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STATE OF ALASKA  
THE LEGISLATURE

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Mary Van Nimwegen

SB 334

H. HESS

2/21/90

H. HESS

3/7/90

# HOUSE COMMITTEE REPORT

3/8

(7)

Date Referred: January 26, 1990

FURTHER REFERRALS:

FINANCE

Date of Committee Action: 3/7/90

The HESS 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
- have attached amendment(s)  a new title
- 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)

APPROVES PREVIOUS: (Date/Dept)

- fiscal impact \_\_\_\_\_
- zero fiscal note \_\_\_\_\_
- zero with analysis \_\_\_\_\_

- fiscal note(s) 1/22/90 DHSS
- zero fiscal note(s) \_\_\_\_\_
- zero fn/analysis \_\_\_\_\_

SIGNING DO PASS:

[Signature]

[Signature]

[Signature]

Cheri Lewis

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

SIGNING:  
(Check approp. column)

	Do Not Pass	No Rec	Amend
<u>[Signature]</u>		<input checked="" type="checkbox"/>	
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[Signature]  
Chairman's Signature



# Alaska State Legislature

## SENATE

Official Business

P.O. Box V  
State Capitol  
Juneau, Alaska 99811

*R - bill file*

### MEMORANDUM

TO: Representative Johnny Ellis  
FROM: Senator Jay Kerttula *[Signature]*  
SUBJ: Senate Bill 335 --  
Health Maintenance Organizations  
DATE: April 17, 1990

Senate Bill 335 is based on the National Association of Insurance Commissioners' Model Act for Health Maintenance Organizations. Alaska is one of two states which have not enacted the NAIC model act or similar or related legislation.

Senate Bill 335 would provide a specific licensing, incorporation, and regulatory scheme for health maintenance organizations. HMOs provide for basic health care services on a prepaid basis and have characteristics of both an insurer and a health care provider. Thus, membership in an HMO can be purchased by either an individual or an employer as a form of health care insurance, or health care in an HMO can be paid for by a traditional insurance policy such as Blue Cross or Aetna. The lack of an Alaska statute which regulates HMOs is a barrier to the development of HMOs in Alaska. State regulation is also necessary in order to ensure the protection of Alaska residents from insolvent HMOs. There are no HMOs in Alaska at this time, although there have been HMOs in Alaska in the past.

Representative Johnny Ellis  
April 17, 1990  
Page Two

Medical costs are soaring -- health care now takes up 11 percent of the gross national product and it is anticipated to rise to 18 percent of the GNP by the year 2,000. HMOs provide both good medical options in terms of preventative medicine and a mechanism for containing costs. As an example of perceived costs savings resulting from HMOs -- the federal administration has proposed reducing medicaid premiums by \$60 per month for beneficiaries who join an HMO.

Attached is information on Senate Bill 335, relating to Health Maintenance Organizations. SB 335 is currently in the House Rules Committee. I think this bill is needed. It has the dual benefit of encouraging preventative health care and containing costs. The bill is supported by the administration and has "0" fiscal note.

I urge your support of Senate Bill 335.

JK:kh

CONTENTS

SENATE BILL 335 PACKET

PROVIDED BY SENATOR KERTTULA

DESCRIPTION OF BILL PROVISIONS.....	2
FISCAL NOTE.....	5
MODEL NAIC ACT.....	6
STATES WITH HMO LEGISLATION.....	19
NEWSPAPER ARTICLES.....	23

DESCRIPTION OF THE MAJOR PROVISIONS OF

CS SSSB 335 (FINANCE)

1. Requirements for Certificate of Authority: Senate Bill 335 requires that a list of conditions be met -- including demonstration of financial solvency -- prior to issuance of a certificate of authority. The bill also lists specific items of information that must be included within an application, and allows the department to acquire any other information that may be found necessary in the future.

2. Coordination with the Department of Health and Social Services: The nature of an HMO is that it is both an insurer and a health care provider. Therefore, both the Department of Commerce and the Department of Health and Social Services have an interest in the quality of an HMOs' operation. Senate Bill 335 requires that a copy of the application be forwarded by the Director of Insurance to the Department of Health and Social Services within 10 days after its receipt. Within 60 days after the Commissioner of Health and Social Services receives a copy of the application, he or she makes a recommendation; and within 30 days after that recommendation, the Department of Commerce either "issues or denies" a certificate of authority.

3. Solvency and Limits on Investments: CS SSSB 335 (Finance) would require a deposit of the greater of 10 percent of an HMOs' estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or \$250,000. The model act would have required a deposit of the greater of 5 percent of an HMOs' estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or \$100,000. The larger deposit which would be required under the CS is viewed as necessary to ensure that Alaska consumers will be protected from insolvent HMOs. The larger deposit is not viewed as an insurmountable barrier to the development of HMOs, since the deposit is only increased for the first year of operation -- after that the deposit requirements under the CS mirror the requirements under the model act (two percent

for the second fiscal year, three percent for the third fiscal year, four percent for the fourth fiscal year, and four percent thereafter.) The deposit requirements do not apply if the HMO has a net worth of \$1 million without buildings, or \$5 million with buildings, or some alternative formulas are met which demonstrate similar financial stability. Finally, the HMO must have and maintain a "capital account of at least \$100,000" in addition to any of the deposit requirements.

4. Governing Body: Senate Bill 335 requires that the governing body of an HMO be made up of at least one-third "consumers who are substantially representative of the participants." The sponsor substitute also requires that the HMO establish advisory panels so that enrollees would have an opportunity to participate in matters of policy and operation.

5. Dual Choice: Senate Bill 335 requires that each employer in the state, whether public or private, having 25 employees or more "shall make available to its employees or members the option to enroll" in an HMO. Mandatory dual choice is viewed as necessary to make an HMO financially viable in Alaska. In addition, federal medicaid regulations require that there be an dual choice requirement before they will provide medicaid reimbursement to an HMO. Under Senate Bill 335, an employer is not required to pay more for employee health benefits than he or she would have been required to pay if not covered by the bill.

Senate Bill 335 also mandates, that the option of enrollment in an HMO should first be submitted to a bargaining unit, if the employees are members of a collective bargaining unit. If the option is approved by the bargaining representative, the option of enrollment shall then be made to each represented employee. This language mirrors the federal regulations.

6. Form Filing and Rate Approval: Senate Bill 335 includes a mechanism for the approval of "an evidence of coverage." The bill provides that the HMO file the form with the Division of Insurance 30 days before it is to be used. The form is considered approved unless the director has affirmatively approved or disapproved the form within the 30 day period.

7. Complaint System : Senate Bill 335 contains a detailed section requiring that the HMO establish and maintain a complaint system.

8. Powers of an HMO: Senate Bill 335 has a section listing the powers of an HMO, and lists prohibited practices. The bill also limits the amount of money that can be recovered from an HMO from a participant who was not entitled to receive certain services to the actual cost of providing the health care service. Senate Bill 335 also provides a window of 10 days in which a participant who has just signed up with an HMO can return the agreement and demand a refund.

9. Taxation: Senate Bill 335 provides that an HMO is to be taxed and shall file reports as an authorized insurer.

10. Other Provisions: Senate Bill 335 contains a section imposing fiduciary obligations in the handling of money by an HMO. The bill also provides that health care services must be provided by appropriately licensed health care providers.

## FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
 Title: An Act relating to Health Maintenance Organizations  
 Sponsor: Sen. Kerttula  
 Requestor: Senate Labor & Commerce

Agency Affected: Commerce & Econ. Dev.  
 BRU: Insurance  
 Components: Operations

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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**FUNDING: (Thousands of Dollars)**

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**POSITIONS:**

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

**ANALYSIS:** (Attach a separate page if necessary) No fiscal impact in FY 90.

No fiscal impact on the division.

Prepared by: Joan Brown, Administrative Officer Phone: 465-2597  
 Division: Insurance Date: February 7, 1990

Approved by Commissioner: Larry Merculieff *SM* Date: 2/7/90  
 Agency: Department of Commerce & Economic Development

**Distribution (by preparer):**

Legislative Finance  
 Legislative Sponsor  
 Requestor  
 Office of Management and Budget  
 Impacted Agency(ies)

Changes in CSSSSB335 (L+C)  
 have no fiscal impact. This  
 fiscal note is appropriate.  
 Projections of no fiscal impact  
 would continue through 1996.

## Model Health Maintenance Organization Act

### Table of Contents.

Section 1.	Short Title
Section 2.	Definitions
Section 3.	Establishment of Health Maintenance Organizations
Section 4.	Issuance of Certificate of Authority
Section 5.	Powers of Health Maintenance Organizations
Section 6.	Governing Body
Section 7.	Fiduciary Responsibilities
Section 8.	Evidence of Coverage and Charges for Health Care Services
Section 9.	Annual Report
Section 10.	Information to Enrollees
Section 11.	Complaint System
Section 12.	Investments
Section 13.	Protection Against Insolvency
Section 14.	Prohibited Practices
Section 15.	Regulation of Agents
Section 16.	Powers of Insurers and (Hospital and Medical Service Corporations)
Section 17.	Examinations
Section 18.	Suspension or Revocation of Certificate of Authority
Section 19.	Rehabilitation, Liquidation, or Conservation of Health Maintenance Organizations
Section 20.	Regulations
Section 21.	Administrative Procedures
Section 22.	Fees
Section 23.	Penalties and Enforcement
Section 24.	Statutory Construction and Relationship to Other Laws
Section 25.	Filings and Reports as Public Documents
Section 26.	Confidentiality of Medical Information
Section 27.	(Commissioner of Public Health's) Authority to Contract
Section 28.	Acquisition of Control of or Merger of a Health Maintenance Organization.
Section 29.	Dual Choice
Section 30.	Severability

### Section 1. Short Title.

This Act may be cited as the Health Maintenance Organization Act of (insert year).

### Introductory Comment.

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

### Shortcomings of Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate; (b) Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc; and (c) Even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

### *Medical Care Foundations*

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept, often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint, the fee-for-service practice is maintained. Under the federal HMO Act, this type of organization is called an Individual Practice Association Type HMO.

#### *The Need for State Authorizing and Regulatory Legislation*

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statutes, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972 the NAIC adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's.

#### *Purpose of a State Model Bill*

The model bill clearly authorizes the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's are rendered inapplicable. Appropriate grants of authority are established to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the model bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Of course, it is also possible that the statutes of a given State are presently broad enough to allow operation of at least certain types of HMO's and provide the commissioners with appropriate authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMO's under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

Comment. Subsection (6) defines an HMO to be any person that undertakes to provide or arrange for at least basic health care services on a prepaid basis. This can be achieved either (a) by providing the services directly through physician or other providers actually employed by the HMO and through hospitals or facilities owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services. The term "arrange" does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, would be an HMO.

Subsection (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in Sections 4(2)(c) and 18(a)(c), establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees. Services for mental illness and alcohol and drug abuse are not included because they are often not covered by insurance or hospital or medical service plans and their inclusion would create a competitive disadvantage of HMO's. If a state believes that such services, or others, should be included as basic health care services, all carriers in the state should be required to offer or cover them.

Since no HMO may function without either a certificate of authority (see Section 3(1)) and since an HMO must furnish basic health care services (see Section 4(2)(c)), no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes: (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits. (See Section 5(1)(f).) These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliated providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of employees or of a mandate as to whether or not the HMO should be a profit or non-profit organization. Permitting both profit and non-profit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Subsection (9) defines uncovered expenditures for use in Section 13. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

- (k) A description of the complaint procedures to be utilized as required under Section 11;
  - (l) A description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4(1)(b);
  - (m) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under Section 6(2);
  - (n) Such other information as the commissioner (director, superintendent) may require to make the determinations required in Section 4.
- (4) (a) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this Act, file a notice describing any material modification of the operation set out in the information required by Subsection (3). Such notice shall be filed with the commissioner (director, superintendent) prior to the modification. If the commissioner (director, superintendent) does not disapprove within (insert number) days of filing, such modification shall be deemed approved.
- (b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirements of Paragraph (a) those items he deems unnecessary;
- (5) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least ninety (90) days following written notice by registered mail of cancellation by either party to the commissioner (director, superintendent).

**Comment.** Section 3 requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as the focus of regulatory attention to assure that the consuming public is well served.

Subsection (1) is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

- (1) require approval of a health maintenance organization by a medical society;
- (2) require that physicians constitute all or a majority of the governing body of a health maintenance organization;
- (3) require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;
- (4) require that such organization submit to regulation as an insurer of health care services;
- (5) require that only unincorporated individuals or associations or partnerships may provide health care services;
- (6) prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection (1), Section 25 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMO's. Furthermore, Section 6 specifically provides that any persons, whether or not providers of health care services, may serve on the governing body. There is no statutory requirement as to the appropriate composition of the membership of the governing body.

- (c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments;
  - (d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner (director, superintendent) may consider:
    - (i) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;
    - (ii) The adequacy of working capital;
    - (iii) Any agreement with an insurer, a (hospital or medical service corporation), a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;
    - (iv) Any agreement with providers for the provision of health care services; and
    - (v) Any deposit of cash or securities submitted in accordance with Section 13.
  - (e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 6;
  - (f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 3 or by independent investigation, is contrary to the public interest; and
  - (g) Any deficiencies identified by the (commissioner of public health) have been corrected.
- (3) A certificate of authority shall be denied only after compliance with the requirements of Section 21.

Comment. A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. Section 4 provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency—the insurance department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Subsection (1)(b) empowers the commissioner of public health to establish and apply standards of quality concerning health care. Among the arguments raised against quality control are: (1) they may limit the number of HMO's which will get started, (2) quality assurance procedures will prove to be expensive and (3) such controls will engender opposition from certain providers. On the other hand, existing methods for quality control are said to be fragmented and inadequate. If the states are to authorize and encourage HMO's by this legislation, they have an obligation to assure that the health care services provided are of reasonable quality. This is particularly true because of the built-in incentive for an HMO to restrict the utilization of services due to the incentives to stay within a fixed budget.

- (2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner (director, superintendent) prior to the exercise of any power granted in Subsections (1)(a), (b) or (d). The commissioner (director, superintendent) shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner (director, superintendent) does not disapprove within (insert number) days of the filing, it shall be deemed approved.
- (b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirement of Paragraph (a) those activities having a de minimis effect.

Comment: The exercise of authority granted in Subsections (1)(a), (1)(b) and (1)(d) shall be subject to disapproval by the commissioner within (insert number) days of a filing by a health maintenance organization. The commissioner may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the section would have little or no effect on the financial condition and ability to meet obligations of the organization.

#### Section 6. Governing Body.

- (1) The governing body of any health maintenance organization may include providers, or other individuals, or both.
- (2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Comment: While Section 3(1) should adequately override restrictive laws related to membership of a governing body, Section 6(1) makes explicit the permissible membership of such a group. The model bill does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer include: (1) such participation is unnecessary and perhaps even harmful to the efficient and professional delivery of health care services, (2) a consumer role will impede the initiation of an HMO since more people must be involved and (3) consumers can always seek alternative health care. The arguments for a consumer role seem more persuasive. These include (1) consumer participation results in a more responsive organization, and (2) consumer participation is not the same as lay control over the rendering of professional service.

#### Section 7. Fiduciary Responsibilities.

- (1) Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.
- (2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than \$100,000 or such other sum as may be prescribed by the commissioner (director, superintendent). All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the commissioner (director, superintendent) unless an earlier date of such cancellation or termination is approved by the commissioner (director, superintendent).

- (b) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary or other qualified person acceptable to the commissioner (director, superintendent), to the appropriateness of the use of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.
- (3) The commissioner (director, superintendent) shall within a reasonable period, approve any form if the requirements of Subsection (1) are met and any schedule of charges if the requirements of Subsection (2) are met. It shall be unlawful to issue such form or to use such schedule or charges until approved. If the commissioner (director, superintendent) disapproves such filing, he shall notify the filer. In the notice, the commissioner (director, superintendent) shall specify the reasons for his disapproval. A hearing will be granted within (insert number) days after a request in writing by the person filing. If the commissioner (director, superintendent) does not approve any form or schedule of charges within (insert number) days of the filing of such forms or charges, they shall be deemed approved.
- (4) The commissioner (director, superintendent) may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Comment: Subsection (1)(a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence. Paragraph (c) establishes requirements which such evidence of coverage must meet. The group contracts to be filed pursuant to Section 3(3)(f) are not subject to the standards and filing requirements of Section 8, since such group contracts are not issued to enrollees. Paragraph (d) clarifies the relationship between filing requirements under this Section and under the state insurance or hospital or medical service corporation law. Filing is required under Paragraph (b) unless the form is already subject to filing requirements under existing state law. However, where existing state law does not apply standards as strict as those contained in Paragraph (c), such standards are, in effect, read into the existing law. Where the filing under state insurance or medical or hospital service corporation law is required to meet standards as strict as those in Paragraph (c), the former would be applicable. A state may want Paragraph (d) to be revised to make specific reference to existing state laws.

Subsection (2)(a) provides for the filing of charges for health care services, i.e., that part of the benefit package which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (b) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Such a rigid requirement as community rating would appear to be inappropriate when the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such requirement might impose could impede the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus it is important that the charges be set at an adequate level. The requirement for certification by an actuary or other qualified person along with supporting information is intended to assist the commissioner in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the commissioner may consider the amount necessary to assure a reasonable return on the initial and subsequent capital invested and an amount needed to accumulate adequate funds to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.

**Comment:** Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. For complaints arising from health care services, the administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

In establishing the format for records and reports pursuant to this Section, the commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act. Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint. (See 1972 NAIC Proceedings I 443).

