HOME AND COMMUNITY-BASED SERVICES FOR OLDER PEOPLE AND YOUNGER PERSONS WITH PHYSICAL DISABILITIES IN ALABAMA

Final Report

Prepared for:

U.S. Department of Health and Human Services
Health Care Financing Administration

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HOME AND COMMUNITY-BASED SERVICES FOR OLDER PEOPLE AND YOUNGER PERSONS WITH PHYISCIAL DISABILITIES IN ALABAMA

INTRODUCTION

Alabama is a fairly small Southern state with substantial low-income and minority populations.[1] The Medicaid program is heavily dependent on intergovernmental transfers and provider taxes to fund the state share and funding crises have been routine.[2] By and large, Alabama's Medicaid program relies on minimum federal requirements to determine eligibility and coverage policy.[3] Most of Alabama's social programs are severely constrained because of the relatively limited tax base, the fact that most tax revenues are earmarked for education, and the strong anti-tax sentiment of the state. The low levels of revenue leave policymakers with little choice but to provide health and welfare benefits at fairly minimal levels.

Although public officials are committed to expanding home and community-based services for older people and younger persons with physical disabilities, the state's long-term care system is dominated by nursing home care. Home care accounts for only a small proportion of Medicaid expenditures for long-term care for older persons and younger people with physical disabilities and there is little funding for noninstitutional services outside of the Medicaid program. In addition to mandatory home health coverage, the Medicaid program funds two home and community-based services waiver programs for older people and younger persons with disabilities—the "elderly and disabled" waiver which serves a generally disabled population and the "homebound" waiver which primarily serves younger people with very severe disabilities, such as traumatic brain injury. Most day-to-day administration of the waivers is done by the Alabama Department of Public Health and the

[1] For an overall discussion of health care in Alabama, see: Joshua M. Wiener, Susan Wall, David Liska, and Stephanie Soscia, *Health Policy for Low-Income People in Alabama*, Assessing the New Federalism, (Washington, DC: The Urban Institute, 1998).

[2] A recent budget crisis was created when the courts ruled that the state's franchise tax, which charged out-of-state companies far more than in-state companies, was unconstitutional. Tobacco settlement funds could be a source of Medicaid funding for home and community-based services, but most of the money is earmarked for services for children.

[3] Many Medicaid covered services have severe limitations in the amount, duration and scope. For example, hospital care for adults is limited to 16 days a year.

Alabama Department of Senior Services. Waiver services are fairly traditional, with no consumer-directed home care or nonmedical residential care included.

Since state funding of the regular Medicaid program is often problematic, cost containment is a major concern and the state has not funded all of its places or "slots" for the elderly and disabled waiver, despite there being a substantial number of people waiting for services. Like other state health departments in the south, the Alabama Department of Public Health is a major direct provider of home health and its home health services have experienced substantial cutbacks in staffing and funding as a consequence of the reimbursement and other changes in the Balanced Budget Act of 1997.

This paper analyzes the home and community-based service system for older people and younger persons with physical disabilities in Alabama, focusing on the state administrative structure for home and community-based services, eligibility and assessment, services covered by Medicaid and other programs, and quality assurance. This paper does not address home and community-based services for persons with mental retardation or developmental disabilities or for children. Information was obtained from public documents, state of Alabama web sites, and interviews with state officials, providers associations, and other stakeholders. Interviews were conducted in person and by telephone in Montgomery, Alabama, during January 2000. Questions were asked using an open-ended interview protocol. To encourage candor in their answers, respondents were told that they would not be quoted by name.

THE LONG-TERM CARE SYSTEM IN ALABAMA

Like other southern states, Alabama has a lower-than-average supply of nursing home beds and a substantial number of home health agencies. Alabama had 25,713 nursing home beds in 231 facilities in 1998—101.1 beds per 1,000 elderly people age 75 and over, compared with a national average of 113.2 per 1000 elderly people age 75 and over.[4] The state also has a very low supply of nonmedical residential facilities, with 282 licensed residential facilities, a total of 7,014 beds in 1998—27.6 beds per 1,000 elderly people age 75

[4] B. Bedney et al., *1998 State Data Book on Long-Term Care Program and Market Characteristics,* (San Francisco: University of California, San Francisco, 1999).

and over compared to the national average of 52.8 beds per 1,000 elderly people age 75 and over. In 1998, Alabama had 180 certified home health agencies, many of them affiliated with rural hospitals.

