MEDICAID'S HOME AND COMMUNITY-BASED ALTERNATIVES TO INSTITUTIONALIZATION IN MONTANA

by

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ABSTRACT

This paper presents a study of home and community-based alternatives to institutionalization under the Medicaid program. In the past, Medicaid had provided long-term health care services primarily in an institutional setting despite arguments that home and community-based alternatives would offer less expensive and more appropriate care for many individuals. The Home and Community-Based Services (HCBS) waiver program was enacted in 1981 in an attempt to allow states to provide home and community-based alternatives under the Medicaid program. In this paper the cost-effectiveness of the HCBS waiver program in Montana has been analyzed. This study found that waiver services for developmentally disabled individuals have been cost-effective. Individuals served by the HCBS waiver received home and community-based services for less cost than if they were served in an institution. The HCBS waiver program's cost-effectiveness for developmentally disabled individuals has been limited by the extensive deinstitutionalization that occurred in the state during the 1970's. HCBS waiver services for Montana's elderly have been provided since July, 1983. An examination of preliminary data revealed that the HCBS waiver program has also been cost-effective for elderly individuals. The HCBS waiver program should continue to be cost-effective in the future as long as the restrictions Montana has placed on participation in the program remain.

CHAPTER 1

INTRODUCTION

The public sector's provision of long-term health care for elderly and disabled individuals faces serious financial problems in the United States. These are rooted in rising medical costs and an increase in the demand for long-term health care services. The increase in demand for the latter is largely the result of an increase in the population of the elderly. It is the elderly population that is most likely to require long-term health care services. The financial problems are likely to continue, and even increase in the future as the cost of and demand for long-term care rises. Interest in the issue of long-term care has increased in the past few years as a result of the strain that health care expenditures are placing on federal and state budgets.[1] Financing long-term health care, as Ronald J. Vogel and Hans C. Palmer point out, is likely to remain a relevant issue for years to come. "It may well be the major health and social issue of the next four decades, . . ."[2]

Since the enactment of the Medicaid program in 1965* the federal government, in a joint partnership with the states, has been providing long-term health care services to the poor. The cost of providing

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* Because the Medicare and Medicaid programs are often mentioned together, it should be noted that the HCBS waiver program relates exclusively to Medicaid.

these services has risen dramatically in the past decade, and demographic trends suggest further increases in the future. For example, in 1970 the United States spent 7.5 percent of its gross national product on health care, in 1980 9.5 percent, and in 1982 10.5 percent.[3] This increase will continue in the future as the proportion of the population over 65 rises. "The elderly population rose from 9.7 percent of the population in 1970 to 11.1 percent in 1980. It is projected that by the year 2030, when the so-called 'baby boom' generation has aged, persons over 65 will comprise an unprecedented 20.4 percent of the total population."[4] This factor is significant because elderly individuals are most likely to be afflicted with the types of illness that require long-term health care, such as; arthritis, hypertension, diabetes, emphysema, and heart disease.[5]

Vogel and Palmer discuss several other demographic trends that will have an effect on long-term health care. These are: An increase in life expectancy rates; a reduction in the ratio of retirement age elderly to the working age group, approaching 1:2.4; and, an increase in the "old-old" population, those individuals over 75 who are most at risk of requiring long-term health care.[6] These trends point to a continued increase in demand for long-term health care services.

The financial problems faced by the Medicaid program have forced policy makers to look for alternatives to reduce costs. One such alternative is home and community-based services. "Nursing homes consume nearly half of all Medicaid dollars, and so getting recipients out of nursing homes and into arrangements with family and friends, officials believe, would yield considerable savings as well as improve the

patients' quality of life."[7] Previously Medicaid provided long-term health care services primarily in an institutional setting. "In fiscal year 1979, . . . home health services, as an example, only accounted for $264 million; while expenditures for nursing homes came to $8.7 billion."[8] Thus, only three percent of Medicaid's long-term health care budget was spent on home and community-based services. Furthermore, most of the amount spent on home and community-based services was accounted for by one state, New York. "Of the over 358,000 Medicaid HC [home care] recipients in fiscal year 1978, over 55 percent lived in New York, which accounted for 77 percent of national Medicaid HC spending."[9]

This low level of expenditure on home and community-based services is the result of Medicaid's built-in bias toward institutionalization. Under the Medicaid program federal matching has only been available to states for services that are primarily medical in nature, and usually only if it can be proven that the care is necessary after a hospital stay.[10] This requirement has effectively limited the provision of home and community-based services by failing to fund the many services needed for a complete home health care package. Louise Bracknell, staff director of the House Select Aging Subcommittee on Health and Long-term Care, has some insight into the problem.

> An elderly person with arthritis might be able to be cared for easily at home, she pointed out, but with no family or friends or money to pay for help, institutionalization paid for by the government often is the only option.
>
> "Sometimes just for the want of a meal, a person can end up in a nursing home." said Bracknell.[11]

Medicaid's structural bias toward institutionalization resulted in their increased utilization. A report by the Senate's Special Committee on Aging, referring to both the Medicare and Medicaid programs as the Medicare insurance system, concluded: "Utilization of home health services in the Medicare insurance system has remained at less than 1 percent of insurance expenditures, and appears to be diminishing. Institutional utilization and expenditures are increasing."[12] This institutional bias existed despite the increased financial problems with the program and the perception that home health care would be less expensive. "In the past neither Medicaid nor Medicare has paid much for home and community-based services even though they tend to be less costly."[13] Also, supporters of home and community-based services believed that many individuals in institutions were inappropriately placed.

> At a November 10, 1981 hearing on long-term health care before the Senate Labor and Human Resources Committee, Chairman Orrin G. Hatch, (R-Utah), estimated that about one-fourth of the elderly now in nursing homes do not have to be there; other estimates run as high as 40 percent."[14]

In response to these concerns, the Home and Community-Based Services (HCBS) waiver program was enacted as Title XXI of the Omnibus Budget Reconciliation Act of 1981.[15] The HCBS waiver program allows for the waiver of certain statutory requirements of the Medicaid program that restricted the states' ability to provide non-institutional alternatives for long-term health care.

Problem Statement

The objectives of the HCBS waiver program are to reduce long-term health care costs by providing individuals with less expensive

home and community-based services and to provide individuals with a more appropriate alternative to long-term health care than institutionalization. However, the effect of the HCBS waiver program on Medicaid's long-term health care policy is uncertain. Is the HCBS waiver program cost effective, and, if so, has it resulted in a reduction in spending for the Medicaid program; or, will the waiver result in an expansion of the Medicaid program? There are several factors to be considered in this context:

(A) Will there be an increase in the number of eligible clients demanding services under the waiver, where in the past Medicaid's built-in tendency toward institutionalization may have controlled the number of individuals seeking services under the program?

(B) Will home and community-based services be viewed as a substitute for, or an add-on to, institutional care?

(C) What level of care is to be provided under the HCBS Waiver program?

The answers to these questions are very important for the future financing of long-term health care by the public sector, especially for the states. State and local governments supplied over $16 billion of the $34 billion spent on the Medicaid program in 1982.[16] This amounted to 47 percent of the total bill. For many states the matching portion of Medicaid becomes a very large budget item. "In a number of states, such as California, Massachusetts and Michigan, Medicaid is the single largest item in the budget consuming up to 15 percent of the states' resources."[17] As a result, states are very interested in ways to reduce the costs of the Medicaid program.

The other major area of uncertainty that the HCBS waiver program faces concerns the appropriateness of care for individuals served in home and community-based settings. Are individuals in home and community-based settings receiving more appropriate, or even as appropriate a level of care as that offered by an institutional setting? Due to the constraints of this project, this aspect of the HCBS waiver program will not be covered.

Research Methodology

This paper focuses on the uncertainties surrounding the financial aspects of the HCBS waiver program with special reference to Montana. Montana has operated an HCBS waiver program for developmentally disabled (DD) individuals in the state since 1981. This has been replaced by a statewide waiver program for both the elderly and the DD. Data from Montana's experience under the DD waiver has been analyzed to determine the cost-effectiveness of the program. In addition, preliminary data from the statewide waiver has been studied.

This paper begins with a descriptive study of the historical development of the HCBS waiver program in Chapter 2. Chapter 3 presents the issues surrounding home and community-based services and describes the actual enactment of the program. Chapter 4 focuses on the application of the HCBS waiver program in Montana. In Chapter 5 the financial aspects of the program are analyzed. Finally, Chapter 6 concludes with a summary of this paper's findings and discusses the future prospects for the program.

Endnotes

[1]Pamela Fessler, "Soaring Health Care Costs for the Elderly: A Problem Growing Worse Every Year." Congressional Quarterly Weekly Report, 28 November 1981, p. 2338.

[2]Ronald J. Vogel and Hans C. Palmer, Long Term Care (Washington, D.C.: U.S. Government Printing Office, 1982), p. v.

[3]Robert M. Gibson, Daniel R. Waldo, and Katharine R. Levit, "National Health Expenditures, 1982," Health Care Financing Review, (Fall 1981), pp. 3-4.

[4]Fessler, op. cit., pp. 2337-2338.

[5]Ibid., p. 2338.

[6]Vogel and Palmer, op. cit., pp. v-vi.

[7]Linda E. Demkovich, "States May Be Gaining in the Battle to Curb Medicaid Spending Growth," National Journal, 18 September 1982, p. 1584.

[8]Vogel and Palmer, op. cit., p. 281.

[9]Ibid., p. 201.

[10]Fessler, op cit., p. 2340.

[11]Ibid., p. 2340.

[12]Brahna Trager, Home Health Services in the United States, A Report to the Special Committee on Aging, United States Senate (Washington, D.C.: U.S. Government Printing Office, 1972), p. 14.

[13]Demkovich, op. cit., p. 1585.

[14]Fessler, op. cit., pp. 2340-2341.

[15]U.S., Statutes at Large, vol. 95, pp. 803-813.

[16]Gibson, Waldo, and Levit, op. cit., p. 23.

[17]Abigail Trafford, "Are Medicare, Medicaid Going Belly Up?" U.S News and World Report, 6 September 1982, p. 37.

CHAPTER 2

THE DEVELOPMENT OF LONG-TERM HEALTH CARE POLICY IN THE UNITED STATES

The HCBS waiver program amends the Medicaid program to allow for the provision of home and community-based services as an alternative to institutionalization for individuals requiring long-term health care services. This program is the latest development in the public sector's provision of long-term health care services. In this chapter a brief definition of long-term care services is presented, followed by a history of the development of long-term health care policy in the United States.

Long-Term Health Care Defined

Long-term health care is the provision of health care services to individuals whose illnesses, injury, handicap, or disease require medical services over an extended period of time. In our society the aged, especially those over 75 years old, constitute the great majority of people who require long-term care, although many younger people also require such care.[1]

Long-term health care can be divided into several categories according to service needs. Montana classifies long-term care patients by the level of care available in a skilled nursing facility (SNF), an intermediate care facility (ICF), or an intermediate care facility for the

mentally retarded (ICF/MR). In addition, long-term care may involve the provision of basic services which are preventive measures. "Basic services may adequately maintain individuals in their homes at effective levels of health and function over long periods of time or permanently without recourse to more concentrated care or to institutionalization."[2]

Individuals requiring a SNF level of care have a need for concentrated services that require multiple professional diagnostic, therapeutic and supportive services under professional supervision and coordination.[3] An ICF provides services to individuals who require intermittent health-related services that are more than custodial but less than the intensity of services offered in an SNF.

It is evident that long-term care requires a mix of resources to meet the needs of a variety of patients with different levels of functioning.[4] It is assumed that the provision of home and community care services will fulfill some of these needs.

Early History of Long-Term Health Care

The present system of providing long-term health care services to the poor in the United States is based on legislation enacted during the 1930's that resulted from a long-standing value of providing medical services to the poor.

> The provision of medicare care to the poor has long been a recognized part of the American system of public relief. Concern over the equitable provision of health services is, however, a twentieth-century phenomenon, born of the great strides in medical science made in the late nineteenth century and accelerating, as they have, to the present.[5]

Long-Term Health Care Prior to the 1930's

Prior to the Welfare Reforms of the 1930's, the public sector's provision of long-term health care was primarily provided in county poorhouses. "Operated and financed by local government these institutions originally supported children and adults of various ages and in various health and financial circumstances, the poor, the old, the disabled, the retarded and the mentally disturbed."[6] County poorhouses generally had a reputation for poor living conditions and efforts of social reformers during the 1930's and the 1940's led to the disappearance of these early government attempts at providing long-term health care services.[7] Religious and voluntary organizations were another early provider of long-term health care services to the elderly and disabled.[8] A third early provider of long-term care services were state governments through state mental hospitals. Although these institutions existed primarily to serve mentally ill individuals, others were also served as Saul Waldman notes:

> The mental hospitals, most of which were state institutions, had long been important facilities for the institutionalization of the aged. In the 1940's, for example, about one-quarter of the institutionalized aged were confined to mental hospitals. To some extent, aged persons who did not suffer mental illness were placed in mental hospitals because such hospitals were the only facilities available for persons needing institutional care.[9]

Early History of Long-Term Care in the Home

The organized provision of long-term care services in the home began in the United States with a program initiated by the Metropolitan Life Insurance Company in the early part of this century.

> In a more formal sense, however, provision and financing for HC [home care] emerged in the early part of the 20th century notably in the program of the Metropolitan Life Insurance Company, which was seeking to improve conditions for the acutely ill and for newborn babies and their mothers.[10]

Federal support for long-term care services in the home was non-existent during this period. What support there was in the public sector for home care came from local governments. Thus it can be seen that early initiatives for organized long-term care services in the home originated in the community through local government and private sector initiatives.