#### **Section 12. Investments.**

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner (director, superintendent) may permit.

**Comment:** Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the commissioner in accordance with the standards set out in Section 5(2).

#### **Section 13. Protection Against Insolvency.**

- (1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner (director, superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this section.
- (2) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) \$100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the commissioner (director, superintendent) or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the commissioner (director, superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

- (3) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent (1%) of the preceding 12 months uncovered expenditures, or (b) \$100,000 on the first day of the fiscal year beginning six (6) months or more after the effective date of this section.

**Comment.** Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this Section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum account, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The commissioner may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group or individual practice association may agree to look only to the organization for payment of services provided to the organization's enrollees and agree not to bill them in the event of insolvency.\* An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the commissioner if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time. (Section 3(5) requires prior notification of cancellation of any reinsurance.) This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

The requirement in Subsection (8) for a capital account only applies to organizations licensed after the effective date of the subsection. Thus, the capital account requirement would have to be taken into consideration by persons starting a new HMO. If a state wishes to apply the requirement to existing HMO's, it should allow for an appropriate phase-in period.

It is believed that these provisions and the related provisions of Section 4(2)(d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 18.

#### **Section 14. Prohibited Practices.**

- (1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:
  - (a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with a health maintenance organization:

\*A Provision to accomplish this might read:

- (2) The commissioner (director, superintendent) may by rule exempt certain classes of persons from the requirement of obtaining a license:
  - (a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or
  - (b) If other existing safeguards make regulation unnecessary.

**Section 16. Powers of Insurers and (Hospital and Medical Service Corporations).**

- (1) An insurance company licensed in this state, or a (hospital or medical service corporation) authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, (hospitals or medical service corporations), or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.
- (2) Notwithstanding any provision of insurance and (hospital or medical service corporation) laws (citations), an insurer or a (hospital or medical service corporation) may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or (hospital or medical service corporation) may make benefit payments to health maintenance organizations for health care services rendered by providers.

Comment: Subsection (2) overrides the group laws to permit an insurer or a hospital or medical service corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insolvent, and (5) to provide coverage against the cost of health care services as the health maintenance organization deems necessary. This section might also be redrafted to make specific reference to the relevant Section of existing law.

**Section 17. Examination.**

- (1) The commissioner (director, superintendent) may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.
- (2) The (commissioner of public health) may make an examination concerning the quality of health care service of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.
- (3) Every health maintenance organization and provider shall submit its relevant books and records for such examinations and in every way facilitate them. For the purpose of examinations, the commissioner (director, superintendent) and the (commissioner of public health) may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

- (2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Section 21.
- (3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.
- (4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner (director, superintendent) may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

#### Section 19. Rehabilitation, Liquidation, or Conservation of a Health Maintenance Organization.

- (1) Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner (director, superintendent) pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner (director, superintendent) may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in (cite sections of state rehabilitation law), or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.
- (2) A claim by a health care provider for an uncovered expenditure has the same priority as an enrollee, provided such provider of services agrees not to assert such claim against any enrollee of the health maintenance organization.

Comment. Section 19 provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the Commissioner under state laws applicable to insurance companies. Inasmuch as all states have existing authority, it is felt that the use of such statutes would be appropriate and would avoid the necessity of developing new administrative procedures applicable only to health maintenance organizations. Subsection (2) is designed to provide the maximum protection for enrollees by paying those providers that can bill the enrollee before those that have agreed not to. However, in order to obtain this priority, the provider must agree that the payment fully discharges the obligation of the enrollee. Incidentally, the NAIC has recommended the adoption of a model liquidation and rehabilitation act (See 1968 NAIC Proceedings I 214).

#### Section 20. Regulations.

The commissioner (director, superintendent) may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with (insert section number providing for review of administrative orders).

#### Section 21. Administrative Procedures.

- (1) When the commissioner (director, superintendent) has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the (commissioner of public health) in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least (insert number) days thereafter for a hearing on the matter.

**Section 23. Penalties and Enforcement.**

- (1) The commissioner (director, superintendent) may, in lieu of suspension or revocation of a certificate of authority under Section 18, levy an administrative penalty in an amount not less than (insert amount) dollars nor more than (insert amount) dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner (director, superintendent) may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.
- (2)
  - (a) If the commissioner (director, superintendent) or the (commissioner of public health) shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner (director, superintendent) or (commissioner of public health) may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.
  - (b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner (director, superintendent) or the (commissioner of public health) may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section or Section 21 of this act are satisfied.
- (3)
  - (a) The commissioner (director, superintendent) may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.
  - (b) Within (insert number) of days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred. Such hearings shall be conducted pursuant to (cite Sections of State Administrative Procedure Act), and judicial review shall be available as provided by (cite sections of State Administrative Procedure Act).
- (4) In the case of any violation of the provisions of this act, if the commissioner (director, superintendent) elects not to issue a cease and desist order, or in the event of non-compliance with a cease and desist order issued pursuant to Subsection (a), the commissioner (director, superintendent) may institute a proceeding to obtain injunctive or other appropriate relief in the (name of court of primary jurisdiction for actions of this nature).

**Comment:** Sections 23(3) and 23(4) authorize the commissioner to issue a cease and desist order and to apply for injunctive relief. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

**Section 24. Statutory Construction and Relationship to Other Laws.**

- (1) Except as otherwise provided in this act, provisions of the insurance law and provisions of (hospital or medical service corporation) laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or (hospital or medical service corporation) licensed and regulated pursuant to the insurance law or the (hospital or medical service corporation) laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

**Section 29. Dual Choice.**

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five employees, and each employee benefit fund in this state which offers its members any form of health benefit, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization(s) to be made available to the employees shall be made under the agreement.

No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, provided that the employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount equal to the lesser of (a) the amount paid on behalf of its other employees or members for health benefits or (b) the health maintenance organization's charge for coverage approved by the commissioner (director, superintendent) pursuant to Section 8 of this act.

Comment: This Section is similar to Section 1310 of the federal HMO Act, but extends the dual choice requirement to state licensed HMO's. The licensing requirements of this act are less stringent than the federal requirements, so this provision will assist in the development and growth of state licensed HMO's.

**Section 30. Severability.**

If any section, term, or provision of this act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

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*Legislative History (all references are to the Proceedings of the NAIC)*

- 1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
- 1973 Proc. II 139 (synopsis of model).
- 1974 Proc. I 12, 14, 405, 413 (amended).
- 1982 Proc. I 19, 28, 431, 498-499, 530-554 (revised and reprinted).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. CODE §§ 27-21A-1 TO 27-21A-32 (1986).	
Alaska	NO ACTION TO DATE	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973/1985) "Health Care Service Organizations".
Arkansas	ARK. STAT. ANN. §§ 66-5201 to 66-5228 (1975/1987).	
California		CAL. HEALTH & SAFETY CODE §§ 134 to 1399.64 (1979/1986) ("Knox-Keene Health Care Services Plan").
Colorado	COLO. REV. STAT. §§ 10-17-101 to 10-17-115 (1963/1986).	
Connecticut		CONN. GEN. STAT. §§ 33-179a to 33-179t (1971/1987) "Health Care Centers".
Delaware	HB 99 Model pending (1987).	DEL. CODE ANN. tit. 16 §§ 9101 to 9118 (1982). <u>See also</u> tit. 18 §§ 6401 to 6406 (1987).
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 641.17 to 641.33 (1985/1987).
Georgia	GA. CODE ANN. §§ 33-21-1 to 33-22-28 (1979/1986).	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO CODE §§ 41-3501 to 41-3934 (1974/1985).

Model Regulation Service - October 1987

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Illinois	ILL. REV. STAT. ch. 111 1-2 §§ 1401 to 1417 (1974/1987).	
Indiana		IND. CODE §§ 27-8-7-1 to 27-8-7-18 (1979/1987) ("Proposed Health Care Delivery Plans").
Iowa	IOWA CODE §§ 514B.1 to 514B.32 (1973).	
Kansas	KAN. STAT. ANN. §§ 40-3201 to 40-3227 (1974/1987).	
Kentucky		KY. REV. STAT. §§ 304.38-010 to 304.38-210 (1982/1986);
Louisiana	LA. REV. STAT. ANN §§ 22:2001 to 22:2025 (1986).	
Maine	ME. REV. STAT. ANN. tit. 24-A §§ 4201 to 4226 (1975/1986).	
Maryland		MD. ANN. CODE art 19 §§ 701 to 734 (1982/1987).
Massachusetts		MASS. GEN LAWS ch. 176G §§ 1 to 17 (1976/1986).
Michigan		MICH. COMP. LAWS. §§ 333.21001 to 333.21098 (1982/1986).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973/1986).	
Mississippi	MISS. CODE ANN. § 41-7-401 et seq. (1986).	
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983).	
Montana	MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987).	

Model Regulation Service - October 1987

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Nebraska	NEB. REV. STAT §§ 44-3201 to 44-3291 (1978, 1985).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/1987).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977/1985).
New Jersey	N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973).	
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-31 (1985/1986).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976).
North Carolina	N.C. GEN. STAT. §§ 57B-1 to 57B-25 (1979).	
North Dakota	N.D. CENT. CODE §§ 26.1-18-01 to 26.1-18-35 (1983).	
Ohio	OHIO REV. CODE ANN. §§ 1742.01 to 1742.36 (1976).	
Oklahoma		OKLA. STAT. tit. 63 §§ 2501 to 2510 (1975).
Oregon		OR. REV. STAT. §§ 750.003 to 750.075 (1985).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 83-101 to 83-119 (1981).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1901 to 1927
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-29 (1983, 1987).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
South Carolina	S.C. CODE ANN. §§ 38-25-10 et seq. (1987).	
South Dakota		S.D. CODIFIED LAWS ANN. §§58-41-1 to 58-41-97 (1974).
Tennessee	TENN. CODE ANN. §§ 56-32-201 to 56-32-225 (1986/1987).	
Texas	TEX. INS. CODE ANN. art. 20A.01 to 20A.35 (1975/1987).	
Utah		UTAH CODE ANN. §§ 31A-8-101 to 31A-8-406 (1986/1987).
Vermont	VT. STAT. ANN. tit. 8 §§ 5101 to 5113 (1979) (Most of model.)	
Virgin Islands	NO ACTION TO DATE	
Virginia	VA. CODE §§ 38.2-4300 to 38.2-4321 (1986).	
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.920 (1975/1986) (Parts of model).
West Virginia	W.VA. CODE §§ 33-25A-1 to 33-25A-28 (1977).	
Wisconsin		<u>See</u> WIS. STAT. § 628-36 (2m) providing that Commissioner may make rules for HMOs. <u>See also</u> ch. 609 (1985) on joint ventures.
Wyoming	WYO. STAT. §§ 26-34-101 to 26-34-128 (1986).	

## HMO Dominance Seen In '90s

BY RICHARD DONAHUE

CHICAGO—Health maintenance organizations will become the dominant financier of private health care in the U.S. before year 2000, a business-forecasting consultant predicts.

Sometime after that, the nation will adopt a Canadian-like national health insurance system, according to Roy Amara, president of the Institute of the Future, Menlo Park, Calif.

Mr. Amara sees an increased use of HMOs in the 1990s as a way to check rapidly increasing health costs. "I mean use of the real HMOs," he said, "the kind that puts the health-care providers at financial risk, the kind that employs salaried physicians and the kind that puts emphasis on wellness and preventive care."

Preferred provider organizations and managed fee-for-service plans are not substitutes for HMOs, he told attendees at a health-care symposium sponsored by Society of Actuaries of Schaumburg, Ill. and the American Hospital Association, Chicago.

Rather, he said, they represent "palatable steps" to HMOs, which were at first a "bridge too far" for many people.

The HMO population in the U.S. will grow from the approximately 30 million persons which now use them to 60 million by 1995, and then up to 60 percent or 70 percent of all privately insured persons by the year 2000, according to Mr. Amara. (Currently, the entire

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### *National Health Care Expected In Next Century*

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privately-insured population is 170 million, according to the Health Insurance Association of America, headquartered in Washington, D.C.)

"In HMOs, patients will lose their freedom to pick their own

physicians, and physicians will lose much of their clinical and economic autonomy as they watch their incomes shrink," Mr. Amara said.

He said the percentage of physicians who are salaried will increase from about eight percent in 1985 to about 35 percent in 2000.

Mr. Amara said Americans are not prepared for the dramatic changes coming in health care.

"The American public is not ready to accept rationing or restrictions in health care because health-care costs still don't bite deeply into the average household income," he said. "Only 5 percent of income goes for health expenditure now."

This will change, he said, as employers are forced to shift more of the burden of health-care cost to employees. Employers, who now pay more than 40 percent of the nation's health-care bill, will demand a bigger say in how the money is spent, he said.

Health-care costs, now at more than 11 percent of GNP, will, according to government predictions, be between 15 and 18 percent of GNP by the end of the century, he said.

*Cont'd on Page 22*

## Dominance Of HMOs Seen By The 1990s

*Cont'd from Page 21*

But employers and the government—which pays about half of health-care costs—cannot tolerate such a level, he said, predicting that health costs will level off at 13.5 percent of GNP by the end of the century.

He said a national health-care system, when it comes, will be similar but not identical to the system in Canada "where government is the insurer and taxes finance the cost."

State governments and private health insurers undoubtedly will play a more significant role in a U.S. system than do the provinces and insurers under the Canadian system, he said.

A U.S. national health system will mean there will be fewer, but larger, health insurers, he said, some of which may be employed to administer the national plan. □

# Medical Benefits

Volume 6, Number 15

August 15, 1989

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## INSIDE

### HEALTH CARE COSTS

Page 1

### COST CONTAINMENT

Page 6

### QUALITY OF CARE

Page 8

### EMPLOYEE BENEFITS

Page 9

**Consumer Price Index,  
Second Quarter, 1989**  
Hospital service prices soared  
in response to higher nursing  
wages.  
Page 5

**Cost Management Aims at  
Worker's Compensation**  
Employers take heed:  
Worker's compensation is a  
prime target for cost shifting.  
Page 6

**1989 COBRA Survey**  
COBRA isn't paying for  
itself—employers are  
subsidizing continuation of  
coverage by more than 40  
percent.  
Page 9

## HEALTH CARE COSTS

# Marion Managed Care Digest HMO Edition 1989

Marion Laboratories, Inc., July 1989

"For the year ended Dec. 31, 1988, 659 HMOs were in operation. Another seven were under development."

Operating HMOs reported total enrollments up 8.7% to 33 million in 1988, compared with 1987 when 707 operating HMOs reported more than 31 million enrollees.

The number of operating HMOs fell 6.8% in 1988, compared with a 12% increase in 1987. An industry shakeout had been predicted for

several years. The industry is likely to continue its consolidation through 1993 as the number of HMOs falls gradually each year.

HMOs are increasing their market penetration nationwide. Plans in 28 states reported enrolling 10% or more of their state's residents in 1988 (Figure 1), up from 24 states in 1987 and 20 a year earlier.

HMOs also successfully reduced the number of days that their enrollees spent in hospitals in 1988. Average annual hospital days per

Continued page 2

Figure 1. HMO market penetration (percent) by state, 1988.



Source: BMO Marketing Group Inc.; Marion Laboratories, Inc., 1988.

# Medical Benefits -

Marion Managed Care Digest  
(continued from page 1)

1,000 non-Medicare members dropped to 364 from 377.2 a year earlier (Table 1).

Nearly 16% of HMOs operating at year-end 1988 offered an open-ended option, the newest and fastest growing HMO product. An open-ended plan offers enrollees the right to choose at point of service whether they want to seek care within the HMO or to go outside to the physician or hospital of their choice.

HMOs with open-ended options expected to have nearly 2 million enrollees in these plans by year-end 1989, an increase of 17.3% from year-end 1988. Enrollment in open-ended plans rose 53% to 1.6 million in 1988 from a year earlier. Enrollees in open-ended plans accounted for 4.8% of all HMO enrollees.

Non-Medicare enrollees averaged 3.7 ambulatory visits each to their HMOs in 1988, according to 167 reporting plans. HMOs averaged 3.7 physician encounters and visits per non-Medicare enrollee in 1988, according to 233 reporting plans.

The average family premium charge for all HMOs rose 11.8% in 1988 to \$242.50 per month from \$216.82 in 1987 (Table 1). ■

**Editor's note:** The source for data used in this report was BMC Marketing Group Inc. See MM, 7/30/89, p. 8, for a report based on the same data base.

To obtain a free copy of this 32-page report, contact: Communications Department, Marion Laboratories, Inc., P.O. Box 440, Kansas City, MO 64116-0440. (816) 466-4333, ext. 4344.

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Table 1. Selected HMO utilization and premium averages by state, 1988.

