successes as well as areas that may require change or attention in the future. The report also contains statistical data concerning the population served. By reviewing the data collected and issues that have been raised by program participants, we can plan more effectively and responsibly for the future.



LOOKING BACK—
HISTORY AND EVOLUTION OF CCPED

Governor Kean in his SFY 1984 budget included a $10.5 million appropriation from the State's Casino Revenue Fund to finance two major initiatives in home and community-based long-term care:

- The Community Care Program for the Elderly and Disabled
- Medicaid's Personal Care Assistant Services Program

The funding of these two programs represented a major shift in State policy toward developing a more balanced long-term care system—one without the "institutional bias" which forced elderly and disabled into nursing homes, but rather one oriented toward helping families care for their kin. It was an effort on the part of New Jersey to provide a full continuum of care so that individuals could have access to services and settings more appropriate to their needs and circumstances, as well as more cost-effective for the State.

The Community Care Program for the Elderly and Disabled (CCPED) was created in New Jersey in response to the Omnibus Budget Reconciliation Act of 1981, Section 2176, Public Law 97-35, which encouraged the development of home and community-based services rather than institutional programs. The Sixth Omnibus Budget Reconciliation Act of 1985 provided the basis for program revisions.

CCPED was initially approved in June of 1983 for a three-year period by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) with an effective date of October 1, 1983. Jointly funded by Federal Title XIX monies and the State of New Jersey Casino Revenue Account funds, CCPED was phased in throughout the state over the three-year period. CCPED was designed to serve a maximum of 1,800 individuals at any one time at home by the end of the third year, offering a limited package of home and community-based services. These individuals otherwise would have been eligible to receive Medicaid services only in a nursing home setting.

Phase-In

The first phase of CCPED began in seven counties on October 1, 1983, with nine counties added on October 1, 1984, and the final five counties added on October 1, 1985 (See Chart 1). This phase-in of counties and population allowed time to implement the program effectively. Important aspects of the phase-in were: outreach to the communities; the training of staff involved in the enrollment process; recruiting, enrolling and training providers; training individuals who would provide comprehensive case management services to each client; and the development and implementation of a uniform assessment and service delivery system.

Services

Phase One of CCPED offered a package of eight services consisting of case management, home health services, medical day care, pharmaceuticals, non-emergency medical transportation, social adult day care, homemaker, and respite care to eligible individuals. These services were selected as most necessary to assist individuals remain home and to complement services available under Medicare. Phase Two, effective October 1, 1984, eliminated pharmaceuticals as part of the service package. Since most clients also met the eligibility requirements for New Jersey's Pharmaceutical Assistance for the Aged and Disabled (PAAD) Program, it had been administratively difficult to terminate their PAAD and offer pharmaceuticals under CCPED.

The client received a monthly Medicaid card from Blue Cross/Blue Shield Insurance Company attesting to CCPED eligibility. This card listed the seven CCPED services to which the client was entitled.

Cost-Effectiveness

In order to comply with Federal cost-effectiveness requirements which stated that the cost of home and community-based services could not exceed the cost of institutional care, a 70% of nursing home cost-cap was imposed on each individual's service package. This meant that the total amount of services paid for by Medicaid under CCPED could not exceed 70% of what Medicaid would have paid for that individual in a nursing home.

The removal of pharmaceuticals from the service package enabled CCPED clients to receive more home care services, such as homemaker and home health aide services, under this service cost-cap.

In 1986, New Jersey amended the CCPED program to allow 10% of the caseload to be served at 100% of nursing home costs, with 90% of the caseload remaining at the 70% cost-cap. This was done to accommodate sicker clients who needed more services to remain at home than could be provided within the 70% cost limit.

Initiated in the fourth waivered year, this change meant a change from a 70% service cap of $770.80 - $1,063.86 to a 100% service cap of $1,101.15 - $1,519.80 a month (the high and low figures representing the skilled and intermediate "B" nursing home levels of care).

Cost-Share Requirements

Federal regulations required that all recipients shared in the cost of the services received when their income exceeded maintenance needs. Medical expenses not subject to payment by a third party were considered deductibles from this cost-share. Maintenance needs were defined by the Federal government as the Social Security Income (SSI) standard. This amount changed from $333.47 a month in 1983 to $367.25 a month in 1986.

New Jersey felt that this regulation posed a hardship on many individuals who had much higher living costs, and served as a deterrent to apply for CCPED and needed services. New Jersey petitioned the Federal government to allow an additional $150 for maintenance needs but the request was denied. New Jersey then opted to use state funds to allow

up to an additional $75 per client for maintenance costs so that more individuals could choose CCPED as an alternative to nursing home care. With assistance from New Jersey Senator Bill Bradley through the mechanism of an amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985, states were allowed to raise the maintenance needs deductible. In 1986, New Jersey elected to add an additional $75 or a total of $150 to the SSI standard as the allowable maintenance deductible for the cost-share. This meant that clients could deduct up to $150 for maintenance, plus medical and remedial expenses from their income before paying the cost-share for CCPED.

Eligibility Requirements

The eligibility criteria for CCPED in 1983 were as follows:

- Individuals had to be 65 or over, *OR* determined disabled under the Social Security Act and receiving Social Security disability payments, *AND* be eligible for Medicare.
- Individuals had to meet Medicaid's skilled or intermediate nursing home level of care

requirements (even though the choice was home care).

- Individual incomes had to exceed the SSI community standard up to the institutional cap ($1,008 as of 1/1/86), or individuals had to be ineligible in the community because of SSI Deeming Rules. (This meant that individuals were determined financially eligible on the basis of their own income.) Parental and spousal income were not considered (deemed) in determining eligibility.
- Individual assets could not exceed the amount allowed to receive Medicaid services under the institutional program. Again, parental and spousal resources were not deemed in determining eligibility.
- Cost of services could not exceed an established amount which reflected 70% of nursing home costs to Medicaid.

In 1986, these criteria were modified as follows:

- Individuals not determined disabled by the Social Security Administration could be determined disabled by the Bureau of Medical Affairs, Division of Public Welfare, Department of Human Services.
- Individuals who were not eligible for Medicare but had other health insurance coverage, which included hospital and physician coverage, could qualify for CCPED.
- Services for 10% of the CCPED slots could cost up to 100% of Medicaid nursing home costs, rather than 70%. For example, an Intermediate Care Facility (ICF) Level A at 70% was $985.98 and at 100%, it was $1,408.55, allowing an additional $422.57 to be spent for service needs. This increase became effective in the beginning of the fourth year.

Expenditures Under CCPED

The cost-effective features of CCPED, namely, the use of case management as the pivotal service to orchestrate the service plan and the utilization of the 70% service cost cap for most recipients, has resulted in considerable savings to the State. As evidenced in Chart 15, the cost of providing services to CCPED recipients in the home was considerably less than if they had been institutionalized. Although the average costs increased each year of the program, at its highest level in Year Three, the cost of serving the CCPED recipient was only one-third of what it would have been in a nursing home, $3,889 as compared to $11,631. Chart 9 demonstrates that CCPED recipients are much the same as nursing home residents. Therefore, CCPED not only is appropriately targeting those who are at risk of institutionalization but is serving them at less cost.

Final Note

We are pleased to conclude this section with the information that CCPED has been renewed for an additional five years, to September 30, 1991. Upon our request, HCFA also approved an annual increase in community care slots for each new waivered year in order to meet the continuing demand for services. The allowable slots will reach 2,900 in 1991.

The following sections of this report discuss in more detail the application and enrollment process, demographic and fiscal data and observations and recommendations concerning CCPED.

APPLICATION AND ENROLLMENT

The overall administration of CCPED is carried out by the Department of Human Services. Division of Medical Assistance and Health Services, within the Office of Home Care Programs. The application and enrollment is performed locally by the County Board of Social Services/County Welfare Agency and the Medicaid District Office in the applicant's county of residence. This process, described in this section and summarized on Chart 2, has not changed since the program began in 1983.

Applicant

At the time of application, the individual may live at home in the community, alone or with others; in a hospital or nursing home; in a rooming or boarding home. The individual can be referred to the County Board of Social Services/County Welfare Agency by a variety of sources.

County Board of Social Services/County Welfare Agency (CBSS/CWA)

The individual makes formal application at the CBSS/CWA serving the county of residence. The CBSS/CWA explains CCPED to the applicant, and in accordance with existing policies and procedures, determines the applicant's financial eligibility. The information regarding income and resource is verified as well as other eligibility factors such as age, residence and citizenship. The CBSS/CWA also determines the applicant's maximum cost-share liability and ensures that disability has been determined if the applicant is under 65 years of age.

Medicaid District Office (MDO)

When the applicant has been determined financially eligible for CCPED, a referral is made to the MDO serving the county of residence. A Medicaid Regional Staff Nurse and Medical Social Care Specialist visit the applicant to assess the level of care required, evaluate the appropriateness of CCPED for the applicant and discuss the choices of care (home or institutional care).

The Nurse and Social Care Specialist then discuss the case with a Medicaid Physician Specialist. If the applicant has been determined to be medically in need of care and the cost of home care to be reimbursed by Medicaid is projected to not exceed the institutional service cost-cap established for the individual, the applicant is enrolled in CCPED and referred to the Case Management Site within the county.

Case Management Site (CMS)

Upon receipt of the referral, the case manager visits the client and, with input from the client, family member, attending physician, Medicaid staff, and service providers, prepares a service plan to meet the client's needs. The case manager then assists the client in securing services approved in the service plan. The client's needs and service program are continuously monitored by the case manager while the client remains in CCPED.

Delivery of Services

CCPED provides access to seven services: case management, home health, homemaker, medical day care, social adult day care, respite care, and non-emergency medical transportation.

A description of each service area, an analysis of service utilization, quality assurance, and other service issues follow.

Case Management

Each CCPED recipient receives case management services from a case manager based in a designated case management site approved by the Division of Medical Assistance and Health Services. Case management sites are located in home health agencies, county boards of social services/county welfare agencies, Medicaid District Offices, homemaker/home health aide agencies, and one area office on aging. The Department of Human Services emphasizes an interdisciplinary approach to case management so that the client's total needs can be evaluated and addressed. This means sites must employ case managers who are both nurses and social workers. In sites where a small number of cases only warrants one case

manager, either a nurse or a social worker can be employed.

Included in the responsibilities of the case manager are assessment of the client, preparation of a service plan (which includes formal and informal supports), cost-share determination, coordination of service delivery, monitoring of services, and assisting and advocating for the client and/or family as needed. Case managers have performed exceptionally well in meeting clients' needs in a cost-effective manner while ensuring that quality care is given.

This report concludes with segments of unsolicited letters sent to case managers by families of clients served under CCPED. These letters attest to the quality of case management provided under this program.

Home Health Services

Home Health services include skilled nursing, homemaker/home health aides, physical and occupational therapies, speech-language pathology, medical social work services and certain medical supplies.

Licensed certified home health agencies under contract to the Division of Medical Assistance and Health Services provide these services. These agencies have provided excellent home care to clients and have been an invaluable part of the CCPED service package.

Prospective reimbursement of home health services established for the program remains a major problem in CCPED. Fees are based upon audited data secured from Medicare cost reports, since New Jersey Medicaid piggybacks Medicare principles of reimbursement. Agencies are particularly concerned that the visit rate paid under Medicare does not accommodate the chronic care required by CCPED clients. To remedy this problem, an hourly fee for home health aide services was suggested by the industry and implemented upon the choice of the agency in November 1987.

Another growing problem is the insufficient number of certified homemaker/home health aides, particularly in some geographical areas, to meet the demands for home care. Inadequate transportation systems compound the problem and in some instances aides are unable to get to a client's home to provide the services.

The New Jersey Department of Human Services and Department of Health have formed an interdepartmental task force to discuss issues related to the homemaker/home health aide shortage. A report will be presented to both Commissioners, perhaps forming the basis for increase in the availability of staff in the home care arena. It is felt that the demand for services under CCPED has provided a mechanism for identifying this developing need in New Jersey.

Homemaker Service

Homemaker Service has been the backbone of CCPED and has grown from 43% of total service payments in the first year of CCPED to 62% of total payments in the third year. Homemaker service provides both basic personal care such as bathing, grooming and dressing, and household tasks such as light housekeeping, meal preparation and shopping. The reimbursement rate, generally lower than for home health aide service, makes this the most sought after service in CCPED. However, agencies continually feel that Medicaid is not meeting true service costs and annually request fee increases.

A new group of agencies was enlisted to become approved Medicaid providers of this service area. About 57 proprietary and 18 non-profit agencies have been enrolled since

1983. Required to meet Division standards, they also were trained in the billing process and, in turn, developed a new set of relationships with MDOs and case managers.

Due to the growing number of agencies and a need to assure continuing quality of care, accreditation by the industry was supported by the Division as a requirement for Medicaid participation of these agencies. All agencies providing homemaker service are now required to become accredited by the National HomeCaring Council (of the Foundation of Hospice and Home Care) or the Commission on Accreditation for Home Care, based in New Jersey, by January 1, 1988 for proprietary agencies and June 30, 1988 for non-profit agencies. The shortage of paraprofessionals is particularly significant with these agencies since homemaker service is their primary agency service.

Medical Day Care

Medical Day Care offers a variety of health, social and supportive services in forty-nine Medicaid approved centers located in nursing homes, freestanding settings, or affiliated with hospitals. Although only 4% of CCPED payments were made for medical day care, the comprehensive package of services is beneficial to clients able to leave their own home for one to five days a week. An average medical day care per diem is considerably less than other home care services purchased separately for the same time frame. Medical Day Care offers not only medical and nursing supervision for the very frail or disabled person, but it also provides needed socialization and peer contacts.

Social Adult Day Care

Social Adult Day Care emphasizes social and recreational activities in a group setting, with some health monitoring. Clients attending social day care do not usually need medical attention during the day but may need close general supervision to prevent such behaviors as wandering. Less than 1% of the total expenditures are for this service. All social day care centers must be publicly funded and monitored to participate in CCPED. They also require a Medicaid provider agreement.

Respite Care

Respite Care is a temporary service offered on an as needed basis to relieve families caring for individuals at home. It can be provided at home by a homemaker/home health aide, employed by approved agencies or in nursing homes by facilities which have a Medicaid provider agreement. The reimbursement of respite care in a nursing home equals either the facility's skilled or intermediate care rate.

There is a need for more nursing homes to provide respite care. The service has been limited because facilities cannot predict when a bed will become available for respite care. Therefore, families who need to be away at a specific time usually cannot be guaranteed the availability of a bed when needed.

Respite care in the home by a homemaker/home health aide is not always feasible due to the shortage of aides willing to work weekends or evenings.

Medical Transportation

Medical Transportation is non-emergency transporting of clients by a suitable vehicle to obtain health services. This service is provided by traditional Medicaid approved medical transportation providers, using, for example, invalid coaches, or by vehicles provided through the county welfare agencies Medicaid-funded transportation programs.

LETTERS OF SUPPORT

We have received numerous unsolicited letters from families of clients sent to case management sites and to the Division of Medical Assistance and Health Services (DMAHS). The following are excerpts from these letters.

TO: *Bergen County Board of Social Services, October 20, 1986.*

TO WHOM IT MAY CONCERN:

"My mother was a recipient of the CCPED Program for almost three years. She passed away on August 22, 1986, but she died in her own home, which is what she wanted. She was 87 years old and was terrified (as I think most older people are) of not being able to take care of herself and having to go to a nursing home. Your Program enabled her to stay in her own home and her own surroundings, and for that I am very, very grateful."

TO: *Passaic County Board of Social Services, November 13, 1986.*

"I want to re-emphasize what I expressed to you in our recent telephone conversation concerning my very deep appreciation for your many kindnesses.

There is little question in my mind that you went out of your way to be helpful to my mother and my sister, in assisting them in their needs. In a day and age when the general public is oftentimes critical of those who serve in the public sector, I can attest to the fact that you personify, in the highest sense,

a dedicated public servant who has a deep concern for the public citizen."

TO: *MCOSS Nursing, Inc., January 30, 1987.*

"On behalf of my mother and myself, we would like to express our appreciation and gratitude regarding the CCPED program, and to you, in particular, for your continued guidance and help.

As you well know, this program has enabled my elderly mother to remain at home, in familiar and comfortable surroundings and still receive the care and attention so vital to someone of ninety-one.

The case management has been thoroughly professional, whether it be on a medical, financial or emotional level.

You have always been there "in the wings" ready to help . . . thank you for the program . . . and thank you for being part of it."

TO: *Division of Medical Assistance & Health Services, Office of Home Care Programs, November 25, 1986.*

"My father-in-law became an active participant in the Community Care Program for the Elderly and Disabled on November 19, 1986. I would like to express our appreciation for his acceptance into the program.

I was very impressed by, and wish to acknowledge with deep appreciation, the very courteous and efficient manner in which we were interviewed by your staff. Each one was friendly, warm and interested.

Thank you not only for your assistance but also for this very positive experience in human services."

TO: *The Administrator of the DMAHS, Office of Home Care Programs from a Regional Staff Nurse employed in a Medicaid District Office.*

"Since I have started doing reassessments on my assigned CCPED cases, I have found the clients to be happy and improved physically and mentally.

It was heartwarming to me, particularly when I saw a recipient yesterday that I had not seen in a year. She looked so much better and was friendly and chatty. Last year, when I saw her, I doubted that she would be able to be kept at home.

This proved to me that this program really works. The family is pleased with the services and only ask that they stay the same.

Three cheers for CCPED!"

POPULATION SERVED

The following is an analysis of data compiled on population served during the first three years of CCPED, representing 4,075 recipients.

Sex

Of the 4,075 clients served, 76% were females; 24% were males (Chart 3).

Age

The numbers of individuals served over age 65 increased from 80% to 87% from 1983 to 1985, with the preponderance of the recipients in the 75-84 age group. It is interesting to note that a sizeable group, an average of 27%, were over the age of 85 in 1985. (Chart 4).

All three years of the program reflected a similar age picture. It is felt that CCPED's limited service package discouraged the younger disabled who need more extensive service coverage and were better accommodated under Medicaid's Home and Community-based Services Waivers for Blind or Disabled Children and Adults, known as Medicaid's Model Waivers.

Race

Race variations as illustrated in Chart 5 appeared to be unusual to staff, until they were compared to the population in New Jersey nursing homes. Seventy-nine percent of individuals served under CCPED were white, with 17% black recipients, and 2% Hispanic re-

cipients in 1985. Medicaid residents in nursing homes in 1986 were 84% white, 10% black and 1% Hispanic, revealing that the racial variation of the population enrolled in both programs was similar.