The Social Security Act of 1935

The Social Security Act of 1935 initiated the federal government's involvement in financing medical care. This care was financed jointly by the federal and state governments. Prior to 1935, welfare provisions were entirely the responsibility of individual localities and states.[11] The Act did not specifically direct the federal government to provide matching funds for medical care; however, states could include these costs as part of their maintenance program to individuals or families.[12]

The Social Security Act of 1935 included a program to provide benefits to individuals over the age of sixty-five. These individuals were required to pass a means test to be eligible for benefits under the Act. This program was known as the Old Age Assistance (OAA) program and it provided monthly benefits to individuals financed jointly by the federal and state governments. For the next twenty years these benefits were increasingly used to purchase nursing home services.

The significance of the federal government's initial involvement in providing long-term health care services was that a pattern toward institutionalization was established that would prove to be hard to change.

> In the 20th century, both hospital and nursing home development have seemed to make the home an unusual site for care, at least in the minds of many policy makers and much of the public. Actually, the home remains the site of much care, most often being replaced only when high technology interventions, heavy nursing care requirements, or the method of finance have dictated a shift in patterns of (largely acute) care. Also, the desire of physicians to concentrate patients in their offices and/or in hospital to economize on professional time has led to the abandonment of house calls in most areas and thus reducing the ability of the house to maintain an adequate support system, or so it has been assumed.[13]

Developments in the 1940's and 1950's

The increased public support available to individuals for nursing home care increased the demand for such services. The result was a shortage in the number of nursing homes available to meet this new demand. The Federal government increased its involvement in long-term care services with the passage of the Hill-Burton Act. This 1946 Act made grants, loans, and loan guarantees available for the construction or modernization of hospitals. These funds could only be obtained if a survey of a community's health care needs indicated that additional, or more modern facilities, were needed.[14] The Hill-Burton Act was amended in 1954 to allow for the construction of non-profit and government nursing homes with financial support from the federal government. Here too the need for the facility had to be determined through a survey.[15]

Legislation in 1950 expanded the federal government's role in financing long-term care services to include disabled individuals. Services and eligibility requirements under the program were similar to that of the Old Age Assistance Program. [16] Also, the retirement system benefits of the Social Security Act, which became available in 1946, were increasing the demand for nursing home services by the 1950's. Funds available for financing nursing home care increased further when coverage under the Social Security Act was expanded in 1956 to provide disability insurance benefits to individuals insured under the program.

Originally, the Old Age Assistance and Aid to the Disabled programs provided federal benefits directly to the individuals through the states. In 1950 the Social Security Act was amended to allow payments to be made directly to providers of services for eligible elderly and disabled clients. These payments were commonly known as medical vendor payments.[17] This action enlarged the potential scope for the public's financing of medical coverage to the poor.

> By expanding the federal public assistance categorical grants-in-aid to include federal cost-sharing with respect to charges for hospital and other medical care paid directly to providers by state welfare agencies, the amendments enlarged the potential scope of welfare medical care.[18]

Benefits provided under the 1950 amendments were still subject to a maximum amount per individual per month requirement. This federal matching maximum minimized the cost of these programs.[19]

Kerr-Mills Program

In 1960, the Social Security Act was again amended to directly provide medical assistance to the elderly. Previously, benefits were

provided solely in the form of income maintenance. The Medical Assistance for the Aged program (MAA), more commonly known as the Kerr-Mills program, was first proposed as a substitute for the Medicare program that was being considered at that time.[20] The Kerr-Mills program provided federal funds to individuals termed medically indigent. The term applied to individuals whose income was above the OAA standards but insufficient to pay for medical care. The program initiated further expansion of the federal government's role in financing health care in the United States.

> This program established a new category of public assistance for medically needy aged persons not receiving cash assistance, provided for reimbursing the states 50 to 80 percent of the costs of the program, and made additional funds available for vendor payments for medical care under the existing Old Age Assistance program in the amount up to an average payment of $15 per year per recipient.[21]

The Kerr-Mills Act set an important precedent for the Medicaid program. "Unlike the OAA vendor payment program, the Federal contributions for medical care under MAA were open ended, with no limit based on individual payments or total state expenditure."[22] Previously, federal programs established maximum levels for payments to individuals. Another significant aspect of the Kerr-Mills program was that the federal government, for the first time, allowed home health care services to be funded through federal funds.

> Federal involvement with HC [home care] really began with the Kerr-Mills legislation, . . . This law allowed payment for home health aides who, in addition to providing nursing service, were permitted to perform light housekeeping in the patient's room and/or near the sickbed.[23]

This aspect of the Kerr-Mills program set an important precedent for home health care services under Medicaid by distinguishing medical

services from housekeeping services for the first time. "In effect, this law divided health care from housekeeping, which may have clarified matters for reimbursement purposes but which also introduced a false distinction into a pattern of continuous provision."[24]

Despite the availability of federal funds for home health care services, the Kerr-Mills program continued the government's reliance on nursing homes for the long-term health care needs of the nation. "Overall, the program had a significant effect in increasing expenditures for nursing care, and by 1965 some 300,000 persons were receiving nursing home care under that program."[25]

These developments in the federal government's provision of long-term health care services from the 1930's through the Kerr-Mills program culminated with the enactment of the Medicaid and Medicare programs of 1965. These programs are the basis for the public sector's provision of long-term health care services today.

The Medical Assistance Program

The Medical Assistance Program (Medicaid) was enacted as title XIX of the Social Security Amendments of 1965.[26] The Amendments also included the Medicare program. These programs have had a great impact on health care in the United States during the past two decades.

The Enactment of Medicaid

The provision of a national program for medicare care became a very important issue in this country during the late 1950's and early 1960's. The Kerr-Mills program was enacted during this period as a

compromise to a more comprehensive medical care program, the Medicare proposal of 1960. However, proponents of Medicare were disappointed with the Kerr-Mills program and pressure for Medicare during the 1960's increased.

The election of President Kennedy in 1960 brightened the prospect for the passage of the Medicare program.

> In November 1960, Senator John F. Kennedy was elected President by the narrowest of margins. Pledged to take America to new frontiers, he included medical care as one of them, and the early days of the Kennedy Administration saw 'medicare' as a prominent issue.[27]

Nevertheless, it took until 1964 for Congress to approve the Medicare and Medicaid programs. During this period of Congressional debate, Medicaid received little attention. Instead, Congress placed primary emphasis on Medicare. The Medicaid program, known as the hidden iceberg of the 1965 Amendments, moved through the legislative process in the shadow of Medicare.[28]

The Medicare program enacted as title XVIII of the 1965 Amendments provides medical insurance to elderly individuals as part of the Social Security System. Medicare is financed solely by the Federal government. Medicaid, on the other hand, is financed jointly by the Federal and state governments. The program is operated largely by the states under federal guidelines. To be eligible for federal matching funds, a state must provide Medicaid services to all persons receiving public assistance in the state. States may also choose to cover other low-income people who are considered medically indigent.

The Medicaid and Medicare programs are based on many aspects of the Kerr-Mills program. However, these programs expanded the role

of the Federal government in providing medical care.[29] Using the Kerr-Mills program as a basis for the Medicare and Medicaid program was surprising in light of all the problems that the earlier program had experienced by 1965.

> Kerr-Mills had indeed received substantial publicity in the debate preceding the 1965 legislation. That program had already demonstrated the basic characteristics which were later to plague Medicaid: the transfer of funds by states from one public pocket to another under the stimulus of greater federal matching funds; the unevenness of the program from state to state; the implications of attaching a system of medical vendor payments to an administrative structure of grants-in-aid which relied on minimal federal direction; the interpretation of "medically indigent" as a rather rigid test of means, albeit at a somewhat higher level than for cash assistance; the greater interest by the state legislatures in balancing their budgets than in reorganizing medical care; and, in the state bureaucracies, the inadequate expertise for running a major medical program. Yet title XIX was developed under similar principles.[30]

Aspects of the Medicaid Program

As stated above, the Medicaid program provides medical services to the poor. A major aspect of the program is the state-federal partnership in financing the program. Federal matching for a state program is determined by a formula which compares per capita income of a state to the per capita income of the United States.

> The federal government helps states to share in the costs of health care for the poor and medically needy by means of variable matching formula. As a minimum, the federal government will pay 50% of the medical assistance costs incurred by a state in providing health care under a Medicaid program. In poorer states, the federal share of medical assistance payments can increase up to 83%.[31]

For a state to be eligible for matching funds it must meet several requirements set by the federal government. First of all, states are required to expand services from "medical assistance to the needy"

under the Kerr-Mills law to the more precise categories of aged, blind, disabled, members of families with dependent children, and the needy whose money sources are insufficient to meet the costs of necessary medical services.[32] Secondly, states must make assurances that certain services will be provided to individuals covered by a state's Medicaid program, and that the services offered are equally available to all eligible individuals in a state.[33] The minimum services that a state must provide are listed below:

1. Inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);
2. Outpatient hospital services;
3. Other laboratory and x-ray services;
4. Skilled nursing home services (other than services in an institution for tuberculosis or mental disease) for individuals aged 21 or older;
5. Physician's services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home, or elsewhere.[34]

In addition to these mandatory services, states were allowed to provide other services including home health care.[35]

Medicaid and Home Health Care

Advocates of home and community-based alternatives to institutions initially viewed the Medicare and Medicaid programs as an opportunity to expand government financing of home and community-based services. "Medicare and Medicaid in the minds of HC [home care] advocates, appeared not only to bring a new era in finance of health care for the elderly and indigent but also to open the door to the implementation of alternative strategies, especially HC."[36] However, the implementation of these programs moderated their expectations. "Under Medicaid, it would appear that HC of many types could be provided; yet

the program is means tested and subject to the eligibility definitions and budget limits of states."[37] Many states implementing Medicaid found the expense of providing the required services a heavy enough burden without expanding the program to include other services such as home care. As a result, the development of home and community-based alternatives to institutionalization was very slow if at all.

Amendments to Medicaid

From the earliest years of the program's operation, Medicaid was faced with problems. "By 1967, localities, states, and the Federal government were feeling increasingly burdened by mounting medical assistance expenditures. There was also anxiety about the quality of long-term care being purchased with Medicaid funds."[38] In 1967, the Medicaid program was amended to help control the financial burden of the program and to improve the quality of care that was being provided.[39] "The 1967 amendments reflected these concerns. They include changes intended to promote both short-term and long-term economy and to control the quality of care being financed in part by Federal appropriation."[40] The amendments also required states to provide two additional services: home health care and screening and diagnosis; and treatment of children.[41]

The 1967 Amendments failed to reduce the burden of the Medicaid program. Congress, concerned over the cost of the program, amended the program once again in 1969 to correct an administrative interpretation that had resulted in higher costs than necessary for the program.[42]

Further attempts to reform the Medicaid program during the past decade centered around preventing abuse and fraud of the system and improving the management of the program. "For years, Congress has been prodding states to improve the Medicaid program's efficiency by streamlining their management methods and cracking down on fraud."[43]

In spite of the efforts to control the costs of financing the Medicaid program, it continued to become more expensive. These efforts did not include the expanded use of home and community-based services to meet the long-term care needs of the Medicaid population. Home health care services under Medicaid became a very insignificant part of the program. Susan Lloyd and Nancy Greenspan examined home health care under Medicaid:

> . . . Medicaid home health benefits are Federally-mandated service inclusions for all categorically needy adults in all State Medicaid programs. However, in 1977 the majority (54 percent) of actual home health recipients were residents of one state, New York, which has 12 percent of the national Medicaid population. These figures indicate that most states must have restrictive (if unwritten) policies concerning the provision of home health services to the Medicaid population, and that the home health benefit is not equally accessible to Medicaid recipients in every locale.
>
> One way for states to curb utilization of home health services is to set the reimbursement rates below market levels. Hence, home health service providers find it economically unattractive to accept Medicaid clients and frequently refuse to accept more than a certain number of them, accept none at all, or set a limit on the total number of services rendered to Medicaid recipients.[44]

Endnotes

[1]Ronald J. Vogel and Hans C. Palmer, Long Term Care (Washington, D.C.: U.S. Government Printing Office, 1982), p. 2.

[2]Brahna Trager, Home Health Services in the United States, A Report to the Special Committee on Aging, United States Senate (Washington, D.C.: U.S. Government Printing Office, 1972), p. 7.

[3]Ibid., p. 6.

[4]Vogel and Palmer, op. cit., p. 3.

[5]Robert Stevens and Rosemary Stevens, Welfare Medicine in America: A Case Study of Medicaid (New York: The Free Press, 1974), p. 1.

[6]Saul Waldman, "A Legislative History of Nursing Home Care," in Long Term Care, ed. Ronald J. Vogel and Hans C. Palmer (Washington, D.C.: U.S. Government Printing Office, 1982), p. 507.

[7]Ibid., p. 507.

[8]Ibid., p. 508.

[9]Ibid., p. 507.

[10]Hans C. Palmer, "Home Care", in Long Term Care, ed. Ronald J. Vogel and Hans C. Palmer (Washington, D.C.: U.S. Government Printing Office, 1982), p. 338.

[11]Stevens and Stevens, Welfare Medicine in America, op. cit., p. 5.

[12]U.S. Department of Health, Education and Welfare, "History and Evaluation of Medicaid," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 5.

[13]Palmer, "Home Care," op. cit., p. 339.

[14]U.S., Statutes at Large, vol. 60.

[15]Waldman, op. cit., p. 510.

[16]Ibid., p. 504.

[17]Ibid., p. 512.

[18]Stevens and Stevens, Welfare Medicine in America, op. cit., p. 23.

[19]Howard N. Newman, "Medicare and Medicaid", in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), pp. 313-314.

[20]Waldman, op. cit., p. 513.

[21]Newman, op. cit., p. 314.

[22]Waldman, op. cit., p. 513.