State	Hospital days per 1,000 non-Medicare members	Physician encounters per member	Amb. visits per member	Premiums	
				Family	Individual
Alabama	380.7	3.0	4.8	\$228.81	\$87.14
Arizona	292.0	3.7	3.9	250.44	84.82
Arkansas	461.4	4.9	1.5	228.55	82.50
California	318.4	3.3	8.5	251.78	95.35
Colorado	275.6	3.5	2.0	228.90	84.53
Connecticut	402.8	3.9	3.1	282.40	112.98
Delaware	350.0	0.2	0.4	229.88	89.99
D.C.	382.7	2.9	3.3	238.32	89.80
Florida	385.9	3.3	2.6	220.67	83.42
Georgia	385.0	4.6	3.5	237.88	90.29
Hawaii	308.7	4.3	4.6	221.01	77.00
Idaho	212.0	—	—	227.50	93.50
Illinois	389.2	4.2	2.8	227.20	86.47
Indiana	383.9	4.5	2.9	237.21	81.68
Iowa	310.0	3.6	—	215.25	80.42
Kansas	441.0	3.3	2.1	248.80	94.79
Kentucky	370.0	—	—	238.99	85.44
Louisiana	406.0	3.7	0.2	235.48	85.66
Maine	343.3	—	—	246.33	96.67
Maryland	328.4	3.7	3.4	255.38	88.78
Massachusetts	389.1	3.5	4.2	292.27	109.89
Michigan	368.8	3.7	5.1	243.91	95.82
Minnesota	362.4	4.0	4.6	229.82	86.53
Missouri	394.3	2.8	1.4	250.50	90.45
Montana	375.0	4.4	3.1	205.00	80.00
Nebraska	329.8	2.8	—	253.75	94.50
Nevada	—	—	—	300.00	115.00
New Hampshire	384.0	4.9	3.5	281.50	100.50
New Jersey	416.2	3.0	3.7	222.79	88.52
New Mexico	385.0	3.5	—	272.27	104.88
New York	374.8	3.7	2.3	216.21	86.12
North Carolina	332.8	3.8	2.0	235.63	88.34
North Dakota	359.0	8.9	2.7	250.24	106.29
Ohio	404.2	3.6	3.2	251.35	93.46
Oklahoma	300.0	3.9	9.9	253.17	87.00
Oregon	298.1	2.8	2.3	213.18	79.93
Pennsylvania	376.5	3.5	2.4	221.64	83.59
Rhode Island	336.5	4.5	—	242.50	101.50
South Carolina	386.7	3.1	0.7	186.87	72.33
South Dakota	578.8	4.4	4.4	280.54	91.30
Tennessee	432.8	4.0	2.1	246.38	98.78
Texas	356.9	4.0	3.0	254.40	90.48
Utah	288.7	2.7	4.2	278.40	89.25
Vermont	—	—	—	208.00	82.00
Virginia	382.1	3.8	3.0	282.89	108.44
Washington	320.1	4.2	3.3	242.99	84.54
Wisconsin	383.2	4.7	3.7	253.81	96.57
Wyoming	560.0	4.0	1.7	220.00	90.00
Total U.S.	384.0	3.7	3.7	242.49	90.90

ALABAMA, MISSISSIPPI and WEST VIRGINIA had no operating HMOs in 1988.

Source: BMC Marketing Group Inc., Marion Laboratories, Inc., 1989

## How Cost-Effective Is Your Health Plan?

Benefits, July 1989

"To determine your plan's rating, add up the points indicated for each answer, then compare your total with those illustrated on the plan evaluation chart at the end. If your plan's cost-effectiveness rating is less than 'excellent,' you should consider incorporating some cost-effective features your score shows are missing from your plan."

1. Does your plan have first-dollar coverage for hospitalization?
  - A) (+20) No/Do have hospital pre-certification
  - B) (-5) No/No hospital pre-certification
  - C) (-15) Yes/Do have hospital pre-certification
  - D) (-30) Yes/No hospital pre-certification
2. Does your plan have first-dollar coverage for medical/surgical services?
  - A) (+10) No/Do have pre-certification
  - B) (0) No/No pre-certification
  - C) (-5) Yes/Do have pre-certification
  - D) (-15) Yes/No pre-certification
3. Your group plan's major medical deductible is:
  - A) (+10) \$300 per calendar year or more
  - B) (0) More than \$100/less than \$300 per calendar year
  - C) (-20) \$100 per calendar year or less
4. Is your major medical deductible indexed to your company's employees' earnings?
  - A) (+10) Yes/Also indexed to trend increases
  - B) (+5) Yes
  - C) (0) No
5. Your major medical co-insurance out-of-pocket limit is:
  - A) (+10) More than \$1,000 per employee per year
  - B) (0) More than \$500 up to \$1,000 per employee per year
  - C) (-10) \$500 or less per employee per year
6. Is your major medical co-insurance limit indexed to the employees' earnings?
  - A) (-10) Yes/Also indexed to trend increases
  - B) (+5) Yes
  - C) (0) No
7. Does your plan include a large claims management review/assistance service?
  - A) (+15) Yes/Also includes psychiatric claim review
  - B) (+10) Yes
  - C) (-10) No
8. Does your plan include a limit, or a review service, for chiropractic and/or podiatric care?
  - A) (+5) Yes/Chiropractic and podiatric care review
  - B) (0) Yes/Chiropractic or podiatric care review
  - C) (-5) No
9. Does your plan include a hospital bill audit service?
  - A) (+5) Yes
  - B) (-5) No
10. Does your plan have a pre-existing conditions limitation for new hires?
  - A) (+10) Yes
  - B) (-10) No
11. Do you require employee contributions for dependent coverage?
  - A) (+10) Yes/Dependents only
  - B) (0) No
12. Do you have an employee assistance program (EAP)?
  - A) (+5) Yes
  - B) (0) No
13. Do you provide a wellness program or incentives for a healthier lifestyle?
  - A) (+5) Yes
  - B) (0) No
14. Does your plan include a mail-order or prescription drug program?
  - A) (+5) Yes
  - B) (0) No
15. Does your plan include a preferred provider organization (PPO)?
  - A) (+15) Yes/PPO pays less than 100% of charges
  - B) (+5) Yes/PPO pays 100% of eligible charges
  - C) (-10) No
16. Do you provide employees with an HMO option?
  - A) (+15) Yes/HMO experience is integrated with primary plan's experience
  - B) (+5) Yes/HMO is a stand-alone service—less than 20% of employees participate
  - C) (-5) Yes/HMO is a stand-alone service—more than 20% of employees participate
  - D) (0) No
17. Do you actively police the coordination of benefits provision of your program?
  - A) (+10) Yes
  - B) (-10) No
18. Is your waiting period for new entrants long enough to avoid providing coverage during the initial 'heavy turnover' period?
  - A) (+5) Yes
  - B) (-5) No
19. Do you have an in-house COBRA compliance system or use an outside service?
  - A) (+10) Yes/Includes notification of new hires, qualifying event notification, monitoring of eligibility period, monthly bill processing and management
  - B) (0) Yes/But doesn't include all of the above
  - C) (-10) No
20. Do you provide retiree health coverage?
  - A) (+10) No
  - B) (-10) Yes/Contributory
  - C) (-15) Yes/Non-contributory

Plan evaluation		Anticipated rate increase
Total points	Plan rating	
170 - 195	Excellent	0% - 10%
130 - 170	Good	10% - 20%
100 - 130	Fair	30% - 40%
80 - 100	Poor	40% - 60%
under 80	Disastrous	50% +

# 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.

A handwritten signature in cursive script, appearing to read "Johnny Ellis".

Rep. Johnny Ellis, Chair

# ALASKA MENTAL HEALTH BOARD

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STEVE COWPER, GOVERNOR  
STATE OF ALASKA

ST. ANN'S CENTER  
419 6th STREET, SUITE 124  
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February 27, 1990

Representative Johnny Ellis  
Room 104, Capitol  
P.O. Box "V"  
Juneau, Alaska 99811

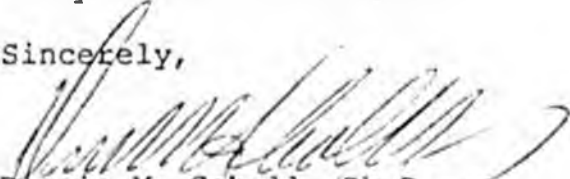
Honorable Representative Ellis,

The Alaska Mental Health Board (AMHB) expresses support for SB334, legislation dealing with options and waivers under Medicaid. At the AMHB meeting February 24-25, the Board, by unanimous vote, supported SB334.

The AMHB has discussed the purposes and benefits of SB334 with representatives of the Older Alaskans Commission, the Governor's Council for the Handicapped and gifted and the Department of Health and Social Services. The planning process enabled by the legislation can come to benefit many persons with disabilities. At the same time, Alaska may come to realize an enhancement of home and community based care, an often preferred type of care that is also less costly.

The AMHB hopes SB334 is reported favorably out of House HESS.

Sincerely,



Dennis M. Scholl, Ph.D.  
Executive Director

cc. Thelma Langdon  
Senator Uehling  
OAC  
GCH&G  
DHSS

TIMELINE FOR IMPLEMENTATION OF SB 334

FY 91					FY 92			
07/01/90		09/01/90		06/01/91	07/01/91	01/15/92	05/92	
OAC and CCHG hire staff	Interagency Policy Team meet--set-up work plan	CAC and CCHG start to gather information	DH&SS hire staff	All staff visit "model" states	Public conference for potential consumers and providers of Medicaid Community Care	OAC and CCHG issue report and recommendations	DH&SS submit cost study and recommendations on effect of options and waivers	Legislative input/decisions regarding options and waivers. Legislature amend AS 47.30 to add options. DH&SS begin to prepare option/waiver applications.

FY 93				FY 94			
07/01/92	07/15	09/15	01/01/93	07/01/93	12/15/93	01/01/04	
	DH&SS give copies of applications to OAC and CCHG	DH&SS apply for chosen options or waivers	Some new service options programmed in MMIS and available (tentative)	DH&SS negotiate waivers and complex options with HCFA	Waiver Approval from HCFA should be received staff hired and trained (tentative)	Waiver system programmed in MMIS; waiver (tentative)	Waiver services available (tentative)

KEY: DH&SS = Department of Health and Social Services  
 CCHG = Governor's Council for the Handicapped and Gifted  
 OAC = Older Alaskans Commission  
 HCFA = Federal Health Care Financial Administration (Medicaid)

Prepared by: Older Alaskans Commission

## The Missed Opportunities of Medicaid

Chris Koyanagi

*Dr. Sharfstein's Introduction: The federal-state mental health care program is a major payer for mental health care. Medicaid could finance additional community services needed by adults and children with severe mental illness, but it is both underutilized and inappropriately utilized in most states. The National Mental Health Association has published Operation Help: An Advocate's Guide to Medicaid, which provides detailed descriptions of how states have used Medicaid options to cover community mental health care and how they might better use these monies to improve planning and service delivery for the severely mentally ill. This month's column by the author of Operation Help recognizes the potential of Medicaid and the need to revise state Medicaid plans to reflect appropriate public health objectives.*

Medicaid is a federal-state program that pays medical bills for certain low-income people who can't afford the costs of care. In 1987, a total of 23.2 million people received Medicaid benefits, and the program now spends more than \$66.9 billion annually (1). Yet despite its size, many low-income people are not covered by Medicaid, resulting in a problem of access to health care that is becoming more and more acute. The percentage of those with incomes below

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the federal poverty level who have Medicaid coverage has declined from 65 percent ten years ago to less than 40 percent (2).

Medicaid is not a single program but a collection of 53 separate state and territorial programs with different target populations and various packages of services. Although the federal government prescribes basic requirements and describes options, each state and territory has its own version of the program. The federal and state governments share the cost of Medicaid expenditures, with the federal share varying from 50 percent to 78 percent, depending on the state's per capita income. Federal funds pay more than half of all Medicaid costs (\$37.4 billion in 1990). States pay between 22 percent and 50 percent of costs (\$29.5 billion in 1990), and in some states local governments contribute to the state share of Medicaid expenditures.

As a result of state decisions on who to cover and which services to reimburse, Medicaid spending varies widely between the states. In 1984 Medicaid per capita spending averaged \$148 but ranged from \$382 in New York to \$52 in Wyoming (3).

Access to Medicaid is also influenced by the number of providers who are participating. For example, the Health Care Financing Administration reports that 25 percent of the nation's physicians do not now participate in Medicaid and will not take Medicaid patients (4). Reasons include low payment scales, burdensome paperwork, and long delays in receiving reimbursement.

The history of the Medicaid program explains, in part, why federal and state Medicaid policymakers

have been reluctant to entertain proposals to expand mental health services. At its inception, Medicaid was viewed as providing the "deserving poor" (those who were eligible for other federal cash-assistance programs) with health care coverage similar to that provided to working people through insurance. Although the program has since been moving away from this model, it still primarily covers individuals receiving cash assistance, and it still emphasizes basic medical services.

In its early years, the costs of Medicaid rose much faster than predicted, but despite this fact major expansions were made both in eligibility (covering those who are disabled and receive Supplemental Security Income benefits) and in services (such as covering care provided in intermediate care facilities for the mentally retarded [ICF-MR]). These changes increased costs still further, ensuring that cost control, more than program expansion, would be the overriding concern of Medicaid policymakers.

Thus, although the percentage of poor people covered by Medicaid has been dropping in recent years, the costs have increased substantially, in large part because of expenditures for ICF-MR coverage and for long-term care in nursing facilities. Medicaid is now the principal payer for long-term care in this country. Fifty-seven percent of nursing home expenditures are paid by public funds, and in 1979 about 87 percent of public funding for nursing home care came from Medicaid (5).

In addition to escalating costs, in the 1970s Medicaid was also faced with a series of scandals concerning fraud and abuse that brought the program under close scrutiny.

Because of these experiences, Medicaid planners have become extremely wary of services that may be costly, uncontrollable, or subject to abuse. They are also concerned about the substantial costs expended for long-term care and about services that are less medical in nature. To Medicaid agencies, mental health services seem to fit into all these categories. And since Medicaid is run by state Medicaid agencies and not

by the state mental health authorities, state Medicaid agency views have tended to prevail as state policy-makers decide on what services should be covered under Medicaid.

Ensuring the availability of an appropriate array of mental health services is further complicated by the extraordinarily complex set of rules that govern the Medicaid program. There are federal laws, regulations, and guidelines, as well as state plans, rules and regulations, and reimbursement policies. The result is considerable confusion about what Medicaid really allows, a situation that benefits Medicaid agency officials whose objective is to control and limit their program's expenditures. Since they are the only ones who know the rules, they can control the game.

A first step to improving a state Medicaid plan for the benefit of those who need mental health care is to understand who uses Medicaid mental health services and what services they most need. It is also important to consider Medicaid policies that may impact on how mental health care can be delivered (for example, institutional versus community care coverage). Then one can compare what federal Medicaid law permits with a package of appropriate community care services as described by the mental health system.

#### Characteristics of Medicaid mental health patients

Recent studies have found that users of Medicaid mental health services seem to fall into three broad categories (6):

- Heavy users of services (discussed more fully below).

- Episodic users who make up to six to ten visits to providers (normally outpatient visits).

- Persistent users who receive a large number of less expensive services, such as outpatient or partial hospitalization, but little inpatient care. Although they may not receive many services, they maintain ongoing contact with the system over a long period.

- Both heavy and persistent users who tend to have diagnoses of

schizophrenia, affective disorders, or other long-term mental illnesses. The episodic users have a variety of diagnoses.

The heavy users are primarily young adults who use Medicaid inpatient hospital services at a disproportionately high rate. They are frequently treated in community hospitals for a short time and then released, often to be readmitted within weeks. In Philadelphia, they make repeated use of emergency services; although they constitute only 20 percent of the case load, they represent 55 percent of admissions and use 70 percent of service hours (7). These individuals are also heavy users of partial hospitalization and other day treatment services and outpatient services. In New York, 29 percent of Medicaid reimbursement for psychiatric inpatient care is for 5.1 percent of patients, and long inpatient stays (an average length of stay is 105 days) often occur because alternative community placements are not available (8).

Clearly, the services utilized by these heavy users are, for the most part, not well suited to their needs. Their special needs do not fit into the traditional brief therapy model of outpatient care, nor are they well served by expensive emergency care and general hospital inpatient care. Yet these are the only services available to many young people with mental illnesses. Because more suitable services are lacking, readmission rates are significant (7).

Similar problems are evident in child and adolescent care, where those who are Medicaid eligible have higher use of emergency mental health services (7).

#### Hospital inpatient bias

Another problem in providing appropriate care to the Medicaid population is the program's general bias toward inpatient care. Several factors contribute to this bias. For example, certain eligibility criteria make it easier to cover individuals when they are in institutions. Medicaid has also helped fuel the enormous growth in the last 15 years in general hospital psychiatric care and now pays \$2 billion a year na-

tionally for general hospital mental health care (6). Some states have caused a further imbalance in mental health coverage by offering unlimited inpatient care coverage but restricting access to community-based services.

#### Coverage of mental health services

Under federal law, certain services must be available to Medicaid-eligible individuals, and other services may be covered at the state's option. However, the special needs of persons with mental illness are not well served by Medicaid. For example, under federal law only persons age 65 and over or under age 22 are entitled to Medicaid-funded care in psychiatric hospitals. Persons with mental illnesses may obtain nursing facility services under Medicaid, but only in institutions that are not required to provide (and often do not provide) appropriate mental health care. There is no category to cover the costs of care for people with mental illnesses in small residential facilities such as halfway houses, group homes, and adult foster homes, although there is such coverage for persons with mental retardation.

In addition to specific prohibitions related to age and treatment sites, the Medicaid law presents states with another barrier to covering mental health services. Because it contains no statements about specific mandatory services for mental health care and few statements about specific optional services, there is no straightforward way for states to develop a package of adequate community-based mental health services under Medicaid. The most explicit statements in the law concerning mental health care are those that exclude coverage. As a result, most mental health services must be provided through other service options, such as clinic services, physician services, or rehabilitative services. Some of these service categories currently have regulatory requirements inappropriate to community mental health care.