Alabama Medicaid long-term care expenditures (nursing facility, home and community-based services waivers, and home health) totaled $654.0 million in fiscal year 1999, and accounted for 26.2 percent of Alabama's Medicaid spending for services (***Table 1***).[5] Of the Medicaid expenditures for long-term care, 87.2 percent were for institutional services and 13.8 percent were for home and community-based waiver services and home health. Between 1997 and 1999, Medicaid expenditures for nursing facilities grew by 9.8 percent, while Medicaid expenditures for home and community-based services increased by 45.0 percent, although from a much smaller base. In 1999, the elderly and disabled waiver served 6,098 beneficiaries and the homebound waiver served 354 beneficiaries, while Medicaid served approximately 7,860 home health beneficiaries.[6] The Alabama Department of Rehabilitation Services served 682 people in its non-waiver Homebound Program and 229 people in its Independent Living Services program.[7] In contrast, 24,952 persons received Medicaid nursing facility services in 1999.[8] ***Table 2*** summarizes characteristics of home and community-based services programs in Alabama.

[5] These figures exclude services for the mentally retarded and mentally disabled in intermediate care facilities.

[6] Alabama Medicaid Agency, *1999Annual Report,* http://www.medicaid.state.al.us/about/99anrep/99anrep/htm, accessed August 2000.

[7] Alabama Department of Rehabilitation Services, *A New Horizon: Alabama Department of Rehabilitation Services FY 1999 Annual Report,* http://www.rehab.state.al.us/NewHorizons/SAIL/sail_intro.html, accessed August 22, 2000.

[8] Alabama Medicaid Agency, *1999 Annual Report: Long-Term Care,* http://www.medicaid.state.al.us/about/99anrep/longterm.htm, accessed August 2000.

Table 1: Alabama Medicaid Long-Term Care (LTC)* Expenditures, FY 1999

Service	Expenditures ($ millions)	% LTC Spending	% Total Medicaid Spending
Nursing Facilities	570.2	87.2	22.8
Elderly and Disabled Waiver	46.2	7.1	1.9
Homebound Waiver	2.7	0.4	0.1
Home Health/DME	34.9	5.3	1.4
Total LTC	654.0	100.0	26.2
Total All Service Payments	2498.4	—	100.0

Source: Alabama Medicaid Agency 1999 Annual Report, http://www.medicaid.state.al.us/about/qqanrep, accessed August 16, 2000.

*Does not include services for the mentally retarded and mentally disabled in intermediate care facilities.

Table 2: Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Alabama

	Medicaid Home Health	Elderly and Disabled Home and Community-Based Services Waiver
Administrative Responsibility	Alabama Medicaid Agency (AMA)	Alabama Medicaid Agency contracts with Alabama Department of Public Health (DPH) and Alabama Department of Senior Services (DSS) to administer waiver. Department of Public Health does case management and quality assurance and is a major direct service provider. Department of Senior Services contracts with local Area Agencies on Aging to do case management and does quality assurance. Service providers bill Medicaid using administering agency's payee number. Payments are sent to the administering agency. The direct service provider is paid by the administering agency. As the Single State Agency, Medicaid sets overall policy, pays providers, does quality assurance, and approves all applications to waiver and their service plans.
Functional Eligibility	Must need skilled nursing and be homebound	Nursing home level of care with no further criteria of risk of institutionalization. Nursing home criteria emphasize need for nursing care rather than functional disabilities.
Financial Eligibility	Supplemental Security Income beneficiaries	Supplemental Security Income or State Supplementation beneficiaries, persons who would be eligible for Medicaid in an institution because income from parents or a spouse is not deemed available to them, "Pickle" individuals, and widows and widowers under age 60 and age 60-64.
Number of Beneficiaries	7,860 in FY 1999	6,098 beneficiaries in FY 1999.

Table 2: Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Alabama, continued

	Medicaid Home Health	Elderly and Disabled Home and Community-Based Services Waiver
Funding Source	Medicaid	Medicaid
Expenditures	$34.9 (including durable medical equipment)	$46.2 million in FY 1999
Covered Services	Nursing services (including home health aide) and durable medical equipment.	Case management, adult day care, homemaker services, personal care services, respite care (skilled and unskilled) up to 30 days a year and companion services.
Nonmedical Residential Facilities	NA	Not covered.
Consumer-Direction	No	No
Cost Containment Mechanisms	Coverage limited to 104 visits per year (RN and home health aide visits counted separately). No coverage of therapies or home oxygen. Medicaid reimbursement rate considered low and has not increased in over 10 years. Certificate of need for home health agencies.	"Active referral list" or waiting list is extensive. Expenditures limited to cost of nursing facilities on per person basis.
Quality Assurance Mechanisms	Alabama Department of Public Health does survey and certification for Medicare and Medicaid.	Quality Assurance done by AMA, DPH, DSS, and provider agencies. AMA does on-site reviews of case management agencies and other providers, conducts home visits for sample of beneficiaries, and conducts beneficiary satisfaction survey.