[23]Palmer, "Home Care," op. cit., p. 340.

[24]Ibid., p. 340.

[25]Waldman, op. cit., p. 513.

[26]U.S., Statutes at Large, vol. 79.

[27]Eugene Feingold, Medicare: Policy and Politics (San Francisco: Chandler Publishing Co., 1966), p. 114.

[28]Newman, op. cit., p. 314.

[29]Ibid., pp. 314-315.

[30]Robert Stevens and Rosemary Stevens, "Medicaid: Anatomy of a Dilemma - Conclusion," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 308.

[31]Allan Brownfeld, "Medicaid: The Anatomy of the Failure of a Government Program," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 285.

[32]U.S. Statutes at Large, vol. 79.

[33]Ibid.

[34]Ibid.

[35]Ibid.

[36]Palmer, "Home Care," op. cit., p. 340.

[37]Ibid.

[38]U.S. Dept. of Health, Education and Welfare, op cit., p.8.

[39]Ibid., p. 8.

[40]Ibid., p. 8.

[41]Ibid., p. 8.

[42]U.S. Congress, Senate, Committee on Finance, Medicaid: Problems, Issues, and Alternatives, Committee Print, 91st Congress, 2nd Session, 1970, p. 43.

[43]Donald C. Bacon, "Medicaid Abuse: Even Worse than Feared," U.S. News and World Report, 4 June 1979, p. 44.

[44]Susan Lloyd and Nancy T. Greenspan, "Nursing Homes, Home Health Services, and Adult Day Care," in Long Term Care, ed. Ronald J. Vogel and Hans C. Palmer (Washington, D.C.: U.S. Government Printing Office, 1972), pp. 156-157.

CHAPTER 3

THE HCBS WAIVER PROGRAM

President Reagan believed his landslide election in 1980 was a mandate from the people to control the runaway costs that many of the social programs were experiencing and on March 10, 1980, "issued a blunt warning to Congress to adopt his sweeping spending and tax cuts or risk angering voters who instructed Washington last November to put 'America's economic house in order'."[1] Included in his spending cuts were measures to reform the Medicaid program. The HCBS waiver program was part of this reform.

Medicaid provides a striking example of a social program that has been experiencing runaway costs. Spending on the program increased from $8.6 billion in 1973 to $23.3 billion in 1981.[2] This increase in the costs of the Medicaid program is parallel to the rapidly increasing costs of health care in the United States. "Underlying the budget squeeze on Medicaid and Medicare is the general crisis in health care costs. While the consumer price index increased by an annual rate of 5.4 percent for the first six months of 1982, medical care prices soared 11.3 percent."[3]

Concern over the high cost of the Medicaid program is not unique to the Reagan Administration. Since Medicaid's earliest years of operation it was evident that financing the program would be costly. In 1970, a staff report of the U.S. Senate's Finance Committee observed

the following:

> The Department of Health, Education and Welfare had estimated at the time Congress was considering the legislation that the Medicaid program would cost the Federal Government an additional $238 million in its first full year of operation. In fact, the Federal share of vendor payments for calendar year 1966 was precisely $238 million more than in calendar year 1965 - but only six States had programs in operation during the full year.
>
> Thus it soon became clear that the Medicaid program would be more expensive than originally contemplated.[4]

Past reform measures attempted to provide short-term relief for the financial woes of the program and ignored the more difficult programmatic issues. Many individuals concerned with reforming Medicaid felt that long-term solutions to the high cost of financing the program could only be achieved through changing the dysfunctional aspects of the program.

> Medicaid economists warn, however, that changing the way Medicare and Medicaid are financed and managed cannot solve the general crisis in health care costs . . .
>
> Leaders in the field say that basic reforms are needed not only to control costs but to correct serious drawbacks in the Medicare and Medicaid programs.[5]

The HCBS waiver program attempts to provide such programmatic changes to the Medicaid program by providing home and community-based alternatives to institutionalization in Medicaid's provision of long-term health care services. Institution services under Medicaid have become a very expensive part of the program.

> Many elderly patients needing nursing-home care must turn to Medicaid, and today Medicaid pays half of the costs for long-term care in nursing homes -- skewing the original purpose of the program to provide such benefits as hospitalization and physician visits to the poor of all ages . . .
>
> For state and federal governments, the Medicaid burden for nursing home care is expected to rise with the aging of the population. If trends continue, nursing home costs will increase from 21 billion dollars in 1980 to 42 billion in 1985 and 76 billion by 1990.[6]

The remainder of this chapter will examine the shortcomings of the Medicaid program with respect to home and community-based services, discuss the issues surrounding home and community-based alternatives to institutionalization, and conclude with an examination of the enactment and aspects of the HCBS waiver program.

Problems with Medicaid

The Medicaid program has been beset with problems throughout its history. As discussed above, one of the earliest problems of Medicaid was the high cost of the program that paralleled a rapid increase in health care costs in the United States. "While the Consumer Price Index was increasing 19.7 percent for all consumer goods during the period 1966-1970, physicians' fees were increasing by 30 percent and hospital daily service charges by 71.3 percent."[7]

In addition to increases in health services costs, the financial difficulties of Medicaid can also be attributed to the inadequate controls over the use of services.

> The basic flaw of Medicaid as originally conceived was that it gave no incentive for economy to either the buyer or seller of medical services. The more services a seller provided -- for example, the more patients a ghetto doctor or dentist saw -- the more money he made. But the patients had no reason to economize either since it cost them nothing to go to a doctor, enter a hospital, or have the dentist work on their teeth.[8]

This lack of control over the use of funds under the Medicaid program often led to abuse and even fraud of the system.

> The Medicaid system clearly invited abuse by providers of health care, and by patients, because it had built-in incentives for needless, wasteful utilization.
> . . . more than a few Medicaid patients learned how to use that mechanism to satisfy non-medical needs; for example, by

> getting a podiatrist to "prescribe" ordinary shoes or taking an unnecessary prescription to a druggist and exchanging the prescription for cash amounting to, say, half the sum the pharmacist would be compensated for the medication.[9]

These main faults of Medicaid, lax administration and unanticipated costs, are the result of unclear goals for the program. Congress never determined whether Medicaid was to be a health care program or part of a larger income maintenance program. Dwelling on this theme, Robert Stevens and Rosemary Stevens noted:

> Title XIX, as drafted, was bound to be ineffective in its double role as a health service program and as an expansion of public assistance. Indeed, it was the combination of a program of cash assistance which provoked Medicaid's initial dilemmas. Whether Medicaid was in fact to be regarded as a health care program or part of a broader program of income maintenance was never sufficiently elucidated . . .
>
> The lack of clearly stated national goals for Medicaid in 1965 was a major and reverberating deficiency. Congress, in so many ways, made a series of classical errors which were transmitted down the line as the programs were developed in the states. These errors led to conflicts in interpreting Medicaid between powerful committees in Washington and the legislatures of major states (particularly New York and California), to state budgetary crisis, and to the sometimes selfish behavior of the Medicaid providers.[10]

With the many problems that Medicaid was experiencing during its early years, it was often assumed that Medicaid would be a transitional program that would eventually be phased out and replaced by a workable program. One proposal often mentioned to take the place of the Medicare and Medicaid programs was a system for national health insurance.[12] Such a system was never agreed to.

Home Health Care Under Medicaid

Although home health care services were included as part of the Medicaid and Medicare programs, their utilization has been minimal.

Long-term health care services under these programs tended toward institutional services. Brahna Trager discusses particular limitations of the Medicaid and Medicare programs which limited the provision of home health care services. These are:

1. Home health services in the Federal Medicare insurance system are focussed upon acute or short-term illness.
2. The definition of the eligible consumer of home health services is inherently contradictory as it is applied to the needs of the insured group.
3. Services which are reimbursable are not those which are most needed by the majority of the insured group.
4. The definitions of the nature of the services which are reimbursable are susceptible to a wide variety of interpretations.
5. The complexities of administration and reimbursement have placed many agencies in financial jeopardy.
6. The difficulties in establishing and maintaining services have substantially limited the range of services offered by providers. A limited range reduces the usefulness of the services.
7. The system has a very strong institutional basis. Entry into the home health services entitlement (Part A) is by way of an institution (a three-day period of hospitalization unless the insured is able to pay for supplementary insurance).[13]

Trager summarizes the extent of these limitations on health care services.

> The present system of Medicare health insurance has not stimulated development of home health services in any appreciable way and may, in fact, have depressed such development by opening up to the providers of home health services a caseload which requires a broader range of services and more appropriate services than those which are reimbursed.[14]

The provision of long-term health care in home and community-based settings was also constrained by certain statutory requirements of the Medicaid program. These requirements made it difficult for states to receive federal approval for home health services even if a state wished to provide such services. These requirements include:

1. A state plan for a service to be provided under the Medicaid program must be in effect in all areas of the state;
2. All eligible individuals under Medicaid in the state must have access to the services that are to be provided.[15]

As the cost of the Medicaid program rose, support for home and community-based alternatives increased. This increased pressure resulted in the enactment of the HCBS waiver program in 1981.

The Alternatives Question

Arguments in favor of home and community-based services surround the suggestion that such services would be less expensive and more appropriate for certain individuals than institutionalization. The arguments over the issue of institutions versus the home and community have existed for years, primarily in the criminal justice system in this country. This issue has been increasingly prominent during the past twenty years.[16] This current trend can be traced to President Kennedy's strong convictions toward deinstitutionalization. "In 1963, President Kennedy, in a special address to Congress, called for reducing the number of mentally ill persons in institutions by 50%."[17]

Concern over the development of alternatives to nursing homes for the elderly came to the forefront during the 1970's.

> Estimates that up to 60 percent of elderly nursing home residents required only minimal nursing services were accompanied by pleas for the generation of non-institutional alternative options for the aged. In 1973, the call for re-directing of public resources to at-home services for impaired elderly was described as having 'taken on the characteristics of a groundswell'.[18]

Andrew Scull believes that support for institutional services and alternatives to institutions occur in cycles with the present trend toward the development of alternatives to institutionalization.

> There have been historical cycles of bias in favor of or against institutional care. We are just now emerging from the latter phase in which it was taken for granted that keeping the elderly out of institutions was a desirable goal subsuming a larger set of secondary goals for the optimization of the quality of life and functioning of the elderly person.[19]

In spite of extended public financing of institutional services under Medicaid and Medicare, long-term care services in the home and community still predominate. "Non-institutional modes of care for the chronically disabled and frail elderly have always predominated. Even at the apogee of institutional care, far greater numbers of dependent elderly have been supported outside rather than inside institutions."[20] Elderly individuals living in home and community-based settings receive health care services from their families and a variety of public and proprietary service providers.[21]

One of the main arguments in favor of alternatives to institutionalization was the belief that many individuals in institutions are inappropriately placed.

> Claims for the efficacy in serving as a substitute care setting were based on the premise that a considerable portion of nursing home residents could be served in less restrictive settings if such programs were available. A spate of small sample studies using widely varying methods and assumptions buttressed the case by producing estimates that between 6 and 76% of those in nursing homes did not really need to be there.[22]

Furthermore, the growth in the number of individuals in nursing homes also raises questions over the degree of personalized care received in nursing homes. "The growth of institutions has also led to

concerns about the depersonalization and demoralization of their residents, about the physical and other abuses to which they may be exposed, and about relocation stress or transfer trauma."[23] It was argued that if the necessary services and financing for such services were available, then the community would be the most appropriate place for an individual to be cared for.

> Until recently, there was prevalent and confident expectation that if there were sufficient and adequate alternatives to institutional care, then potential candidates for institutional admission would be diverted to community care programs where they would be less expensively managed, less demoralized, less disengaged and isolated, less depersonalized, and less abused than in institutions, and would, in addition, fare better in the course of their physical and mental disorders. In short, it was assumed that alternatives to institutional care would then turn out to be cost-effective and also desirable from both humane and public health viewpoints.[24]

However, Shinn and Felton argue that deinstitutionalization does not necessarily mean a more appropriate level of care. "It has become clear that neither the rhetoric of deinstitutionalization nor the movement of persons from one setting to another by themselves lead to better quality of life, more effective provision of services, or better outcomes for the people affected."[25] The successful provision of home and community-based alternatives to institutional care is not without problems. Garland, Bennett and Wilder point out several.

1. A potentially high demand for these services, from elderly who are not yet and might never be in institutions, that might swamp the existing and planned services without much impact on the number in institutions;
2. Difficulty of gaining entry to alternatives of care, given their patchy and often evanescent geographic representation, the maze of rules of eligibility and the inadequacy of information and referral pathways;
3. A lack of well trained staff, hence problems of supervising, monitoring, and regulating against the possibility of

fraud, abuse and poor quality care, especially when care is given in such a wide range of sites;
4. High costs of transport for clients to central sites, and high travel time for service providers to peripheral sites; and
5. Inefficiencies that are inherent in a system in which clients with multiple problems use multiple services that cut across traditional disciplinary boundaries, where the services are neither coordinated or integrated. Furthermore, even when the alternative care system is functioning smoothly and efficiently, it may sometimes have the paradoxical effect of hastening rather than delaying a client's admission to an institution.[26]

In determining the type of care that is most appropriate for an individual, a reliable tool should exist to evaluate alternatives. Unfortunately, reliable methodological procedures are not available to evaluate home and community-based care and institutional care; even for the most straightforward type of care.

> Two classes of characteristics are especially germane: 1) baseline prognostic features that affect rates of decline or recovery irrespective of initial severity of health or social problems; and 2) prognostic features that affect rates of decline or recovery irrespective of initial severity (e.g., type of problem, premorbid level of function). There are a variety of assessment procedures that can serve these ends, including measures of contracts, objective and subjective health, and operationally defined diagnosis. Unfortunately, these may vary, unexpectedly, between treatment setting. Similar patients may not obtain similar scores when placed in different settings in which different other variables are operating.[27]

Furthermore, to determine the most appropriate level of care assumes that goals for long-term health care are agreed upon.