Living Arrangements

Other characteristics of CCPED recipients were examined. Chart 6 shows the living arrangement of enrollees. The largest number, 39.4%, resided with adult children, 30.3% lived alone, 23.2% lived with a spouse and 7.1% had other arrangements, such as living with a sibling, friend, or other relative. Since the support network is so important in this program, the availability of an adult child or spouse provided the needed support for the limited service received under CCPED. The fact that about 1/3 of the recipients lived alone, although difficult to accept by concerned professionals, attests to the strength of the freedom of choice given to all individuals electing this program. Many persons refused to enter nursing homes, despite the unavailability of family and the limitation of services. However, a number of these "loners" did have friends or children who lived nearby and looked in on the recipient on a regular basis.

Income Level and Cost Share

Income levels of CCPED clients as seen in Chart 7 were restricted by the eligibility requirements of the program. Whereas most (45%) had incomes from $368 to $521 a month, a considerable number (26%) had higher incomes, from $522 to $899 a month and lower incomes (27%) under $367 a month (yet were ineligible for regular Medicaid because of spousal or parental incomes). Few had incomes which exceeded $900 a month, although the maximum income eligibility was $1,008 a month. The primary reason for this can be attributed to the cost-share liability requirement. All recipients were required in accordance with Federal regulation to share in the cost of care. The cost-share was determined by deducting a standard maintenance allowance plus medical and remedial expenses from the client's gross income. Those clients with high incomes had a high cost-share, thereby discouraging participation in the program. Those individuals would purchase services directly rather than through CCPED.

Diagnosis

Primary diagnoses of CCPED recipients are illustrated in Chart 8. The most common physical problem was a circulatory disorder, found in 49% of the population served. Remaining disorders, occurring at equal distribution, were difficulties with nervous system, respiration, metabolism, musculoskeletal problems, cancer and mental disorders. All disorders appeared to not only be reflective of the elderly population in the program, but descriptive of a similar population residing in long-term care facilities. Therefore, this information appeared to confirm the appropriate targeting of the population.

Level of Care

Federal regulations require that clients served under CCPED must require a level of care provided in a nursing home, although they may choose to remain home with services. (See Attachment A for a description of the three levels of nursing home care.) Chart 9 clearly demonstrates that CCPED is attracting the appropriate population. The level of care of individuals served under CCPED over the three years compares favorably to the

Medicaid population served in New Jersey nursing homes. Note that in Year One, 16% of CCPED clients were assessed Skilled Nursing Facility (SNF) Level compared to 8% of patients assessed SNF in nursing homes; 59% of CCPED clients were assessed Intermediate Care Facility (ICF) A level compared to 69% ICFA patients in nursing homes, and 25% CCPED clients were at Intermediate Care Facility (ICF) B level compared to 23% ICFB patients in nursing homes. All three years indicated there was great similarity between the levels of care required by CCPED recipients to those in nursing homes. Since the same level of care criteria was utilized by Medicaid Medical Evaluation Teams to determine medical eligibility for CCPED and for nursing home placement, it is concluded that CCPED has indeed appropriately targeted individuals who without home and community-based care would have been candidates for nursing home admission.

As an added note, it appeared that the individuals served in CCPED could in some instances have been sicker than those served in nursing homes, since the SNF percentages are considerably higher in the CCPED population.

Termination

Chart 10 delineates the principal reasons for termination from CCPED. With the majority of clients in the age group of 75-84, having numerous chronic illnesses and matching patients who are institutionalized, it is understandable that termination from CCPED results from death or admission to a nursing home.

Length of Stay on Program

Chart 11 illustrates the length of time clients remained on CCPED. Although considered a long term care services program, it is interesting to note that 59.8% were served in CCPED under six months. Very few, 17.1%, remained on CCPED over a year. The frailty of the population served attributed to a shortening of program involvement.

Payment of Services

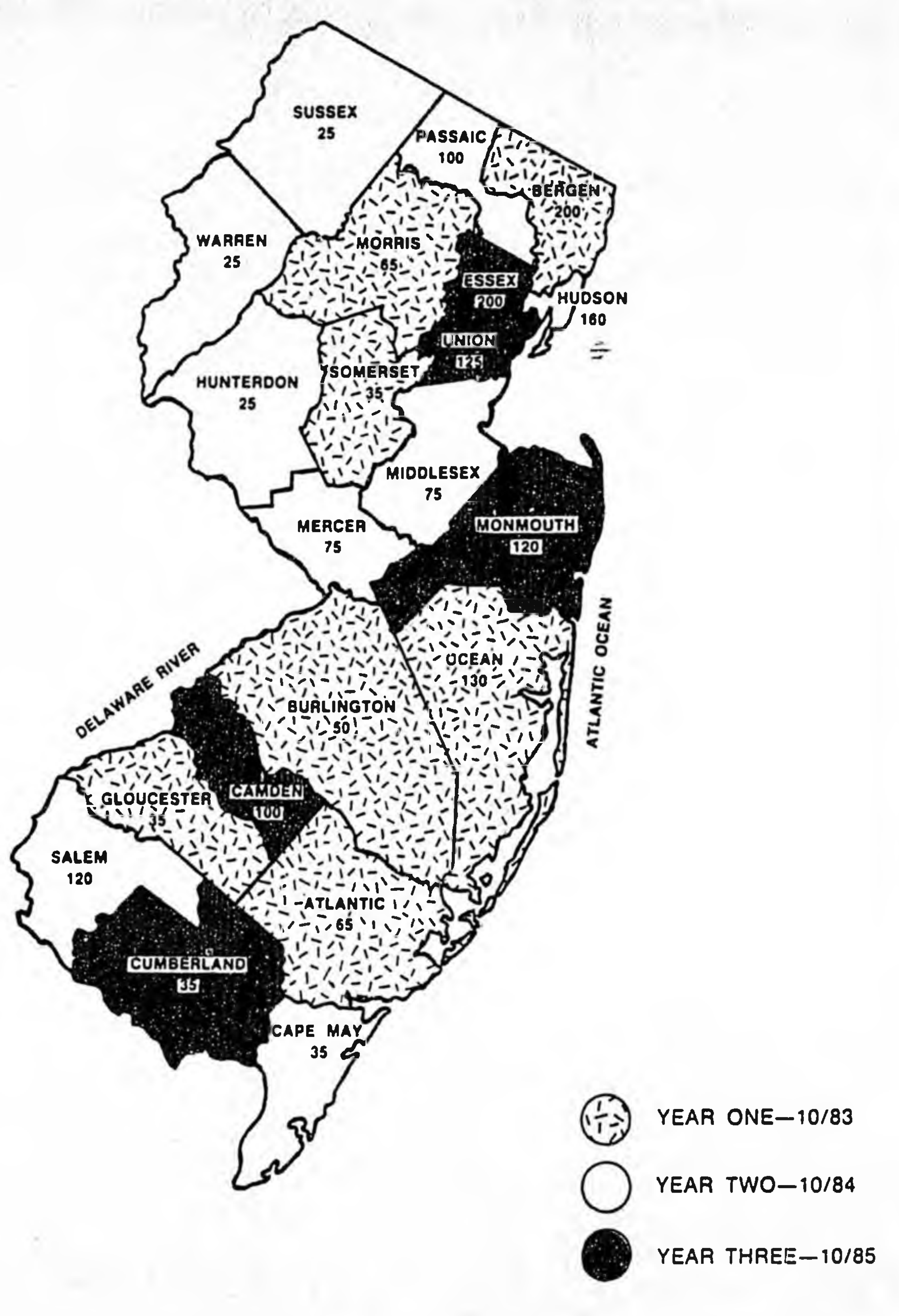
Charts 12-14 demonstrate the change in payments made for services over the three years. There was a noticeable growth in funds expended for homemaker services. All other service expenditures remained about the same. Total payments grew from almost $700,000 in Year One to more than $8.5 million in Year Three as the program became better known and served a larger population statewide.

Chart 15

Chart 15 compares expenditures under CCPED to nursing home expenditures. Although the average costs per CCPED recipient increased each year of the program, at its highest cost in Year three, it was still only one-third of nursing home costs.

CHART 1

THREE YEARS OF CCPED PHASING IN THE COUNTIES



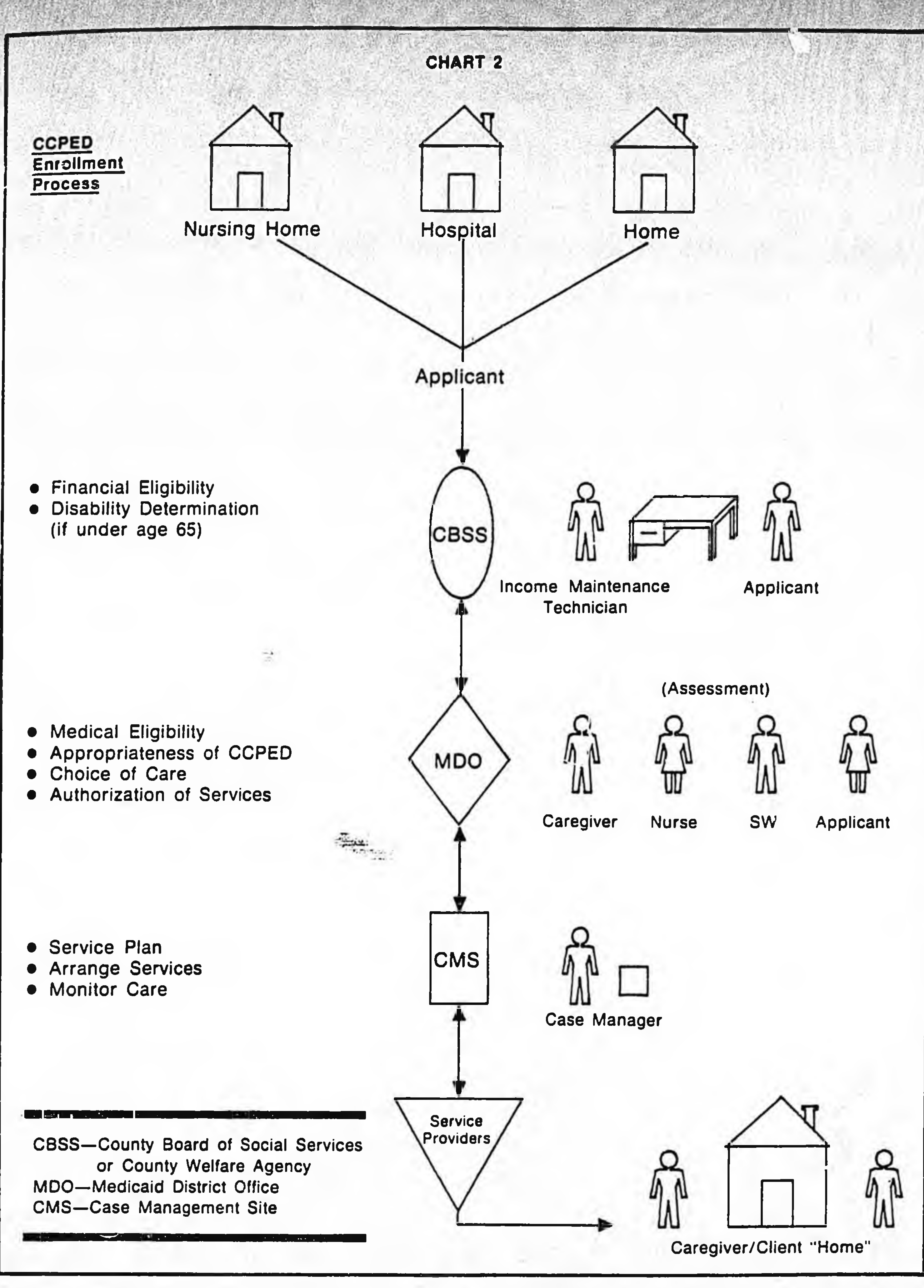


CHART 2
CCPED
Enrollment
Process
Nursing Home
Hospital
Home
Applicant
• Financial Eligibility
• Disability Determination
(if under age 65)
CBSS
Income Maintenance
Technician
Applicant
(Assessment)
• Medical Eligibility
• Appropriateness of CCPED
• Choice of Care
• Authorization of Services
MDO
Caregiver
Nurse
SW
Applicant
• Service Plan
• Arrange Services
• Monitor Care
CMS
Case Manager
Service
Providers
CBSS—County Board of Social Services
or County Welfare Agency
MDO—Medicaid District Office
CMS—Case Management Site
Caregiver/Client "Home"

CHART 3

PERCENTAGE MALE/FEMALE CLIENTS

LEGEND

MALE 24%

FEMALE 76%

4,075 CLIENTS SERVED

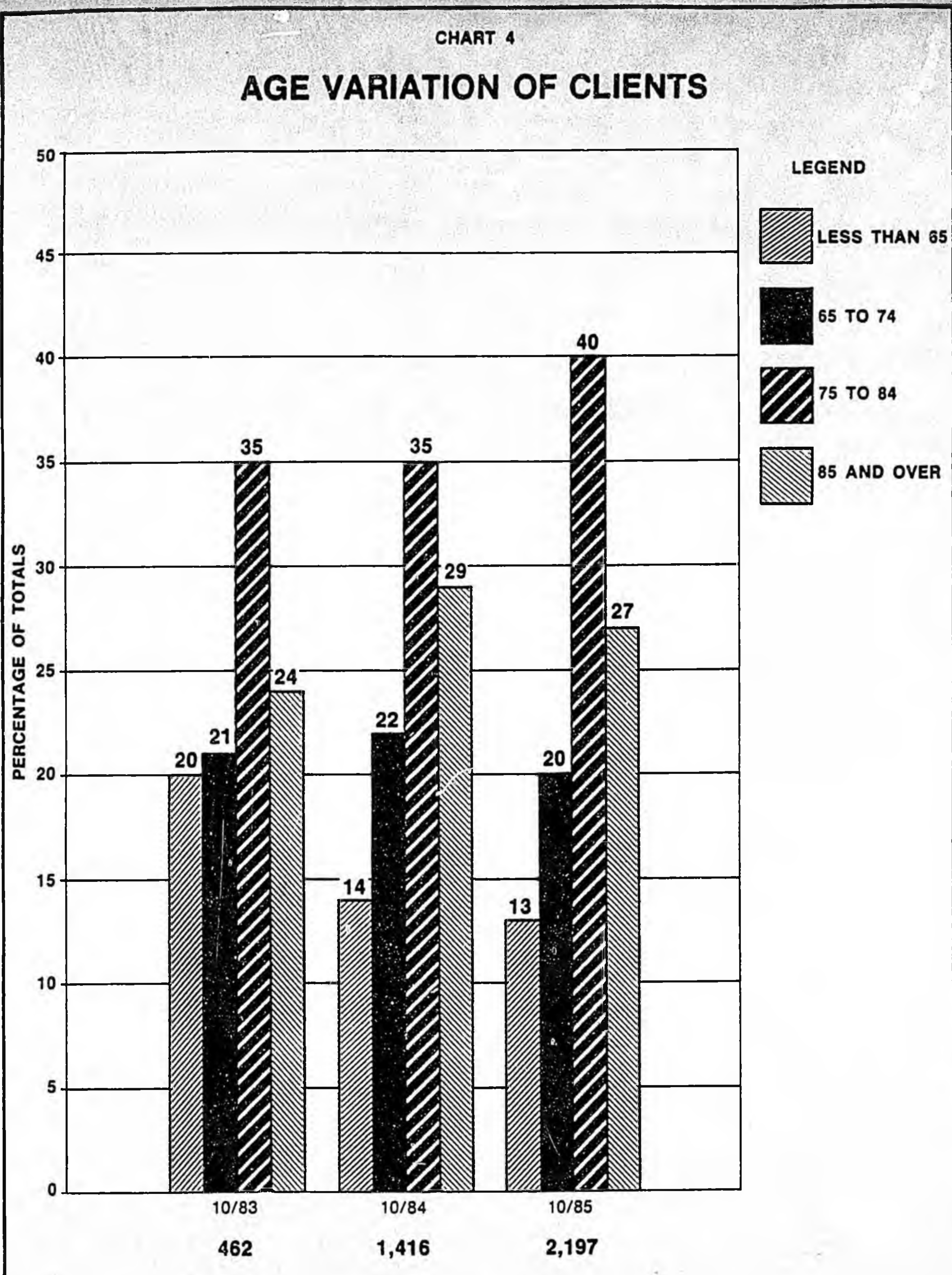


CHART 4
AGE VARIATION OF CLIENTS
PERCENTAGE OF TOTALS
50
45
40
35
30
25
20
15
10
5
0
LEGEND
LESS THAN 65
65 TO 74
75 TO 84
85 AND OVER
20
21
35
24
14
22
35
29
13
20
40
27
10/83
10/84
10/85
462
1,416
2,197