But the picture is not nearly as bleak as this quick summary sug-

gests. While mandatory Medicaid benefits do not provide comprehensive coverage for community mental health services, combining the mandatory services with certain optional services allows a state to cover a very comprehensive package of services. Moreover, many of the restrictions facing community mental health providers are state restrictions, not federal policy, and thus are subject to change at the state level.

Once a state elects to cover a Medicaid service, it can define the exact meaning of each service within broad federal guidelines. The states, not the federal government, determine who may provide the service and under what conditions, for how long (or for how many visits) coverage is available, whether preadmission screening and other reviews of appropriateness of care are required, and the reimbursement rate that will be paid to providers for services. Under federal law, states must have a uniform benefit package for all Medicaid recipients and cannot set limits solely on the basis of diagnosis or type of illness or condition. However, states are allowed so much flexibility that they have been able, in fact, to restrict mental health care far more than care for other illnesses.

The Community Support Program of the National Institute of Mental Health has identified 12 essential services for adults with long-term mental illnesses (9). Medicaid, while it is not relevant for financing all of these various services, can provide substantial support for six of the 12: case management, rehabilitation, mental health treatment, crisis response services, health and dental care, and transportation. If a state wanted to maximize Medicaid reimbursement for community support services, it should add to the mandatory services of general hospital inpatient and outpatient care and physician services the following optional Medicaid services:

**Targeted case management.** This is defined by Medicaid as services that help eligible individuals gain access to needed medical, social, educational and other services, such as housing, vocational services, and financial assistance. States can target

these services to certain populations, such as individuals with long-term mental illnesses.

**Rehabilitation.** Medicaid's definition of rehabilitation is very broad. It covers any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. Services may be provided in any setting, including the client's residence or work place. States are just beginning to use this option to cover the services of psychosocial rehabilitation and similar community day programs, where social skills training, medication management, and other supportive services are provided.

**Clinic services.** Traditionally, states have used the clinic services option to cover the services provided in community mental health centers. The widespread use of this option has resulted in detailed federal requirements, some of which are not conducive to good patient care. Clinic services must, for example, always be furnished in the clinic (except for services to homeless people), and mental health professionals may not provide clinic services in the client's home. The clinic services option includes both outpatient therapy visits and partial hospitalization programming.

**Prescription drugs.** Prescription drug coverage is now nearly universal under Medicaid, although often there are limits on the numbers of prescriptions allowed or the frequency of refills.

**Personal care services.** Under this option, direct patient care and services related to activities of daily living can be provided in the recipient's home. Services must be provided or supervised by a registered nurse and prescribed by a physician in accordance with the patient's plan of care. Personal care services can include assistance with grocery shopping and household services. Clients must require direct patient care services to be eligible for other services.

**Care provided by other practitioners.** Medicaid can cover the services of other mental health practitioners, and a number of states now cover psychologists under this option and a few also include psychiatric social workers.

**Inpatient psychiatric hospital care for those age 65 and over.** This option allows states to finance psychiatric hospital care for older individuals.

Similarly, for children and adolescents, Medicaid can contribute resources to many of the services identified by NIMH as essential components of a community system of care. As for adults, Medicaid can finance case management, day treatment services, early identification, assessment and intervention services, outpatient assessment and treatment, emergency and crisis management, crisis residential hospital services, intensive care services, health care, and transportation for children (9).

In addition to the services described above for adults, for children federal Medicaid law also requires states to furnish early and periodic screening and diagnostic services to identify physical or mental problems. Treatment to correct or ameliorate "any defects or chronic conditions" discovered must also be furnished (10). This provision requires a comprehensive assessment of a child's overall health, development, and nutritional status, including an assessment of mental health factors. However, screening and diagnostic assessments are not aggressively pursued. Only 3 million Medicaid-eligible children and adolescents received these exams in 1987, even though studies show that those who do receive such services have lower health care costs as a result (11).

Other important service options for children are targeted case management, rehabilitation, clinic services, prescription drugs, and services of other mental health professionals. Case management is a particularly important service for children and adolescents who normally receive services from many community agencies. The rehabilitation option can provide for family-

based in-home services and services to young people in foster care or therapeutic group homes as well as for day treatment.

State Medicaid plans should also include the one optional service target specifically to children in need of mental health care: inpatient psychiatric hospital services for individuals under age 22. Although this option covers only certain facilities (many residential treatment centers cannot qualify), it is an important option to have available for children who need inpatient care.

Unfortunately, it is impossible to find a single state with a Medicaid services package that provides comprehensive coverage as described above either for adults or children.

#### Proposed action

Mental health advocates should focus far more attention on Medicaid. After several years of control and retrenchment, Medicaid is now growing. The federal government has been expanding eligibility for low-income pregnant women and children and in the process has broken the tie between Medicaid and welfare, so that Medicaid is moving toward becoming a program of health care for all low-income people. Although the prospects for further federal expansions are not good at this time, states have also begun to expand both program eligibility options and services coverage. State mental health agencies in most states are now paying greater attention to the Medicaid system, and many states have recently expanded community mental health coverage.

Although some problems remain with federal law and regulations, most of the current barriers to providing adequate mental health coverage for Medicaid recipients stem from state policies. Changing this situation should be a high priority for those who want to improve access to appropriate mental health care for low-income people.

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#### 1990 H&CP Institute

The 42nd Institute on Hospital and Community Psychiatry will be held October 7-11 at the Marriott City Center in Denver. James T. Barter, M.D., of Chicago is chairman of the program committee. A preliminary program will be published in the June issue.

The institute is one of two national meetings sponsored annually by the American Psychiatric Association. Last fall's institute in Boston drew almost 1,800 mental health professionals.

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# Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage



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


## MEMORANDUM

TO: Representative Johnny Ellis  
Chair, House HESS Committee

FROM: Senator Rick Uehling

DATE: January 26, 1990

RE: The Home Care Initiative,  
SB <sup>334</sup>~~344~~: "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."



I have asked staff to provide the following background and analysis to SB 334, which has been referred to the HESS Committee. At this time, I respectfully request that this bill be scheduled for a HESS Committee hearing as soon as possible.

Senate Bill 334 directs the Department of Health and Social Services to apply for federal approval to modify Alaska's medicaid program to allow for home care services for certain medicaid eligible Alaskans.

I know that through your work with the disabled and elderly people in this state, you understand the importance of this legislation. Thank you for your consideration.

Attachment

# 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.

# Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage



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

## TABLE OF CONTENTS

- I. Copy of SB 334 and Fiscal Notes  
Senate Journal Notes
- II. Bill Sectional Analysis  
Position Papers: Health & Social Services  
Older Alaskans Commission
- III. 42 U.S.C. 1396n(c) - (d)
- IV. Article Excerpt "Medical Care"  
Human Services Research Institute
- V. Budget Detail Dept. of Health & Social Services  
Division of Medical Assistance
- VI. "Medicaid Services State by State"  
U.S. Dept. of Health & Human Services
- VII. "Alaska Nursing Homes Census" November 30, 1989
- VIII. "Pioneers' Homes Occupancy Report" Feb. 2, 1989
- IX. Article "Looking Back- Looking Ahead, The First  
Three Years of the New Jersey Community Care  
Program for the Elderly and Disabled"  
State of New Jersey

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

6-1564J

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  
Services to seek permission to use options and re-  
ceive waivers under the Medicaid program for the cost  
of home or community-based services for develop-  
mentally delayed children, developmentally disabled  
persons, disabled adults, and older Alaskans; direct-  
ing other agencies to assist in that process; and  
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-  
dren and adults who are experiencing disabling conditions have individual  
and changing needs that can be best addressed by having available to them a  
mix of services, including home and community-based services and institu-  
tional care. The historical focus of the Medicaid program has been on  
providing services in institutional settings for adults who need outside  
assistance in daily living and for children who need developmental help.  
Therefore, some persons whose needs could be met outside of institutions  
have, nevertheless, become institutionalized so that they could receive  
services through the Medicaid program. Other persons in need have received  
no services until their conditions deteriorated to the point where they met  
the Medicaid criteria for institutionalization. Nursing facilities, hos-  
pitals, and intermediate care facilities for the mentally retarded should  
remain readily available for those whose needs require that kind of set-  
ting, but the availability of home and community-based services should also

29

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

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

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

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

23 \* Sec. 4. FINAL DETERMINATION; APPLICATIONS FOR OPTIONS AND WAIVERS.

24 (a) After legislative review during the Second Session of the Seventeenth  
25 Alaska State Legislature, and before September 15, 1992, the Department of  
26 Health and Social Services shall apply to the Secretary of Health and Human  
27 Services for permission to use home and community-based options and waivers  
28 that may be approved under 42 U.S.C. 1396n(c) - (d) and other federal laws  
29 for developmentally delayed children, developmentally disabled persons.

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

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

16 (c) While preparing applications required under (a) of this section,  
17 the Department of Health and Social Services shall consult with the Gover-  
18 nor's Council for the Handicapped and Gifted and the Older Alaskans Commis-  
19 sion. In addition, 60 days before submitting applications to the Secretary  
20 of Health and Human Services, the department shall deliver a copy of the  
21 proposed applications to the council and the commission for their review  
22 and comment. The department shall consider comments made by the council  
23 and commission and amend the applications as considered appropriate by the  
24 department before submitting them to the Secretary of Health and Human  
25 Services.

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

1 (d) and other federal laws.

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

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

9 (2) all three agencies will cooperate with each other in provid-  
10 ing requested nonconfidential information that would assist the agencies in  
11 fulfilling their duties under this Act.

12 \* Sec. 6. DEFINITIONS. In this Act

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

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

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

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

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

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

1 combination of mental and physical impairments;

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

3 (C) is likely to continue indefinitely;

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

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

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

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

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

22

# FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
 Title: An Act Relating to directing  
the Department of Health and...  
 Sponsor: Uehling, Fahrenkamp, Duncan  
 Requestor: Uehling

Agency Affected: Health and Social Services  
 BRU: Medical Assistance Administration

Components: Central Administration

**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						
<b>TOTAL OPERATING</b>	<b>466.0</b>	<b>432.5</b>	<b>440.5</b>			

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						
<b>TOTAL</b>	<b>466.0</b>	<b>432.5</b>	<b>440.5</b>			

**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 activities. Funding is 50% federal financial participation and 50% state general fund match.

Prepared by: Kim Busch  
 Division: Medical Assistance

Phone: 465-3355  
 Date: January 22, 1990

Approved by Commissioner: Myra H. 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)

Detail of Fiscal Note on SB 334  
FY91 OPERATING

		<u>Medical Assistance</u>	<u>RSA Governor's Council</u>	<u>RSA Older Alaskans Commission</u>
100	<u>Personal Services</u>			
	.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)		<u>58.0</u>	<u>58.0</u>
	Sub-Total	<u>148.8</u>	58.0	58.0
200	<u>Travel</u>	<u>10.6</u>	<u>15.4</u>	<u>10.0</u>
300	<u>Contractual</u>			
	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 RSA's		14.0	6.0
	Older Alaskans Commission	110.0		
	Governor's Council H & G	<u>110.0</u>		
	Sub-Total	278.6	29.6	35.0
400	<u>Supplies</u>	<u>6.0</u>	<u>1.5</u>	<u>1.5</u>
500	<u>Equipment</u>			
	Microcomputer hardware and software	16.0	4.0	4.0
	Desks, chairs, etc.	<u>6.0</u>	<u>1.5</u>	<u>1.5</u>
	Sub-Total	22.0	5.5	5.5
TOTAL FY91 OPERATING		<u>466.0</u>	<u>110.0</u>	<u>110.0</u>
FUNDING:				
	50% Federal Financial Participation	233.0		
	50% State General Fund Match	233.0		

Detail of Fiscal Note on SB 334  
FY92 OPERATING

		<u>Medical Assistance</u>	<u>RSA Governor's Council</u>	<u>RSA Older Alaskans Commission</u>
100	<u>Personal Services</u>			
	1 PFT Health Planner III (R21)	63.6		
	2 PFT Research Analyst III (P18)	110.7		
	1 PFT Clerk Typist III (R8)	29.3		
	2 PFT Health Planner II (R19)	<u>        </u>	<u>60.0</u>	<u>60.0</u>
	Sub-Total	203.7	60.0	60.0
200	<u>Travel</u>	<u>4.9</u>	<u>5.7</u>	<u>5.7</u>
300	<u>Contractual</u>			
	Office Space, Risk Management, telephone, etc.	54.7	13.5	13.5
	RSA			
	Older Alaskans Commission	82.0		
	Governor's Council H & G	<u>80.7</u>	<u>        </u>	<u>        </u>
	Sub-Total	217.4	13.5	13.5
400	<u>Supplies</u>	<u>6.5</u>	<u>1.5</u>	<u>1.5</u>
TOTAL FY92 OPERATING		<u>432.5</u>	<u>80.7</u>	<u>80.7</u>
FUNDING:				
	50% Federal Financial Participation	216.3		
	50% State General Fund Match	216.2		

Detail of Fiscal Note on SB 334  
FY93 OPERATING

		<u>Medical Assistance</u>	<u>RSA Governor's Council</u>	<u>RSA Older Alaskans Commission</u>
100	<u>Personal Services</u>			
	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)	<u>        </u>	61.7	61.7
	Sub-Total	210.4	61.7	61.7
200	<u>Travel</u>	<u>4.7</u>	<u>4.4</u>	<u>4.4</u>
300	<u>Contractual</u>			
	Office Space, Risk Management, telephone, etc.	56.8	13.5	13.5
	RSA			
	Older Alaskans Commission	81.1		
	Governor's Council H & G	<u>81.1</u>	<u>        </u>	<u>        </u>
	Sub-Total	218.9	13.5	13.5
400	<u>Supplies</u>	<u>6.5</u>	<u>1.5</u>	<u>1.5</u>
TOTAL FY93 OPERATING		<u>440.5</u>	<u>81.1</u>	<u>81.1</u>
FUNDING:				
	50% Federal Financial Participation	220.2		
	50% State General Fund Match	220.3		

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)

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:

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. Sipe *Frances B. Toland* Phone: 465-3250  
Division: Older Alaskans Commission *for* 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)

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

Detail of Fiscal Note on SB 334

FY 91

100	<u>Personal Services</u>	
	1 PFT Health Planner II (Range 19) Juneau	\$ 58,027
200	<u>Travel</u>	10,000
	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).	
300	<u>Contractual Services</u>	
	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)	
350		35,000
400	<u>Supplies</u>	1,500
500	<u>Equipment</u>	5,500
	Includes as one-time expenses:	
	Computer, desk, etc.	
		<hr/>
	FY 91 TOTAL:	\$110,027

SB 334

SENATE BILL NO. 334 by Senators Uehling, Fahrenkamp, Duncan, Sturgulewski, Faiks, Halford, Rodey and Jones, 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."

was read the first time and referred to the Health, Education and Social Services Committee and the Finance Committee.

SB 334

Senator Eliason moved and asked unanimous consent that he be shown as a co-sponsor on SENATE BILL NO. 334 (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). Without objection, it was so ordered.

SB 334

The Health, Education and Social Services Committee considered SENATE BILL NO. 334 (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) and a majority of the committee recommended do pass. The report was signed by Senator Fischer, Chair and concurred in by Senators Jones and Duncan. Senator Adams signed "no recommendation."

SB 334 con'td

Two fiscal notes from Department of Health and Social Services and a fiscal note from Department of Administration published today.

SENATE BILL NO. 334 was referred to the Finance Committee.

January 22, 1990

SENATE JOURNAL

p. 2166

SB 334

The Finance Committee considered SENATE BILL NO. 334 (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) and a majority of the committee recommended do pass. The report was signed by Senator Uehling, Co-Chair, and concurred in by Senators Zharoff, Duncan, Frank, Pearce and Fischer.

Fiscal notes from Department of Health and Social Services and Department of Administration published today.

SENATE BILL NO. 334 was referred to the Rules Committee.

January 22, 1990

SENATE JOURNAL

p. 2172

SB 334

Senator Zharoff moved and asked unanimous consent that he be shown as a co-sponsor on SENATE BILL NO. 334 (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). Without objection, it was so ordered.

SB 334

Senator Pourchot moved and asked unanimous consent that he be shown as a co-sponsor on SENATE BILL NO. 334 (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). Without objection, it was so ordered.

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.

**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  
Senate Bill No. 334  
Page 2

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

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Juneau, Alaska 99811-0209  
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### 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. Island*  
Peggy Burgin, Chair  
Older Alaskans Commission

DATED: 1/17/90

REVIEWED:

*Frank Baxter*  
Frank Baxter, Commissioner  
Department of Administration

DATED: 1/19/90

CH. 7 MEDICAL ASSISTANCE PROGRAMS

42 § 1396n

this subchapter) can obtain medical care services (other than in emergency circumstances) if such restriction does not substantially impair access to such services of adequate quality where medically necessary.

(2) to allow a locality to act as a central broker in assisting individuals (eligible for medical assistance under this subchapter) in selecting among competing health care plans if such restriction does not substantially impair access to services of adequate quality where medically necessary.

(3) to share (through provision of additional services) with recipients of medical assistance under the State plan cost savings resulting from use by the recipient of more cost-effective medical care, and

(4) to restrict the provider from (or through) whom an individual (eligible for medical assistance under this subchapter) can obtain services (other than in emergency circumstances) to providers or practitioners who undertake to provide such services and who meet, accept, and comply with the reimbursement, quality, and utilization standards under the State plan, which standards are consistent with access, quality, and efficient and economic provision of covered care and services, if such restriction does not discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing those services.

(c) Waiver respecting medical assistance requirement in State plan; scope, etc.

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan.