> The most pertinent criteria for evaluating alternatives in long-term care is the effectiveness of these alternatives in achieving certain outcome goals, including: securing for the functionally impaired, elderly person, whatever personal assistance, basic care and shelter is required and is not available from informal or other formal sources; enhancement of survival, functioning and social engagement levels as much as possible for that person; and doing so while preserving as far as possible the continuing of the person's lifestyle and a high state of morals.[28]

However, different components of the long-term health care sector place different emphasis on these varying aspects.

> Those components at the institutional end of the spectrum, or those espousing a medical and nursing model of treatment, may stress the preservation or improvement of functioning; while components at the other end of the spectrum may focus on the quality of life of their clients.[29]

Finally, these various goals are faced with yet another, often contradictory goal of keeping government expenditures on the program at a minimum. "Cost containment goals are also regarded as crucial goals for long-term care alternatives in the current politico-economic view of a society with limited resources."[30]

When analyzing the alternatives of home and community-based services and institutional services, the question of life satisfaction of the elderly should be included in the equation. However, this isn't easy. "It is difficult to integrate these factors into cost-effective equations in a quantitative fashion but it makes a travesty of the concept of effectiveness if they are omitted."[31]

There are also hidden goals in the provision of long-term care that should be considered when analyzing alternatives. Garland, Bennett, and Wilder provide examples of some of these.

> However, quite different goals may be equally important in shaping the nature and utilization of the long-term care system: the desire of a service to perpetuate itself; the striving for identify and purposefulness on the part of administrators and staff; the perceptions and preferences about fulfillment of needs held by the clients, their families, or their neighbors; the competing interests of other services or other clients; and the conservation of personal as opposed to public resources. Obvious difficulties can arise in an evaluation study in documenting and reconciling these various perspectives with their differing and sometimes conflicting goals.[32]

Nevertheless, proponents of home and community-based alternatives to institutionalization have claimed that a home and community-based system designed to meet the health and social needs of the elderly, is a more appropriate level of care than institutionalization.

> Good news has emerged, however, from recent studies and actual field experience. Consistently it appears that the quality of life for elderly people who remain in the community and receive care is better than for those who enter long-term care facilities. In fact, alternative services are taking their place in communities throughout the country in a continuum of care for the elderly that encompasses nursing homes.[33]

Although the issue of appropriateness of care is difficult to settle, the question of the cost savings associated with home and community-based care is less vague. Whenever home and community-based alternatives are proposed, the cost-saving aspects of the program were always mentioned.

> In that study, the average cost of participating in a day care program was added to the cost of living at home, and this combined figure was compared to the cost of nursing home residency. The comparison provided a promising possibility of 12-35% savings, with one important caveat: savings would accrue only if day care was actually used as a full substitute for nursing home care.[34]

This leads to another issue which surrounds the provision of home and community-based services: the potential population that would receive services under such a program. Tobin and Kulys discuss demographic problems the public sector could face in providing home and community-based alternatives.

> For example, while less than 6 percent of all those aged 65 and over reside in institutions, 7 to 8 percent of community-dwelling elderly are essentially homebound (one of four of whom are bedridden), and an equal percentage are quickly becoming homebound. A more recent study revealed that 17 percent of community elderly are greatly or extremely impaired in carrying out the activities of daily living. Indeed

> in 1975, 47 percent of non-institutionalized elderly were limited in some way because of chronic impairment. Impairment is characteristic of those who live in institutions but a greater percentage of those with similar impairments live outside of institutions.[35]

In the absence of publicly supported home and community-based services for long-term health care, it is the family that primarily provides assistance to the impaired elderly in the home.

> Only 6 of the 249 elderly respondents were unable to name a responsible other and of the 243 who named a specific other person, 88 percent named a family member. That percentage is almost identical to the 89 percent of elderly in a General Accounting Office study who, when asked who would be the primary source for assistance if sick or disabled, identified family members.[36]

It is safe to assume that in the absence of the HCBS waiver program, the family would continue to assume the burden of providing the long-term health care needs of their elderly family members. "Family members, therefore, care for their impaired elderly at home even when the burden of caring is enormous; suffer great pangs of guilt when institutional care becomes necessary; and maintain contact after institutionalization."[37]

The demographic problems surrounding the HCBS waiver program are less severe if the program is offered as a substitute for institutional care. However, this often isn't the case. "Home health services are not considered a substitute for institutional care. They frequently offer an alternative to such care."[38] Weissert discusses the problem surrounding the substitutability of home and community-based services for institutional care.

> Generically, the problem is the substitution of ambulatory care for inpatient care, . . . All too typically, the substitution does not really work. The problem is that for every

> case that is actually shunted from an inpatient to an outpatient setting, several more entirely new cases are drawn into the health care system by virtue of the more accessible outpatient care . . . Consequently, solving the problem of substitutability looms as a major barrier to implementation of alternatives in long-term care as a cost-effective substitute for nursing home care.[39]

An alternative care program could result in an expansion of services, which would limit the potential dollar savings for such a program.

> Earlier hopes that alternative care might result in uniform cost savings have been modified. Some critics feel that, under the current financing system, alternatives services are 'add-ons' not previously offered, rather than substitutes for more expensive nursing home care, and may not delay entry into a nursing home. They argue that substituting community-based for institutional care would probably result in substantial savings for only a small number of nursing home residents, whose beds would then likely be filled by individuals awaiting placement from hospitals and the community.[40]

In order for the HCBS waiver program to be financially successful, the provision of home and community-based alternatives to institutional care may not result in the expansion of services to individuals who were not previously covered by Medicaid.

Enactment of the HCBS Waiver Program

As mentioned above, President Reagan came into office pledging to reform many of the social programs that had become very expensive. Medicaid was one of these programs, and after his inauguration he announced his plan to lower spending on the program.

> Reagan hopes to cut $1 billion out of Medicaid's $18.2 billion budget for 1982 amount and save up to $5 billion annually by 1989. He would do so mainly by setting a limit on the federal contributions to the program, which is financed jointly with the states, and letting Washington's support grow only to keep up with inflation.[41]

In addition to the limit on the program, the President's plans included a program which would allow home and community-based services to replace more institutional care when appropriate. To achieve this, certain requirements of the Medicaid program would have to be waived. President Reagan's support for the waiver of Medicaid's requirements, which often prevented less expensive and more appropriate services, came to a test in 1981 in the case of Katie Beckett, a three year old who was receiving Medicaid benefits for her hospital care. It was argued that Katie could receive less expensive, more appropriate care at home. Nevertheless, Katie remained hospitalized because Medicaid would not finance all of the services she required for home care, and her parents could not afford the difference.

> Paralyzed almost since birth, the three-year-old girl was kept in a hospital at Cedar Rapids, Iowa, because of a welfare rule -- even though doctors said she could get better care at home at a big saving to taxpayers.
>
> Under federal rules, Katie would lose Medicaid benefits if she went home. Since her parents could not afford the $3,400 a month cost for home treatment, the government was paying $12,000 a month to keep her in the hospital.[42]

Although the Beckett case involved hospital services, it reflects the President's attitude toward programmatic aspects which prevent sensible cost savings.

> It was the sort of government red tape Ronald Reagan has denounced for decades that prompted the President to go to bat for Katie Beckett . . .
>
> Reagan, who heard of Katie's plight through Representative Thomas Tauke (R-Iowa) told his November 10 news conference that it was 'an example of the type of thing that goes on that has to be corrected'. Within two days, Health and Human Services Secretary Richard Schweiker waived the rules and hospital officials said Katie would be home by Christmas.[43]

The HCBS waiver program was just one of President Reagan's plans to reduce the high cost of the Medicaid program. His main proposal to control spending on the program was by imposing limits on federal contributions to states. These limits, he believed, would result in a $1.3 billion saving over the $18.8 billion federal Medicaid budget for fiscal year 1982 requested by President Carter.[44] President Reagan proposed a spending cap which would limit the amount a state could claim in federal matching revenue to a five percent increase each year.[45]

This five percent limit was rejected by the Senate Finance Committee and was replaced by a nine percent cap.[46] Meanwhile, the House passed Medicaid without a spending cap. Instead, the House achieved similar savings by reducing federal contributions to state Medicaid programs by three percent for 1982, two percent in 1983, and an additional one percent in 1984.[47]

The Reagan Administration believed that the only way to control spending on the Medicaid program was through a cap.

> Leading the administration's fight for the Medicaid cap had been David A. Stockman, Director of the Office of Management and Budget. Stockman argues that a ceiling on the increase in federal contributions to Medicaid, the state-funded health care program for the poor, is the only way to control costs. Otherwise, he contents, spending for the entitlement program will continue to rise at the 'budget busting' rate of 15 percent a year, which has been the annual rise in health care costs.[48]

Chief opposition to the spending cap came from state officials who felt that the federal government would only be transferring the program's financial problems to the states. "State officials, guided by the National Governors Association (NGA), contend that a cap would

only shift millions of dollars in costs to the states, which say they are already overburdened by Medicaid budgets swollen by escalating hospital costs."[49] This opposition to the cap by state officials already had resulted in the exclusion of a budget cap in the House's budget reconciliation bill.[49]

The final outcome that was agreed to reduced Medicaid spending by about $1 billion annually; however, Reagan's efforts to place a cap on the program failed.[50] The final compromise basically resembled the House bill.

> Under the reconciliation agreement, the Medicaid program still faces a substantial loss of federal funds. A cut of 3 percent is planned for fiscal 1982, for estimated savings of $920 million; 4 percent for 1984, saving $1.002 billion. The savings could be less, however, if economic conditions made more people eligible for Medicaid.[51]

The report of the conference committee was approved as Title XXI of the Omnibus Budget Reconciliation Act of 1981. Even with this action, many still expected the cost of the health care program to rise.

> Despite the percentage reductions, federal spending for the entitlement program still is expected to increase in future years because of rising health care costs. The Congressional Budget Office estimated the federal government will spend about $600 million more for Medicaid in fiscal 1982 than in 1981, and $2.3 billion more in 1983.[52]

The inability of the Reagan Administration to place a "cap" on the program probably reduced the opportunity for significant savings for the HCBS waiver program. In the absence of the cap, individual states are left to decide whether a HCBS waiver program will be an expansion of, or a substitution for, current Medicaid services. If Medicaid was capped, most states would have been forced to cut back on Medicaid services, provide less expensive alternatives such as home

and community-based services, or make up the difference with state funds.

Aspects of the Waiver

The HCBS waiver program was enacted as section 2176 of Title XXI of the Omnibus Budget Reconciliation Act of 1981.[53] As mentioned above, the main feature of Title XXI in reducing costs of the Medicaid program is a reduction in the total federal reimbursement rates for states by 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984.[54] The Omnibus Budget Reconciliation Act also attempts to save money by allowing states greater flexibility in the operation of their Medicaid programs. ". . . the state Medicaid programs have been given much more flexibility in reimbursement for hospitals and in certain matters of coverage, which should help them to hold down their costs."[55]

In addition to the HCBS waiver program, Title XXI includes several other provisions which attempt to provide the states with greater flexibility in administering the Medicaid program. These provisions include: repealing most Medicaid coverage and service requirements with respect to the medically needy, allowing states greater flexibility in covering individuals 18-20 years old; the removal of Medicaid's reasonable charge limitation; and the waiver of certain requirements of state Medicaid plans such as the statewideness requirement and the freedom of choice provision.[56] Other Medicaid requirements may be waived by the Secretary of Health and Human Services to allow a state

the ability to implement certain service alternatives which would result in a more efficient program in that state.

> Certain federal requirements may be waived to the extent that the Secretary finds it to be cost-effective, efficient and not inconsistent with program intent for a state to (1) implement a primary-care, case-management system; (2) allow a locality to act as a central broker in assisting Medicaid beneficiaries in selecting among competing health plans; (3) share with recipients (in the form of additional services) savings resulting from the use of more cost-effective care; and (4) restrict the provider from whom the beneficiary can obtain services (in other than emergencies).[57]

Section 2176 of the Act implements the HCBS waiver program.[58] Formally entitled the Waiver to Provide Home and Community-Based Services, this program gives the states greater flexibility in administering long-term health care services. The HCBS waiver program allows states to receive federal matching funds for approved home and community-based services that are not primarily medical in nature as previously required.

> Federal matching has been available under Medicaid only for services that are primarily medical in nature. Now the Secretary may by waiver allow a state to include under its Medicaid plan approved home or community-based services, except for room and board to individuals who, without these services, would require care in an SNF (skilled nursing facility) or ICF (intermediate care facility) paid for under the state plan.[59]

This program allows a state to provide Medicaid clients with a complete home health care package. This would include both medical services and other non-medical services that are necessary to allow an individual to reside in a non-institutional setting. Home and Community-Based Services included in the waiver consist of the following:

> (1) Case management services; (2) homemaker services; (3) home health aids services: (4) personal care services; (5) adult day care services; (6) habilitation services; (7) respite care services; and (8) other services requested

> by the state Medicaid Agency and approved by the HCFA as being cost-effective.[60]

The provision of home and community-based services by a state is subject to assurances made by the state to the Secretary of Health and Human Services.