CHART 5

RACE VARIATION OF CLIENTS

PERCENTAGE OF TOTAL

	10/83	10/84	10/85
Total	462	1,416	2,197
WHITE	84	84	79
BLACK	11	13	17
HISPANIC	2	2	2
OTHER	3	1	1

CHART 6

LIVING ARRANGEMENT OF CLIENTS

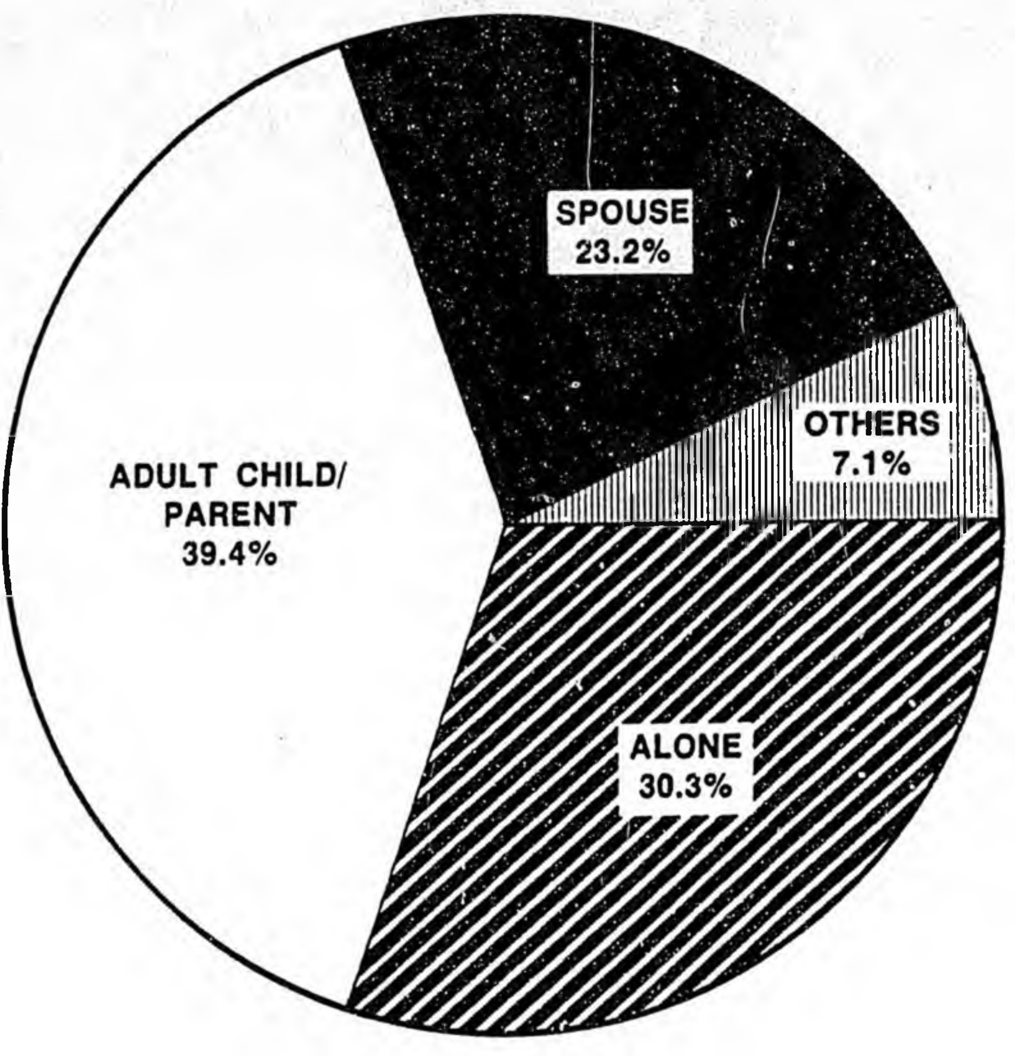


CHART 7

MONTHLY INCOME OF CLIENTS

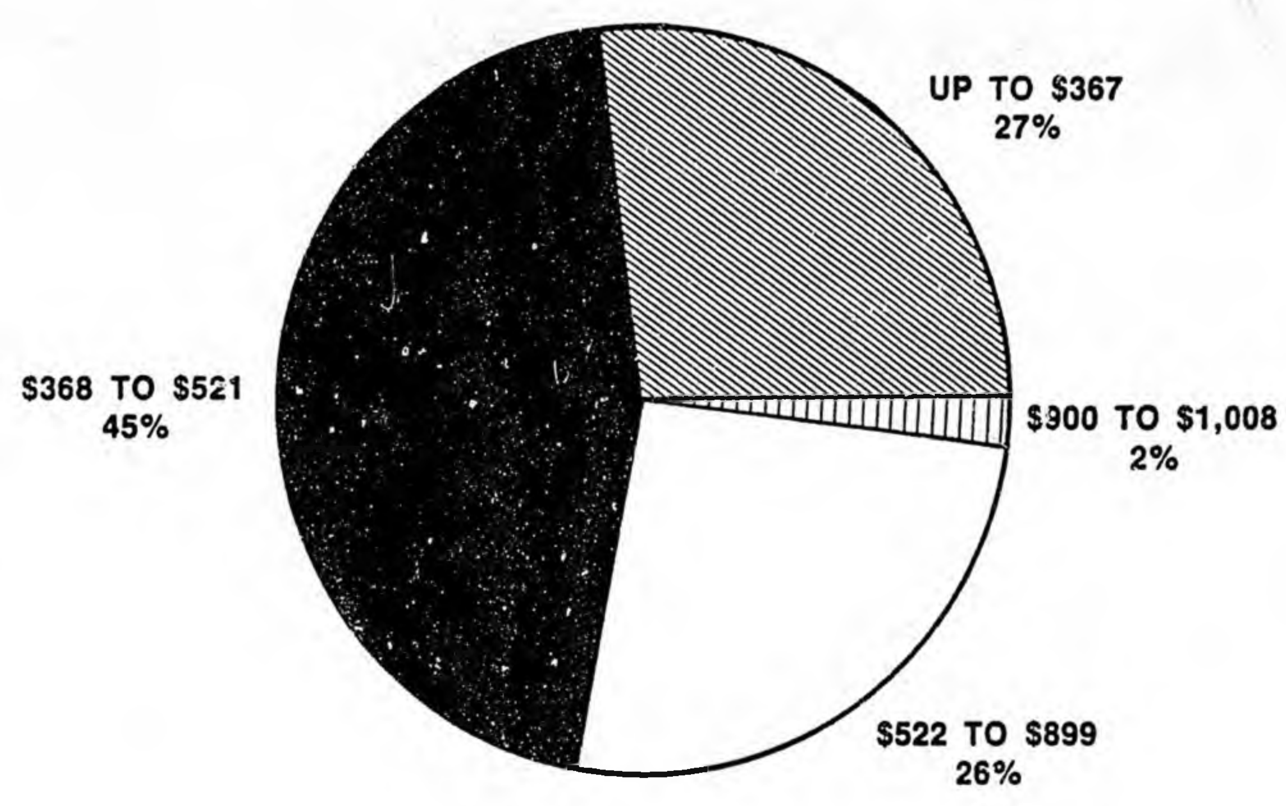
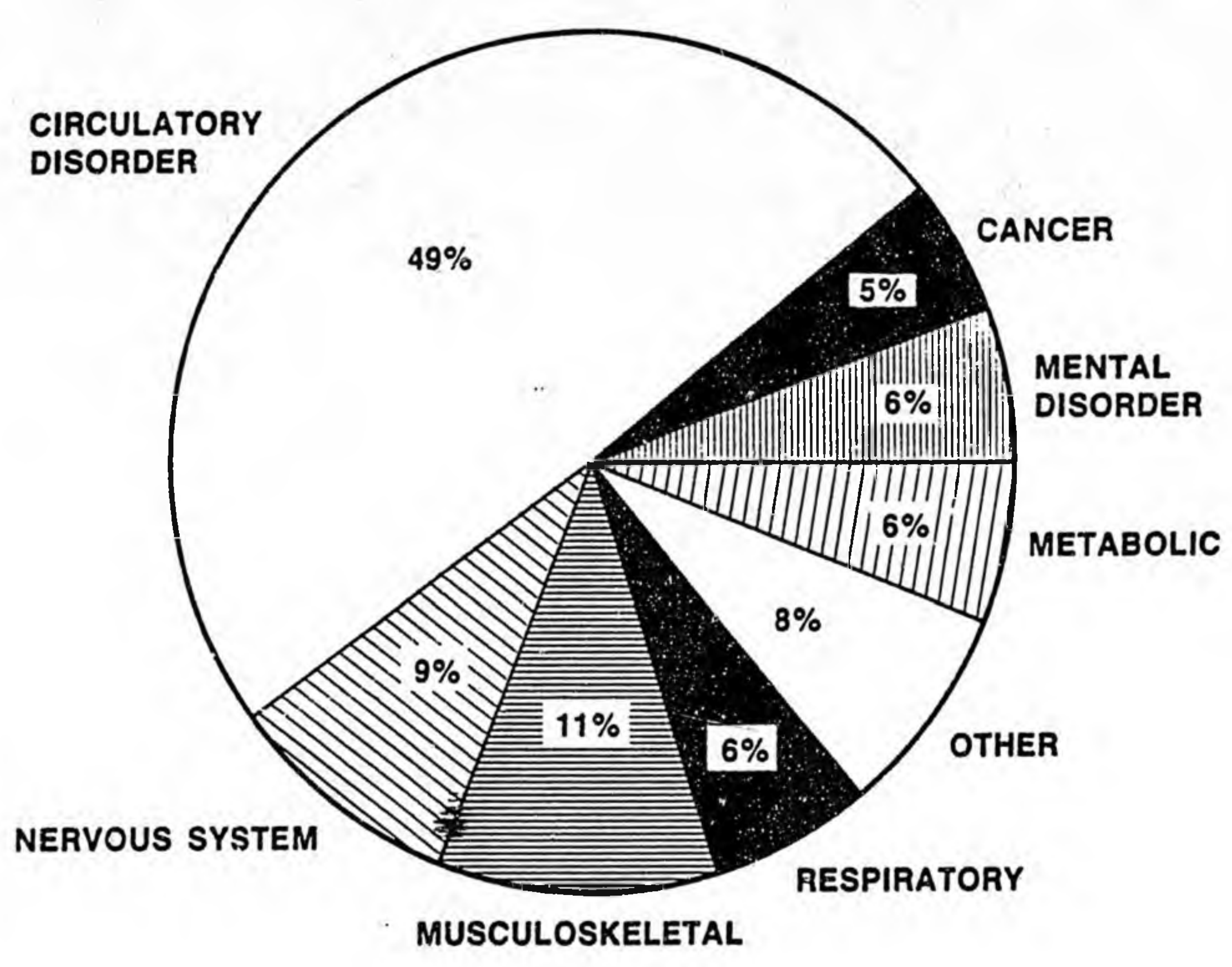


CHART 8

PRIMARY DIAGNOSIS OF CLIENTS



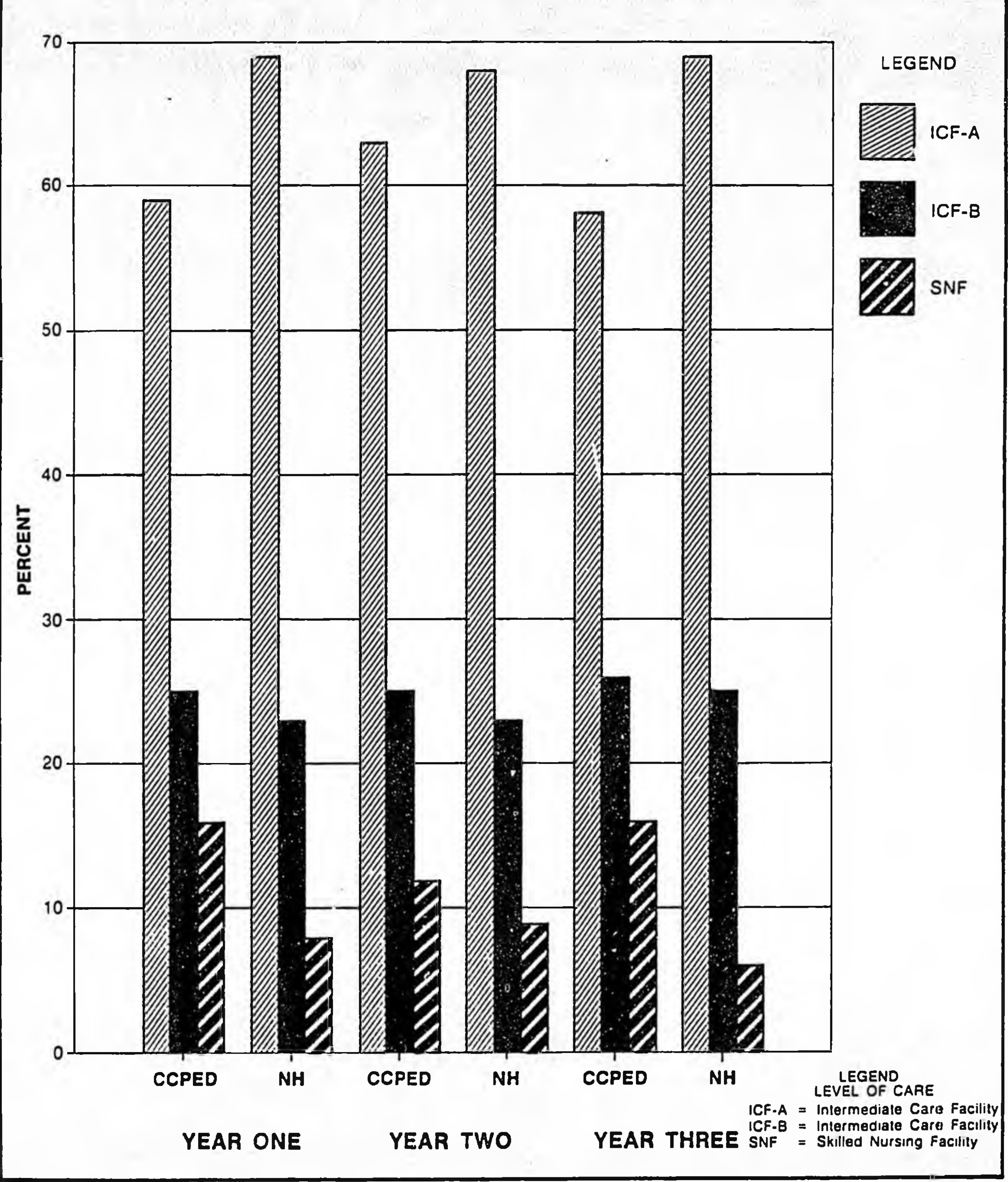


CHART 9
LEVEL OF CARE
CCPED COMPARED TO NURSING HOME (NH)
70
60
50
40
30
20
10
0
PERCENT
LEGEND
ICF-A
ICF-B
SNF
CCPED
NH
CCPED
NH
CCPED
NH
YEAR ONE
YEAR TWO
YEAR THREE
LEGEND
LEVEL OF CARE
ICF-A = Intermediate Care Facility
ICF-B = Intermediate Care Facility
SNF = Skilled Nursing Facility