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver.

for an evaluation of the need for such skilled nursing facility or intermediate care facility services:

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of skilled nursing facility or intermediate care facility services;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

(E) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewide) and section 1396a(a)(10) of this title. A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve.

**(d) Period of waivers; continuations**

No waiver under this section (other than a waiver under subsection (c) of this section) may extend over a period of longer than two years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

**(e) Monitor of implementation of waivers; termination of waiver for noncompliance; report**

(1) The Secretary shall monitor the implementation of waivers granted under this section to assure that the requirements for such waiver are being met and shall, after notice and opportunity for a hearing, terminate any such waiver where he finds noncompliance has occurred.

(2) The Secretary shall report, not later than September 30, 1984, to Congress on waivers granted under this section.

**(f) Time limitation for action on requests for plan approval, amendments, or waivers**

A request to the Secretary from a State for approval of a proposed State plan or plan amendment or a waiver of a requirement of this subchapter submitted by the State pursuant to a provision of this subchapter shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

(Aug. 14, 1935, c. 531, Title XIX, § 1915, as added Aug. 13, 1981, Pub. L. 97-35, Title XXI, § 2175(b), 95 Stat. 809, and amended Aug. 13, 1981, Pub. L. 97-35, Title XXI, §§ 2176, 2177(a), 95 Stat. 812, 813; Sept. 3, 1982, Pub. L. 97-248, Title I, § 137(b)(19)(A), (20)-(25), 96 Stat. 380; Jan. 12, 1983, Pub. L. 97-448, Title III, § 309(b)(17), 96 Stat. 2409.)

**Historical Note**

**Codification.** In the original of subsec. (c) (1), "this subchapter" read "this part". However, since this subchapter does not contain part designations but does contain provisions for approval of a State plan, "this part" was editorially translated as "this subchapter" as the probable intent of Congress.

**1983 Amendment.** Subsec. (c)(2)(B). Pub. L. 97-448 substituted in text following cl. (iii) "need for such skilled nursing facility or intermediate care facility services" for "need for such services".

**1982 Amendment.** Subsec. (b). Pub. L. 97-248, § 137(b)(19)(A), struck out "and section 1396b(m) of this title" following "section 1396a of this title".

Subsec. (b)(1). Pub. L. 97-248, § 137(b)(20), inserted "primary care" preceding "case-management system", and substituted "medical care services" for "primary care services".

Subsec. (c)(1). Pub. L. 97-248, § 137(b)(21), inserted "payment for part or all of the

cost of" following "may include as 'medical assistance' under such plan".

Subsec. (c)(2)(B). Pub. L. 97-248, § 137(b)(22), redesignated existing provisions as cl. (i) and (ii), and added cl. (iii).

Subsec. (c)(3). Pub. L. 97-248, § 137(b)(23), substituted "section 1396a(x)(1) of this title" for "subsection (a)(1) of this section" and "section 1396a(x)(10)" for "subsection (a)(10) of section 1396a".

Subsec. (c)(4). Pub. L. 97-248, § 137(b)(24), substituted "subsection" for "section".

Subsec. (f). Pub. L. 97-248, § 137(b)(25), inserted "approval of" preceding "a proposed State plan".

**1981 Amendment.** Subsec. (c). Pub. L. 97-35, § 2176(2), added subsec. (c). Former subsec. (c) was redesignated (d).

Subsec. (d). Pub. L. 97-35, § 2176(1), (2), redesignated former subsec. (c) as (d), and in subsec. (d) as so redesignated inserted "(other than a waiver under subsection (c) of this section)".

(B) under such restriction, individuals eligible for medical assistance for such services have reasonable access (taking into account geographic location and reasonable travel time) to such services of adequate quality.

(b) *Waivers to promote cost-effectiveness and efficiency*

The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title as may be necessary for a State—

*[See main volume for text of (1) to (4)]*

No waiver under this subsection may restrict the choice of the individual in receiving services under section 1396d(a)(4)(C) of this title.

(c) *Waiver respecting medical assistance requirement in State plan: scope, etc.; "habilitation services" defined; imposition of certain regulatory limits prohibited; computation of expenditures for certain disabled patients; coordinated services; substitution of participants*

(1) The Secretary may by waiver provide that a State plan approved under this subchapter may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

*[See main volume for text of (A)]*

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for inpatient hospital, skilled nursing facility, or intermediate care facility services under the State plan,

*[See main volume for text of (ii) and (iii)]*

for an evaluation of the need for such inpatient hospital, such skilled nursing facility or intermediate care facility services;

(C) such individuals who are determined to be likely to require the level of care provided in a hospital or skilled nursing facility or intermediate care facility are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital services or skilled nursing facility or intermediate care facility services;

(D) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

*[See main volume for text of (E)]*

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396e(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(I-II) of this title (relating to income and resource rules applicable in the community). A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

(4) A waiver granted under this subsection may, consistent with paragraph (2)—

*[See main volume for text of (A)]*

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.

(5) For purposes of paragraph (4)(B), the term "habilitation services", with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

(C) does not include—

(i) special education and related services (as defined in section 1401(16), (17) of Title 20, which otherwise are available to the individual through a local educational agency; and

(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 730 of Title 29.

(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.

(7)(A) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or condition who are inpatients in, or who would require the level of care provided in, hospitals, or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients in, or who would require the level of care provided in, those respective facilities.

(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a skilled nursing facility or intermediate care facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded, without regard to the availability of beds for such inpatients.

(8) The State agency administering the plan under this subchapter may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under subchapter V of this chapter in order to assure improved access to coordinated services to meet the needs of such children.

(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.

(10) The Secretary shall not limit to fewer than 200 the number of individuals in the State who may receive home and community-based services under a waiver under this subsection.

(d) Home and community-based services for the elderly

(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) with respect to individuals 65 years of age or older who—

(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1396a(a)(1) of this title (relating to statewideness), section 1396a(a)(10)(B) of this title (relating to comparability), and section 1396a(a)(10)(C)(i)(III) of this title (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c) of this section.

(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1396b of this title to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and communi-

ty-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

(i) The aggregate amount of the State's medical assistance under this subchapter for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(ii) The aggregate amount of the State's medical assistance under this subchapter for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year involved or the sum of—

(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the beginning of the base year and the beginning of the waiver year involved, plus

(II) the percentage increase between the beginning of the base year and the beginning of the waiver year involved in the number of residents in the State who have attained the age of 65, plus

(III) 2 percent for each year (rounded to the nearest quarter of a year) beginning after the base year and ending at the end of the waiver year.

(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 65 years of age for any period.

The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period. Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the "lesser of 7 percent" shall be deemed to be a reference to the "greater of 7 percent".

(iv) If there is enacted after December 22, 1987, an Act which amends this title and which results in an increase in the aggregate amount of medical assistance under this title for nursing facility services and home and community-based services for individuals who have attained the age of 65 years, the Secretary, at the request of a State with a waiver under this subsection for a waiver year or years and in close consultation with the State, shall adjust the

projected amount computed under this subparagraph for the waiver year or years to take into account such increase.

(C) In this paragraph:

(I) The term "home and community-based services" includes services described in sections 1395d(a)(7) of this title and 1395d(a)(8) of this title, services described in subsection (c)(4)(B) of this section, services described in paragraph (4), and personal care services.

(II) Subject to subclause (II), the term "base year" means the most recent year (ending before December 22, 1987) for which actual final expenditures under this subchapter have been reported to, and accepted by, the Secretary.

(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before December 22, 1987, the term "base year" means fiscal year 1989.

(III) The term "intermediate care facility services" does not include services furnished in an institution certified in accordance with section 1395d(d) of this title.

(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1316(b) of this title.

(B) Notwithstanding any other provision of this chapter, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).

(e) Waiver for children infected with AIDS or drug dependent at birth

(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

(B) Children described in this subparagraph are individuals under 21 years of age who—

(I) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

(II) have such syndrome, or

(III) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of subchapter IV.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

# MEDICAL CARE

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## **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 waived. 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.

## 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, an individual 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 option 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 services 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 undeeding 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 institutionalized; 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)

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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"

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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 waived 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)

## DIVISION OF MEDICAL ASSISTANCE

## Prior Year Expenditures

ACCT	CATEGORY OF SERVICE	Prior Year Expenditures			FY89	FY90
		FY 86 ACTUALS	FY 87 ACTUALS	FY 88 ACTUALS	ITD ACTUALS	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
<b>TOTAL ALL MEDICAID SERVICES</b>		<b>66,868.1</b>	<b>74,518.9</b>	<b>97,668.9</b>	<b>119,782.9</b>	<b>133,749.6</b>
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
<b>TOTAL ALL GRM SERVICES</b>		<b>11,348.9</b>	<b>6,508.0</b>	<b>8,557.8</b>	<b>7,713.8</b>	<b>6,385.0</b>
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
PERMANENT FUND DIVIDEND H.H.		0.0	353.6	740.4	910.2	1,300.0
<b>TOTAL MEDICAL ASSISTANCE</b>		<b>78,730.7</b>	<b>81,400.0</b>	<b>107,642.4</b>	<b>129,408.2</b>	<b>142,671.2</b>

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06-Jul-89

## DIVISION OF MEDICAL ASSISTANCE

ACCT	CATEGORY OF SERVICE	Prior Year Expenditures			FY89	FY90
		FY 86 ACTUALS	FY 87 ACTUALS	FY88 ACTUALS	ITD ACTUALS	Authorized
<b>MEDICAID</b>						
<b>MEDICAID HOSPITALS</b>						
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	PFDRH RSA	0.0	353.6			
811	TPL Recovery Contract			139.4	138.8	260.0
<b>MEDICAID STATE FACILITIES</b>						
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
<b>MEDICAID PHYSICIAN SERVICES</b>						
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
<b>MEDICAID OTHER</b>						
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	Chiropractic	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	Nursing 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
<b>TOTAL ALL MEDICAID SERVICES</b>		<b>66,868.1</b>	<b>74,518.9</b>	<b>97,668.9</b>	<b>119,782.9</b>	<b>133,749.6</b>

## 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
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## 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
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TOTAL ALL GRM SERVICES	11,348.9	6,508.0	8,557.8	7,713.8	6,385.0
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CATASTROPHIC ILLNESS	513.7	0.0	0.0		
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ALASKA LONGEVITY BONUS H.H.	0.0	19.5	675.3	1,001.3	1,236.6
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## PERMANENT FUND DIVIDEND HOLD HARMLESS

809	PFH Hold Harmless Non-Facility			647.1	199.5	567.5
810	PFH Hold Harmless Facilities			93.3	710.7	732.5
	TOTAL PFH HOLD HARMLESS			740.4	910.2	1,300.0

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TOTAL MEDICAL ASSISTANCE	78,730.7	81,400.0	107,642.4	129,408.2	142,671.2
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# MEDICAID SERVICES STATE BY STATE

October 1, 1987

Medicaid recipients receiving federally supported financial assistance must receive at least these services:

- Inpatient hospital services
- Outpatient hospital services
- Rural health clinic services
- Other laboratory and X-ray services

- Skilled nursing facility services and home health services for individuals 21 and older
- Early and periodic screening, diagnosis, and treatment for individuals under 21
- Family planning services and supplies
- Physician services
- Nurse 180-hour services

### Basic Required Medicaid Services

Federal financial participation is also available to States desiring to expand their Medicaid Programs by covering additional services and/or by including people at risk for medical but not for financial assistance. For the latter group, States may offer the services required for financial assistance recipients

or may substitute a combination of seven services. Definitions and annotations on eligibility and services vary from State to State. Details are available from local welfare offices and State Medicaid agencies.

Services provided only under the Medicare buy-in or the screening and treatment program for individuals under 21 are not shown on this chart.

### Optional Services in State Medicaid Programs

FMAP*	State	Skilled Nursing Facility Services	Home Health Services	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	Family Planning Services	Physician Services	Nurse 180-hour Services	Services for Age 64 or Older in Skilled Institution							Other Services	Total Available	Notes	
								Skilled Nursing Facility	Home Health	Physician	Nurse 180-hour	Skilled Institution	Other	Skilled Institution				Home Health
75.00	Alabama	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	18	AL
86.88	Alaska	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	16	AK
58.00	American Samoa	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		AS
66.12	Arizona	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	12	AZ
74.21	Arkansas	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	21	AR
66.62	California	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	66	CA
64.20	Colorado	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	10	CO
66.20	Connecticut	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	24	CT
61.00	Delaware	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	10	DE
66.20	D.C.	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	DC
66.20	Florida	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	FL
66.24	Georgia	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	10	GA
66.24	Hawaii	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	0	HI
66.71	Idaho	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	22	ID
76.47	Illinois	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	14	IL
66.62	Indiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	IN
66.71	Iowa	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	IA
66.70	Kansas	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	KAN
66.25	Kentucky	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	24	KY
66.25	Louisiana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	14	LA
67.00	Maine	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	27	ME
61.00	Maryland	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	10	MD
66.66	Massachusetts	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	24	MA
66.48	Michigan	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	MI
66.00	Minnesota	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	MN
70.00	Mississippi	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	12	MS
66.27	Missouri	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	14	MO
66.48	Montana	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	27	MT
66.75	Nebraska	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	NE
66.20	Nevada	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	21	NV
66.00	New Hampshire	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	NH
66.00	New Jersey	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	NJ
71.00	New Mexico	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	10	NM
66.00	New York	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	NY
66.00	North Carolina	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	NC
64.67	North Dakota	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	26	ND
66.00	N. Mariana Islands	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	11	MI
66.10	Ohio	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	OH
66.22	Oklahoma	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	OK
66.11	Oregon	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	OR
67.26	Pennsylvania	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	PA
66.00	Puerto Rico	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	1	PR
64.00	Rhode Island	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	RI
70.40	South Carolina	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	SC
70.10	South Dakota	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	SD
66.00	Tennessee	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	18	TN
66.00	Texas	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	18	TX
70.70	Utah	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	UT
66.00	Vermont	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	24	VT
66.00	Virgin Islands	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	1	VI
61.04	Virginia	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	17	VA
61.21	Washington	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	WA
64.24	West Virginia	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	20	WV
66.00	Wisconsin	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	27	WI
67.00	Wyoming	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	9	WY
0	10	1	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
0	40	1	20	71	20	20	16	20	20	21	21	20	27	20	24	17	10	
0	60	1	20	21	20	20	20	20	20	21	21	20	27	20	24	17	10	
0	80	1	20	21	20	20	20	20	20	21	21	20	27	20	24	17	10	

Federal Medical Assistance Percentage (FMAP): Rate of Federal Financial Participation in a State's Medicaid Assistance Program under Title XIX of the Social Security Act. Effective October 1, 1987 through September 30, 1988 (Fiscal Year 1988).  
 \*Categorically Needy: Individuals receiving federally supported financial assistance.  
 \*Medically Needy: Individuals who are eligible for medical but not for financial assistance.  
 \*American Samoa operates a special Medicaid program.  
 The data shown were supplied by individual Regional Offices and compiled by the Office of Intergovernmental Affairs.  
 HCFA Pub. No. 98-106-02

\*Arizona operates a federal entitlement program under a Section 1115 Demonstration Project.  
 \*\*All services are provided through public health facilities.  
 †Services indicated as available to the Medicaid Needy are not available to all Medicaid Needy Groups.

FACILITY	MEDICAID PER DIEM RATE	CERTIFIED CAPACITY		MEDICAID/GRH PLACEMENTS		NON-OHA PLACEMENTS MEDI- CARE **		TOTAL CENSUS	VACANT BEDS	% OCCUPANCY OF TOTAL BEDS	
		SNF/ ICF	SWING BEDS	ICF	SNF	CARE	OTHER			OVERALL	MEDICAID
COROONA 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 HANOR (Ketchikan)	232.28	46	0	24	1	2	3	30	16	65%	54%
KOTZEBUE SENIOR CITIZEN CARE CIR.	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 (Home)	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%
<b>SWING BEDS (Acute to LTC):</b>											
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%
SIKA COMMUNITY HOSPITAL	177.51	0	2	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%
<b>TOTAL:</b>			<b>740</b>	<b>442</b>	<b>76</b>	<b>25</b>	<b>69</b>	<b>612</b>	<b>126</b>	<b>83%</b>	<b>70%</b>

\* - beds certified ICF only.

\*\* - includes VA, private pay, insurance, and other.