> Such services must be provided pursuant to a written plan of care, and states must assure that: (1) necessary safeguards have been taken pertaining to beneficiaries' health and welfare and to financial accountability for funds expended on these services; (2) they will evaluate the need for such services with respect to those entitled to SNF or ICF care; (3) individuals determined likely to require SNF or ICF care are informed of these alternative services; (4) the estimated average per capita expenditure for all services provided to individuals under this waiver would not exceed what would have been spent in the absence of the waiver; and (5) they will provide information annually to the Secretary on the impact of the waiver.[61]

In addition to waiving the requirement that Medicaid services must be primarily medical in nature, the HCBS waiver program allows the Secretary of Health and Human Services to waive other restrictions placed on the states. "In this connection, the Secretary also may waive the requirements that services be provided statewide and that services for comparable groups must be the same in amount, duration, and scope."[62] This aspect of the HCBS waiver allows a state to offer services under Medicaid to certain areas of a state, either for demonstration purposes or for economic reasons. Without this provision, all individuals with comparable service needs eligible for Medicaid in a state must have equal access to services offered by the program.

Paragraph (4) of section 2176 limits services under the waiver to individuals for whom waiver services would not exceed the cost of services in the absence of the waiver.[63] This aspect insures that

waiver services will only be provided to individuals for whom such a program would be cost-effective.

The Tax Equity and Fiscal Responsibility Act of 1982 amended section 2176 of the Omnibus Budget Reconciliation Act of 1981 by requiring assurances that states will evaluate individual eligibility for home and community-based care under the waiver.[64]

The Health Care Financing Administration of the Department of Health and Human Services is responsible for the federal administration of the HCBS waiver program. Federal regulations issued by the HCFA emphasize the financial aspects of the program. Also, states must make assurances that they are following the intent of the HCBS waiver. The state agency must submit to the HCFA sufficient information to ensure the requirements of a state waiver program are being met. The state must supply, at a minimum, the following information:

A. A description of the safeguards necessary to protect the health and welfare of recipients.
B. A description of the records and information that will be maintained to support financial accountability.
C. A description of the agency's plan for the evaluation and re-evaluation of recipients, including a description of who will make these evaluations and how they will be made. The information must include a copy of the evaluation instrument to be used and provide for the maintenance of written documentation of all evaluations and re-evaluations.
D. An explanation with supporting documentation of how the agency estimated the per capita expenditures for both institutional and non-institutional services included in the plan.[65]

The final point above relates to assurances made to the HCFA by the state that average per capita expenditure for services under the waiver must not exceed the average per capita expenditures of the cost of all services in the absence of a waiver. To determine that the state

is in compliance with this requirement, the state must provide data to support the following equation:

$$\frac{(A \times B) + (C \times D)}{F + H} < \frac{(F \times G) + (H \times I)}{F + H}$$

where:

A = the estimated number of beneficiaries who would receive the level of care provided in an SNF, ICF, or ICF/MR under the waiver.
B = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
C = the estimated number of beneficiaries who would receive home and community-based services under the waiver or other institutional alternative services included under the state plan.
D = the estimated Medicaid payment per eligible Medicaid user of such home and community-based services.
F = the estimated number of beneficiaries who would likely receive the level of care provided in an SNF, ICF, or ICF/MR in the absence of the waiver.
G = the estimated Medicaid payment per eligible Medicaid user of such institutional care.
H = the estimated number of beneficiaries who would receive any of the noninstitutional, long-term care services otherwise provided under the state plan as an alternative to institutional care.
I = the estimated Medicaid payment per eligible Medicaid user of the noninstitutional services referred to in H.[66]

A waiver granted under the HCBS waiver program may be terminated upon request of a state prior to the expiration of the three-year period, provided the state notifies recipients of services under the waiver and the HCFA thirty days prior to termination.[67] Furthermore, the HCFA may terminate a waiver if it finds that the state is not meeting any of the above requirements.[68]

Immediately after the HCBS waiver programs became an available option for states, Montana began planning for a waiver program. By December of 1981, Montana was operating such a program in the state. The next chapter begins with this.

Endnotes

[1]Gail Gregg, "Reagan Proposes Dramatic Reduction in Federal Role," Congressional Quarterly Weekly Report, 14 March 1981, p. 443.

[2]Abigail Trafford, "Are Medicare, Medicaid Going Belly Up?" U.S. News and World Report, 6 September 1982, p. 37.

[3]Ibid., p. 37.

[4]U.S. Congress, Senate, Committee on Finance, Medicaid: Problems, Issues, and Alternatives, Committee Print, 91st Congress, 2nd Session, 1970, p. 42.

[5]Trafford, op. cit., p. 37.

[6]Ibid., pp. 37-38.

[7]Howard N. Newman, "Medicare and Medicaid," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 321.

[8]Allan Brownfeld, "Medicaid: The Anatomy of the Failure of a Government Program," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 289.

[9]Ibid., p. 289.

[10]Robert Stevens and Rosemary Stevens, "Medicaid: Anatomy of a Dilemma - Conclusion," in Medicaid: Lessons for National Health Insurance, ed. Allan D. Spiegel and Simon Podair (Rockville, Maryland: Aspen Systems Corp., 1975), p. 308.

[11]Ibid., p. 307.

[12]Judith Fedler, Jack Hadley, and John Holahan, Insuring the Nation's Health (Washington, D.C.: Urban Institute, 1981), p. xiii.

[13]Brahna Trager, Home Health Services in the United States, A Report to the Special Committee on Aging, United States Senate (Washington, D.C.: U.S. Government Printing Office, 1972), pp. 10-13.

[14]Ibid., p. 45.

[15]U.S., Statutes at Large, vol. 79.

[16]Mary Beth Shinn and Barbara J. Felton, "Institutions and Alternatives," Journal of Social Issues, 37 (Summer 1981), p. 1.

[17]Ibid., p. 1.

[18]Ibid., pp. 1-2.

[19]Andrew Scull, "Deinstitutionalization and the Rights of the Deviant," Journal of Social Issues 37 (Summer 1981), pp. 6-7.

[20]Barry Garland, Ruth Bennett, and David Wilder, "Reevaluating the Place of Evolution in Planning for Alternatives to Institutional Care for the Elderly," Journal of Social Sciences 37 (Summer 1981), p. 54.

[21]Ibid., p. 54.

[22]William G. Weissert, "Toward a Continuum of Care for the Elderly," Public Policy 29 (Summer 1981), p. 333.

[23]Garland, Bennett and Wilder, op. cit., p. 53.

[24]Ibid., p. 54.

[25]Shinn and Felton, op. cit., p. 2.

[26]Garland, Bennett and Wilder, op. cit., p. 55.

[27]Ibid., p. 61.

[28]Ibid., p. 62.

[29]Ibid., p. 62.

[30]Ibid., p. 62.

[31]Ibid., p. 62.

[32]Ibid., p. 63.

[33]Gloria Billings, "Alternatives to Nursing Home Care: An Update," Aging 325 (March/April 1982), p. 2.

[34]Weissert, op. cit., p. 333.

[35]Wheldon S. Tobin and Regina Kulys, "The Family in the Institutionalization of the Elderly," Journal of Social Issues 37 (Summer 1981), p. 146.

[36]Ibid., p. 147.

[37]Ibid., p. 153.

[38]Trager, op cit., p. 45.

[39]Weissert, op. cit., p. 336.

[40]Garland, Bennett, and Wilder, op. cit., pp. 64-65.

[41]Robert A. Kittle, "Limits to Put Stress on States," U.S. News and World Report, 4 May 1981, p. 20.

[42]"Katie Finds a Friend with Clout," U.S. News and World Report, 23 November 1981, p. 10.

[43]Ibid., pp. 10-11.

[44]Harrison Donnelly, "What Reagan Budget Would Do to the Poor," Congressional Quarterly Weekly Report, 18 April 1981, p. 666.

[45]Allan Murry, "Finance Committee Votes $10.3 Billion Cuts," Congressional Quarterly Weekly Report, 9 May 1981, p. 796.

[46]"Summary of Differences in Reconciliation Measure," Congressional Quarterly Weekly Report, 4 July 1981, p. 1175.

[47]Ann Pelham, "Administration Fighting for Medicaid Cap," Congressional Quarterly Weekly Report, 4 July 1981, p. 1183.

[48]Ibid., p. 1183.

[49]Ibid., p. 1183.

[50]Ann Pelham, "Congress Votes Medicaid Cuts, Block Grants," Congressional Quarterly Weekly Report, 15 August 1981, p. 1497.

[51]Ibid., p. 1497.

[52]Ann Pelham, "Medicaid Spending Cut 'Cap' Rejected," Congressional Quarterly Weekly Report, 15 August 1981, p. 1497.

[53]U.S., Statutes at Large, vol. 95.

[54]Health Care Finance Administration, "Season of Change for Health Services," Forum 5 (October 1981), p. 22.

[55]Ibid., p. 22.

[56]Ibid., pp. 24-25.

[57]Ibid., p. 25.

[58]U.S. Statutes at Large, vol. 95.

[59]HCFA, "Season of Change . . .,", op. cit., p. 25.

[60]42 Code of Federal Regulations, 440.180.

[61]HCFA, "Season of Change . . .,", op. cit., p. 26.

[62]Ibid., p. 26.

[63]U.S., Statutes at Large, vol. 95.

[64]U.S., Statutes at Large, vol. 96.

[65]42 Code of Federal Regulations, 441.303.

[66]Ibid., 441.303.

[67]Ibid., 441.305.

[68]Ibid., 441.304.

CHAPTER 4

ALTERNATIVES IN MONTANA

The HCBS waiver program has been providing alternatives to institutionalization for Medicaid recipients in Montana since Decesmber, 1981. Montana applied for, and was granted, two separate waiver programs. The first waiver program was implemented in December of 1981. This program covered developmentally disabled individuals in Lewis and Clark County. This program has been replaced by a second waiver program which is statewide for both elderly and developmentally disabled individuals. Montana's adoption of the HCBS waiver program is the latest development in the state's movement toward deinstitutionalization and the development of community-based alternatives.

The movement toward deinstitutionalization for the developmentally disabled (DD) in Montana culminated with the enactment of major legislation during the 1975 Legislative session. This legislation was in response to changing attitudes toward deinstitutionalization.

> In recent years, attitudes toward the care and treatment of mentally ill and developmentally disabled individuals have shifted significantly. While historically, care and treatment emphases focused on aiding people within the confines of an institution, more recent philosophy holds that care and treatment for both developmentally disabled and mentally ill people should be provided in the least restrictive setting possible consistent with the availability of adequate care and treatment services.[1]

With these changes in the philosophy toward the long-term care of the DD came a variety of federal and state mandates to develop

deinstitutionalization programs. In Montana the movement toward deinstitutionalization followed two main thrusts.

1. To the extent possible, recognizing patient and resident needs and community treatment services available, to relocate patients from the state institutions and place them in community-based treatment settings.
2. To sharply restrict the future institutionalization of most developmentally disabled people and selected mental health patients and provide alternative treatment and developmental services at the community level.[2]

This new attitude toward caring for the DD in Montana sharply contradicted previous policies expressed in legislation of the 1940's.

Montana's Institutional Bias

The Developmental Disabilities Act of 1943 established the Montana State Training School and Hospital at Boulder.[3] This Act expressed a strong bias toward institutionalization based on the "medical model" of mental retardation.[4] The attitude behind this 1943 Act is shown in the responsibilities it stated for the institution at Boulder:

> . . . the mental, moral and physical education and training of subnormal persons whose defects prevent them from receiving proper instruction and training in the public school, or who are so mentally deficient that they are incapable of managing themselves or their affairs independently with ordinary prudence or of being taught to do so, or who require control and education for their own welfare and the welfare of others, and minors whose intelligence will not devlop without such care; epileptics and subnormal adults whose defects prevent them from taking care of themselves or their property, or who, from social standards, are a menace to society.[5]

This list of responsibilities accurately represents the attitude that prevailed for caring for the developmentally disabled. The attitude expressed in the 1943 law was summarized in a 1976 study on deinstitutionalization.

> . . . but the Act of 1943 makes clear that, traditionally, the policy toward the developmentally disabled was to segregate and institutionalize them. They were not merely "sub-average" in intellect, but they were "subnormal persons." The intellect itself was not amoral, but moral. Consequently, educational and training efforts intrude even into the realm of morality.
>
> However, the developmentally disabled were "a menace to society" from, of course, prevailing "social standards." Not only did their "defects prevent them from taking care of themselves or their property," but also from respecting, let alone understanding, the rights of others -- presumably the persons of others and their property. The developmentally disabled required "control and education for their own welfare and the welfare of others."[6]

Home and community-based services for the DD weren't even a consideration of the 1943 legislation.

> They are, after all, subnormal -- vegetables with no potential for human development -- and they have no rights. They are capable of living in physically 'unaesthetic' surroundings and incapable of leading a 'normal' life in the community. The prognosis for them is a life of dependency. Treatment is futile, and when offered a privilege.[7]

In 1967 the Legislature established the Eastmont Training Center at Glendive. This act, which created a second institution to serve DD individuals in Montana, indicated a slight trend toward deinstitutionalization. "It's properly speaking, a mental retardation center for residential and outpatient care of mentally retarded persons residing in Montana."[8] Nevertheless, like the Boulder institution, Eastmont basically reinforced the state's reliance on institutions to serve the developmentally disabled.[9]

The Deinstitutionalization Movement

The basis of Montana's present system of providing alternatives to institutionalization for the developmentally disabled rests on legislation enacted during the 1974* and 1975 Legislative Sessions.[10] The catalyst for reform was a strike by employees at both the Warm Springs State Hospital and the Boulder River School and Hospital (BRSH) in 1974. Prior to this strike, the number of patients at both institutions had grown to almost twice the recommended level. From 1970 to 1973, the population at Boulder averaged 766 patients; the recommended maximum capacity for the institution was 400.[11]

When the National Guard was called in to replace the striking workers, attention focused on the poor conditions existing in the institutions. This led to a suit by the federal government against the State Director of Institutions, the Acting Superintendent of Boulder River School and Hospital, and the Acting Director of the Division of Mental Retardation alleging severe violations of the rights of the residents of the institutions. The lawsuit was dismissed by the U.S. District Court on the grounds that the federal government lacked standing to bring the suit. Nevertheless, the strike and subsequent lawsuit provided the impetus for the state to reconsider its long-term care policy toward the developmentally disabled.