CHART 10

REASONS FOR TERMINATION

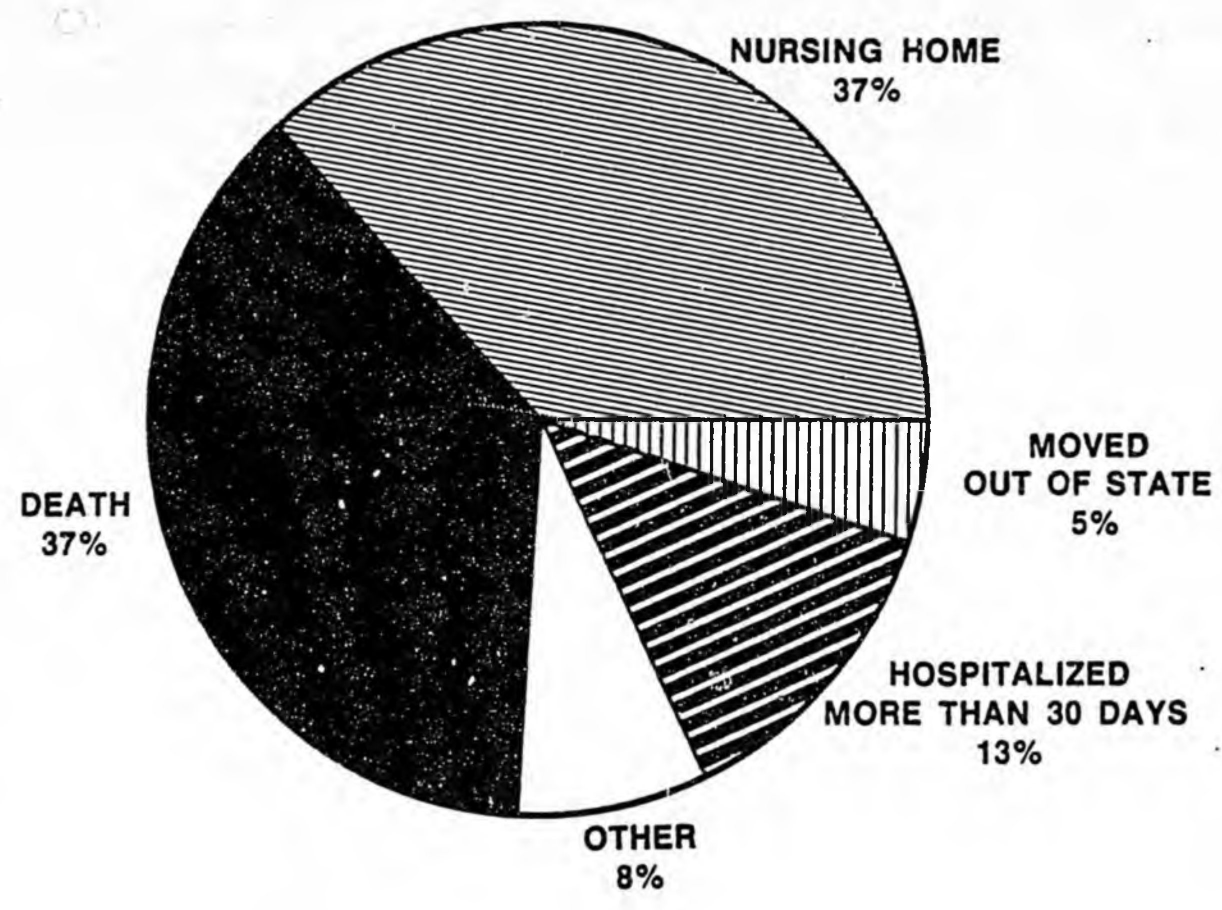


CHART 11

LENGTH OF STAY IN PROGRAM

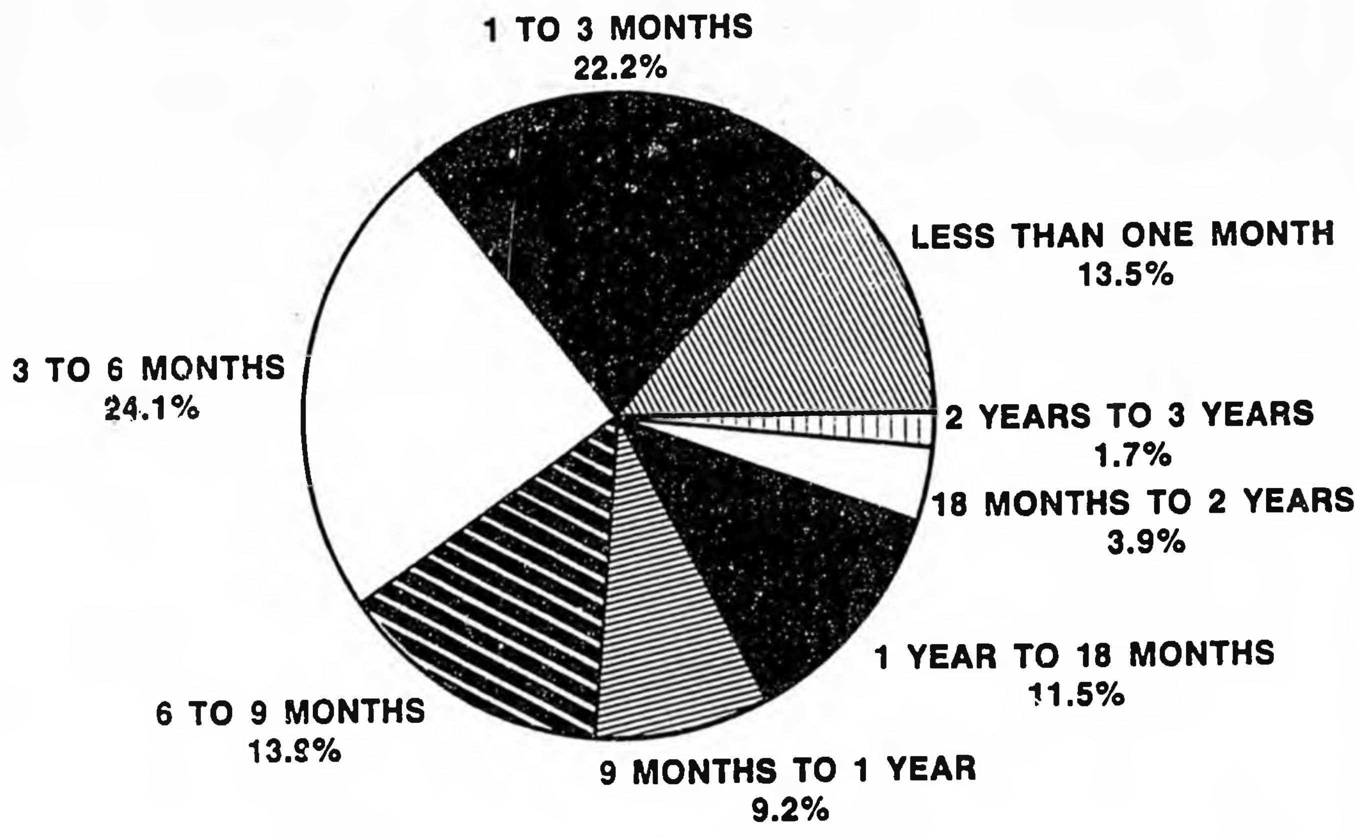
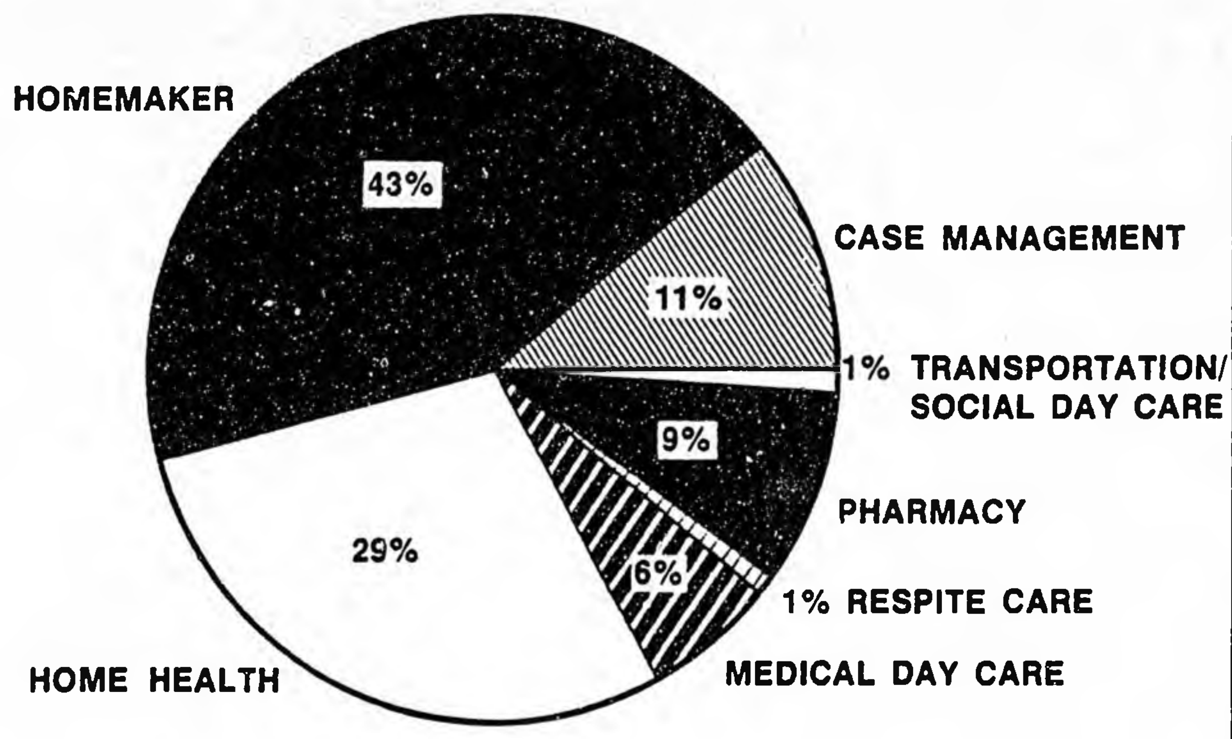


CHART 12

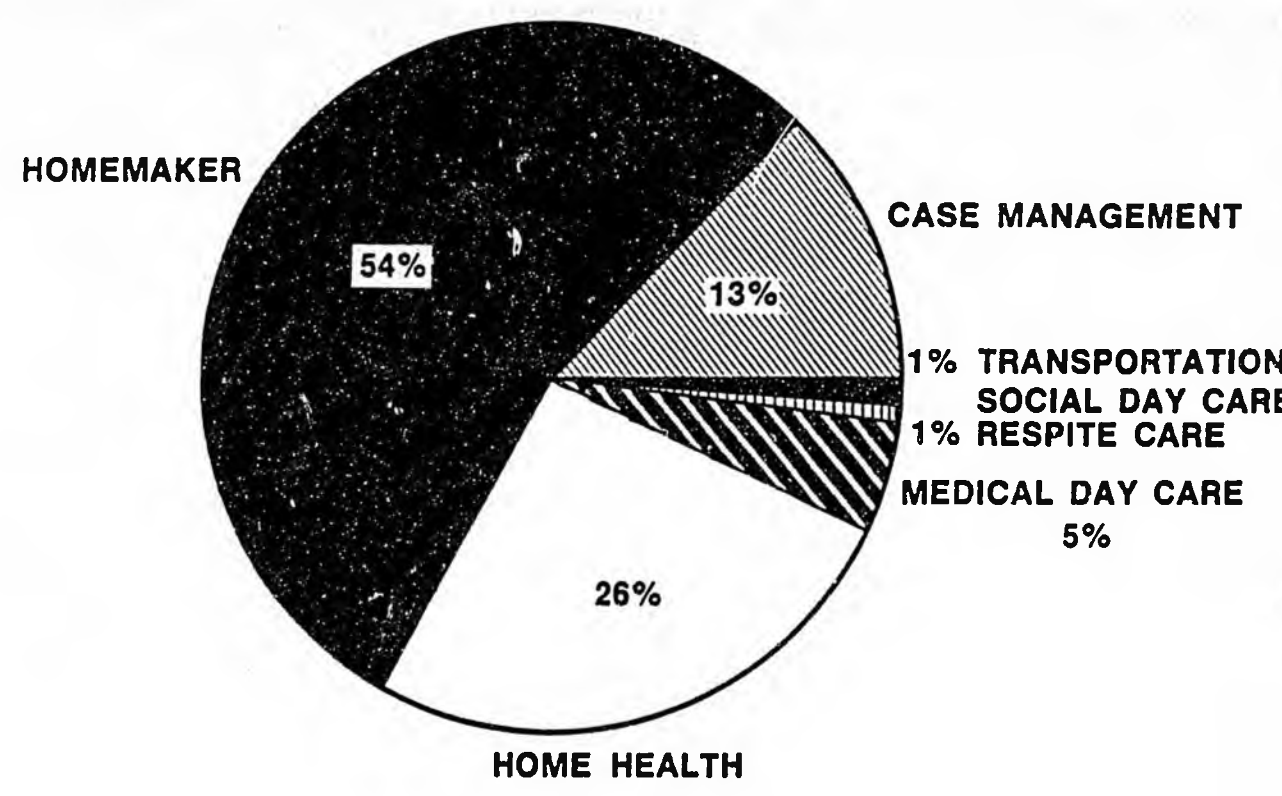
TOTAL AMOUNT PAID FOR SERVICES
YEAR ONE
$690,197.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 13

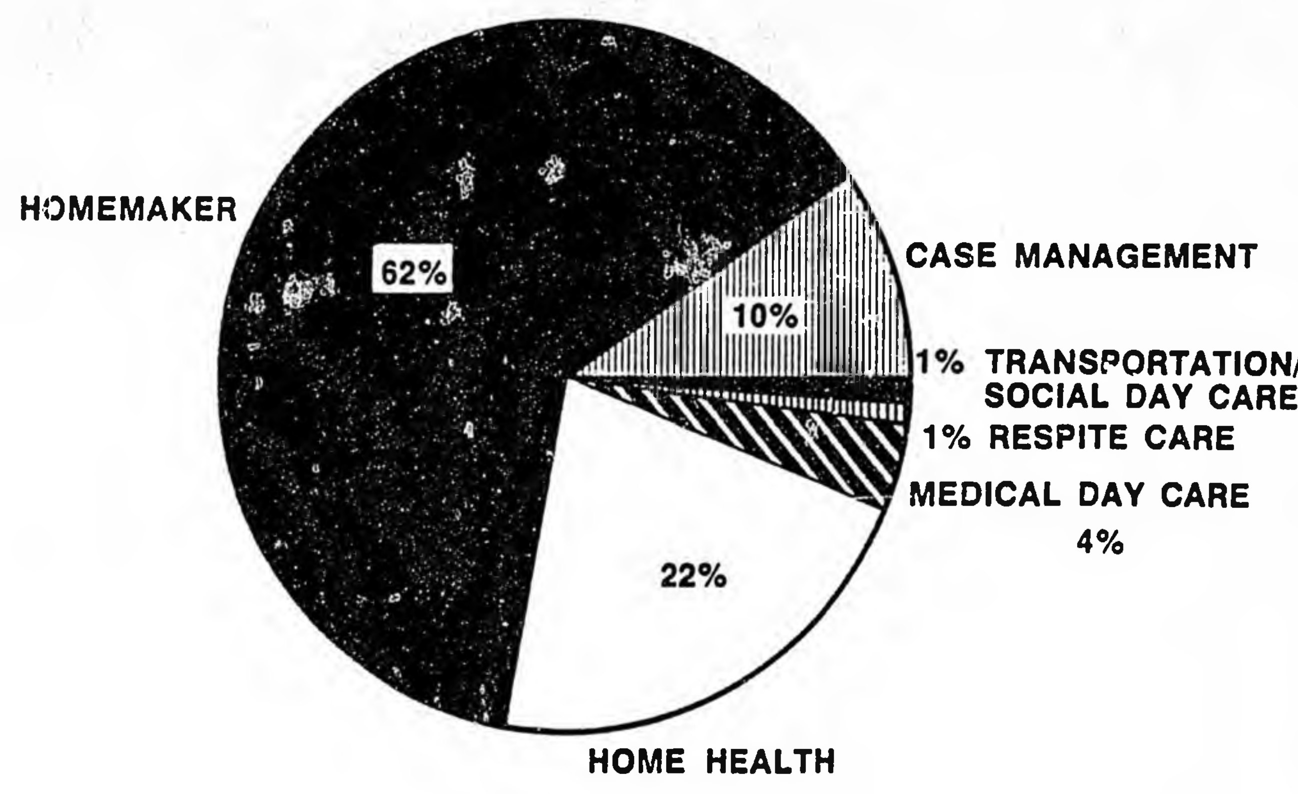
TOTAL AMOUNT PAID FOR SERVICES YEAR TWO $4,060,389.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 14

TOTAL AMOUNT PAID FOR SERVICES
YEAR THREE
$8,544,333.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 15

*EXPENDITURES AND AVERAGE PER CAPITA COSTS CCPED vs. NURSING HOME

YEAR ONE—10/83 THROUGH 09/84

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 690,197.00	462	$ 1,478.00
NURSING HOME	$332,063,329.00	29,157	$11,389.00

YEAR TWO—10/84 THROUGH 09/85

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 4,060,389.00	1,416	$ 2,868.00
NURSING HOME	$363,338,654.00	30,521	$11,905.00

YEAR THREE—10/85 THROUGH 09/86

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 8,544,333.00	2,197	$ 3,889.00
NURSING HOME	$375,460,917.00	32,281	$11,631.00

*SOURCE: EXTRACTED FROM ANNUAL FEDERAL REPORTS

NURSING HOME LEVEL OF CARE CRITERIA

The following definitions were taken from the Long Term Care Services Manual, N.J.A.C. Title 10, Chapter 63, Subchapter 1, 9/79:

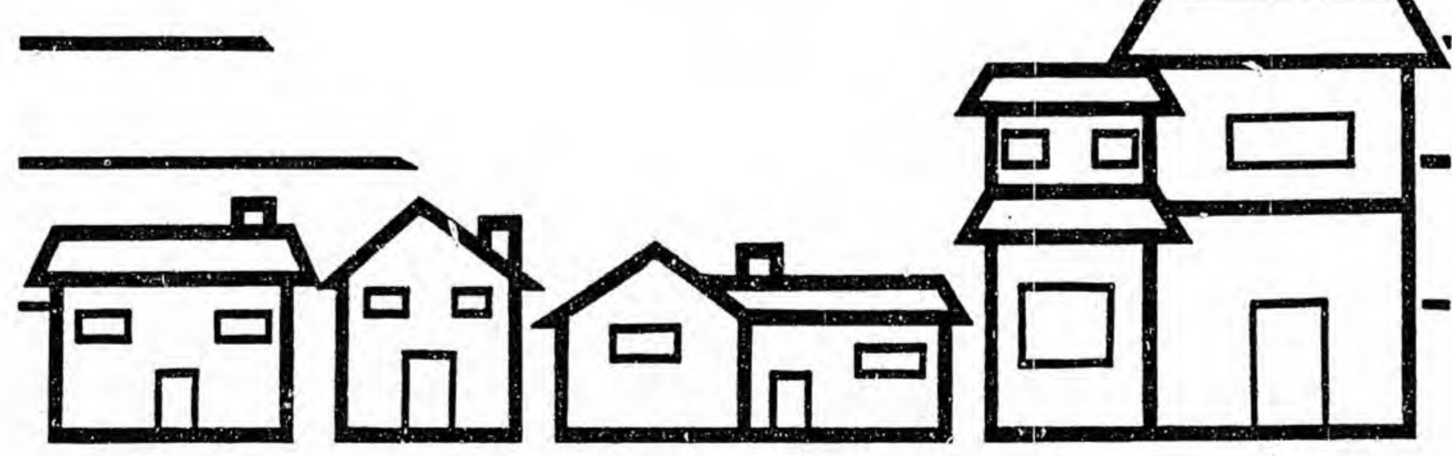
"Level III, skilled nursing patient" means a person with acute or subacute medical and/or mental dysfunction requiring skilled nursing, psycho-social and restorative care during a 24-hour period. The Level III patient requires continuous 24-hour availability of nursing personnel at the licensed nurse level under the general direction of a registered professional nurse and will require other skilled services on an intensive basis including rehabilitation. The dysfunction may involve one or several physiological systems, may be stabilized or not, with symptoms subsiding or increasing. The patient may be bed-fast, chair-fast, semi-ambulant or ambulant (with or without assistive devices). Determination of this level of care requires an identification of skills required and evidence that as a practical matter such care can only be provided in a Long Term Care Facility setting.

"Level IV-A, intermediate care patient" means a person with physical and/or mental and/or social dysfunction requiring on a daily basis substantial assistance with personal care needs involving activities of daily living. Nursing care at Level IV-A must be provided 24 hours a day by licensed and nonlicensed personnel under the general direction of a registered professional nurse. These patients require continued restorative and psycho-social services which as a practical matter can only be provided in a Long Term Care Facility setting.

"Level IV-B, intermediate care patient" means an ambulant or semi-ambulant person with physical and/or mental dysfunction requiring minimal assistance with personal care needs on a daily basis. The Level IV-B patient requires continuous onsite availability of licensed and nonlicensed personnel for each 24-hour period under the general direction of a licensed practical nurse. The patients at this level of care will require continuing restorative, preventive and maintenance care which as a practical matter can only be provided in a Long Term Care Facility setting. The Level IV-B patient is usually fairly self-sufficient in activities of daily living with or without self-help devices and his/her needs usually have greater social than medical significance.

(Rev. 3/88)

The First Three Years of the New Jersey Community Care Program for the Elderly and Disabled (CCPED)



LOOKING BACK
LOOKING AHEAD

The First Three Years of the

COMMUNITY CARE PROGRAM FOR THE ELDERLY AND DISABLED (CCPED)

(October 1, 1983 through September 30, 1986)

STATE OF NEW JERSEY
THOMAS H. KEAN, *Governor*

DEPARTMENT OF HUMAN SERVICES
DREW ALTMAN, *Commissioner*

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
THOMAS M. RUSSO, *Director*

ACKNOWLEDGEMENTS

We wish to thank the County Boards of Social Services/County Welfare Agencies, Medicaid District Offices, Case Management Sites, and providers for their dedication and commitment to serving elderly and disabled individuals under the Community Care Program for the Elderly and Disabled. This report could not have been produced without their input and assistance, and CCPED would not be an alternative to institutional care without their enthusiastic support of the program.

The report was prepared by staff from the Division of Medical Assistance and Health Services' Office of Home Care Programs, which provides centralized administration of CCPED. Carol H. Kurland is the administrator of this program.