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

ICF/MR AND IMH CENSUS

CURRENT OCCUPANCY

PSYCHIATRIC BEDS	PER DIEM RATE	CERTIFIED BEDS	MEDICAID			NON-MEDICAID	TOTAL CENSUS	VACANT BEDS
			TOTAL	UNDER 22	OVER 65			
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

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*Janet*

# MEMORANDUM

# State of Alaska

TO: Commissioner John M. Andrews  
Department of Administration

DATE: February 2, 1989

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

FILE NO:

FROM: Barbara Bathony, Director <sup>AB</sup>  
Division of Pioneers' Benefits  
Department of Administration

TELEPHONE NO: 465-4400

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

	Available Beds				I	Not Available V	Total Beds =	Occupied Beds				% Occupancy of Available Beds this mo. last mo.	
	R	R2	N	=				R	R2	N	=		
SIT	45	*	39	84	2	41	127	36	*	35	71	85	87
FBX	56	*	46	102	2	0	104	54	*	46	100	98	99
PHR	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	47	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	*	*
PHR	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
PHR	0	0	0	0	1	0	2	2	29	33
ANC	4	0	2	0	0	0	0	2	53	55
KTN	*	*	0	0	*	*	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
PHR	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

# LOOKING BACK — LOOKING AHEAD

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.*

## TABLE OF CONTENTS

Introduction .....	3
Looking Back—History and Evolution of CCPED .....	4
Application and Enrollment .....	7
Letters of Support .....	10
Population Served .....	11
Chart 1 Three years of CCPED Phasing in the Counties .....	14
Chart 2 CCPED Enrollment Process .....	15
Chart 3 Percentage Male/Female Clients .....	16
Chart 4 Age Variation of Clients .....	17
Chart 5 Race Variation of Clients .....	18
Chart 6 Living Arrangement of Clients .....	19
Chart 7 Monthly Income of Clients .....	20
Chart 8 Primary Diagnosis of Clients .....	21
Chart 9 Level of Care: CCPED Compared to Nursing Home .....	22
Chart 10 Reasons for Termination .....	23
Chart 11 Length of Stay in Program .....	24
Chart 12 Total Amount Paid for Services—Year One .....	25
Chart 13 Total Amount Paid for Services—Year Two .....	26
Chart 14 Total Amount Paid for Services—Year Three .....	27
Chart 15 Expenditures and Average Per Capita Costs: CCPED Vs. Nursing Home .....	28
Attachment A—Nursing Home Level of Care Criteria .....	29

## 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 waived 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 waived 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 ex-

cellent 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-

ipients 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 pa-

tients 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

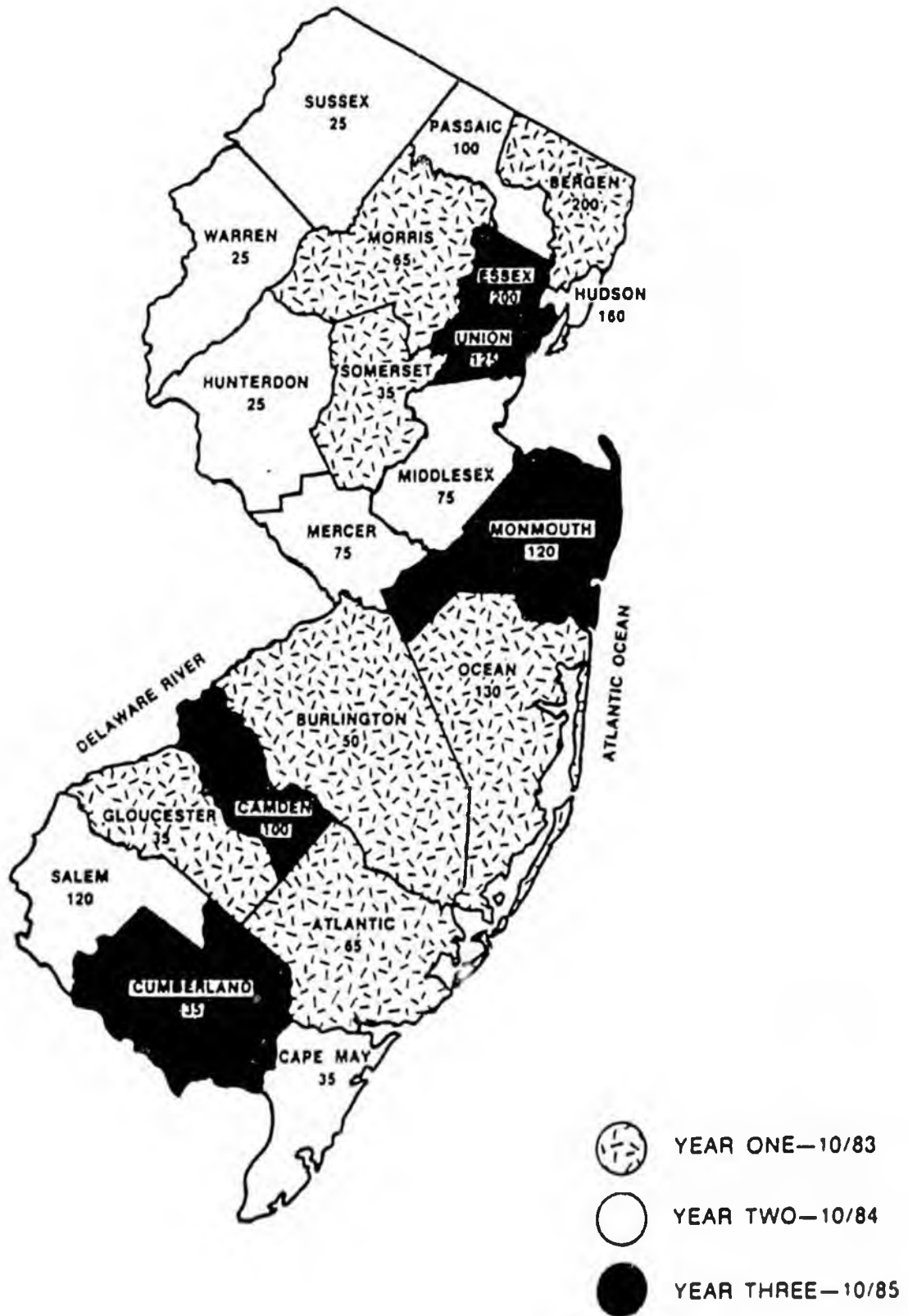
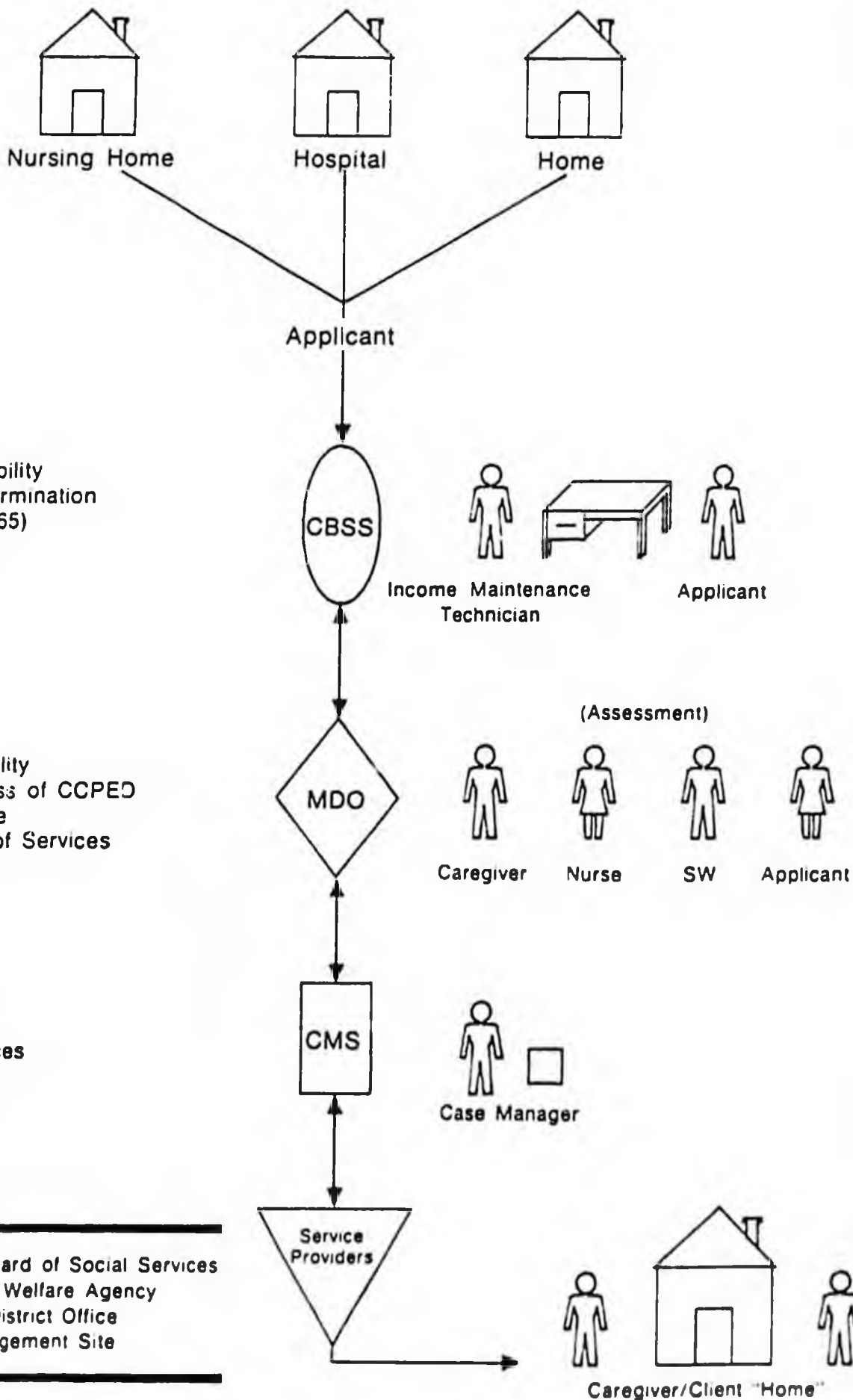


CHART 2

**CCPED  
Enrollment  
Process**



- Financial Eligibility
- Disability Determination (if under age 65)

- Medical Eligibility
- Appropriateness of CCPED
- Choice of Care
- Authorization of Services

- Service Plan
- Arrange Services
- Monitor Care

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CBSS—County Board of Social Services  
or County Welfare Agency  
MDC—Medicaid District Office  
CMS—Case Management Site

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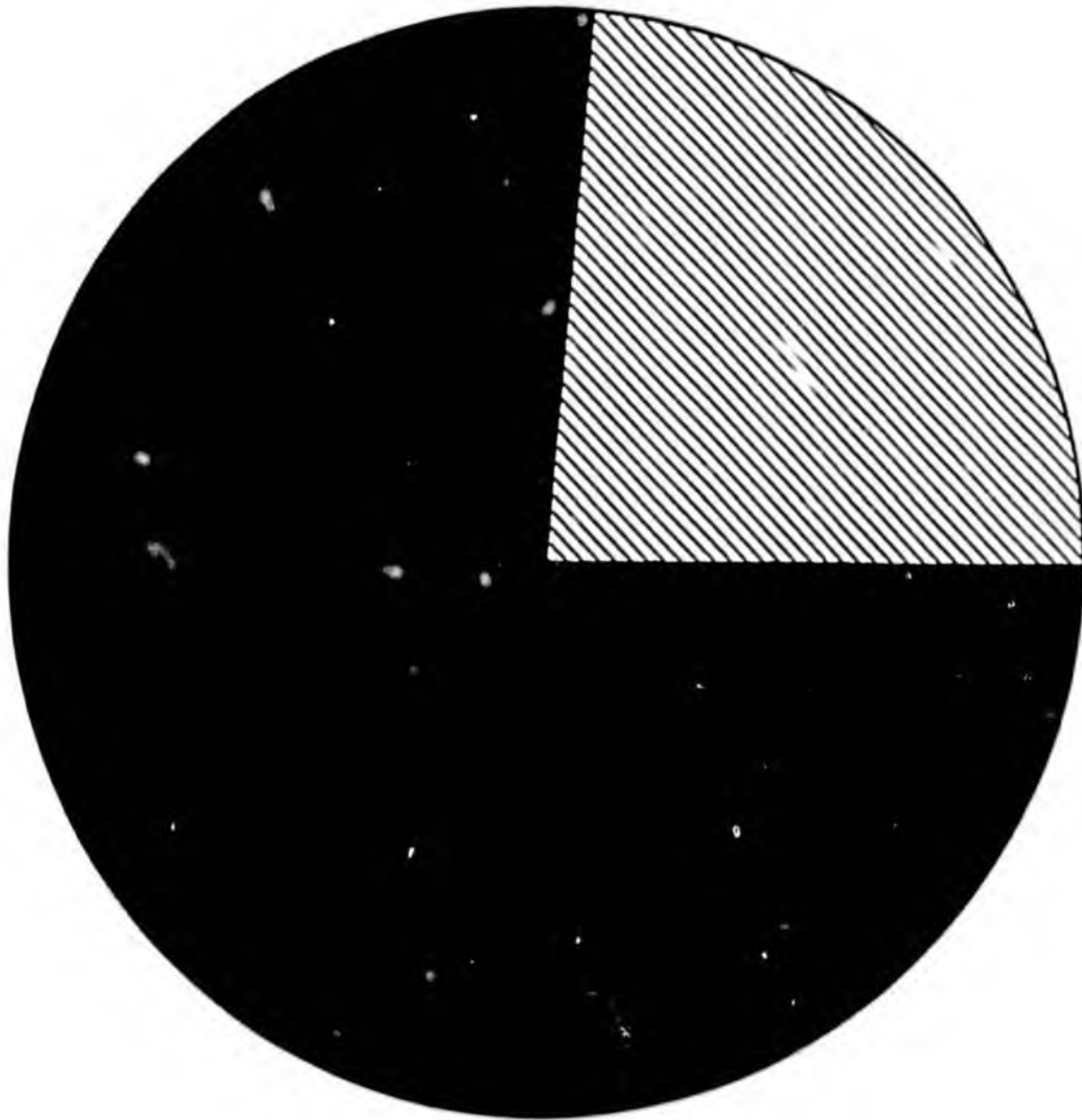
CHART 3