Table 2: Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Alabama, continued

	Homebound Home and Community-Based Services Waiver	State of Alabama Independent Living Services (SAIL), Alabama Department of Rehabilitation Services
Administrative Responsibility	Alabama Medicaid Agency contracts with Alabama Department of Rehabilitation Services (ADRS) to administer the waiver. ADRS provides case management. Providers bill Medicaid using the ADRS provider number. Medicaid payments are sent to ADRS, which pays the direct service providers. Medicaid sets overall policy, does quality assurance, and approves all applications to waiver and their service plans.	Alabama Department of Rehabilitation Services (ADRS) operates the programs and contracts with providers. ADRS provides case management. In addition to the Homebound Waiver, the program consists of the homebound program and independent living.
Functional Eligibility	Nursing home level of care with no further criteria of risk of institutionalization. Nursing home criteria emphasize need for nursing care rather than functional disabilities. Must be age 16 or older with physical disabilities not associated with process of aging and with onset prior to age 60. This includes, but is not limited to the following diagnoses: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and other substantial neurological impairments, and severely disabling diseases (such as Lesch-Nehan Syndrome).	Persons age 18 with quadriplegia or traumatic brain injury are eligible for Homebound Program. Provision of services must free someone in the household for employment, but that person does not necessarily have to go to work. Persons age 18 and older who are severely disabled and provide evidence that services will improve their independence qualify for Independent Living Support Services.
Financial Eligibility	Persons with incomes up to 300 percent of SSI (the institutional eligibility standard).	For Homebound Program, applicants must demonstrate financial need. No income standard for Independent Living Support Services.
Number of Beneficiaries	354 in FY 1999.	901 in FY 1999 (excluding Homebound Waiver).

Table 2: Home and Community-Based Services for Older People and Younger Persons with Physical Disabilities in Alabama, continued

	Homebound Home and Community-Based Services Waiver	State of Alabama Independent Living Services (SAIL), Alabama Department of Rehabilitation Services
Funding Source	Medicaid	State funds, with some small federal grants.
Expenditures	$2.7 million in FY 1999.	$4.9 million in FY 1999.
Covered Services	Case management, personal care, respite care, environmental adaptations, personal emergency response systems, medical supplies, and assistive technology.	Patient and family education, counseling and guidance, nursing management, disability-related prescriptions, medical supplies, attendant care, peer counseling, training in activities of daily living, and information and referral.
Consumer-Direction	Technically possible in highly limited circumstances, but very rarely permitted.	Yes.
Nonmedical Residential Facilities	Not covered.	Not covered.
Cost Containment Mechanisms	Limited target population (but no waiting list). Limit expenditures to cost of nursing home care.	State appropriations are limited. Independent Living Support Services limited to $1,500 per person.
Quality Assurance	Quality Assurance done by AMA, ADRS, and provider agencies. AMA does on-site reviews of case management agencies and other providers, conducts home visits for sample of beneficiaries, and conducts beneficiary satisfaction survey.	Alabama Department of Rehabilitation Services monitors services.

STATE ADMINISTRATIVE STRUCTURE

The Alabama Medicaid Agency is the state's "single state agency" for Medicaid and directly administers the nonwaiver home and community-based services, principally home health. Both state officials and Health Care Financing Administration regional office staff report that working relationships between the two governments are good. State officials believe that the waiver application process is too time consuming and burdensome and that it sometimes takes a long time to get a decision from HCFA, but the waiver requirements are not serious impediments to the state doing what it wants to do.

The Alabama Medicaid Agency contracts with the Alabama Department of Public Health and the Alabama Department of Senior Services (formerly the Commission on Aging) to administer the elderly and disabled waiver and with the Alabama Department of Rehabilitation Services to administer the homebound waiver. These other state agencies pay the state Medicaid match for the waiver services for which they are responsible. Providers bill the state Medicaid agency using the administering agencies' payee number. Payments are then made by Medicaid to the administering agency, which then pays the provider. For the elderly and disabled waiver, the caseload has been explicitly divided by the legislation between the Department of Public Health and the Department of Senior Services. The Department of Public Health is the administering agency for about two-thirds of waiver beneficiaries and the Department of Senior Services is the administering agency for the remaining one third of beneficiaries. Applicants for elderly and disabled waiver services are free to use either the Department of Public Health or the Department of Senior Services for their case management, but younger people are somewhat more likely to rely on the Department of Public Health because it is less identified as a state agency for older people. Although the Department of Senior Services uses local Area Agencies on Aging to perform case management, overall policymaking and administrative decisions are centralized at the state level (like other health and social services programs in the state).