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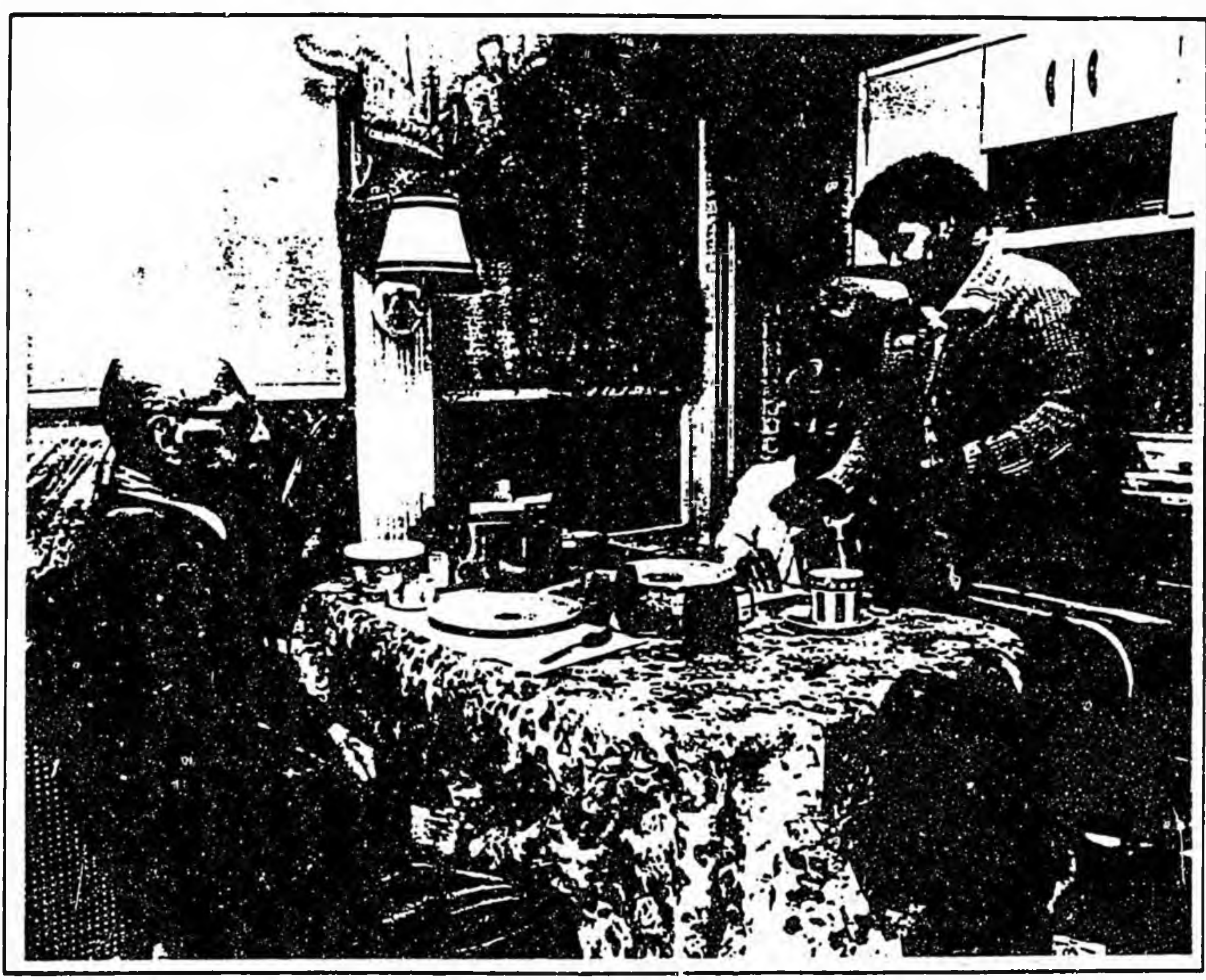
INTRODUCTION

The Community Care Program for the Elderly and Disabled (CCPED) is in its fifth year of operation. With the combined efforts of County Boards of Social Service/County Welfare Agencies, Medicaid District Offices, Case Management Sites, service providers, families, other support persons, and other committed individuals in government, CCPED has served more than 5,000 elderly and disabled individuals in New Jersey since October 1, 1983.

The intent of this report is to look back at the first three years of CCPED to see how the program has evolved, identifying its strengths and successes as well as areas that may require change or attention in the future. The report also contains statistical data concerning the population served. By reviewing the data collected and issues that have been raised by program participants, we can plan more effectively and responsibly for the future.



LOOKING BACK— HISTORY AND EVOLUTION OF CCPED

Governor Kean in his SFY 1984 budget included a $10.5 million appropriation from the State's Casino Revenue Fund to finance two major initiatives in home and community-based long-term care:

- The Community Care Program for the Elderly and Disabled
- Medicaid's Personal Care Assistant Services Program

The funding of these two programs represented a major shift in State policy toward developing a more balanced long-term care system—one without the "institutional bias" which forced elderly and disabled into nursing homes, but rather one oriented toward helping families care for their kin. It was an effort on the part of New Jersey to provide a full continuum of care so that individuals could have access to services and settings more appropriate to their needs and circumstances, as well as more cost-effective for the State.

The Community Care Program for the Elderly and Disabled (CCPED) was created in New Jersey in response to the Omnibus Budget Reconciliation Act of 1981, Section 2176, Public Law 97-35, which encouraged the development of home and community-based services rather than institutional programs. The Sixth Omnibus Budget Reconciliation Act of 1985 provided the basis for program revisions.

CCPED was initially approved in June of 1983 for a three-year period by the United States Department of Health and Human Services, Health Care Financing Administration (HCFA) with an effective date of October 1, 1983. Jointly funded by Federal Title XIX monies and the State of New Jersey Casino Revenue Account funds, CCPED was phased in throughout the state over the three-year period. CCPED was designed to serve a maximum of 1,800 individuals at any one time at home by the end of the third year, offering a limited package of home and community-based services. These individuals otherwise would have been eligible to receive Medicaid services only in a nursing home setting.

Phase-In

The first phase of CCPED began in seven counties on October 1, 1983, with nine counties added on October 1, 1984, and the final five counties added on October 1, 1985 (See Chart 1). This phase-in of counties and population allowed time to implement the program effectively. Important aspects of the phase-in were: outreach to the communities; the training of staff involved in the enrollment process; recruiting, enrolling and training providers; training individuals who would provide comprehensive case management services to each client; and the development and implementation of a uniform assessment and service delivery system.

Services

Phase One of CCPED offered a package of eight services consisting of case management, home health services, medical day care, pharmaceuticals, non-emergency medical transportation, social adult day care, homemaker, and respite care to eligible individuals. These services were selected as most necessary to assist individuals remain home and to complement services available under Medicare. Phase Two, effective October 1, 1984, eliminated pharmaceuticals as part of the service package. Since most clients also met the eligibility requirements for New Jersey's Pharmaceutical Assistance for the Aged and Disabled (PAAD) Program, it had been administratively difficult to terminate their PAAD and offer pharmaceuticals under CCPED.

The client received a monthly Medicaid card from Blue Cross/Blue Shield Insurance Company attesting to CCPED eligibility. This card listed the seven CCPED services to which the client was entitled.

Cost-Effectiveness

In order to comply with Federal cost-effectiveness requirements which stated that the cost of home and community-based services could not exceed the cost of institutional care, a 70% of nursing home cost-cap was imposed on each individual's service package. This meant that the total amount of services paid for by Medicaid under CCPED could not exceed 70% of what Medicaid would have paid for that individual in a nursing home.

The removal of pharmaceuticals from the service package enabled CCPED clients to receive more home care services, such as homemaker and home health aide services, under this service cost-cap.

In 1986, New Jersey amended the CCPED program to allow 10% of the caseload to be served at 100% of nursing home costs, with 90% of the caseload remaining at the 70% cost-cap. This was done to accommodate sicker clients who needed more services to remain at home than could be provided within the 70% cost limit.

Initiated in the fourth waivered year, this change meant a change from a 70% service cap of $770.80 - $1,063.86 to a 100% service cap of $1,101.15 - $1,519.80 a month (the high and low figures representing the skilled and intermediate "B" nursing home levels of care).

Cost-Share Requirements

Federal regulations required that all recipients shared in the cost of the services received when their income exceeded maintenance needs. Medical expenses not subject to payment by a third party were considered deductibles from this cost-share. Maintenance needs were defined by the Federal government as the Social Security Income (SSI) standard. This amount changed from $333.47 a month in 1983 to $367.25 a month in 1986.

New Jersey felt that this regulation posed a hardship on many individuals who had much higher living costs, and served as a deterrent to apply for CCPED and needed services. New Jersey petitioned the Federal government to allow an additional $150 for maintenance needs but the request was denied. New Jersey then opted to use state funds to allow

up to an additional $75 per client for maintenance costs so that more individuals could choose CCPED as an alternative to nursing home care. With assistance from New Jersey Senator Bill Bradley through the mechanism of an amendment to the Consolidated Omnibus Budget Reconciliation Act of 1985, states were allowed to raise the maintenance needs deductible. In 1986, New Jersey elected to add an additional $75 or a total of $150 to the SSI standard as the allowable maintenance deductible for the cost-share. This meant that clients could deduct up to $150 for maintenance, plus medical and remedial expenses from their income before paying the cost-share for CCPED.

Eligibility Requirements

The eligibility criteria for CCPED in 1983 were as follows:

- Individuals had to be 65 or over, *OR* determined disabled under the Social Security Act and receiving Social Security disability payments, *AND* be eligible for Medicare.
- Individuals had to meet Medicaid's skilled or intermediate nursing home level of care

requirements (even though the choice was home care).

- Individual incomes had to exceed the SSI community standard up to the institutional cap ($1,008 as of 1/1/86), or individuals had to be ineligible in the community because of SSI Deeming Rules. (This meant that individuals were determined financially eligible on the basis of their own income.) Parental and spousal income were not considered (deemed) in determining eligibility.
- Individual assets could not exceed the amount allowed to receive Medicaid services under the institutional program. Again, parental and spousal resources were not deemed in determining eligibility.
- Cost of services could not exceed an established amount which reflected 70% of nursing home costs to Medicaid.

In 1986, these criteria were modified as follows:

- Individuals not determined disabled by the Social Security Administration could be determined disabled by the Bureau of Medical Affairs, Division of Public Welfare, Department of Human Services.
- Individuals who were not eligible for Medicare but had other health insurance coverage, which included hospital and physician coverage, could qualify for CCPED.
- Services for 10% of the CCPED slots could cost up to 100% of Medicaid nursing home costs, rather than 70%. For example, an Intermediate Care Facility (ICF) Level A at 70% was $985.98 and at 100%, it was $1,408.55, allowing an additional $422.57 to be spent for service needs. This increase became effective in the beginning of the fourth year.

Expenditures Under CCPED

The cost-effective features of CCPED, namely, the use of case management as the pivotal service to orchestrate the service plan and the utilization of the 70% service cost cap for most recipients, has resulted in considerable savings to the State. As evidenced in Chart 15, the cost of providing services to CCPED recipients in the home was considerably less than if they had been institutionalized. Although the average costs increased each year of the program, at its highest level in Year Three, the cost of serving the CCPED recipient was only one-third of what it would have been in a nursing home, $3,889 as compared to $11,631. Chart 9 demonstrates that CCPED recipients are much the same as nursing home residents. Therefore, CCPED not only is appropriately targeting those who are at risk of institutionalization but is serving them at less cost.

Final Note

We are pleased to conclude this section with the information that CCPED has been renewed for an additional five years, to September 30, 1991. Upon our request, HCFA also approved an annual increase in community care slots for each new waivered year in order to meet the continuing demand for services. The allowable slots will reach 2,900 in 1991.

The following sections of this report discuss in more detail the application and enrollment process, demographic and fiscal data and observations and recommendations concerning CCPED.

APPLICATION AND ENROLLMENT

The overall administration of CCPED is carried out by the Department of Human Services, Division of Medical Assistance and Health Services, within the Office of Home Care Programs. The application and enrollment is performed locally by the County Board of Social Services/County Welfare Agency and the Medicaid District Office in the applicant's county of residence. This process, described in this section and summarized on Chart 2, has not changed since the program began in 1983.

Applicant

At the time of application, the individual may live at home in the community, alone or with others; in a hospital or nursing home; in a rooming or boarding home. The individual can be referred to the County Board of Social Services/County Welfare Agency by a variety of sources.

County Board of Social Services/County Welfare Agency (CBSS/CWA)

The individual makes formal application at the CBSS/CWA serving the county of residence. The CBSS/CWA explains CCPED to the applicant, and in accordance with existing policies and procedures, determines the applicant's financial eligibility. The information regarding income and resource is verified as well as other eligibility factors such as age, residence and citizenship. The CBSS/CWA also determines the applicant's maximum cost-share liability and ensures that disability has been determined if the applicant is under 65 years of age.

Medicaid District Office (MDO)

When the applicant has been determined financially eligible for CCPED, a referral is made to the MDO serving the county of residence. A Medicaid Regional Staff Nurse and Medical Social Care Specialist visit the applicant to assess the level of care required, evaluate the appropriateness of CCPED for the applicant and discuss the choices of care (home or institutional care).

The Nurse and Social Care Specialist then discuss the case with a Medicaid Physician Specialist. If the applicant has been determined to be medically in need of care and the cost of home care to be reimbursed by Medicaid is projected to not exceed the institutional service cost-cap established for the individual, the applicant is enrolled in CCPED and referred to the Case Management Site within the county.

Case Management Site (CMS)

Upon receipt of the referral, the case manager visits the client and, with input from the client, family member, attending physician, Medicaid staff, and service providers, prepares a service plan to meet the client's needs. The case manager then assists the client in securing services approved in the service plan. The client's needs and service program are continuously monitored by the case manager while the client remains in CCPED.

Delivery of Services

CCPED provides access to seven services: case management, home health, homemaker, medical day care, social adult day care, respite care, and non-emergency medical transportation.

A description of each service area, an analysis of service utilization, quality assurance, and other service issues follow.

Case Management

Each CCPED recipient receives case management services from a case manager based in a designated case management site approved by the Division of Medical Assistance and Health Services. Case management sites are located in home health agencies, county boards of social services/county welfare agencies, Medicaid District Offices, homemaker/home health aide agencies, and one area office on aging. The Department of Human Services emphasizes an interdisciplinary approach to case management so that the client's total needs can be evaluated and addressed. This means sites must employ case managers who are both nurses and social workers. In sites where a small number of cases only warrants one case

manager, either a nurse or a social worker can be employed.

Included in the responsibilities of the case manager are assessment of the client, preparation of a service plan (which includes formal and informal supports), cost-share determination, coordination of service delivery, monitoring of services, and assisting and advocating for the client and/or family as needed. Case managers have performed exceptionally well in meeting clients' needs in a cost-effective manner while ensuring that quality care is given.

This report concludes with segments of unsolicited letters sent to case managers by families of clients served under CCPED. These letters attest to the quality of case management provided under this program.

Home Health Services

Home Health services include skilled nursing, homemaker/home health aides, physical and occupational therapies, speech-language pathology, medical social work services and certain medical supplies.

Licensed certified home health agencies under contract to the Division of Medical Assistance and Health Services provide these services. These agencies have provided excellent home care to clients and have been an invaluable part of the CCPED service package.

Prospective reimbursement of home health services established for the program remains a major problem in CCPED. Fees are based upon audited data secured from Medicare cost reports, since New Jersey Medicaid piggybacks Medicare principles of reimbursement. Agencies are particularly concerned that the visit rate paid under Medicare does not accommodate the chronic care required by CCPED clients. To remedy this problem, an hourly fee for home health aide services was suggested by the industry and implemented upon the choice of the agency in November 1987.

Another growing problem is the insufficient number of certified homemaker/home health aides, particularly in some geographical areas, to meet the demands for home care. Inadequate transportation systems compound the problem and in some instances aides are unable to get to a client's home to provide the services.

The New Jersey Department of Human Services and Department of Health have formed an interdepartmental task force to discuss issues related to the homemaker/home health aide shortage. A report will be presented to both Commissioners, perhaps forming the basis for increase in the availability of staff in the home care arena. It is felt that the demand for services under CCPED has provided a mechanism for identifying this developing need in New Jersey.

Homemaker Service

Homemaker Service has been the backbone of CCPED and has grown from 43% of total service payments in the first year of CCPED to 62% of total payments in the third year. Homemaker service provides both basic personal care such as bathing, grooming and dressing, and household tasks such as light housekeeping, meal preparation and shopping. The reimbursement rate, generally lower than for home health aide service, makes this the most sought after service in CCPED. However, agencies continually feel that Medicaid is not meeting true service costs and annually request fee increases.

A new group of agencies was enlisted to become approved Medicaid providers of this service area. About 57 proprietary and 18 non-profit agencies have been enrolled since

1983. Required to meet Division standards, they also were trained in the billing process and, in turn, developed a new set of relationships with MDOs and case managers.

Due to the growing number of agencies and a need to assure continuing quality of care, accreditation by the industry was supported by the Division as a requirement for Medicaid participation of these agencies. All agencies providing homemaker service are now required to become accredited by the National HomeCaring Council (of the Foundation of Hospice and Home Care) or the Commission on Accreditation for Home Care, based in New Jersey, by January 1, 1988 for proprietary agencies and June 30, 1988 for non-profit agencies. The shortage of paraprofessionals is particularly significant with these agencies since homemaker service is their primary agency service.

Medical Day Care

Medical Day Care offers a variety of health, social and supportive services in forty-nine Medicaid approved centers located in nursing homes, freestanding settings, or affiliated with hospitals. Although only 4% of CCPED payments were made for medical day care, the comprehensive package of services is beneficial to clients able to leave their own home for one to five days a week. An average medical day care per diem is considerably less than other home care services purchased separately for the same time frame. Medical Day Care offers not only medical and nursing supervision for the very frail or disabled person, but it also provides needed socialization and peer contacts.

Social Adult Day Care

Social Adult Day Care emphasizes social and recreational activities in a group setting, with some health monitoring. Clients attending social day care do not usually need medical attention during the day but may need close general supervision to prevent such behaviors as wandering. Less than 1% of the total expenditures are for this service. All social day care centers must be publicly funded and monitored to participate in CCPED. They also require a Medicaid provider agreement.

Respite Care

Respite Care is a temporary service offered on an as needed basis to relieve families caring for individuals at home. It can be provided at home by a homemaker/home health aide, employed by approved agencies or in nursing homes by facilities which have a Medicaid provider agreement. The reimbursement of respite care in a nursing home equals either the facility's skilled or intermediate care rate.

There is a need for more nursing homes to provide respite care. The service has been limited because facilities cannot predict when a bed will become available for respite care. Therefore, families who need to be away at a specific time usually cannot be guaranteed the availability of a bed when needed.

Respite care in the home by a homemaker/home health aide is not always feasible due to the shortage of aides willing to work weekends or evenings.

Medical Transportation

Medical Transportation is non-emergency transporting of clients by a suitable vehicle to obtain health services. This service is provided by traditional Medicaid approved medical transportation providers, using, for example, invalid coaches, or by vehicles provided through the county welfare agencies Medicaid-funded transportation programs.