Several other factors were also important in bringing changes to Montana's policy toward caring for the developmentally disabled and

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* Montana's 1972 Constitution provided for annual legislative sessions. The Constitution was amended in 1974 to the present system of biennial sessions.

mentally ill. First of all, precedent established in two federal court decisions made future suits against Montana likely. Wyatt vs. Stickney and the New York Association for Retarded Children, Inc. vs. Carey established a level of service that public providers of care for the developmentally disabled were responsible for.

> While these decisions did not bind Montana, they did indicate that the state was vulnerable to suit and that suit could impose standards which might result in: (1) substantial increases in institutional operating costs; and (2) significant loss of state control over the design and the cost of services provided to institutional patients.[12]

Secondly, perhaps in response to the court decision, the federal government enacted legislation which could result in the withholding of federal funds under Title XX of the Social Security Act. This would occur if it was determined that a state's actions were not consistent with the intent of the law which required that services to the developmentally disabled should help them to maximize their potential in the least restrictive setting possible.

> Perhaps as an outgrowth of the Wyatt-Stickney and related decisions, the U.S. Congress mandated (Section III, Title II, Public Law 94-103) not only that developmentally disabled individuals had the right to certain services which would help them maximize their full development potential, but also that these services should be provided in a setting which is "least restrictive of a person's liberty." The law also held that federal funds could be withheld if services were not provided consistent with the spirit and specific requirements of the law.[13]

The result of these events was the passage of two important bills concerning deinstitutionalization in Montana during the 1975 Legislative Session. Prior to the 1975 legislation, the 1974 Legislature passed the Montana Developmental Disabilities Act.[14] This Act assigned

specific responsibility to the Montana Department of Social and Rehabilitation Services:

> The Department may establish and administer community comprehensive services, programs, clinics, or other facilities throughout the state for the purpose of aiding in the prevention, diagnosis, amelioration, or treatment of developmental disabilities. Programs, clinics, or other services may be provided directly by state agencies, or indirectly through contract or cooperation arrangements with other agencies of the government, regional, or local, private or public agencies, private professional persons or in accredited health or long-term care facilities.[15]

The 1974 Legislature also established the State Mental Hospital Advisory Council. This council, appointed by the Governor, provided continuous input on care for the developmentally disabled. "Committee activities culminated in the issuance of a comprehensive report in January, 1977, a report which recommended reduction in institutional populations and increase in the treatment of the mentally ill with community-based services."[16]

In 1975 the Legislature effectively changed the state's orientation for treatment of the mentally ill and developmentally disabled from institutions to the community. The Developmental Disabilities Act of 1975 amended certain aspects of the 1943 and 1967 Acts.[17] The 1975 Act stated the following goals for the care of developmentally disabled individuals:

1. to secure for each person who may be developmentally disabled such treatment and habilitation as will be suited to the needs of the person, and to assure that such treatment and habilitation are skillfully and humanely administered with full respect for the person's dignity and personal integrity;
2. to accomplish this goal in an institutional setting only when less restrictive alternatives are unavailable or inadequate and only when a person is so severely disabled as to require institutionalized care;

3. to accomplish this goal whenever possible in a community-based setting; and
4. to assure that due process of law is accorded any person coming under the provisions of this act.[18]

This Act changed the pattern of care for the developmentally disabled in Montana from the institution to the community.

> Moreover, the proper place of those who are developmentally disabled, until shown to be otherwise, is assumed to be in the community. Treatment and habilitation should not be designed to remove them from this setting. Treatment and habilitation should be designed to increase their capacity for maintaining and protecting their position there.[19]

Similarly, the Treatment of the Mentally Ill Act of 1975 applied the same principles adopted for caring for the developmentally disabled. "Essentially the act made involuntary commitments more difficult and stated that patients should be institutionalized only when adequate community-based services were unavailable."[20]

The result of the 1975 legislation was rapid deinstitutionalization in Montana for developmentally disabled individuals.

Deinstitutionalization

Deinstitutionalization of developmentally disabled and mentally ill individuals has been in operation in Montana for the past decade. The experiences of this program are important in predicting the outcomes for the HCBS waiver program. An evaluation of the deinstitutionalization program in Montana reveals that immediately after the 1975 legislation, Montana experienced widespread deinstitutionalization. By 1977, the number of patients at Boulder River School and Hospital had decreased 68 percent to 274.[21] This rapid decrease led many to claim great success for the program. Governor Thomas Judge, praising the

program, called Montana a "forerunner in the field of deinstitutionalization."[22]

Although the main intent of the deinstitutionalization program was to lower the number of individuals in institutions, which was achieved, the program also benefitted from the lower costs of non-institutional care.

> The report indicated that the deinstitutionalization program has been adequately funded (appropriated funds increased by 63% in FY 1977) and has provided services at far less cost per capita than has Montana's institution for DD persons. Average annual per capita cost for community-placed DD persons was $10,891 in FY 1977; institutional costs were $28,257 per capita, omitting fixed capital costs. The ratio of institutional cost per capita to community cost per capita then is 2.59:1.[22]

Nevertheless, the state's expenditures for both institutional and non-institutional services did not decrease, as there was little reduction in the budget for institutions. "The initial appropriation to the DD deinstitutionalization program was $3,837,297 in FY 1976. In FY 1977, this amount increased to $6,259,443, a 63 percent increase. By contrast, the DD institutional appropriations were $8,930,850 in FY 1976, and $8,038,070 in FY 1977."[24] Even with the main thrust of the program aiming to reduce the number of individuals in institutions, there is evidence that the Legislature intended the program to be operated from savings from the institutional program. The intent of the legislation follows:

> 1. To encourage the institution to reduce operating costs as patient population decreases.
> 2. To ensure that institutional cost reductions could be transferred to the community to contribute to the costs of the community-based services being provided to individuals.[25]

Nevertheless, funds were never transferred from the institutions' budgets to the deinstitutionalization program. Instead, the Legislature provided more than enough funds for both of the programs.

> To date, the mechanism has not been used and no budget transfers have occurred . . . More than adequate funds (Federal Title XX and Montana General Fund resources) were allocated to the DD division to purchase community-based services. Because of funding adequacy, there has been no pressure to transfer funds from the Boulder budget.[26]

Evidently the fixed costs associated with operating state institutions prevent any significant reductions in cost when deinstitutionalization services are added. "As can be clearly seen . . . more than 95% of the costs in each institution can be classified as fixed or semi-variable costs and as such, are not sensitive to small shifts in patient population."[27]

An evaluation of the deinstitutionalization program revealed several other interesting aspects. First of all, the difference in per capita costs for individuals served in an institution and for those deinstitutionalized can be accounted for in part by the fact that institutions generally care for the more severe cases.

> Obviously it costs more to provide care and treatment for a severely profoundly mentally retarded person who may be non-ambulatory than a mildly mentally retarded person who is ambulatory. As a result, institutional costs may not be totally comparable to deinstitutionalized costs because of patient differences.[28]

Secondly, community-based services under the deinstitutionalization program are less costly to the state because of the higher percentage of federal contribution to such programs. The federal government pays 33.9 percent of the costs for institutions, 53.1 percent for community-based services.[29]

Thomas Clack in a study for the Office of Budget and Program Planning found that the deinstitutionalization program was cost-effective. "When viewed from a cost perspective alone, it would seem to be to the state's advantage to deinstitutionalize the maximum feasible number of DD persons."[30] Although services were less expensive, the study revealed that individuals were not necessarily better off. "The report says that although no aspect of behavior deteriorated from levels found in the institution, the success must be qualified. 'As mans [sic] of them stated that they missed friends or routines at the institution as they expressed happiness with their new surroundings'."[31]

One outcome of the deinstitutionalization program that is important for the HCBS waiver program is that further deinstitutionalization in the state will be difficult.

> Placements have slowed in recent months and 1977 activities are below previous levels. In addition, most FY 1977 placements occurred during the early months of the fiscal year and in recent months, placements have been extremely limited.
>
> As placements have slowed, the severity, in terms of retardation, of the population remaining to be placed has increased.
>
> There appears to be a consensus among program operators that future community placements will be increasingly difficult.
>
> In general, community facilities and services consistent with the needs of the remaining deinstitutionalized population are extremely limited.
>
> There is some question whether services can be cost-effectively developed to meet the needs of the bulk of the remaining client population.[32]

The deinstitutionalization program in Montana was very successful in that it was able to place many clients in the community. However, deinstitutionalization occurred with little regard for costs. Furthermore, the program limits the cost savings possible under the HCBS

waiver programs by having already placed the less expensive patients in the community.

The Elderly

With deinstitutionalization for the developmentally disabled slowing by 1978, concern shifted to creating alternatives to nursing homes for the elderly. As early as 1978, the Department of Social and Rehabilitation Services was seriously considering providing home and community-based services as a substitute for nursing homes. Estimates in late 1977 predicted that the state's Medicaid budget would overspend its general fund appropriation by $30 million, leaving the general fund $12 million in the red.[33] The major part of this budget overrun was caused by nursing home care costs. Pat Melby, Director of the Department of Social and Rehabilitation Services, proposed a program that would utilize twelve social workers throughout the state to facilitate the development of community-based alternatives.[34]

Melby argued that a large percentage of the nursing home population could be served in less expensive community-based settings. "As many as 20 percent of those people now in nursing homes receiving Medicaid don't really need to be in such a setting. Medicaid continues to flow to these residents, he said, because there aren't alternatives available."[35] Expenditures, according to Melby, would have been as little as $300 per month per client while nursing home costs were $1,000 a month per client.[36] Such services, he claimed, would also reclaim the dignity of the elderly.[37] This proposal, however, was rejected by the Legislature.

In July of 1980, Montana's Department of Health and Environmental Sciences released a report which examined the feasibility of establishing alternative long-term care programs to care for the elderly of the state. The results of this study determined that there was sufficient need in the state to justify an alternative care program.[38] The study identified a need to overcome the financial barriers associated with private insurance, Medicare and Medicaid in order for alternatives to nursing home care to be successful.[39]

Also, the study indicated that 18 percent of the state's nursing home population would not have to be there if other alternatives existed.

> Approximately 3% of Medicaid recipients in nursing homes score high enough on the Geriatric Functional Rating Scale to indicate independent living. Eighty-two percent of the Medicaid recipients in nursing homes scored less than 20 on the Geriatric Functional Rating Scale, indicating likely institutionalization. For many of the others, no alternative is available. These findings indicate that for the elderly Medicaid population in nursing homes, Montana is performing better than the often quoted 20 to 25% inappropriate placements in nursing homes (for the elderly).[40]

The study did not claim that such services would be less expensive than nursing home services; instead, it argued that there was insufficient evidence to make predictions on costs for home and community-based services. The study did find, however, that the existence of home and community-based alternatives would eventually lessen the state's need for additional nursing home services.

> Indications are that no current nursing home beds would be vacant if appropriate alternatives were in place and were utilized as estimated . . . Therefore, in the short run, nursing home bed occupancy would not be signficantly impacted. However, there is likely to be a significant decrease in the growth of nursing home bed requirements (occupancy) if appropriate alternatives are available and utilized.[41]

This study was released in 1980. Its effects on the provision of long-term care services to elderly Medicaid recipients in the state were minimal. However, events at the federal level were soon to change the state's provision of long-term care services to the elderly under Medicaid.

Montana's Waiver Program

With the enactment of the Omnibus Budget and Reconciliation Act of 1981, states were allowed to apply for the waiver of certain Medicaid requirements under the HCBS waiver program. Montana applied for and received permission to operate a waiver program, and by December 2, 1981, it was in operation. Montana's original waiver program was limited to developmentally disabled individuals in Lewis and Clark County. This waiver was replaced by a statewide waiver for both elderly and developmentally disabled individuals in July of 1983.

Montana's original waiver for developmentally disabled individuals was specifically proposed to provide services to individuals who were residing in Parkside Manor, a group home located in Helena, Montana. The operator of the group home was increasing the cost to the state of caring for the individuals placed there. The opportunity provided by the HCBS waiver program was very timely, as the state was able to remove individuals from the group home and place them in other community-based services under the waiver program.

The original waiver program in the state operated without a budget of its own. Instead, money for the program could be obtained from funds budgeted for the services that the waiver program would be

replacing. The authorization to use funds in this way was stated by the Legislature during the special session in November of 1981, thus:

> The department is encouraged to utilize medicaid funds to support community services for the developmentally disabled where the use of such funds is cost-effective in providing services in the least restrictive environment. The department may use any savings generated from the budget for the developmentally disabled to develop additional community services.[42]

During 1982, the Department of Social and Rehabilitation Services began preparing a proposal for a statewide waiver program. John LaFaver, Director of the Department, submitted the statewide waiver proposal to the 1983 legislative session. The waiver program was widely supported by senior citizens' groups, but opposition had been raised by the state's nursing home industry.[43]

The statewide waiver program was approved by the 1983 Legislature and became effective July 1, 1983. The state's original waiver for the developmentally disabled was phased out and replaced by the statewide waiver on October 31, 1983.

Contents of the Waiver

The Montana Department of Social and Rehabilitation Services took advantage of the flexibility offered by the HCBS waiver program to develop a program which provides alternatives to a limited number of individuals. "The Department of Social and Rehabilitation Services of the State of Montana does not intend to offer home and community-based services to all individuals who would otherwise likely require institutionalization."[44] Hopefully, this action will improve the program's chances for success.