The Department of Public Health's Bureau of Home and Community Services has three units involved with home care. First, like many public health departments in the South, the Department of Public Health is a Medicare-certified home health agency. It is

the largest provider of home health services in the state and is the main provider of these services for the low-income population. Second, the Department of Public Health administers the elderly and disabled Medicaid waiver by providing case management, developing plans of care, and helping clients to choose direct service providers. Third, through its Life Care division, the Department of Public Health is a direct provider of nonskilled home care services, including homemaker services, companion services, personal care, skilled and unskilled respite care, and adult day care. These services are funded through a variety of public programs, including Medicaid, but can also be purchased on a self-pay basis.

The HCFA regional office has raised concerns that the Department of Public Health is both an administrator of the elderly and disabled waiver and a provider in it, opening the possibility of conflict-of-interest. To prevent such conflict, the Department of Public Health has historically separated case management and direct service operations by placing them in separate and distinct divisions within the Department. In addition, upon admission, the Department of Public Health provides all waiver clients with a list of available providers in their geographic area and have complete freedom of choice of providers. However, most providers operate in limited geographic areas. If the Alabama Department of Public Health was not a provider, there would be access to care issues in many rural areas within the state.

The Department of Senior Services is the state unit on aging and administers programs funded through the federal Older Americans Act as well as part of the Medicaid elderly and disabled waiver. There are no major state-funded home care programs. There are 13 Area Agencies on Aging (AAAs), which the Department uses to administer its share of the elderly and disabled waiver. Unlike the Department of Health, the Department of Senior Services is not a direct provider of services. The AAAs, most of which are housed in council of local governments and regional planning commissions, range from one to ten counties in size. The AAAs provide case management and billing services for the organizations that supply services.

The Department of Rehabilitation Services administers the State of Alabama Independent Living Services (SAIL) program, which focuses on younger adults with disabilities. The SAIL program has three components—the homebound Medicaid waiver, the homebound service and independent living services (funded by the federal Rehabilitation Services Administration). The state-funded homebound program was started by Governor George Wallace after he was shot and experienced the problems of obtaining services for persons with spinal cord injuries. The program is virtually entirely state funded.

ELIGIBILITY CRITERIA AND ASSESSMENT

Eligibility criteria can be divided into financial and medical/functional standards. In terms of financial standards, Alabama enrolls all Supplemental Security Income (SSI) beneficiaries in the regular Medicaid program, but it does not have a medically needy program. As a result, people with incomes above the SSI level are ineligible for Medicaid regardless of their medical expenses. Financial eligibility for the elderly and disabled waiver is slightly less restrictive, covering persons who are receiving SSI or state supplementation, "Pickle" individuals, widows and widowers under age 60 and aged 60-64, and individuals who would be eligible for Medicaid in an institution because income from parents or a spouse is not deemed available to them (institutional deeming).[9] Some state officials believe that the restricted financial eligibility standard for the waiver results in some people entering nursing homes because they cannot pay for prescription drugs and still afford rent and food. These observers argued that if people cannot afford their prescription drugs, then their health declines and they ultimately enter a nursing home.

[9] "Pickle" individuals are persons who would be eligible for SSI if Social Security cost-of-living increases were deducted from their income. They are deemed to be receiving SSI for Medicaid purposes.

Financial eligibility for the smaller homebound waiver is more inclusive than the elderly and disabled waiver, covering persons eligible for Supplemental Security Income, (SSI) or Aid to Families with Dependent Children, special home and community-based optional categorically needy groups whose income is less than 300 percent of the federal SSI benefit rate (the institutional eligibility standard), individuals who would be eligible for Medicaid either by being in an institution or by meeting the institutional level of care and the income for a parent or spouse is not available to them, children of disabled adults who lose supplemental income or have an increase in Social Security benefits, and Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs). In some cases, an insurance settlement or family property precludes individuals from being eligible. For the non-Medicaid Department of Rehabilitation Services programs, eligibility is offered to persons who demonstrate financial need.

For the elderly and disabled and the homebound waivers, beneficiaries must meet the nursing facility level of care, but there are no other standards that attempt to assess the risk of institutionalization. The requirements for nursing facility level of care are quite medically oriented, emphasizing the need for skilled care. According to the regulations, the controlling factor in determining nursing home eligibility is whether a person is receiving medical supervision. Daily nursing care is required and there is a list of nursing services, of which the resident must receive at least two. Activities of daily living and instrumental activities of daily living are not mentioned as criteria for nursing home eligibility. According to state officials, persons who need oxygen often enter nursing homes because Medicaid does not cover that service at home.