LETTERS OF SUPPORT

We have received numerous unsolicited letters from families of clients sent to case management sites and to the Division of Medical Assistance and Health Services (DMAHS). The following are excerpts from these letters.

TO: *Bergen County Board of Social Services, October 20, 1986.*

TO WHOM IT MAY CONCERN:

"My mother was a recipient of the CCPED Program for almost three years. She passed away on August 22, 1986, but she died in her own home, which is what she wanted. She was 87 years old and was terrified (as I think most older people are) of not being able to take care of herself and having to go to a nursing home. Your Program enabled her to stay in her own home and her own surroundings, and for that I am very, very grateful."

TO: *Passaic County Board of Social Services, November 13, 1986.*

"I want to re-emphasize what I expressed to you in our recent telephone conversation concerning my very deep appreciation for your many kindnesses.

There is little question in my mind that you went out of your way to be helpful to my mother and my sister, in assisting them in their needs. In a day and age when the general public is oftentimes critical of those who serve in the public sector, I can attest to the fact that you personify, in the highest sense,

a dedicated public servant who has a deep concern for the public citizen."

TO: *MCOSS Nursing, Inc., January 30, 1987.*

"On behalf of my mother and myself, we would like to express our appreciation and gratitude regarding the CCPED program, and to you, in particular, for your continued guidance and help.

As you well know, this program has enabled my elderly mother to remain at home, in familiar and comfortable surroundings and still receive the care and attention so vital to someone of ninety-one.

The case management has been thoroughly professional, whether it be on a medical, financial or emotional level.

You have always been there "in the wings" ready to help . . . thank you for the program . . . and thank you for being part of it."

TO: *Division of Medical Assistance & Health Services, Office of Home Care Programs, November 25, 1986.*

"My father-in-law became an active participant in the Community Care Program for the Elderly and Disabled on November 19, 1986. I would like to express our appreciation for his acceptance into the program.

I was very impressed by, and wish to acknowledge with deep appreciation, the very courteous and efficient manner in which we were interviewed by your staff. Each one was friendly, warm and interested.

Thank you not only for your assistance but also for this very positive experience in human services."

TO: *The Administrator of the DMAHS, Office of Home Care Programs from a Regional Staff Nurse employed in a Medicaid District Office.*

"Since I have started doing reassessments on my assigned CCPED cases, I have found the clients to be happy and improved physically and mentally.

It was heartwarming to me, particularly when I saw a recipient yesterday that I had not seen in a year. She looked so much better and was friendly and chatty. Last year, when I saw her, I doubted that she would be able to be kept at home.

This proved to me that this program really works. The family is pleased with the services and only ask that they stay the same.

Three cheers for CCPED!"

POPULATION SERVED

The following is an analysis of data compiled on population served during the first three years of CCPED, representing 4,075 recipients.

Sex

Of the 4,075 clients served, 76% were females, 24% were males (Chart 3).

Age

The numbers of individuals served over age 65 increased from 80% to 87% from 1983 to 1985, with the preponderance of the recipients in the 75-84 age group. It is interesting to note that a sizeable group, an average of 27%, were over the age of 85 in 1985. (Chart 4).

All three years of the program reflected a similar age picture. It is felt that CCPED's limited service package discouraged the younger disabled who need more extensive service coverage and were better accommodated under Medicaid's Home and Community-based Services Waivers for Blind or Disabled Children and Adults, known as Medicaid's Model Waivers.

Race

Race variations as illustrated in Chart 5 appeared to be unusual to staff, until they were compared to the population in New Jersey nursing homes. Seventy-nine percent of individuals served under CCPED were white, with 17% black recipients, and 2% Hispanic re-

cipients in 1985. Medicaid residents in nursing homes in 1986 were 84% white, 10% black and 1% Hispanic, revealing that the racial variation of the population enrolled in both programs was similar.

Living Arrangements

Other characteristics of CCPED recipients were examined. Chart 6 shows the living arrangement of enrollees. The largest number, 39.4%, resided with adult children, 30.3% lived alone, 23.2% lived with a spouse and 7.1% had other arrangements, such as living with a sibling, friend, or other relative. Since the support network is so important in this program, the availability of an adult child or spouse provided the needed support for the limited service received under CCPED. The fact that about 1/3 of the recipients lived alone, although difficult to accept by concerned professionals, attests to the strength of the freedom of choice given to all individuals electing this program. Many persons refused to enter nursing homes, despite the unavailability of family and the limitation of services. However, a number of these "loners" did have friends or children who lived nearby and looked in on the recipient on a regular basis.

Income Level and Cost Share

Income levels of CCPED clients as seen in Chart 7 were restricted by the eligibility requirements of the program. Whereas most (45%) had incomes from $368 to $521 a month, a considerable number (26%) had higher incomes, from $522 to $899 a month and lower incomes (27%) under $367 a month (yet were ineligible for regular Medicaid because of spousal or parental incomes). Few had incomes which exceeded $900 a month, although the maximum income eligibility was $1,008 a month. The primary reason for this can be attributed to the cost-share liability requirement. All recipients were required in accordance with Federal regulation to share in the cost of care. The cost-share was determined by deducting a standard maintenance allowance plus medical and remedial expenses from the client's gross income. Those clients with high incomes had a high cost-share, thereby discouraging participation in the program. Those individuals would purchase services directly rather than through CCPED.

Diagnosis

Primary diagnoses of CCPED recipients are illustrated in Chart 8. The most common physical problem was a circulatory disorder, found in 49% of the population served. Remaining disorders, occurring at equal distribution, were difficulties with nervous system, respiration, metabolism, musculo-skeletal problems, cancer and mental disorders. All disorders appeared to not only be reflective of the elderly population in the program, but descriptive of a similar population residing in long-term care facilities. Therefore, this information appeared to confirm the appropriate targeting of the population.

Level of Care

Federal regulations require that clients served under CCPED must require a level of care provided in a nursing home, although they may choose to remain home with services. (See Attachment A for a description of the three levels of nursing home care.) Chart 9 clearly demonstrates that CCPED is attracting the appropriate population. The level of care of individuals served under CCPED over the three years compares favorably to the

Medicaid population served in New Jersey nursing homes. Note that in Year One, 16% of CCPED clients were assessed Skilled Nursing Facility (SNF) Level compared to 8% of patients assessed SNF in nursing homes; 59% of CCPED clients were assessed Intermediate Care Facility (ICF) A level compared to 69% ICFA patients in nursing homes, and 25% CCPED clients were at Intermediate Care Facility (ICF) B level compared to 23% ICFB patients in nursing homes. All three years indicated there was great similarity between the levels of care required by CCPED recipients to those in nursing homes. Since the same level of care criteria was utilized by Medicaid Medical Evaluation Teams to determine medical eligibility for CCPED and for nursing home placement, it is concluded that CCPED has indeed appropriately targeted individuals who without home and community-based care would have been candidates for nursing home admission.

As an added note, it appeared that the individuals served in CCPED could in some instances have been sicker than those served in nursing homes, since the SNF percentages are considerably higher in the CCPED population.

Termination

Chart 10 delineates the principal reasons for termination from CCPED. With the majority of clients in the age group of 75-84, having numerous chronic illnesses and matching patients who are institutionalized, it is understandable that termination from CCPED results from death or admission to a nursing home.

Length of Stay on Program

Chart 11 illustrates the length of time clients remained on CCPED. Although considered a long term care services program, it is interesting to note that 59.8% were served in CCPED under six months. Very few, 17.1%, remained on CCPED over a year. The frailty of the population served attributed to a shortening of program involvement.

Payment of Services

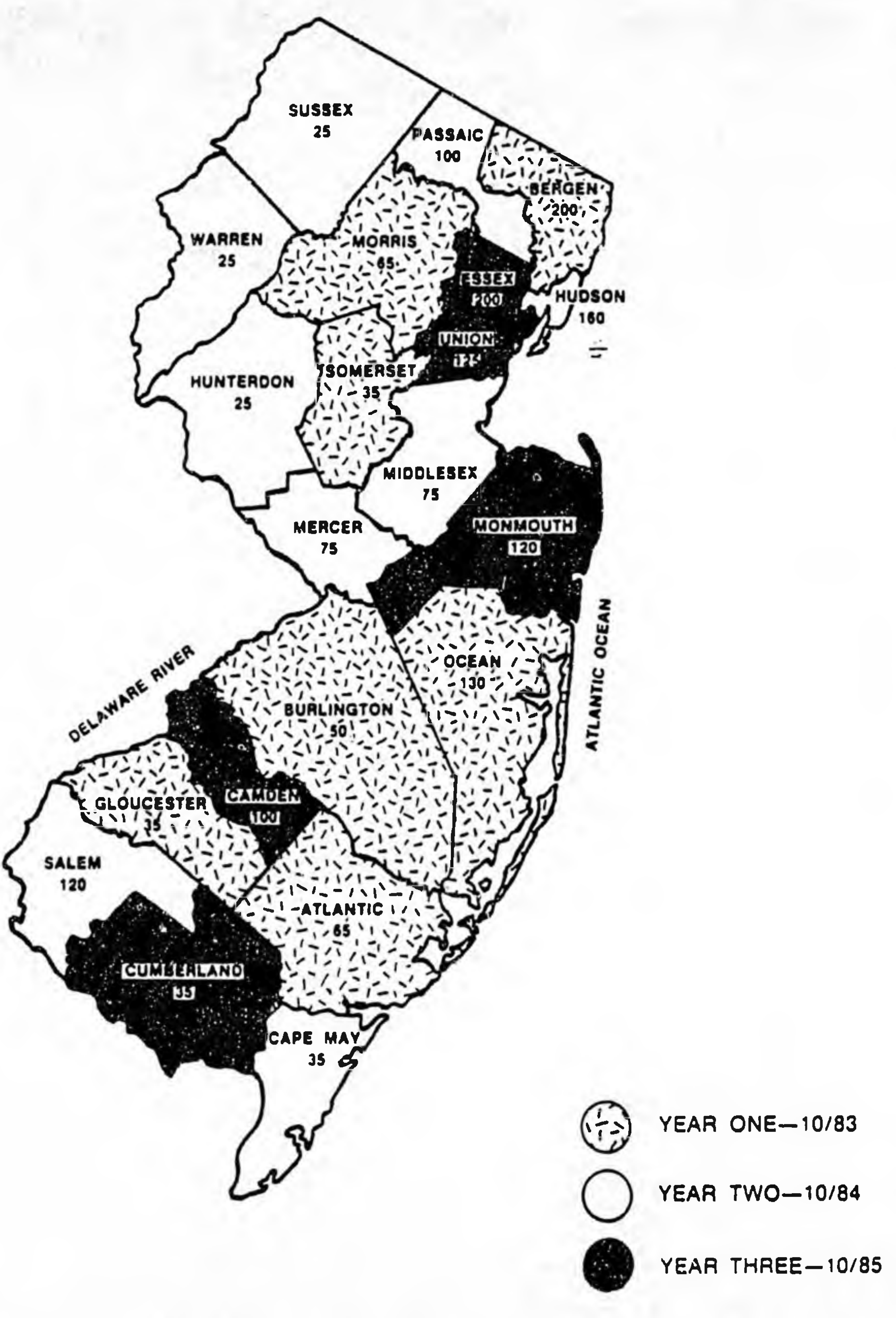
Charts 12-14 demonstrate the change in payments made for services over the three years. There was a noticeable growth in funds expended for homemaker services. All other service expenditures remained about the same. Total payments grew from almost $700,000 in Year One to more than $8.5 million in Year Three as the program became better known and served a larger population statewide.

Chart 15

Chart 15 compares expenditures under CCPED to nursing home expenditures. Although the average costs per CCPED recipient increased each year of the program, at its highest cost in Year three, it was still only one-third of nursing home costs.

CHART 1

THREE YEARS OF CCPED PHASING IN THE COUNTIES



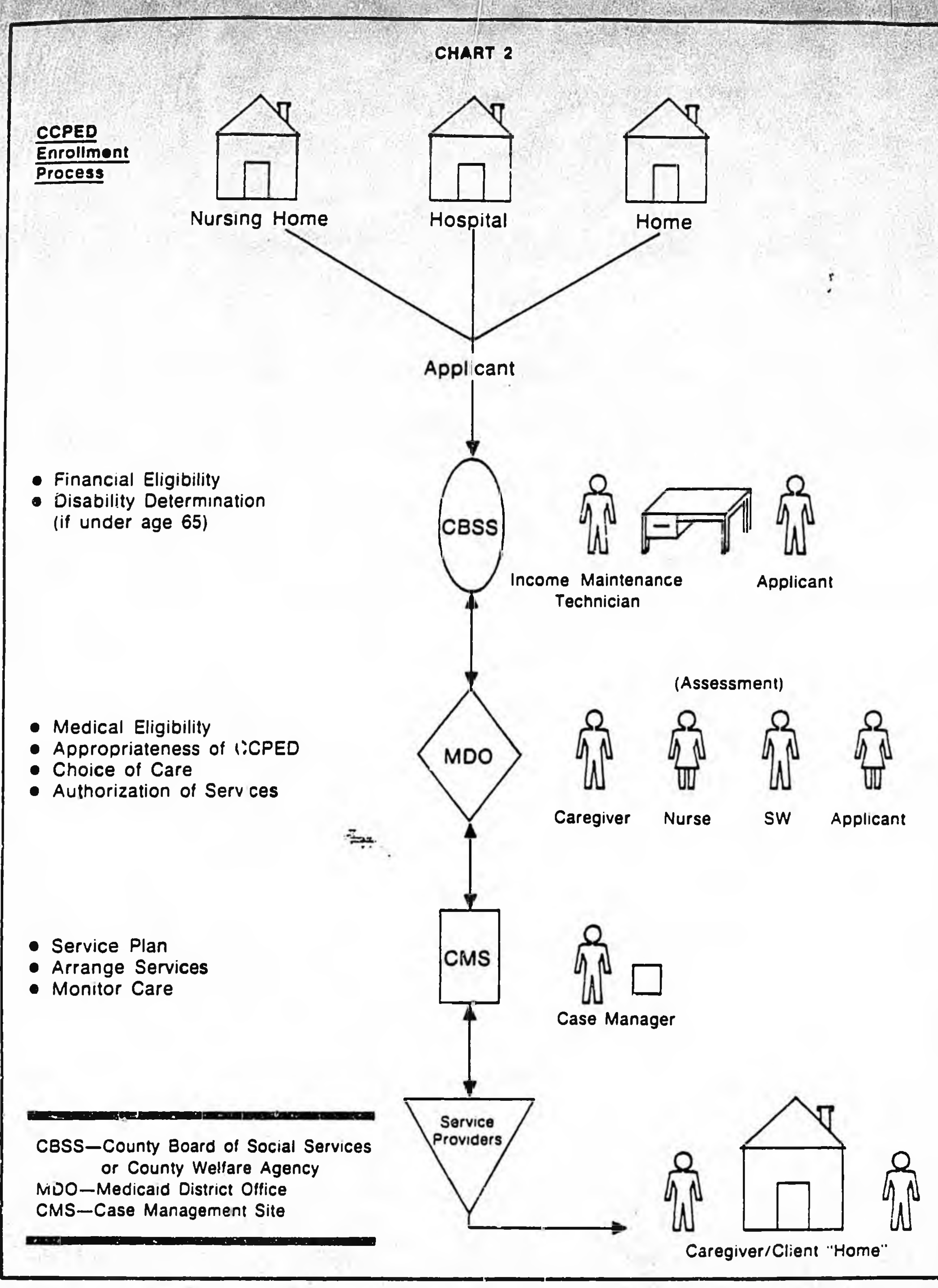


CHART 2
CCPED Enrollment Process
Nursing Home
Hospital
Home
Applicant
• Financial Eligibility
• Disability Determination (if under age 65)
CBSS
Income Maintenance Technician
Applicant
(Assessment)
• Medical Eligibility
• Appropriateness of CCPED
• Choice of Care
• Authorization of Services
MDO
Caregiver
Nurse
SW
Applicant
• Service Plan
• Arrange Services
• Monitor Care
CMS
Case Manager
Service Providers
CBSS—County Board of Social Services or County Welfare Agency
MDO—Medicaid District Office
CMS—Case Management Site
Caregiver/Client "Home"

CHART 3

PERCENTAGE MALE/FEMALE CLIENTS

LEGEND

MALE 24%

FEMALE 76%

4,075 CLIENTS SERVED

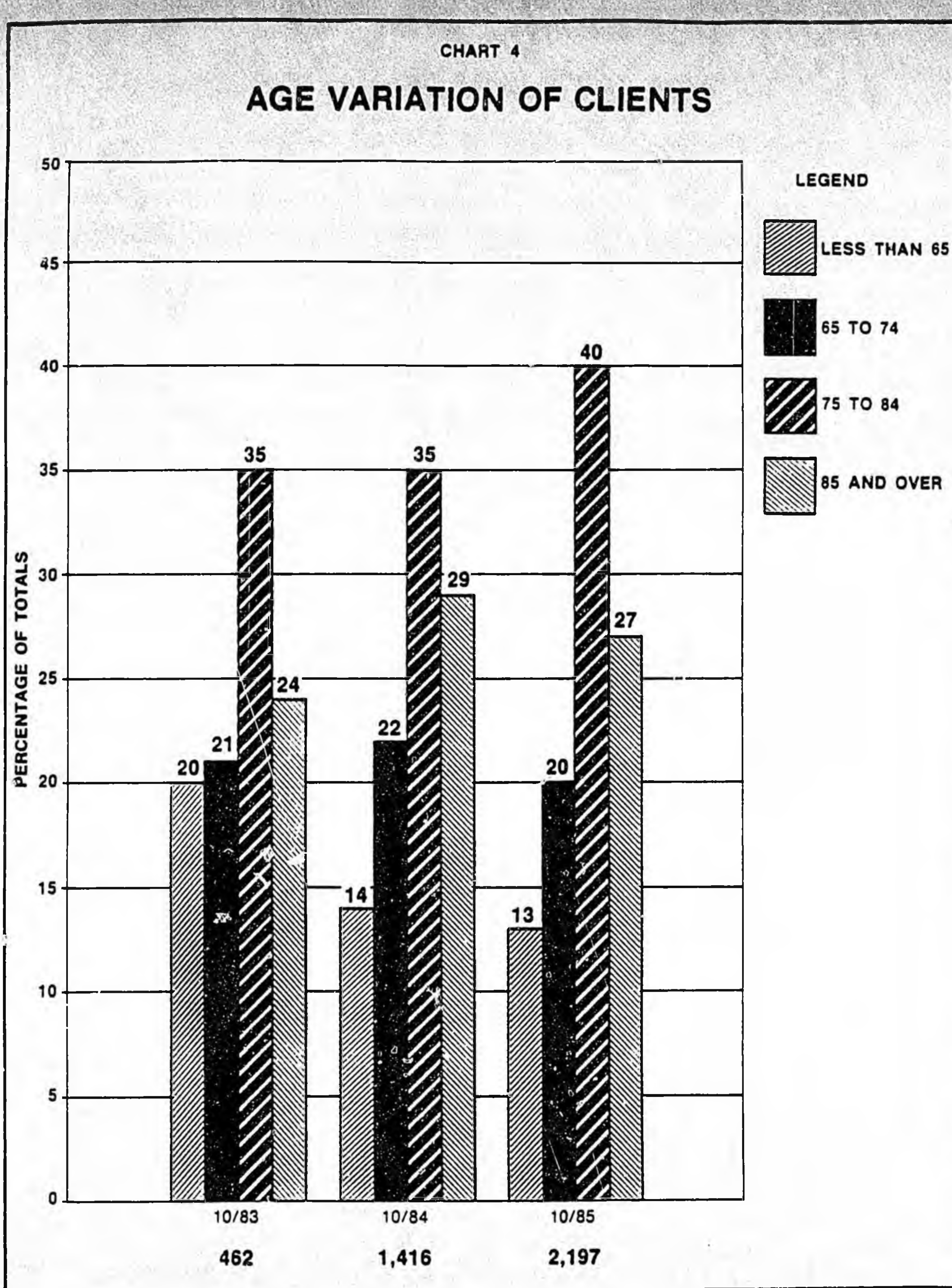


CHART 4
AGE VARIATION OF CLIENTS
PERCENTAGE OF TOTALS
50
45
40
35
30
25
20
15
10
5
0
LEGEND
LESS THAN 65
65 TO 74
75 TO 84
85 AND OVER
20
21
35
24
14
22
35
29
13
20
40
27
10/83
10/84
10/85
462
1,416
2,197