Coverage under Montana's waiver program will be denied to individuals for whom home and community-based alternatives would be more expensive than institutional care.

> Home and community-based services under the waiver will be denied to individuals who have been determined eligible for Medicaid and for whom such alternative services have been determined appropriate if the cost of such services, when adjusted to include the equivalent of room and board costs in the institutional setting, would exceed the cost of institutional care for the individuals. The state will make the determination of whether the cost of home and community-based services will exceed the cost of institutional care after the results of the individual assessment have been obtained and during the process of establishing the plan of care for the individual.[45]

Services under the waiver can only be received by Medicaid-eligible individuals who would otherwise require institutional care.[46] Furthermore, the state limits the total number of individuals that can be served by the statewide waiver to 510.[47] This includes 410 individuals who would normally be served in an ICF or SNF and 100 individuals who would normally be served in an ICF/MR. As mentioned above, an ICF (intermediate care facility) and an SNF (skilled nursing facility) are types of nursing homes that serve patients depending on service level requirements. An ICF/MR (intermediate care facility for the mentally retarded) provides developmentally disabled individuals with long-term care services in an institution. HCBS waiver services are only offered to individuals who are in the process of entering an institution. The state hopes that these restrictions on the waiver program will make it cost-effective by offering home and community-based services as a less expensive alternative, as opposed to the expansion of services.

The basic services that the HCBS waiver program provides in Montana are: case management services; homemaker services; personal care attendant services; adult day health services; habilitation services; and respite care services.[48] These services will be offered to eligible developmentally disabled, elderly and physically disabled individuals.

Montana requested and was granted waivers for several other Medicaid requirements to facilitate its piecemeal implementation of the program. Montana received waivers for sections 1902 (a) (1) statewideness, and 1902 (a) (10) comparability. This allowed the state to implement the program in different regions of the state according to a schedule which began July 1, 1983, and was to be completed by January 1, 1984.[50] Montana has also made the necessary assurances to the federal government that the health and safety of individuals covered under the waiver have been safeguarded according to standards set by federal law.[51] The cost-effectiveness of the HCBS waiver program is dealt with in the following chapter.

Endnotes

[1]Montana, Office of the Governor, Office of Budget and Program Planning, An Evaluation of Deinstitutionalization in Montana, study prepared for the Office of Budget and Program Planning by Hughes, Heiss, and Associates, 1977, p. 1.

[2]Ibid., p. 2.

[3]Revised Codes of Montana, 1947, The Developmental Disabilities Act of 1943.

[4]Montana, Office of the Governor, Office of Budget and Program Planning, Social Services: A Background Statement, report prepared for the Office of Budget and Program Planning by the Title XX Needs Assessment Project, vol. 1, 1976, p. 35.

[5]Ibid., p. 33.

[6]Ibid., p. 34.

[7]Ibid., p. 35.

[8]Ibid., p. 34.

[9]Ibid., p. 37.

[10]An Evaluation of Deinstitutionalization in Montana, op. cit., p.2.

[11]Ibid., p. 75.

[12]Ibid., pp. 3-4.

[13]Ibid., p. 4.

[14]Revised Codes of Montana, 1947, op. cit.

[15]Social Services, op. cit., p. 30.

[16]An Evaluation of Deinstitutionalization in Montana, op. cit., p. 5.

[17]Social Services, op. cit., p. 30.

[18]Ibid., pp. 31.

[19]Ibid., p. 22.

[20]An Evaluation of Deinstitutionalization in Montana, op. cit., p. 6.

[21]Ibid., p. 15.

[22]Garry J. Moes, "Deinstitutionalization, The Costs are Less But Successes are Varied," Great Falls Tribune, 3 March 1978, p. 4.

[23]Montana, Office of the Governor, Office of Budget and Program Planning, A Brief Report on an Evaluation of Deinstitutionalization in Montana, report prepared for the Office of Budget and Program Planning by Theodore H. Clack, Jr., July, 1977, p. 7.

[24]Ibid., p. 2.

[25]An Evaluation of Deinstitutionalization in Montana, op. cit., p. 10.

[26]Ibid., p. 10.

[27]Ibid., p. 79.

[28]Ibid., pp. 60-62.

[29]Ibid., p. 62.

[30]Ibid., p. 62.

[31]Moes, op. cit., p. 4.

[32]An Evaluation of Deinstitutionalization in Montana, op. cit., p. 17.

[33]Thomas Kotynski, "Montana Medicaid Leaves General Fund Ailing," Great Falls Tribune, 23 September 1977, p. 7.

[34]Thomas Kotynski, "New State Social Workers Zero in on Medicaid Costs," Great Falls Tribune, 24 March 1978, p. 4.

[35]Ibid., p. 4.

[36]Ibid., p. 4.

[37]Ibid., p. 4.

[38]Montana, Departmenst of Health and Environmental Sciences, Cost of Alternative Care Study: Final Report, report prepared for the Montana Department of Health and Environmental Sciences, by JRB Associated, July, 1980, pp. 2-6.

[39]Ibid., pp. 2-7.

[40]Ibid., pp. 2-7.

[41]Ibid., pp. 2-7.

[42]Montana, Legislature, Senate and House Journal, 47th Legislature, Special Session, November, 1981, p. 30.

[43]Charles S. Johnson, "Expanded Elderly Care Tops Priorities," Great Falls Tribune, 18 November 1982, p. 12A.

[44]Montana, Department of Social and Rehabilitation Services, Home and Community-Based Service Request for Waiver, submitted to the Health Care Finance Administration by the Department of Social and Rehabilitation Services, December, 1982, p. 10.

[45]Ibid., p. 11.

[46]Ibid., p. 13.

[47]Ibid., pp. 26-32.

[48]Ibid., p. 3.

[49]Ibid., p. 12.

[50]Ibid., p. 10.

[51]Ibid., pp. 14-17.

CHAPTER 5

COST-EFFECTIVENESS ANALYSIS

The HCBS waiver program, as mentioned above, allows states the opportunity to provide home and community-based services to Medicaid recipients. In Montana the program is seen as a means to provide cost-effective alternatives to institutional care under the Medicaid program. Montana is strictly controlling participation under the program through regulations that restrict HCBS waiver services to a specified number of individuals who would otherwise be entering an institution. Montana has virtually assured that services under the waiver will not expand the Medicaid program but will instead provide cost-effective alternatives to current recipients of services. The success and continuation of the program in the state depend on its cost-effectivness.

In this chapter the cost-effectiveness of the HCBS waiver program is analyzed. The analysis includes information for both the Developmental Disabilities (DD) waiver program and Montana's statewide waiver program. The DD waiver was in effect from December 2, 1981 through October 31, 1983. The analysis of the DD waiver is based on final data for the program. The statewide waiver, which provides services for both elderly and disabled individuals, has been operating since July 1, 1983. Implementation of this program has been slow, and only preliminary information for elderly individuals served under the waiver is presented in this analysis.

In Table 1 a comparison between annual per capita expenditure for ICF/MR (Intermediate Care Facility for the Mentally Retarded) and DD waiver services is presented. The comparison reveals that per capita expenditures for home and community-based services under the DD waiver are less than per capita expenditures for services provided in an ICF/MR. In year 1, per capita expenditures for DD waiver services were $12,500 (46%) below per capita expenditures in an ICF/MR. Year 2 produced almost equal results. From this standpoint the DD waiver program is cost-effective since recipients of home and community-based services can be served for almost one-half the cost of those individuals receiving institutional care.

Table 1. Annual Per Capita Expenditure, ICF/MR and DD Waiver

	ICF/MR	DD Waiver*	Difference	±%
Year 1	$27,200	$14,700	$12,500	-45.9
Year 2**	$30,369	$16,862	$13,507	-44.5

* One individual who received services under the DD waiver would have been served in an ICF in the absence of the waiver.
** Year 2 annualized amount is based on 11 months of actual data.

Source: Health Care Finance Administration, Form 371, September 1982 and January 1984.
Montana Department of Social and Rehabilitation Services, Federal Report 2082, Fiscal Years 1982 and 1983.

It should be noted that the cost of services for individuals in an ICF/MR vary widely, depending on the degree of care an individual requires. "For example, interviews with representatives of BRSH [Boulder River State Hospital] indicate that per patient care costs range from $6,000 to $80,000 depending on severity of retardation, associated medical problems and the like."[1] Table 2 accounts for these

differences in the level of care between ICF/MR and DD waiver recipients.

Table 2. Per Capita Expenditures for Institutional Care in the Absence of the DD Waiver.

	Annual Expenditures, ICF/MR Services		
	DD Waiver Recipients*	ICF/MR Recipients	Difference
Year 1	$18,200	$27,200	$9,000
Year 2	$19,400	$30,369	$10,969

* Annual ICF/MR expenditures for DD waiver recipients is estimated by the Department of Social and Rehabilitation Services based on actual data for the year immediately preceding year 1, plus 6.5 percent allowed for inflation for each year.

Source: Health Care Finance Administration, Form 371, September 1982 and January 1984.
Montana Department of Social and Rehabilitation Services, Federal Report 2082, Fiscal Years 1982 and 1983.

The table reveals that per capita expenditures for institutional services (ICF/MR) if provided to DD waiver recipients would be less than per capita expenditures for the individuals who remained institutionalized. This difference is attributed to the lower level of care required by DD waiver recipients and accounts for a large part of the savings associated with the DD waiver as shown on Table 1. Of the $12,500 savings in the first year, $9,000 can be attributed to the lower level of care required by individuals served under the DD waiver. In year 2 almost $11,000 of the $13,507 savings can be attributed to this factor.

Table 3 presents a picture of the actual cost savings for individuals served by the waiver. Actual per capita expenditures for the DD waiver are compared to the estimated per capita institutional expenditures for the 39 recipients of services under the DD waiver.

Table 3. Per Capita Expenditures for DD Waiver Recipients, Estimated ICF/MR to Actual DD Waiver.

	ICF/MR (Estimate)*	DD Waiver (Actual)	Difference	±%
Year 1	$18,200	$14,700	$3,500	-19.2
Year 2	$19,400	$16,862	$2,538	-13.1

* Annual ICF/MR expenditures for DD waiver recipients is estimated by the Department of Social and Rehabilitation Services based on actual data for the year immediately preceding year 1, plus 6.5 percent allowed for inflation for each year.

Source: See Tables 1 and 2.

Table 3 reveals that home and community-based services under the DD waiver were less expensive than the cost of services provided in an institution for the same group of individuals. By deinstitutionalizing 39 individuals, the DD waiver resulted in a per capita savings of $3,500 in the first year and $2,538 for the second year. This finding is based on the assumption that the waiver program is providing individuals with the same degree of care that they would receive in an institution.

Table 4 compares predicted per capita expenditures and number to be served for the DD waiver to actual results for the program.

Table 4. Comparison of Actual to Predicted Number Served and Per Capita Expenditures under the DD Waiver.

	Year 1		Year 2	
	Actual	Predicted*	Actual	Predicted*
Number Served	39	39	45	46
Per Capita Expenditures	$14,700	$14,600	$16,862	$16,800

* Estimates of number served and per capita cost for the waiver were prepared by the Montana Dept. of Social and Rehabilitation Services.

Source: Health Care Finance Administration, Form 371, September 1982 and January 1984.

It can be seen from this table that predictions for the waiver have almost matched the actual results. Per capita expenditures under the waiver differed from actual results by less than one percent for both years of the program. Precictions for the DD waiver program were facilitated by the fact that the waiver was designed to serve a specific group of individuals whose service needs were already known.

The data from the above tables reveal that the DD waiver program was cost-effective for the individuals that it served. This cost-effectiveness is the result of the lower level of care required by DD waiver recipients and actual savings that resulted from placing individuals in home and community-based settings. Table 3 showed that per capita expenditures were 19.2 and 13.1 percent, respectively, below the estimated per capita expenditures for these individuals served in an institution for years 1 and 2. This finding is supported by the fact that estimates for the DD waiver program have almost equaled actual results.

Preliminary data for Montana's statewide waiver is presented in Table 5. This data provides for a comparison of costs between waiver and institutional services for elderly individuals who require an ICF (Intermediate Care Facility) level of care. Individuals who received services in an SNF (Skilled Nursing Facility) require a higher level of care than waiver recipients, and therefore are excluded from this analysis.

The preliminary data from Table 5 reveals that statewide waiver services for elderly individuals appear to be cost-effective. Per capita costs under the waiver for elderly individuals are less than per capita costs for individuals served in an ICF. Preliminary data reveals that

Table 5. Annual Expenditures for ICF Level of Care, Preliminary Results.

	ICF
Actual FY 1983 ICF Per Capita Expenditures	$7,739
Estimated State FY 1984 Per Capita Expenditures	$7,800
	Statewide Waiver
Projected Average Annual (FY 1984) Per Capita Expenditures:	
Billings	$5,640
Missoula	$7,166*

* Includes $24,000 annual cost for an individual who is not covered by the waiver program that could not be separated because of data limitations.

Source: Montana Department of Social and Rehabilitation Services, Home and Community-Based Services Request for Waiver, December 1982.
Letter to Montana Health Systems Agency from John LaFaver, Director, Montana Department of Social and Rehabilitation Services, April 1984.

individuals served by the statewide waiver in Billings and Missoula will have a lower per capita expenditure than individuals served in an ICF. Per capita expenditures for Billings' and Missoula's elderly waiver recipients are expected to average $5,640 and $7,166 per year, respectively. Billings elderly served by the waiver are 28 percent below the $7,800 per capita expenditures predicted for individuals served in an ICF in state fiscal year 1984. Cost savings for Missoula's elderly served by the waiver are understated because of the inclusion of a recipient not covered by Medicaid whose annual service cost is expected to be $24,000. When this individual is excluded, higher savings will result.