While the elderly and disabled waiver includes the general population with disabilities, the homebound waiver targets a much narrower population, specifically individuals age 18 and older with physical disabilities not associated with the process of aging and with onset prior to age 60. This includes, but is not limited to the following diagnoses: quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, spinal muscular atrophy, severe cerebral palsy, stroke and

other substantial neurological impairments, and severely debilitating diseases (such as Lesch-Nehan Syndrome).

Prior to admission to the waiver program, an evaluation must be completed for each individual. Case managers, in conjunction with the attending physician, coordinate completion of the medical needs admission form for submission to the Medicaid Agency's Long-Term Care Admissions/Records Unit for approval. Few applications are turned down. The level of care determination is reviewed annually with a new form completed by a physician as part of an annual reevaluation of need for waiver services.

The non-waiver homebound program of the Department of Rehabilitation Services serves people who are at 18 years of age and older and have a spinal cord injury that results in quadriplegia or have traumatic brain injury with a loss of functioning requiring assistance with six of eight activities of daily living. Provision of services must free someone in the household for employment, but that person does not necessarily have to go to work.

CASE MANAGEMENT AND SERVICE PLANNING

Case management for clients in Medicaid home and community-based services waivers is required and is done through the agencies delegated administrative responsibility by the Alabama Medicaid Agency—the Department of Public Health and the Department of Senior Services for the elderly and disabled waiver and the Department of Rehabilitation Services for the homebound waiver. The Department of Public Health's Bureau of Home and Community Services performs the case management functions for the elderly and disabled waiver beneficiaries who choose that department. The Department of Senior Services depends on Area Agencies on Aging to carry out the case management functions for its elderly and disabled waiver recipients. Clients of the elderly and disabled waiver may choose to receive their case management through either agency. Department of Rehabilitation Services staff perform the case management functions in the homebound waiver. Case management is treated as a "service" (making it eligible for a 70 percent federal match) rather than an administrative function (eligible for a 50 percent federal match).

Case managers have an average caseload of 35-50 clients for the elderly and disabled waiver and about 50 for the homebound waiver. The Department of Public Health reported that caseloads are likely to increase to 50 because of budget constraints. Case managers are primarily social workers with a few registered nurses. Face-to-face contact is required monthly and some clients may receive more intensive monitoring depending on the situation.

SERVICES

Compared to some other states, Alabama covers a relatively narrow range of home and community-based services through its Medicaid program.[10] The home and community-based services waivers cover what one observer called a "basic and fundamental" set of services. As required by federal law, Alabama covers home health, but does not offer the optional personal care benefit, thus personal care is only provided under the home and community-based waivers. Over the last ten years, Medicare home health has been a major source of home and community-based services in Alabama, but use has fallen sharply in response to the coverage and reimbursement changes of the Balanced Budget Act of 1997. The state offers a somewhat broader range of services through the small SAIL program of the Department of Rehabilitation Services.

The changes in Medicare home health reimbursement and coverage mandated by the Balanced Budget Act of 1997 very strongly affected services in Alabama, especially those provided by the Department of Public Health. State officials reported that they were half way into their fiscal year before they knew what their Medicare reimbursement rates would be and they were much lower than anticipated. Department of Public Health home health expenditures dropped by about 50 percent following the implementation of the Medicare home health interim payment system and continued to decline in 2000. To live within their budget, they laid off over a third of their employees, and reduced the number of branch offices from 65 to 31. In addition to reimbursement changes, the elimination of venipuncture as a service qualifying an individual for skilled care

[10] As is required nationally, children whose Early, Periodic Screening, Diagnosis, and Testing (EPSDT) evaluation results in a need for a Medicaid-covered optional or required service are eligible to receive them regardless of what the state covers for adults.

disqualified as much as 20 percent of the Department of Public Health's home health patients. According to health department officials, their patients are now much more acutely ill and much less likely to be chronic care patients.

In the wake of the Medicare changes in the Balanced Budget Act of 1997, there has been a significant increase in Medicaid home health utilization, with expenditures doubling and the number of beneficiaries increasing by 30 percent between fiscal years 1997 and 1999.[11] The Medicaid home health benefit for adults is very medically oriented and restrictive. To receive Medicaid home health, the individual must be "homebound" and in need of skilled nursing care. Medicaid home health does not include physical or occupational therapies or home oxygen. There is an absolute limit of 104 visits per year, and home health aide and nursing visits are counted separately. In general, private home health agencies have not been very interested in serving Medicaid patients because the reimbursement rate of $27 a visit is considered very low and has not been raised for over a decade. The Alabama Department of Public Health is the primary provider of Medicaid home health services and receives a substantially higher reimbursement rate than do private providers. The Department of Public Health pays the state Medicaid match on the costs above the $27 base payment rate.