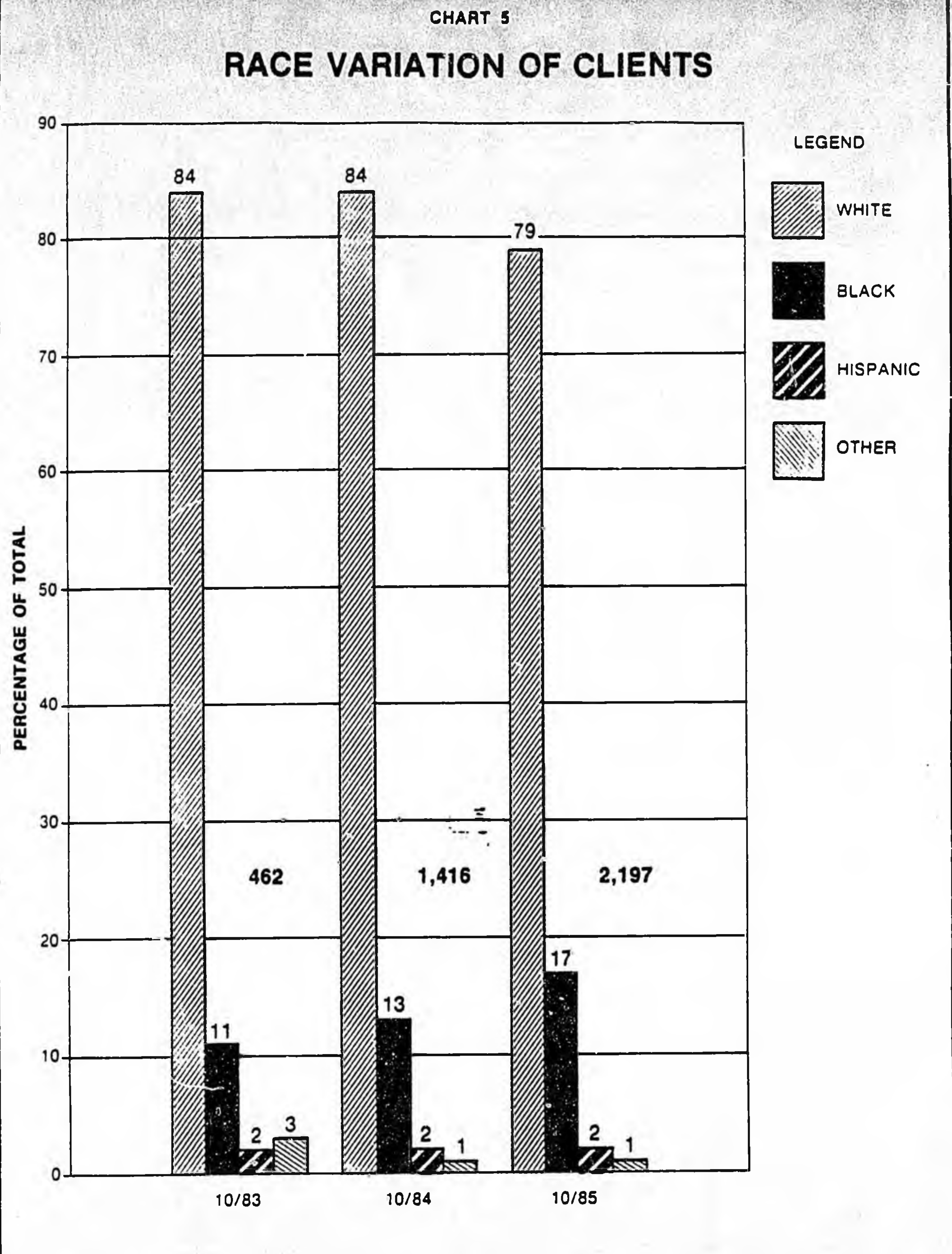


CHART 5
RACE VARIATION OF CLIENTS
PERCENTAGE OF TOTAL
90
80
70
60
50
40
30
20
10
0
84
84
79
11
2
3
13
2
1
17
2
1
462
1,416
2,197
10/83
10/84
10/85
LEGEND
WHITE
BLACK
HISPANIC
OTHER

CHART 6

LIVING ARRANGEMENT OF CLIENTS

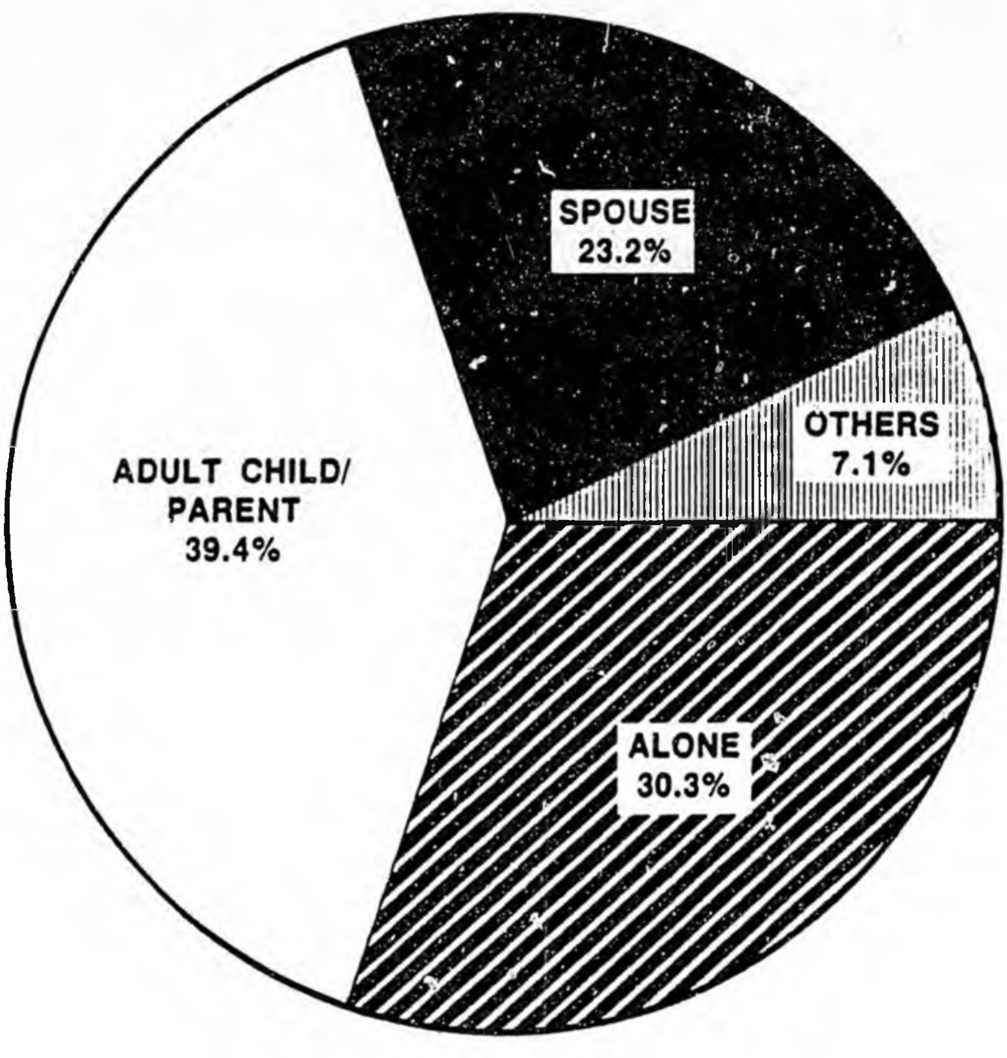


CHART 7

MONTHLY INCOME OF CLIENTS

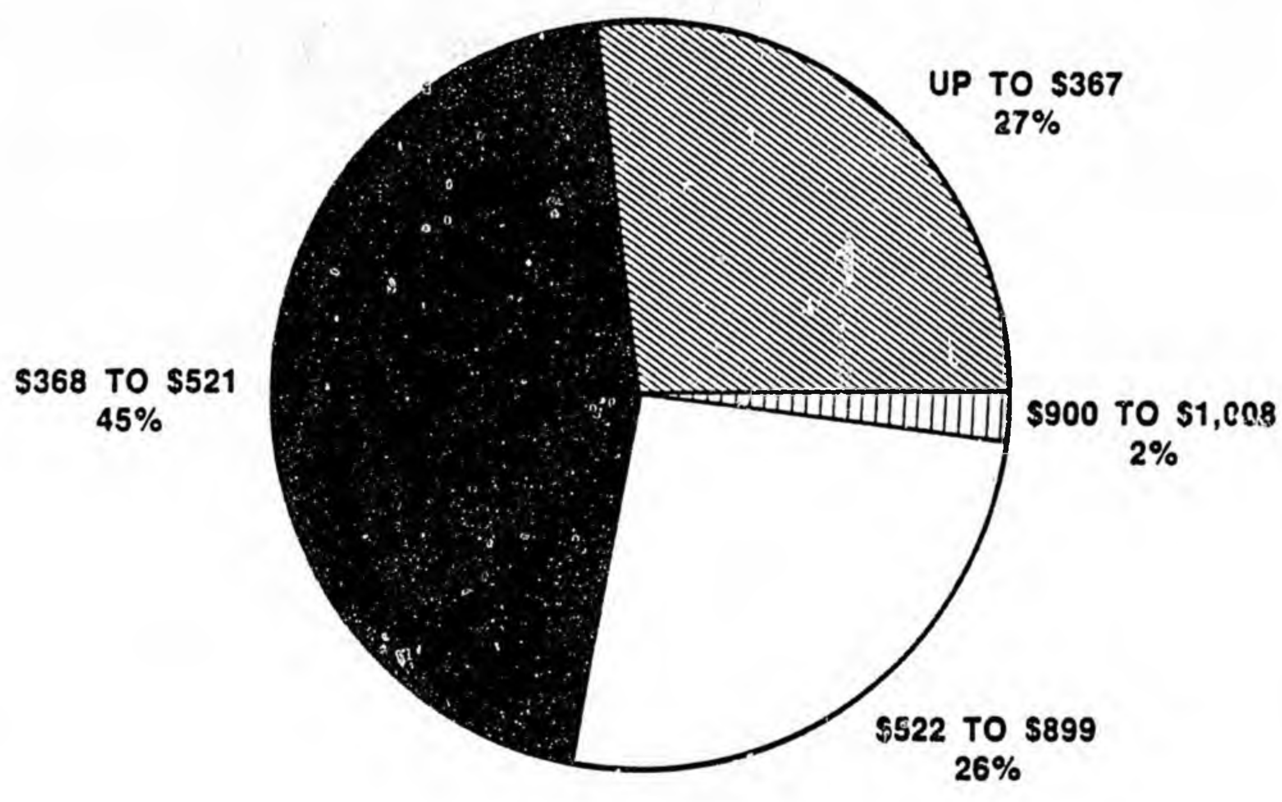


CHART 8

PRIMARY DIAGNOSIS OF CLIENTS

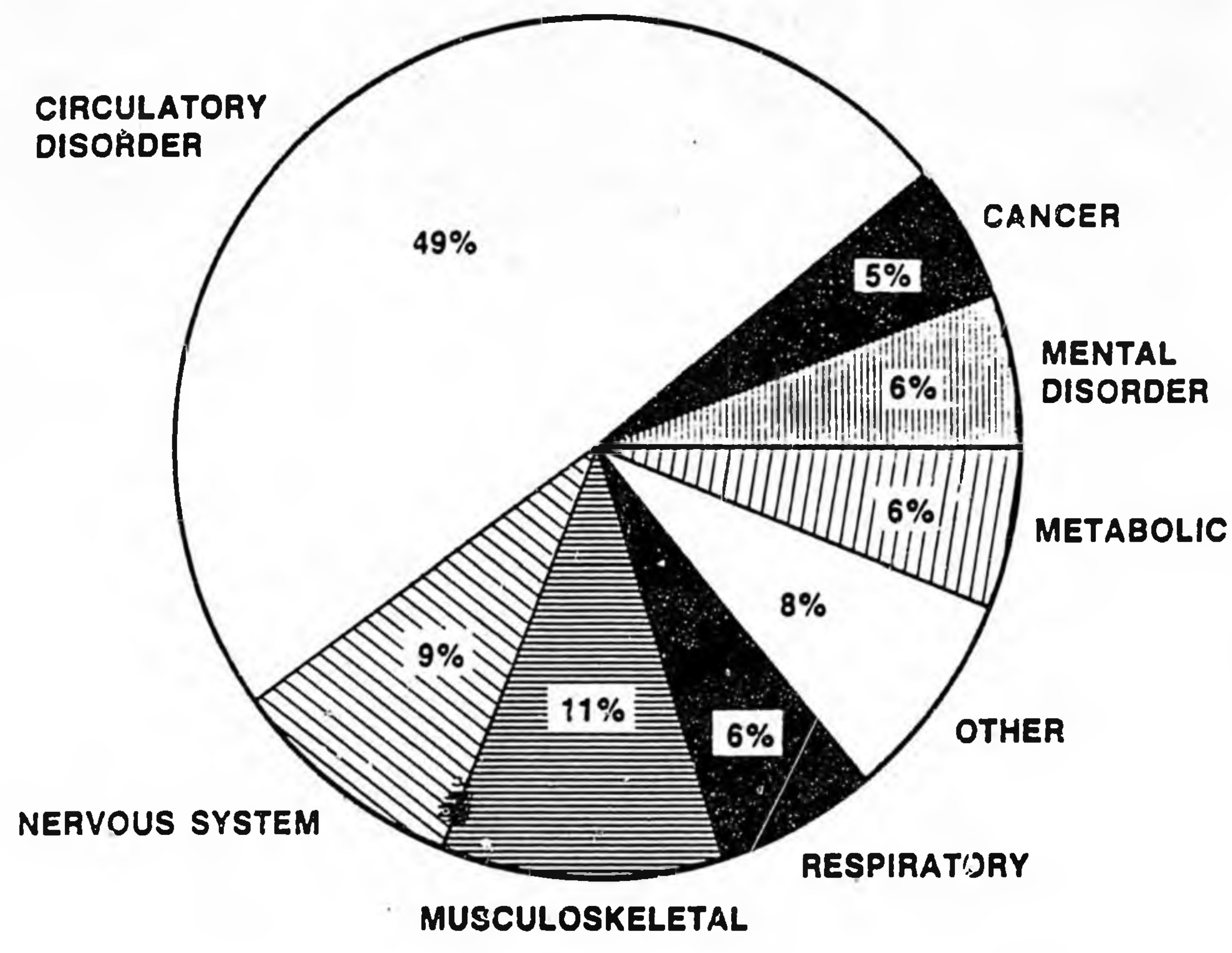


CHART 9

LEVEL OF CARE
CCPED COMPARED TO NURSING HOME (NH)

PERCENT

70
60
50
40
30
20
10
0

CCPED NH CCPED NH CCPED NH

YEAR ONE YEAR TWO YEAR THREE

LEGEND

ICF-A

ICF-B

SNF

LEGEND
LEVEL OF CARE

ICF-A = Intermediate Care Facility
ICF-B = Intermediate Care Facility
SNF = Skilled Nursing Facility