The data for Montana's statewide waiver is incomplete. The analysis should include an examination similar to that for the DD waiver

which compares per capita cost for individuals under the statewide waiver to estimated per capita costs for the same individuals in an institution. However, this data is unavailable at this time because the implementation of the statewide waiver has been slow. Montana had originally planned to serve 350 elderly, 50 physically disabled, and 100 developmentally disabled individuals under the statewide waiver in fiscal year 1984.[2] Delays in awarding contracts and training providers of services have resulted in fewer recipients than expected. Also, the Department of Social and Rehabilitation Services' policy, which only offers waiver services as an option to individuals who are in the process of entering a nursing home, has minimized participation.[3] This policy is the result of uncertainties in the number of individuals in the general population that may be eligible for waiver services. The Department waits for an individual to show up at the nursing home door before offering services under the waiver.[4] An increase in the number served under the program is likely in the near future, as the program is now in operation in all areas of the state with all contracts for services awarded and training of providers complete.

In summary, the analysis has shown that the DD waiver appears to be cost-effective. Furthermore, preliminary data indicates that services for the elderly under the statewide waiver will also prove to be cost-effective. Further study is needed, however, to determine the long-term consequences of the program on long-term health care costs.

Endnotes

[1]Office of the Governor, Office of Budget and Program Planning, An Evaluation of Deinstitutionalization in Montana, a report prepared for the Office of Budget and Program Planning by Hughes, Heiss and Associates, July 1977, p. 62.

[2]Montana Department of Social and Rehabilitation Services, Home and Community-Based Service Request for Waiver, submitted to the Health Care Finance Administration by the Department of Social and Rehabilitation Services, December 1982, pp. 26-31.

[3]Ibid., p. 22.

[4]Interview with Ken Wahlstrand, Montana Department of Social and Rehabilitation Services, Helena, Montana, 18 May 1984.

CHAPTER 6

CONCLUSION

Montana's provision of home and community-based services under the HCBS waiver program appears to be cost-effective for the state, as can be seen from the above data. However, the newness of the program and the many uncertainties that home and community-based alternatives under Medicaid face suggest that the program should be closely watched in the future.

Montana's HCBS waiver program's cost-effectiveness is partly the result of restrictions placed on the program by the state to limit eligibility under the program. The state has effectively controlled uncertainties surrounding the number of individuals who may demand home and community-based services under Medicaid by limiting the number of individuals that can participate in the program. The state controls per capita costs for the program by allowing services to be provided to individuals for whom the predicted cost for home and community-based services would be less than similar services provided in an institution. Finally, the extent of service under the waiver has been controlled by Montana's policy which allows only individuals actually in the process of entering an institution to be eligible for services. Thus, the analysis findings that per capita cost for HCBS waiver services have been less than the per capita expenditures for institutional services is not surprising.

The HCBS waiver program in Montana will probably remain cost-effective as long as the restrictions placed on eligibility for the program exist. Under the current waiver program in Montana, home and community-based services for both the developmentally disabled and the elderly have been cost-effective. However, further data is needed on waiver services for the elderly before a final judgment can be made.

The HCBS waiver program is likely to remain in effect in Montana for the next several years. Although public pressure may eventually force the state to remove some of its restrictions on the program, this is not expected to happen in the 1985 Legislative Session. The program has received little publicity since its enactment and should receive little attention from the Legislature.

The per capita expenditures for the elderly under the waiver program should fall as the program becomes fully operable and the fixed costs associated with the program are spread out. Furthermore, the difference in costs between per capita waiver expenditures and per capita nursing home expenditures should increase as less severe cases are deflected from the nursing homes into home and community-based settings, with the more severe cases continuing to reside in the nursing homes. Further reductions in the per capita expenditures for the DD waiver will not be significant, if they exist at all, because of the extensive deinstitutionalization that occurred previously. This prior deinstitutionalization covered many of the less expensive cases.

Although the HCBS waiver program in Montana appears to be cost-effective, this can change if the current restrictions on participation under the program are removed. If state controls on the program

are eventually lifted, the program may result in the expansion of Medicaid services in the state. Such an expansion may finally break Montana's Medicaid program. Meanwhile, the waiver program allows the state to provide cost-effective alternatives to institutions for certain individuals in the state.

As mentioned in Chapter 1, a study of the appropriateness of the care for individuals served by the waiver should be made. Due to the constraints of this project, this paper has not dealt with the appropriateness question for Montana's waiver recipients. Future research should attempt to determine if individuals are receiving a more appropriate, or even as appropriate, level of care than they would normally receive in an institutional setting.

Finally, Montana's coverage of the elderly under the statewide waiver is in its infancy, but the existence of the program may have already saved costs in the long run by creating a less favorable climate for the construction of nursing homes in the state. John LaFaver, Director of the Montana Department of Social and Rehabilitation Services, discusses the Department's new attitude toward the development of additional nursing homes.

> In light of the opportunity to provide in-home services, SRS believes that Montana should rethink its current bed need and reassess alternatives to institutional care. Our track record indicates that we can produce the results necessary to keep senior citizens in their own homes . . .
>
> Clearly, this is a time to evaluate Certificate of Need requests required for nursing homes more in line with current health care trends which allow less costly alternatives while also maintaining quality services.[1]

LaFaver believes that HCBS waiver services should be allowed to be developed in order to replace the need for future nursing homes.

Besides the demonstrated reductions in the average cost of care, as the program matures and grows in experience and acceptance, it will effectively reduce the need for additional nursing home beds. For this reason, the Department recommends that funds that might be expended to build nursing home beds be used instead for strengthening and further developing the community-based, long-term care system. The need for one reduces the need for the other.[2]

Endnotes

[1]Letter to the Montana Health Systems Agency from John LaFaver, Director, Montana Department of Social and Rehabilitation Services, Helena, Montana, 24 April 1984.

[2]Ibid.

REFERENCES CITED

Bacon, Donald C. "Medicaid Abuse: Even Worse Than Feared." U.S. News and World Report, 4 June 1979.

Billings, Gloria. "Alternatives to Nursing Home Care: An Update." Aging 325 (March/April 1982).

Brownfeld, Allan. "Medicaid: The Anatomy of the Failure of a Government Program." In Medicaid: Lessons for National Health Insurance, edited by Allan D. Spiegel and Simon Podair. Rockville, Maryland: Aspen Systems Corp., 1975.

Code of Federal Regulations, 42:440.

Code of Federal Regulations, 42:441.

Demkovich, Linda E. "States May Be Gaining in the Battle to Curb Medicaid Spending Growth." National Journal, 18 September 1982.

Donnelly, Harrison. "What Reagan Budget Would Do to the Poor." Congressional Quarterly Weekly Report, 9 May 1981.

Fedler, Judith; Jack Hadley; and John Holohan. Insuring the Nation's Health, Washington, D.C.: Urban Institute, 1981.

Feingold, Eugene. Medicare: Policy and Politics, San Francisco: Chandler Publishing Co., 1966.

Fessler, Pamela. "Soaring Health Costs for the Elderly: A Problem Growing Worse Every Year." Congressional Quarterly Weekly Report, 28 November 1981.

Garland, Barry; Ruth Bennett; and David Wilder. "Re-evaluating the Place of Evolution in Planning for Alternatives to Institutional Care for the Elderly." Journal of Social Issues 37 (Summer 1981).

Gibson, Robert M.; Daniel R. Waldo; and Katharine R. Levit. "National Health Expenditures, 1982." Health Care Financing Review, Fall 1983.

Gregg, Gail. "Reagan Proposes Dramatic Reductions in Federal Role." Congressional Quarterly Weekly Report, 14 March 1981.

Health Care Finance Administration. Form 371, prepared by Montana Department of Social and Rehabilitation Services, September 1982.

Health Care Finance Administration. Form 371, prepared by Montana Department of Social and Rehabilitation Services, January 1984.

Health Care Finance Administration. "Season of Change for Health Services." Forum 5 (October 1981).

Johnson, Charles S. "Expanded Elderly Care Tops Priorities." Great Falls Tribune, 18 November 1982, p. 12A.

"Katie Finds a Friend with Clout." U.S. News and World Report, 23 November 1981.

Kittle, Robert A. "Limits to Put Stress on States." U.S. News and World Report, 4 May 1981.

Kotynski, Tom. "Montana Medicaid Leaves General Fund Ailing." Great Falls Tribune, 23 September 1977, p. 7.

Kotynski, Tom. "New State Social Workers Zero In on Medicaid Costs." Great Falls Tribune, 24 March 1978, p. 4.

LaFaver, John. Director, Department of Social and Rehabilitation Services. Letter to Montana's Health Systems Agency. Helena, Montana, 24 April 1984.

Lloyd, Susan and Nancy T. Greenspan. "Nursing Homes, Home Health Care Services, and Adult Day Care." In Long Term Care, edited by Ronald J. Vogel and Hans C. Palmer. Washington, D.C.: U.S. Government Printing Office, 1972.

Moes, Garry J. "Deinstitutionalization, The Costs are Less but Successes are Varied." Great Falls Tribune, 3 March 1978, p. 4.

Montana. Legislature. Senate and House Journal, 47th Legislature, Special Session, November, 1981: p. 30.

Montana. Department of Health and Environmental Sciences. Cost of Alternative Care Study: Final Report, report prepared for the Montana Department of Health and Environmental Sciences, by JRB Associates, July 1980.

Montana. Department of Social and Rehabilitation Services. Federal Report 2082, Federal Fiscal Year 1982.

Montana. Department of Social and Rehabilitation Services. Federal Report 2082, Federal Fiscal Year 1983.

Montana. Department of Social and Rehabilitation Services. Home and Community-Based Service Request for Waiver, submitted to the Health Care Finance Administration, by the Department of Social and Rehabilitation Services, December 1982.

Montana. Office of the Governor. Office of Budget and Program Planning. A Brief Report on an Evaluation of Deinstitutionalization in Montana, report prepared for the Office of Budget and Program Planning by Theodore H. Clack, Jr., 1977.

Montana. Office of the Governor. Office of Budget and Program Planning. An Evaluation of Deinstitutionalization in Montana, study prepared for the Office of Budget and Program Planning, by Hughes, Heiss, and Associates, 1977.

Montana. Office of the Governor. Office of Budget and Program Planning. Social Services: A Background Statement, report prepared for the Office of Budget and Program Planning, by the Title XX Needs Assessment Project, vol. 1, 1976.

Murray, Allan. "Finance Committee Votes $10.3 Billion Cuts." Congressional Quarterly Weekly Report, 9 May 1981.

Newman, Howard N. "Medicare and Medicaid." In Medicaid: Lessons for National Health Insurance, edited by Allan D. Spiegel and Simon Podair. Rockville, Maryland: Aspen Systems Corp., 1975.

Palmer, Hans C. "Home Care." In Long Term Care, edited by Ronald J. Vogel and Hans C. Palmer. Washington, D.C.: U.S. Government Printing Office, 1982.

Pelham, Ann. "Administration Fighting for Medicaid Cap." Congressional Quarterly Weekly Report, 4 July 1981.

Pelham, Ann. "Congress Votes Medicaid Cuts, Block Grants." Congressional Quarterly Weekly Report, 1 August 1981.

Pelham, Ann. "Medicaid Spending Cut 'Cap' Rejected." Congressional Quarterly Weekly Report, 15 August 1981.

Revised Codes of Montana, 1947. The Developmental Disabilities Act of 1943.

Scull, Andrew. "Deinstitutionalization and the Rights of the Deviant." Journal of Social Issues 37 (Summer 1981).

Shinn, Mary Beth and Barbara J. Felton. "Institutions and Alternatives." Journal of Social Issues 37 (Summer 1981).

Stevens, Robert and Rosemary Stevens. "Medicaid: Anatomy of a Dilemma -- Conclusion." In Medicaid: Lessons for National Health Insurance edited by Allan D. Spiegel and Simon Podair. Rockville, Maryland: Aspen Systems Corp., 1975.

Stevens, Robert and Rosemary Stevens. Welfare Medicine in America: A Case Study of Medicaid. New York: The Free Press, 1974.

"Summary of Differences in Reconciliation Measure." Congressional Quarterly Weekly Report, 4 July 1981.

Tobin, Sheldon S. and Regina Kulys. "The Family in the Institutionalization of the Elderly." Journal of Social Issues 37 (Summer 1981)

Trafford, Abigail. "Are Medicare, Medicaid Going Belly Up?" U. S. News and World Report, 6 September 1982.

Trager, Brahna. Home Health Services in the United States. A report to the Special Committee on Aging, United States Senate. Washington, D.C.: U.S. Government Printing Office, 1972.

U.S. Congress. Senate. Committee on Finance. Medicare and Medicaid: Problems, Issues, and Alternatives. Committee Print, 91st Congress, Second Session, 1970.

U.S. Department of Health, Education and Welfare. "History and Evaluation of Medicaid." Medicaid: Lessons for National Health Insurance, edited by Allan D. Spiegel and Simon Podair. Rockville, Maryland: Aspen Systems Corp., 1975.

U.S. Statutes at Large. vol. 60.

U.S. Statutes at Large. vol. 79.

U.S. Statutes at Large. vol. 95.

U.S. Statutes at Large. vol. 96.

Vogel, Ronald J. and Hans C. Palmer. Long Term Care. Washington, D.C.: U.S. Government Printing Office, 1982.

Wahlstrand, Ken. Department of Social and Rehabilitation Services, Helena, Montana. Interview, 18 May 1984.

Waldman, Saul. "A Legislative History of Nursing Home Care." In Long Term Care, edited by Ronald J. Vogel and Hans C. Palmer. Washington, D.C.: U.S. Government Printing Office, 1982.

Weissert, William G. "Toward a Continuum of Care for the Elderly." Public Policy 29 (Summer 1981).