Services covered under the elderly and disabled waiver include case management, adult day health services, homemaker services, personal care services, respite care services (both skilled and unskilled) up to 30 days a year and companion services. Personal care services must be supervised by a nurse and provided either by a home health agency or an agency approved by the Alabama Medicaid Agency. Adult day clear that it is not the intent of the waiver to provide 24-hour a day care. In 1997, the HCFA health care is the only service that is provided outside of the home. Personal care and homemaker services are the most heavily used services. Implementing regulations make

[11] Medicaid home health expenditures were $10 million in fiscal year 1997 and $22 million in fiscal year 1999. The number of Medicaid home health patients were 6,000 in fiscal year 1997 and $7,860 in fiscal year 1999. Alabama Medicaid Agency, 1999 Annual Report, http://www.medicaid.state.al.us/about/99anrep/homecare.htm#HH, accessed August 2000; and, Alabama Medicaid Agency, 1997 Annual Report, http://www.medicaid.state.al.us/about/97anrep/homecare.htm, accessed August 2000.

Regional Office raised the possibility that the current waiver service package was too "socially oriented" and encouraged the state to include more medically-oriented services.

The homebound waiver provides case management services, personal care, respite care, environmental accessibility adaptations, personal emergency response systems, medical supplies and assistive technology. The most commonly used services are personal care, medical supplies, and assistive technology. Personal care services are almost all provided in the beneficiary's home, but there is no policy preventing out-of-home use. In the view of the Alabama Department of Rehabilitation Services officials, the eligible population is so severely disabled that it would be difficult for them to be out of the home much of the time. Personal care is often preferred to respite care services because respite care is perceived as only "sitting" with a client rather than providing care.

Services in nonmedical residential facilities, such as assisted living facilities and adult foster care, are not covered services under the waivers. Assisted living is growing rapidly in the state, with about 40 percent of facilities owned by nursing facilities. Under existing regulations, assisted living facilities may not serve persons needing a nursing home level of care. As a result, assisted living facilities cannot provide services to people who would be eligible for Medicaid home and community-based services waivers. Proposed assisted living regulations will give facilities an ability to be more involved in medication administration and will establish a distinct category of "specialty care dementia assisted living facilities" which will allow more disabled people to reside in these residences.

Consumer-directed home care services (that is, allowing individuals to hire, train, direct, and fire their own workers) is not widely used. Under the elderly and disabled waiver, all providers must work for agencies. While consumer-directed care is theoretically possible under the homebound waiver where "a relative or friend is qualified and there is proof of lack of other qualified providers in a remote area," this is rarely done. The Alabama Medicaid Agency has considered consumer direction, but is not actively pursuing that option, preferring to wait to see the experience of other states. Quality of care under consumer direction is a concern to the agency as is the possibility

that payments may function more as an income supplement to the family rather than as a mechanism to pay for care of the client.

Services in the Department of Rehabilitation Services state-funded non-waiver homebound program are more flexible than in the Medicaid home and community-based services waiver, and include assistive technologies, home modifications, medical supplies, prescription drugs not covered by Medicaid, and skilled nursing management. A few recipients are working. Unlike under the Medicaid waiver, relatives can be paid to provide care, most commonly a parent or sibling.

The Independent Living program in the Department of Rehabilitation Services consists of a staff of seven specialists who assist case managers find services not available from Medicaid through churches, voluntary organizations, or corporate grants. There is a limited budget of about $1,500 per person to provide "seed money" to purchase services or equipment. The number of beneficiaries fluctuates as people quickly cycle on and off the Independent Living program.

For all home and community-based services programs, the rural nature of the state was identified as an ongoing problem of service delivery, especially in the Southwestern portion of the state. Workers must travel substantial distances and are not usually paid transportation costs. In addition, there are fewer home care vendors in rural areas. Public transportation is a problem in both urban and rural areas of the state. On the other hand, almost two-thirds of the total population lives in metropolitan rather than rural areas, and the state is fairly small geographically compared to some Midwestern and Western states, making most distances manageable.[12]

COST CONTAINMENT

Because of the state's chronic problems funding the Medicaid program and other health and social services, cost containment is a major concern and home and

[12] Joshua M. Wiener, Susan Wall, David Liska, and Stephanie Soscia, *Health Policy for Low-Income People in Alabama*, Assessing the New Federalism Project, (Washington, DC: The Urban Institute, 1998).

community-based services waivers are seen as part of a cost containment strategy. The state controls expenditures for home and community-based services by using five mechanisms.