CHART 10

REASONS FOR TERMINATION

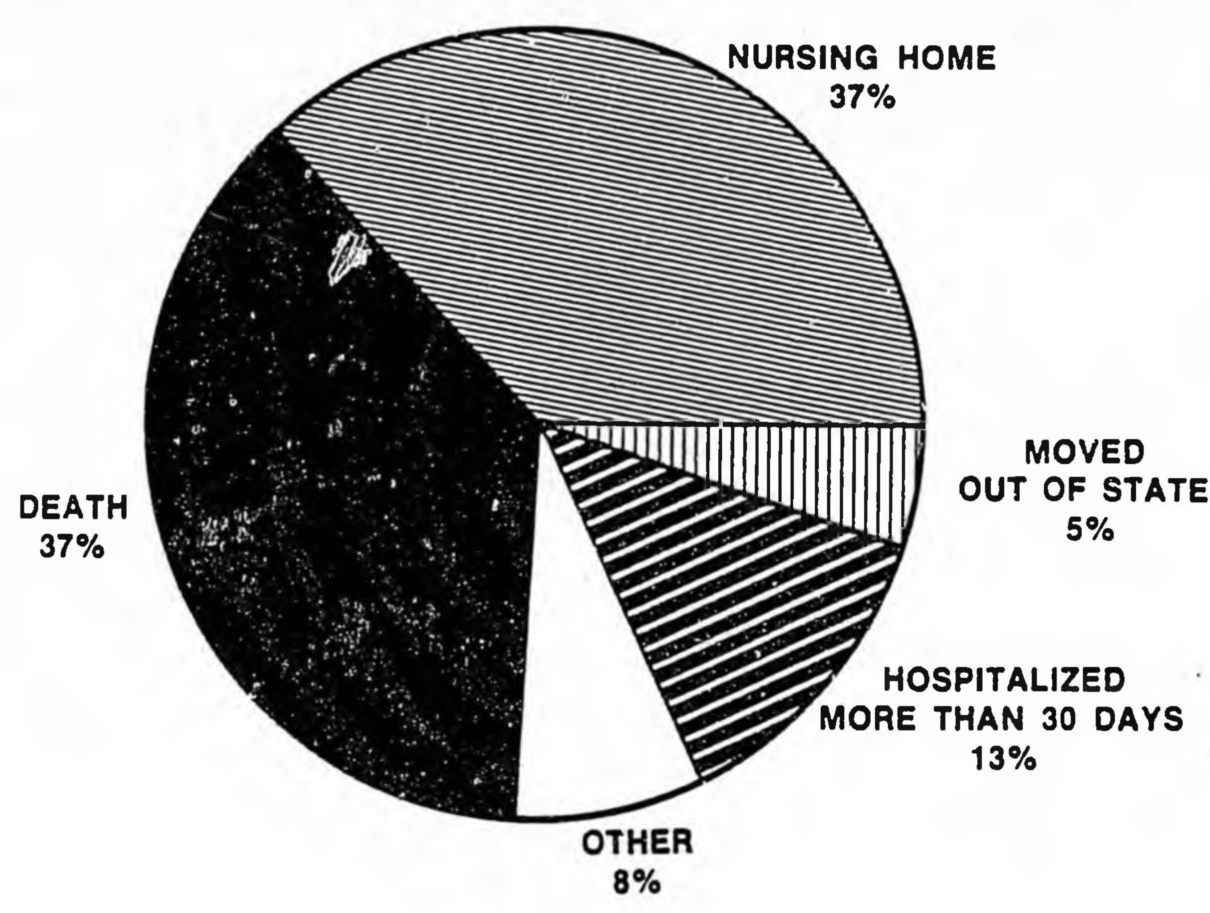


CHART 11

LENGTH OF STAY IN PROGRAM

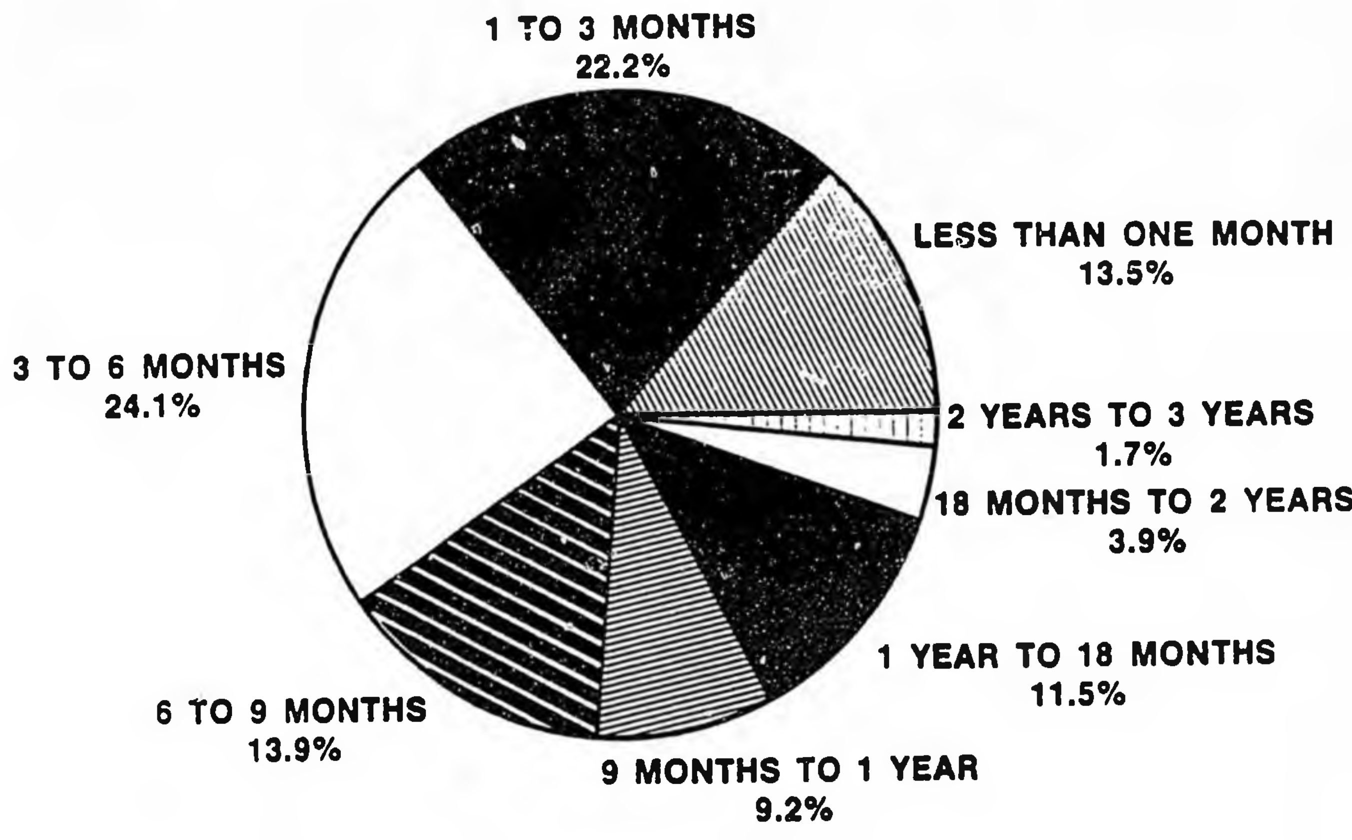
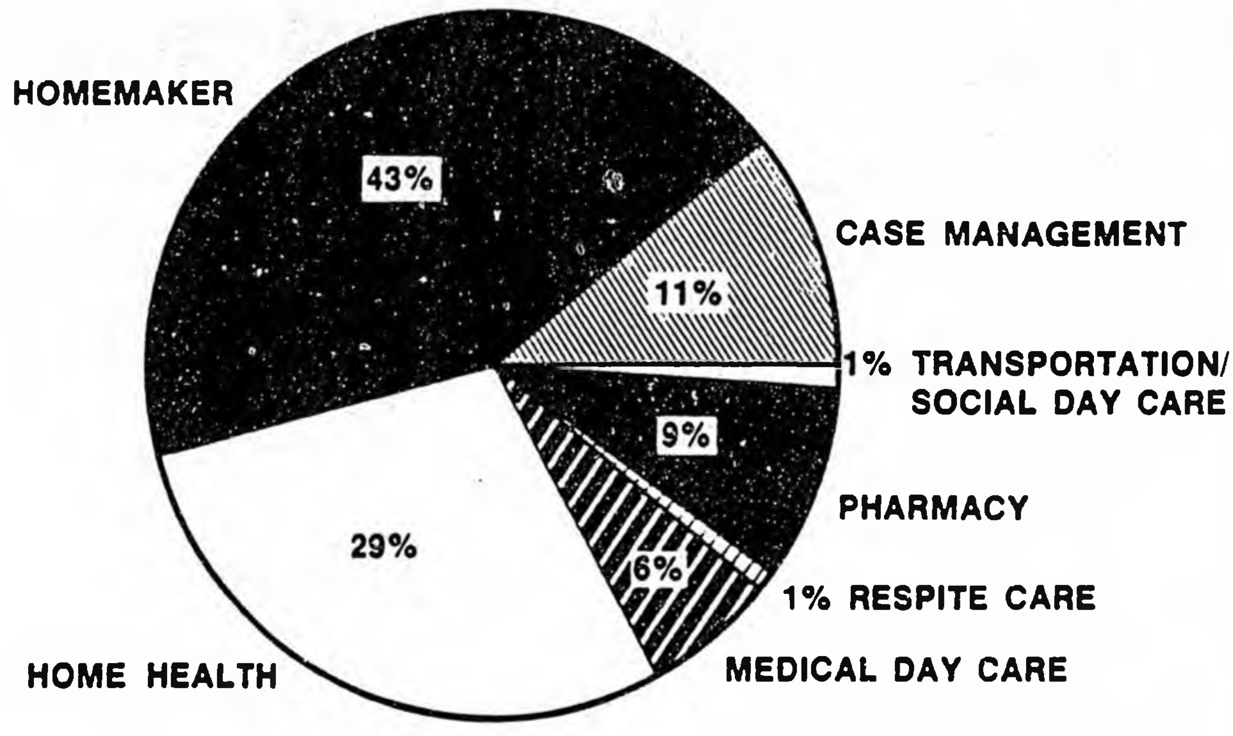


CHART 12

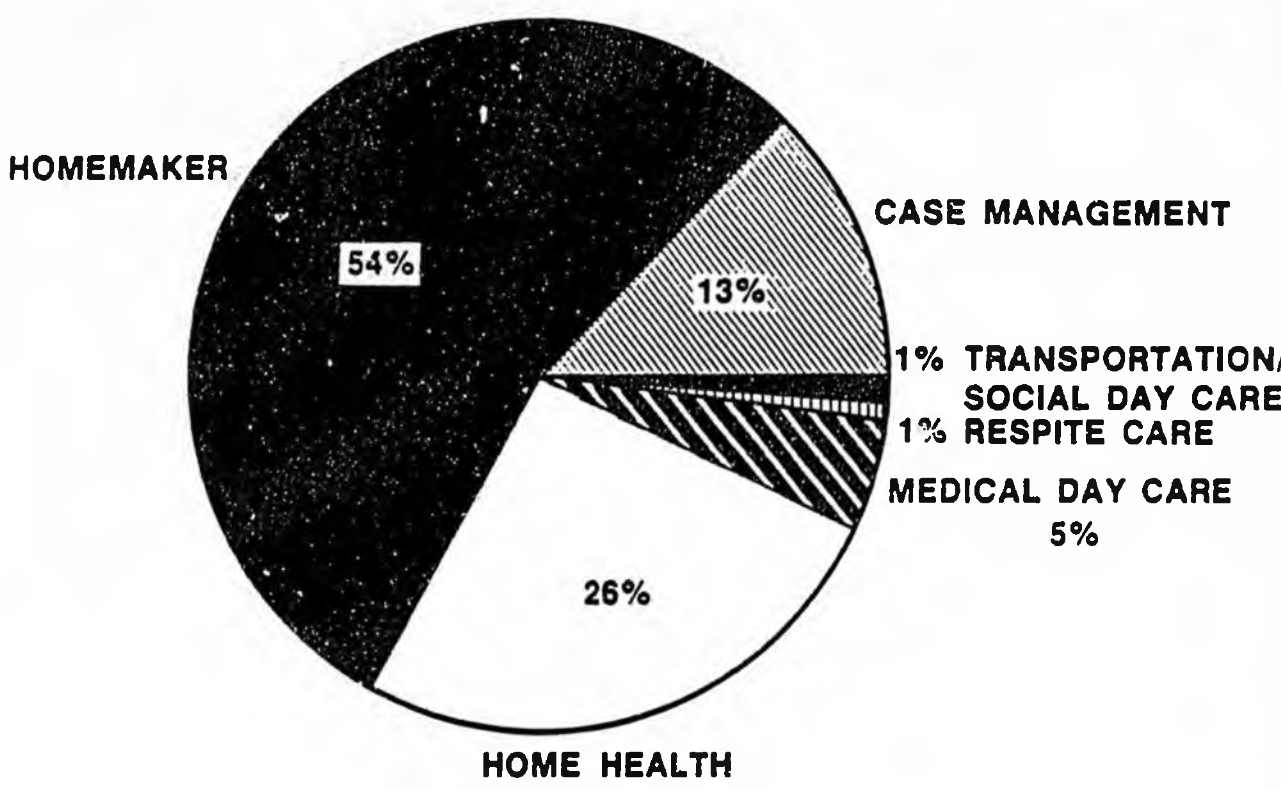
TOTAL AMOUNT PAID FOR SERVICES
YEAR ONE
$690,197.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 13

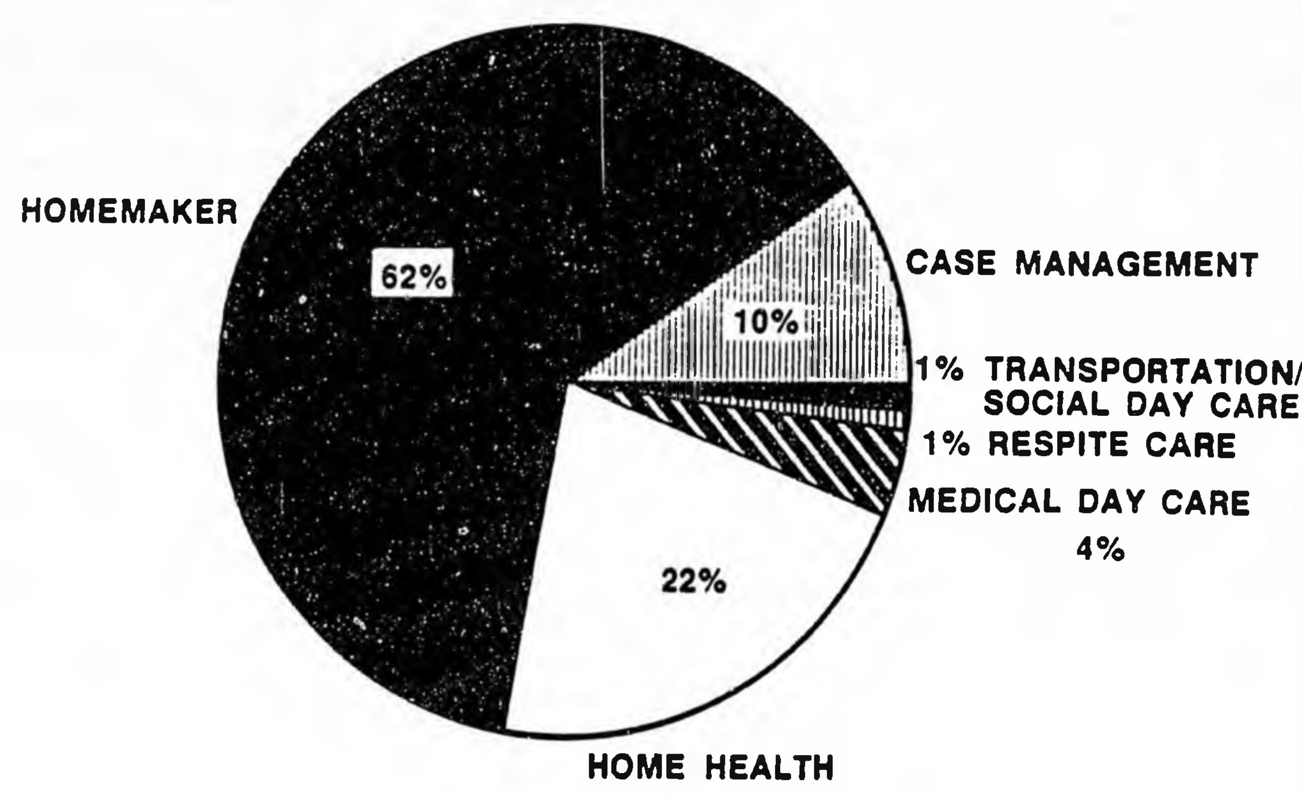
TOTAL AMOUNT PAID FOR SERVICES
YEAR TWO
$4,060,389.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 14

TOTAL AMOUNT PAID FOR SERVICES
YEAR THREE
$8,544,333.00



SERVICES/PERCENTAGE OF TOTAL PAYMENT

CHART 15

*EXPENDITURES AND AVERAGE PER CAPITA COSTS CCPED vs. NURSING HOME

YEAR ONE—10/83 THROUGH 09/84

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 690,197.00	462	$ 1,478.00
NURSING HOME	$332,063,329.00	29,157	$11,389.00

YEAR TWO—10/84 THROUGH 09/85

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 4,060,389.00	1,416	$ 2,868.00
NURSING HOME	$363,338,654.00	30,521	$11,905.00

YEAR THREE—10/85 THROUGH 09/86

	EXPENDITURES	RECIPIENTS	AVG. COST/RECIP.
CCPED	$ 8,544,333.00	2,197	$ 3,889.00
NURSING HOME	$375,460,917.00	32,281	$11,631.00

*SOURCE: EXTRACTED FROM ANNUAL FEDERAL REPORTS

NURSING HOME LEVEL OF CARE CRITERIA

The following definitions were taken from the Long Term Care Services Manual, N.J.A.C. Title 10, Chapter 63, Subchapter 1, 9/79:

"Level III, skilled nursing patient" means a person with acute or subacute medical and/or mental dysfunction requiring skilled nursing, psycho-social and restorative care during a 24-hour period. The Level III patient requires continuous 24-hour availability of nursing personnel at the licensed nurse level under the general direction of a registered professional nurse and will require other skilled services on an intensive basis including rehabilitation. The dysfunction may involve one or several physiological systems, may be stabilized or not, with symptoms subsiding or increasing. The patient may be bedfast, chair-fast, semi-ambulant or ambulant (with or without assistive devices). Determination of this level of care requires an identification of skills required and evidence that as a practical matter such care can only be provided in a Long Term Care Facility setting.

"Level IV-A, intermediate care patient" means a person with physical and/or mental and/or social dysfunction requiring on a daily basis substantial assistance with personal care needs involving activities of daily living. Nursing care at Level IV-A must be provided 24 hours a day by licensed and nonlicensed personnel under the general direction of a registered professional nurse. These patients require continued restorative and psycho-social services which as a practical matter can only be provided in a Long Term Care Facility setting.

"Level IV-B, intermediate care patient" means an ambulant or semi-ambulant person with physical and/or mental dysfunction requiring minimal assistance with personal care needs on a daily basis. The Level IV-B patient requires continuous onsite availability of licensed and nonlicensed personnel for each 24-hour period under the general direction of a licensed practical nurse. The patients at this level of care will require continuing restorative, preventive and maintenance care which as a practical matter can only be provided in a Long Term Care Facility setting. The Level IV-B patient is usually fairly self-sufficient in activities of daily living with or without self-help devices and his/her needs usually have greater social than medical significance.