# PERCENTAGE MALE/FEMALE CLIENTS

LEGEND

 MALE 24%

 FEMALE 76%



4,075 CLIENTS SERVED

CHART 4

# AGE VARIATION OF CLIENTS

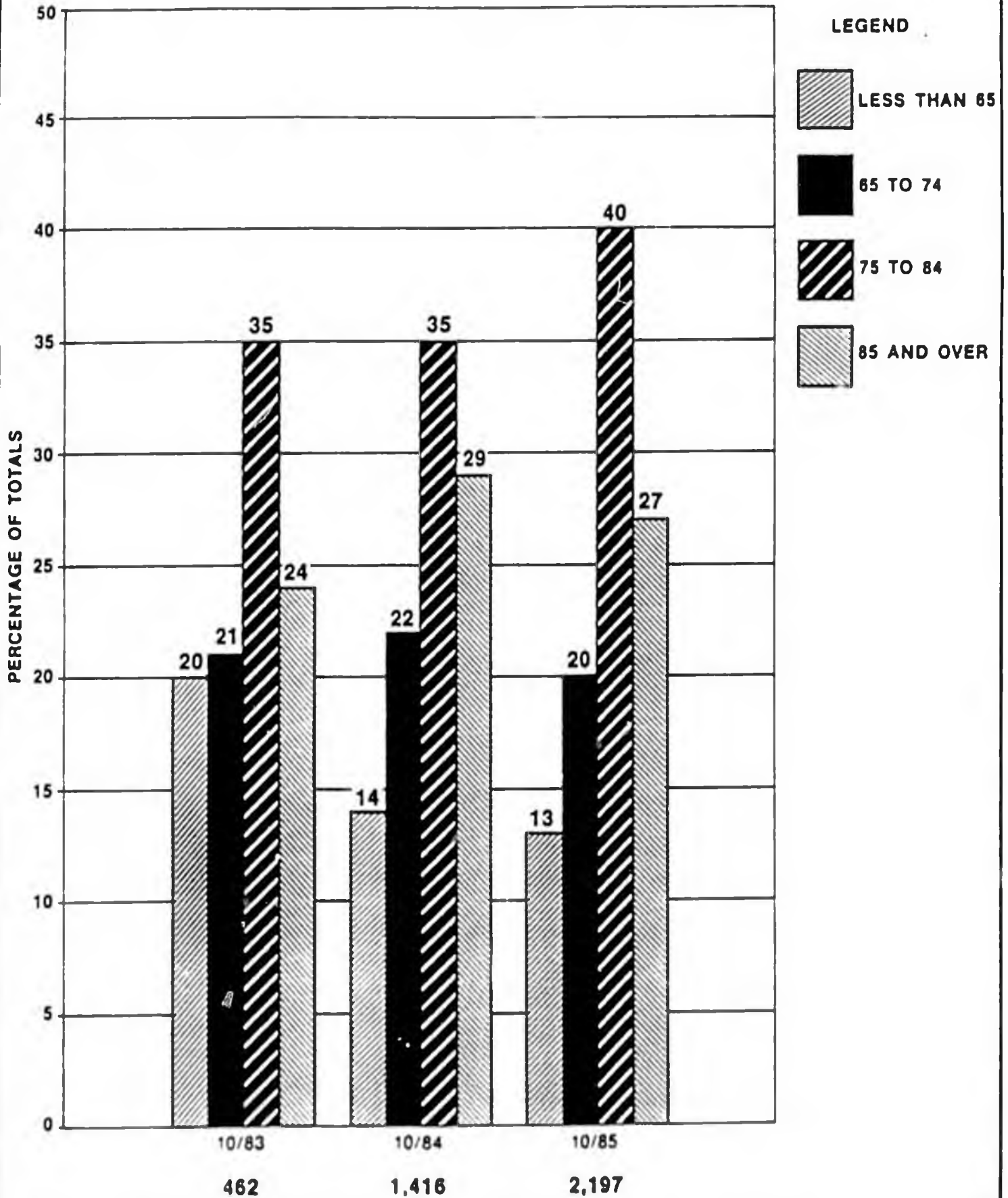


CHART 5

# RACE VARIATION OF CLIENTS

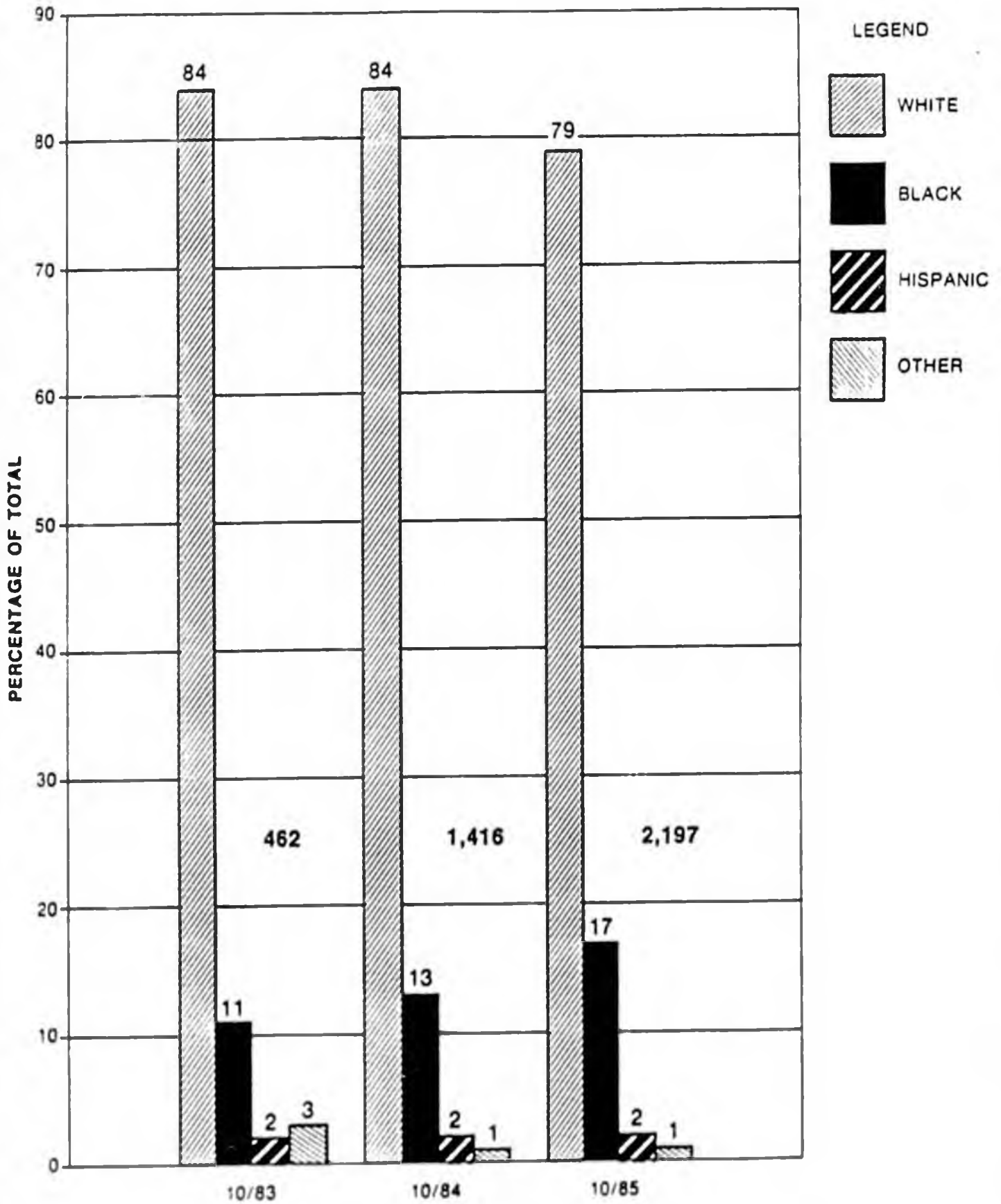


CHART 6

# LIVING ARRANGEMENT OF CLIENTS

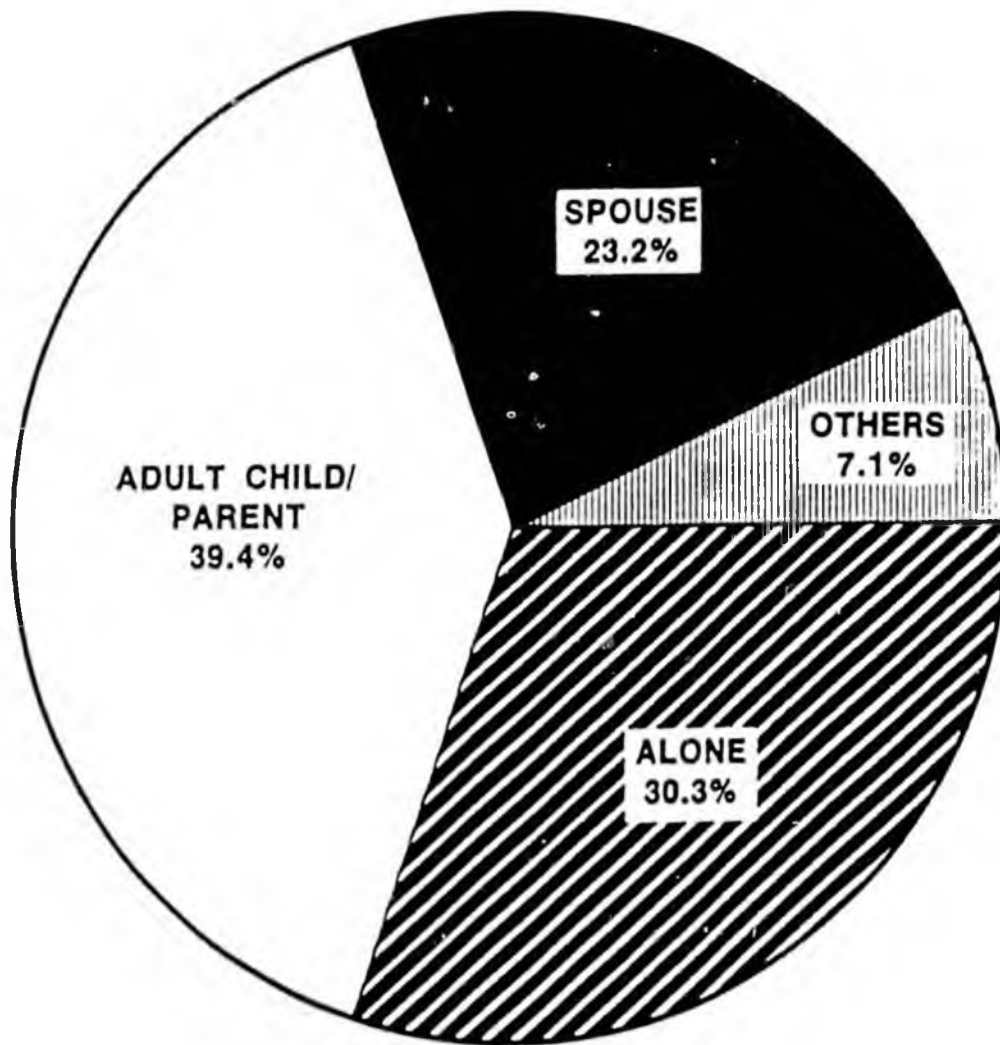


CHART 7

# MONTHLY INCOME OF CLIENTS

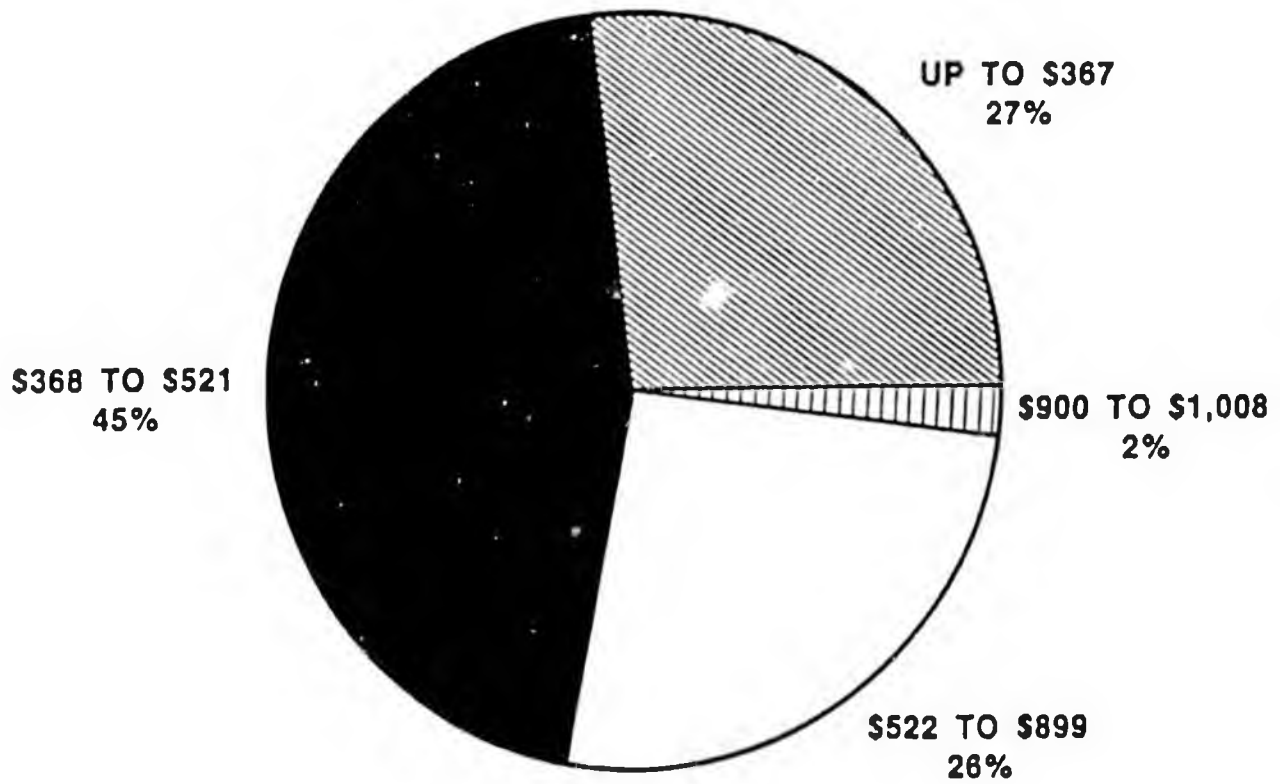


CHART 8

# PRIMARY DIAGNOSIS OF CLIENTS

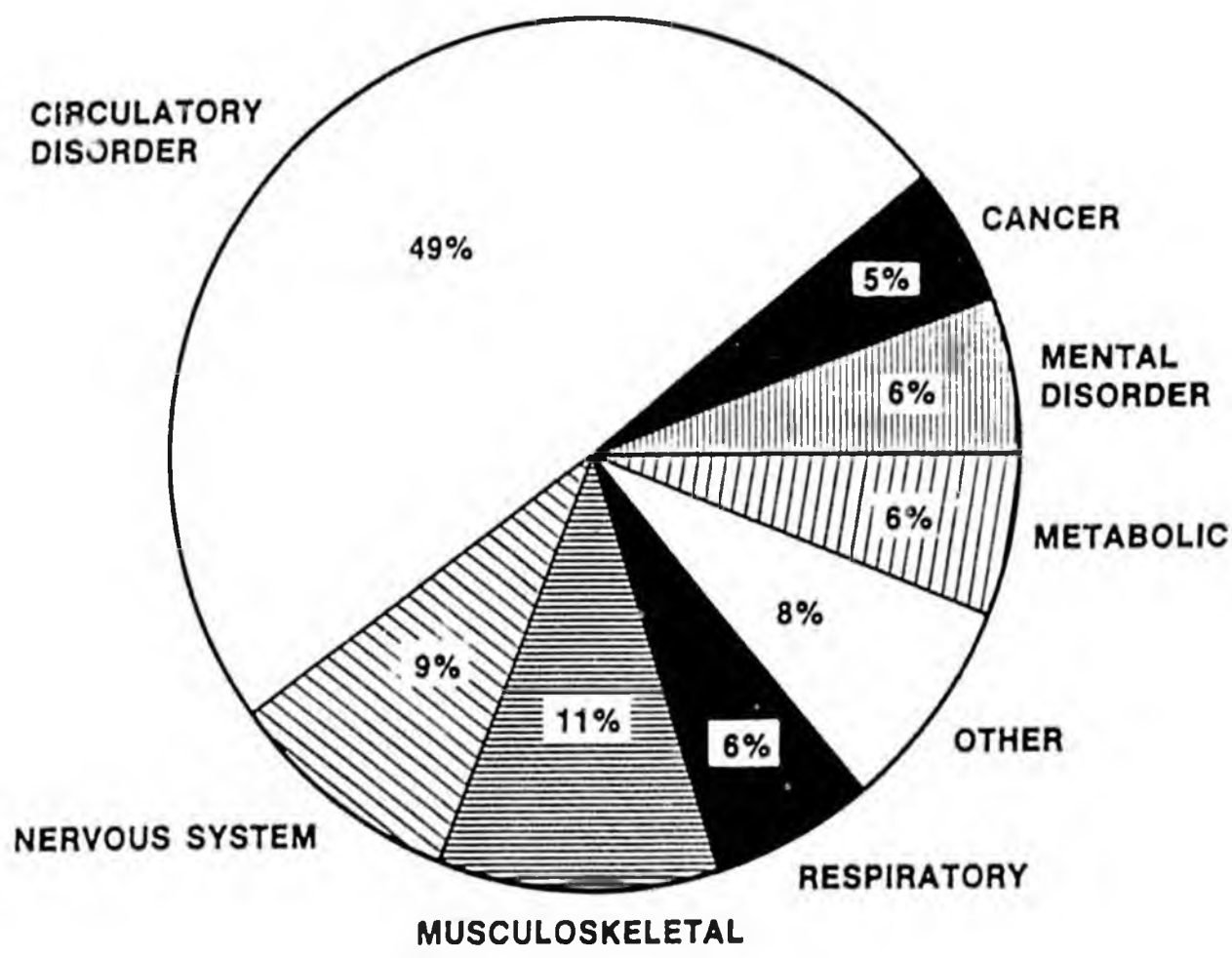


CHART 9

## LEVEL OF CARE CCPED COMPARED TO NURSING HOME (NH)

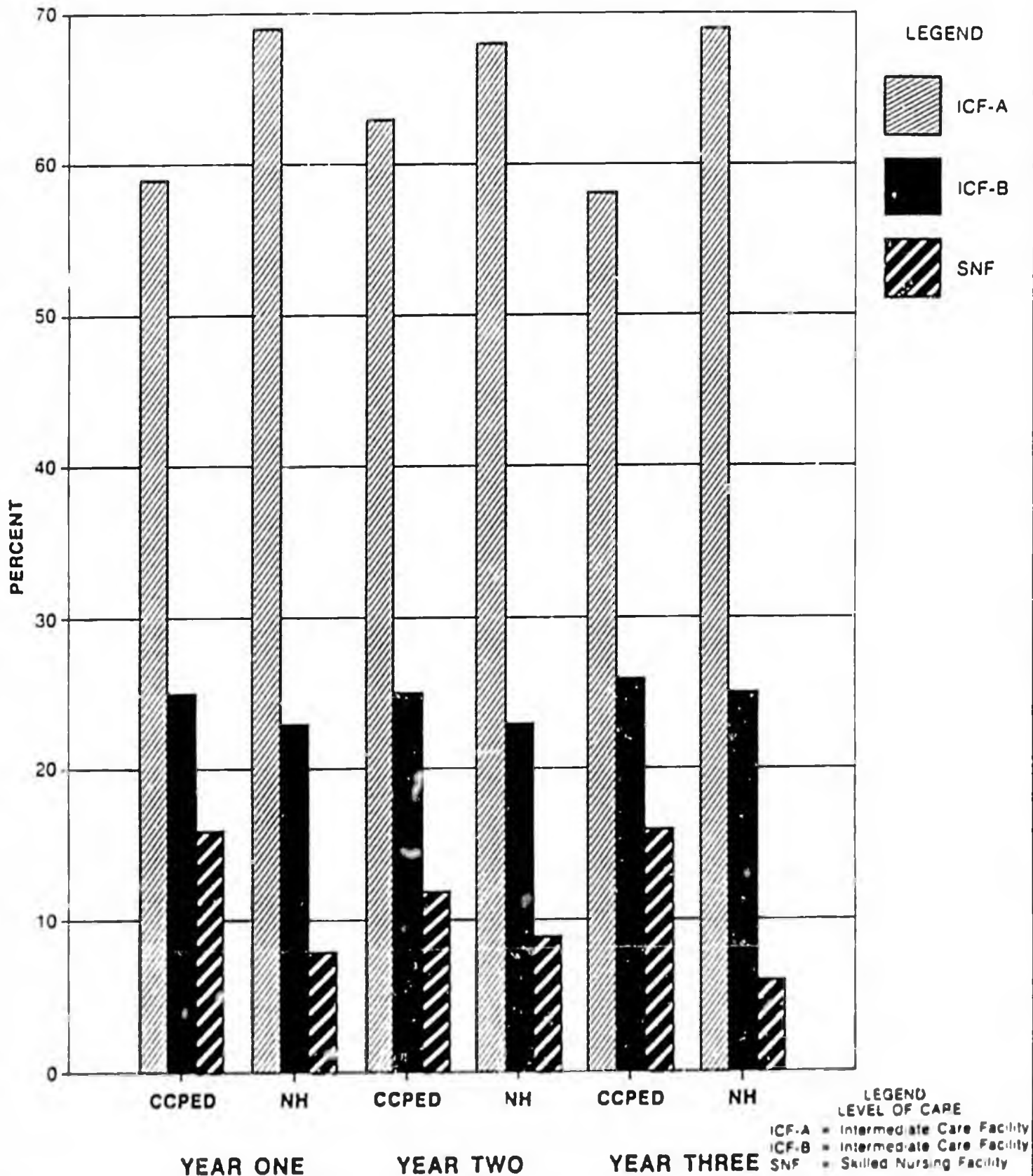


CHART 10

# REASONS FOR TERMINATION

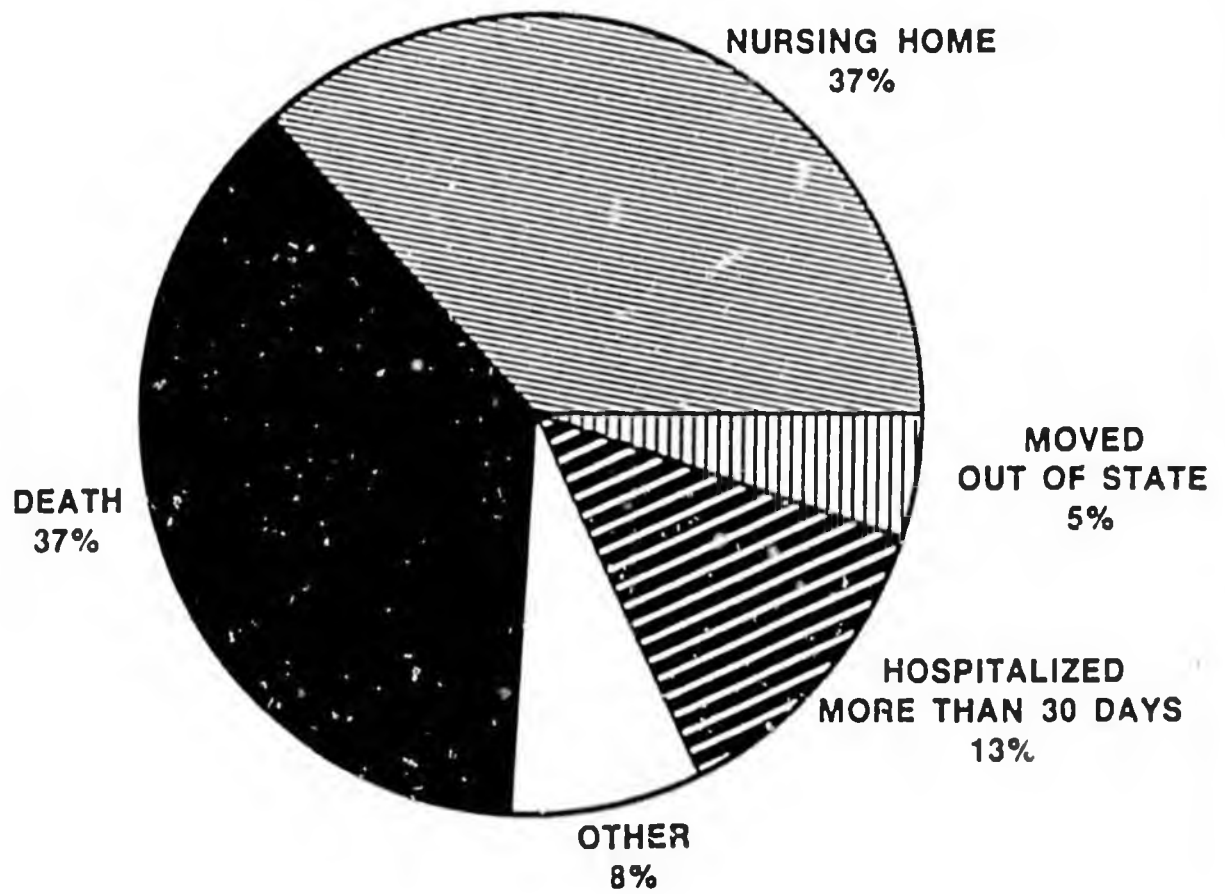


CHART 11

# LENGTH OF STAY IN PROGRAM

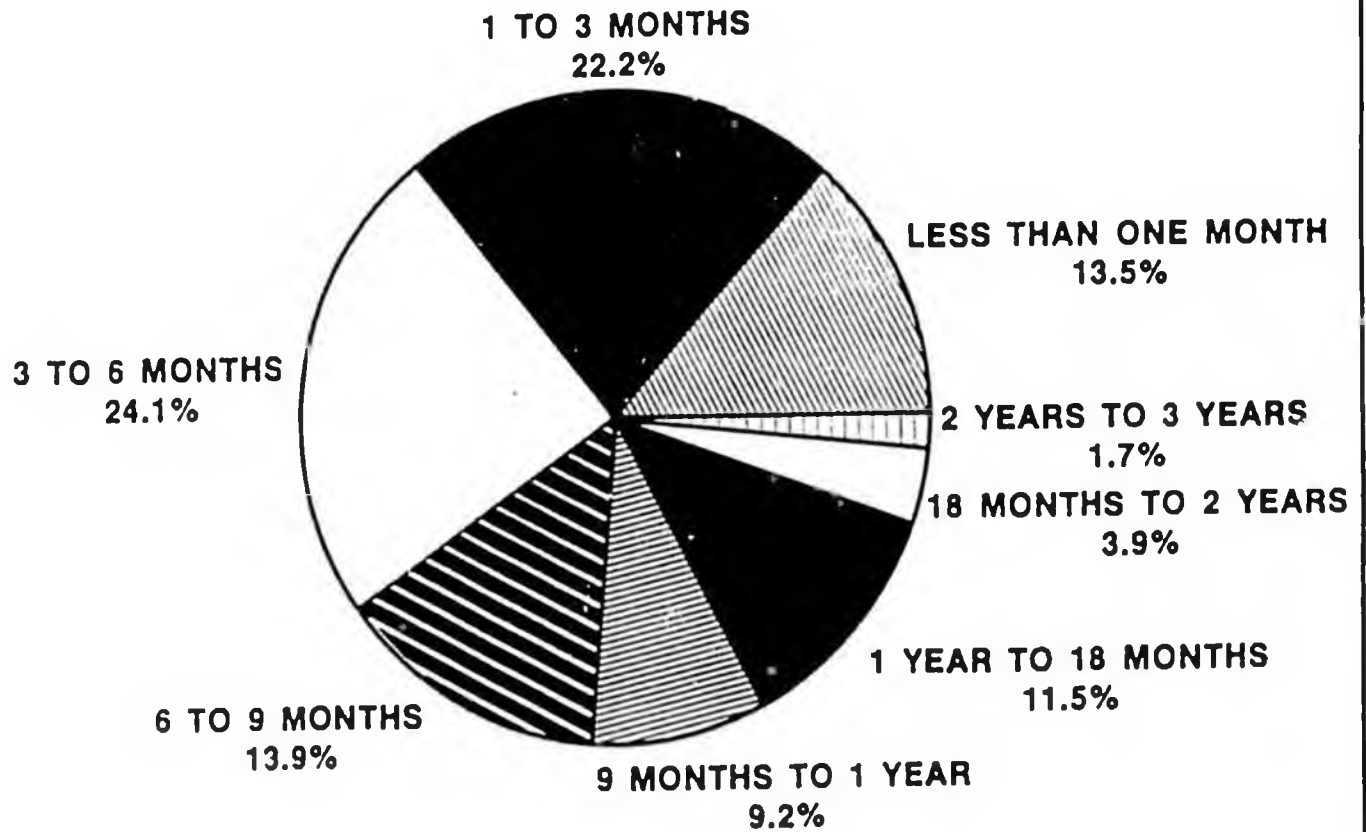