First, as noted above in the section on services, the regular Medicaid program does not cover personal care and offers a very restricted set of home health services. Thus, individuals who do not receive waiver services have limited options for home and community-based services through the open-ended entitlement part of the Medicaid program.

Second, the state has not funded all of its HCFA-approved home and community-based services waiver slots. As a result, there is an extensive "active referral list" for the elderly and disabled waiver, which is basically a waiting list. Unmet demand has been large enough that the Department of Public Health closed applications for a period of time in 1999. At the time of the site visit in January 2000, the Department of Senior Services had almost as many people on its "active referral list" as they had people receiving services. Access to waiver services from the waiting list is on a first come-first served basis. State agencies and AAAs try to arrange other Medicaid services for people on the waiting list, but the limited range of covered services makes this difficult. In contrast, the homebound waiver does not have a waiting list and generally operates about 10 percent below capacity, which may reflect the narrow eligibility criteria.

Third, the state limits expenditures by controlling reimbursement rates.[13] Again, as noted above in the discussion on services, home health reimbursement rates are low and have not increased for over a decade. For waiver services, Medicaid pays agency-specific rates based on audited costs. Payment rates have been increasing, which is a matter of concern to state agencies. Personal care workers and home health aides tend to be paid close to the minimum wage, which makes recruitment increasingly difficult. One

[13] The previous governor, Forrest "Fob" James, proposed major cuts in Medicaid nursing home reimbursement rates to close a Medicaid funding shortfall. The nursing home industry bitterly fought these cuts and basically prevailed. They worked hard to defeat James in the subsequent election. For a variety of reasons, James did not win re-election.

state official commented that the federal freedom-of-choice requirements of the home and community-based services waivers require the state to contract with high cost providers who do not necessarily provide higher quality care.

Fourth, the state limits expenditures per person under the Medicaid home and community-based services waiver, but not very rigorously. In general, individuals are limited to services that cost less than Medicaid nursing facilities. For the homebound waiver, there is a $5,000 per person cap on environmental modifications and a $15,000 per person cap on assistive technology. Maintaining this standard of costing less than institutional care has generally not been a problem for the elderly and disabled waiver or the homebound waiver, where the average cost per beneficiary in fiscal year 1999 was $6,612 and $7,836, respectively, compared to $22,771 for nursing facility care.[14]

Fifth, the state controls the supply of both home health agencies and nursing facilities through certificate of need requirements, imposing moratoriums from time to time. Home health agencies have contested new applicants in recent years, limiting the number of new entrants.

The state is not pursuing some cost containment strategies that are being tried in other states. For example, in part because of the general hostility to managed care, especially health maintenance organizations, by providers in the state, the Alabama Medicaid Agency is not pursuing initiatives to integrate acute and long-term care financing and delivery. In fact, the state's major initiative in managed acute care, primarily for the younger nondisabled population in Mobile County, Alabama, was terminated in September 1999. The state is also not funding residential care or client-directed services as lower cost alternatives.

QUALITY ASSURANCE

According to state agency staff, there has been some isolated quality of care problems, but there have not been a lot of complaints from clients. Quality assurance

[14] Alabama Medicaid Agency, *1999 Annual Report*, http://www.medicaid.state.al.us/about/99anrep, accessed August 16, 2000

activities are combined with making sure that the authorized and billed services are actually provided.

Quality assurance is done through four mechanisms. First, the Department of Public Health certifies home health agencies for participation in Medicare and Medicaid. The Department of Public Health also licenses assisted living facilities, but several observers noted that maintaining regulatory oversight is a major problem because of regulatory understaffing and that there is a proliferation of unlicensed facilities in the state. Second, case managers, through their monthly contact with clients are supposed to make sure that the needs of clients are met. Third, the Departments of Public Health, Senior Services, and Rehabilitation Services all have their own internal quality assurance mechanisms for monitoring quality of care in the portion of the system for which they are responsible.

Fourth, the Quality Assurance Division within the Alabama Medicaid Agency, which is separate from the Long-Term Care Division that administers the home and community-based services waivers, is responsible for quality assurance activities under the waivers. This Medicaid unit does on-site reviews of case management by the Departments of Public Health, Senior Services and Rehabilitation Services and other providers, examining their records, plan of care, and narrative record documenting the outcomes of care, conducts home visits for a small portion of clients, and conducts a beneficiary satisfaction survey. The 1999 beneficiary survey was very simple, asking clients if they were "very satisfied," "satisfied" or "dissatisfied." A mailing to 321 Medicaid elderly/disabled waiver clients yielded a 50 percent response rate. Of the 161 respondents, 78 were "very satisfied," 73 were "satisfied," and only five "dissatisfied." Notably, 18 respondents asked for more hours of service and 63 claimed that they did not have a choice in selecting types of services or providers.

Workforce issues are of growing importance, with a shortage of home care workers in some areas. However, the difficulty in recruiting workers does not appear to be at the "crisis" stage that exists in some other states. In addition to problems recruiting paraprofessional workers, registered nurses are also in short supply and the state's nursing

schools are turning out fewer graduates. Personal care aides are required to be high school graduates or to have a GED and to be trained by their agency. Criminal background checks are not conducted. According to some observers, a major problem, especially for the homebound waiver, is the failure of workers to consistently show up and some agencies to have adequate back-up arrangements.

ISSUES FOR THE FUTURE

As Alabama considers the future of home and community-based services, it faces three major issues. First, the long-term care system in Alabama is currently very heavily dependent on institutional services, although progress is being made to create a more balanced system. State officials would like to expand home and community-based services, but they are very constrained in their ability to do so by the lack of state funding. State-only funded programs are extremely small or nonexistent. Moreover, even with a 70 percent nominal federal Medicaid match rate (which is higher in reality because of intergovernmental transfers and provider taxes), the state has not been willing to spend very much for Medicaid in general or home and community-based services in particular. The tobacco settlement will provide the Department of Senior Services with $3 million a year for the next 25 years, but most of the money is earmarked for other purposes. The state could obtain more home and community-based services waiver "slots", but has not funded all of its already-approved elderly and disabled waiver capacity. Some state staff argue that it would be desirable to liberalize financial eligibility for the elderly disabled waiver, but Alabama does not have the funds to finance the additional persons who would become eligible. At the time of the site visit, observers believed that the impact of the Supreme Court's *Olmstead* decision, which held that unnecessary institutionalization was discrimination under the Americans with Disabilities Act, would be mostly on mental retardation/developmental disability services rather than on the elderly population or younger people with physical disabilities. More recently, the state has secured an *Olmstead* planning grant from the Center for Health Care Strategies. In addition, the Governor has established a long-term care task force to explore, among other things, how the state can expand home and community-based services.

Several observers also pointed to the powerful for-profit nursing home industry as a major barrier to expanding home and community-based services. Especially in comparison with the home care association and consumer advocates for older people and younger persons with disabilities, the nursing home association is a highly organized, well-financed trade association with strong ties to the legislature, while the home care association and consumer advocates for older people and younger people with disabilities are not as well organized or connected. The nursing home industry is not opposed to noninstitutional services and does not view them as a major competitor (in part because there is excess demand for long-term care), but nursing homes have successfully obtained yearly Medicaid rate increases that have absorbed a substantial portion of the Medicaid expenditure growth that could pass the legislature. Because of their political power, repeal of the Boren Amendment, which set federal minimum reimbursement standards for nursing homes, by the Balanced Budget Act of 1997 has had little impact. State observers report that efforts to reallocate funds from nursing homes to home and community-based services as has been done in Oregon and Washington would be opposed by the industry and are given little chance of enactment.

Second, compared to some other states, Alabama's delivery system includes a relatively restricted range of services, which reflects a generally conservative approach to funding and to the potential role of home and community-based services. Over the last ten years, the state, especially the home health operations within the Department of Public Health, has depended heavily on Medicare home health and has been very adversely affected by the changes in the Balanced Budget Act of 1997. How the implementation of Medicare prospective payment will affect home health providers will be a critical issue. Within the Medicaid program, home health is quite strictly medical in orientation and has an absolute limit on the number of visits per year that make it difficult for it to serve as a long-term care service. Although the Department of Rehabilitation Services offers a very flexible set of services through its own small programs and through the homebound Medicaid waiver, their target population is very narrow and limited to the nonelderly population. The Medicaid waiver does not include assisted living facilities or adult foster care, nor does it offer consumer directed care relying on agencies to deliver services. In addition, the state does not use the waiver to cover certain medical services

that are not covered under the regular Medicaid program (e.g., home oxygen) or to eliminate the widespread restrictions on amount, duration and scope (e.g., a limit of 16 hospital days per year) in Medicaid benefits.

Third, policy and administration for long-term care in Alabama, including home and community-based services are spread across four agencies, although the Alabama Medicaid Agency is legally responsible. Especially for the Medicaid home and community-based services waivers, the number of agencies involved in administration appears to create some duplication of effort, at least in quality assurance.