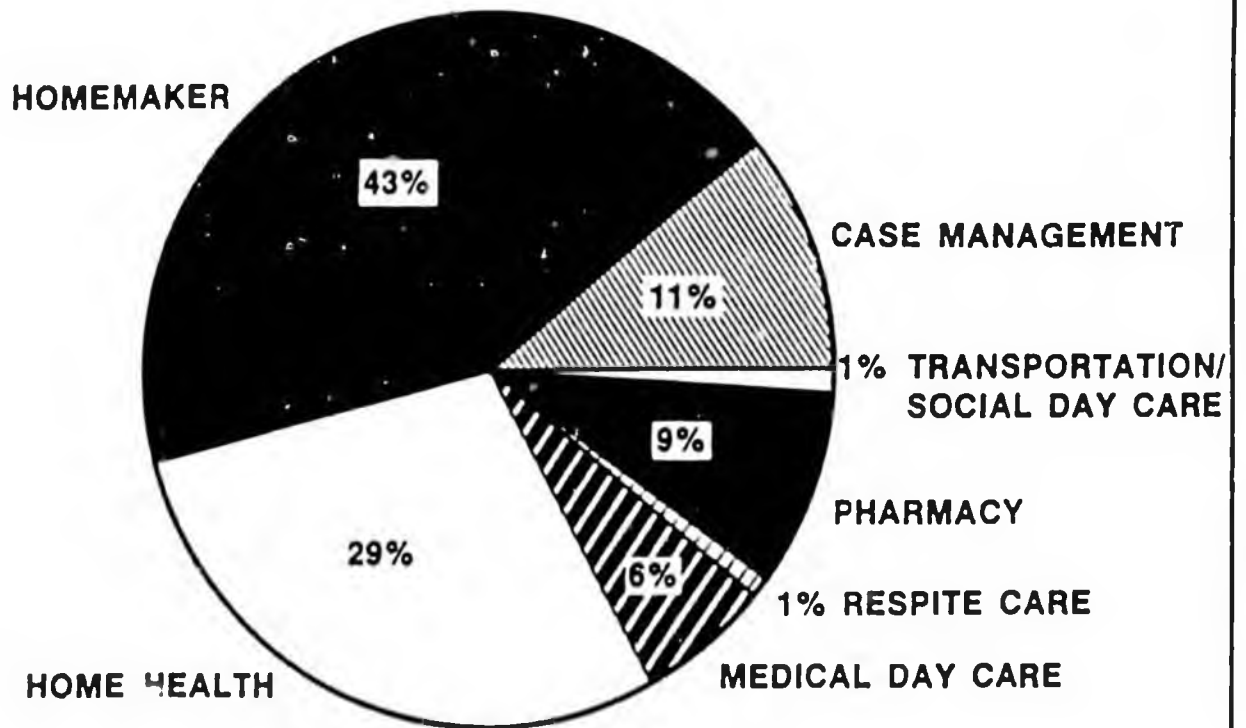


CHART 12

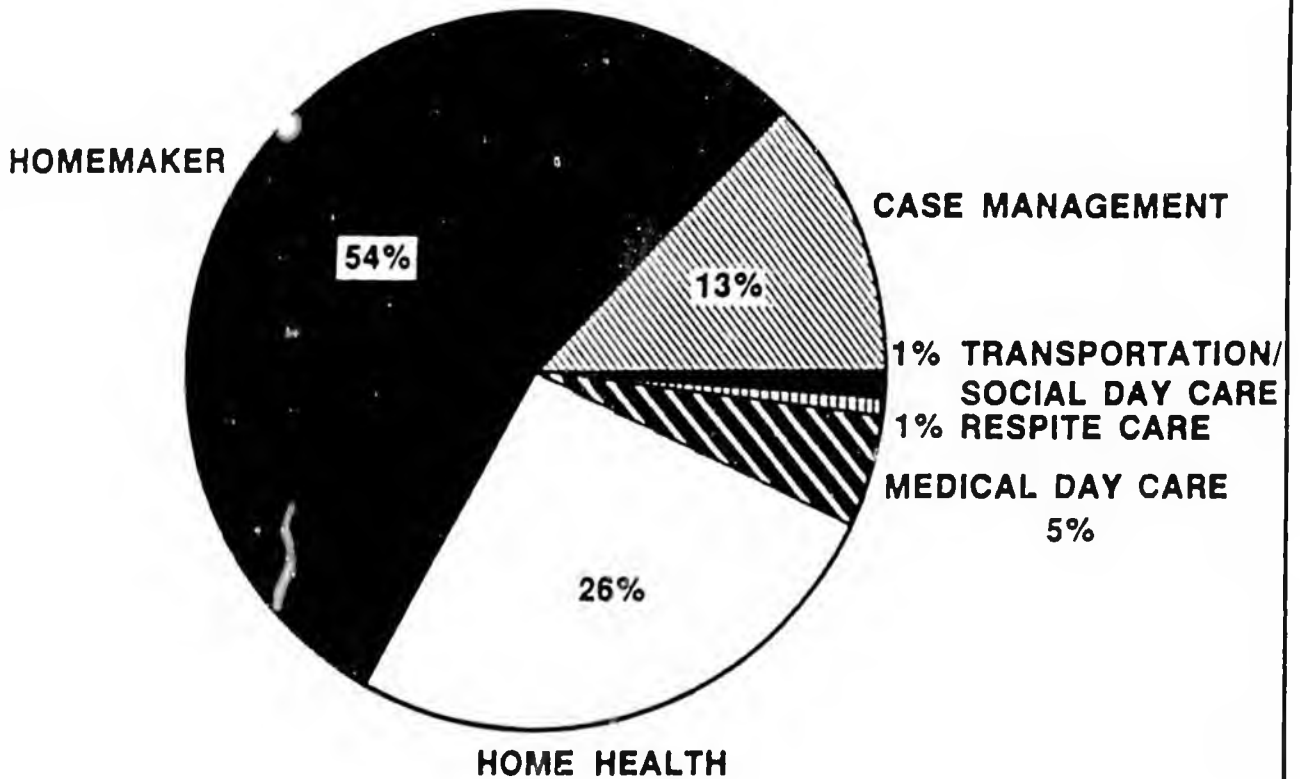
**TOTAL AMOUNT PAID FOR SERVICES  
YEAR ONE  
\$690,197.00**



**SERVICES/PERCENTAGE OF TOTAL PAYMENT**

CHART 13

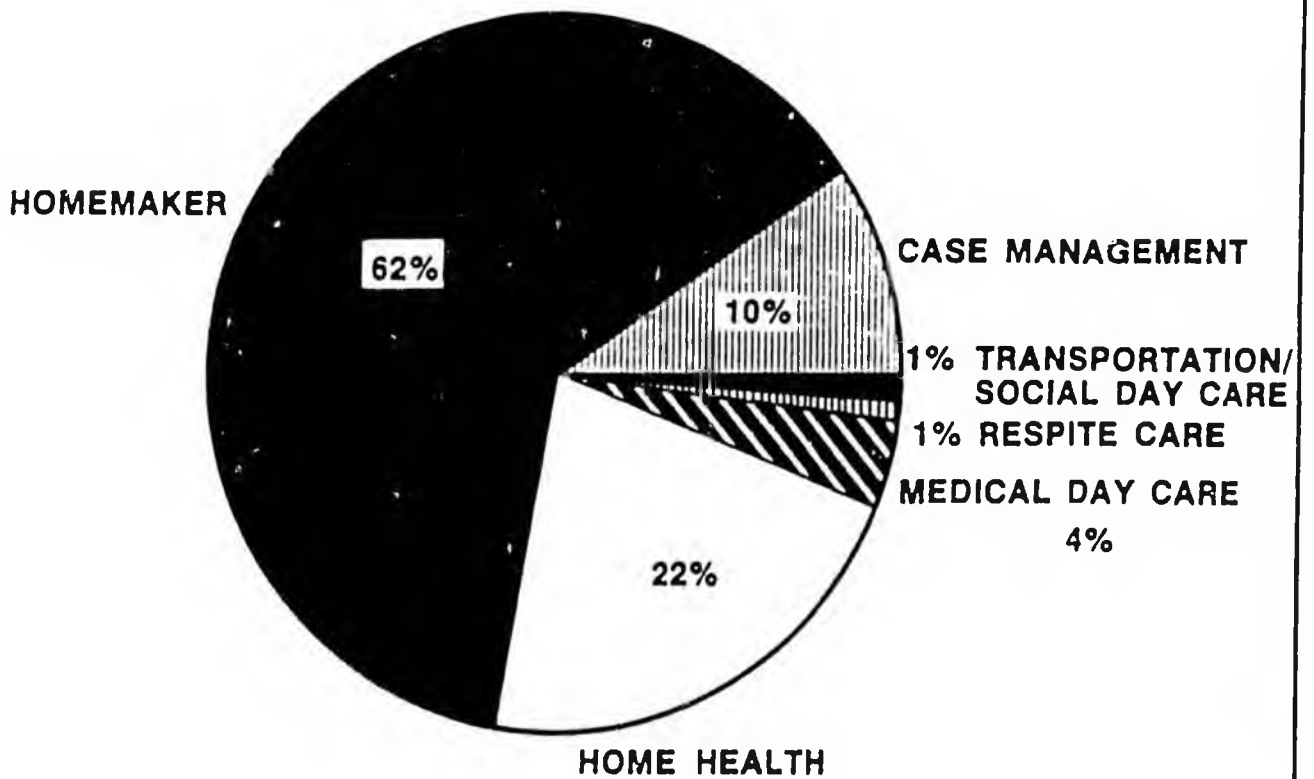
**TOTAL AMOUNT PAID FOR SERVICES  
YEAR TWO  
\$4,060,389.00**



**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

	<u>EXPENDITURES</u>	<u>RECIPIENTS</u>	<u>AVG. COST/RECIP.</u>
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

	<u>EXPENDITURES</u>	<u>RECIPIENTS</u>	<u>AVG. COST/RECIP.</u>
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

	<u>EXPENDITURES</u>	<u>RECIPIENTS</u>	<u>AVG. COST/RECIP.</u>
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

## ATTACHMENT A

### 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.