NASBO Information Brief

Managing State Costs in Services for the Elderly, Disabled, and Special Populations

October 1998

Topic

States are increasingly using managed care as part of their overall health care delivery system. NASBO surveyed the states to identify cost-effective programs for the elderly, disabled, and special populations. This information brief summarizes responses from thirteen states and focuses on state use of managed care and other options for providing services to the elderly, disabled, and special populations including chronically ill children, the mentally ill, and individuals with AIDS. Summary information on programs for the elderly/disabled appears in Table A and summary information on programs for special populations appears in Table B. The Appendix provides short descriptions and savings achieved (if available) on programs for the elderly and/or disabled in thirteen states and programs for special populations in eight states.

Background

Managed care has been a part of private health coverage for over 20 years. A Mercer/Foster Higgins survey found that 85 percent of American workers with health insurance now belong to some kind of managed care plan. For the past several years, state Medicaid programs have moved from traditional fee-for-service programs to capitated managed care arrangements in an effort to control costs. According to the Health Care Financing Administration (HCFA), Medicaid managed care enrollment tripled between 1991 and 1994.

Quality of Care

Quality of care is a concern and has become a subject of debate both at the federal and state levels. Numerous bills have been introduced in the 105th Congress to regulate the

quality of health insurance plans, particularly managed care plans. The proposals include measures regarding consumer rights, access, malpractice issues, privacy, and standards.

Potential Savings

As of June 30, 1997, about 15 million Medicaid beneficiaries were enrolled in managed care plans, representing 47 percent of all beneficiaries. The amount and source of cost savings achievable from managed care varies by the type of managed care program, services incurred, the population to which it is being applied, and the current level of cost and utilization of the population.

While most of the enrollment has focused on relatively healthy populations of younger women and children, states are increasingly turning to waivers and managed care to provide services to the elderly and disabled who generate most of the Medicaid program costs. In capitated managed care arrangements, a provider is typically paid a monthly fee on behalf of an enrollee and is expected to provide the necessary health care services while assuming the financial risk.

By 2020, it is expected that there will be twice as many Americans over the age of 65 needing some type of long term care service, increasing from 7 million today to over 14 million. Thus, it will become increasingly important for states to develop expertise in long term care cost management.

Generally, services in outpatient settings cost less than hospital based alternatives. A common approach is to provide long term care services traditionally offered in institutional settings in the community. In the case of large state operated institutions, savings are realized by avoiding large capital investments and the high cost of maintaining older institutions. Many of the programs highlighted in this report point to costs avoided by placing clients at risk of nursing home placement in community based settings, including in-home support services that allow elderly or disabled clients to remain in their home.

Recipient and Expenditures

In 1996, the state and federal government spent approximately $160 billion on Medicaid. The aged, blind, and disabled comprised only 29 percent of Medicaid

recipients while they accounted for 73 percent of the expenditures. The remaining recipients, adults and children, used 24 percent of expenditures and represented 66 percent of the caseload.

Medicaid Spending

The growth in Medicaid spending has slowed significantly in recent years; however, it still commands about 20 percent of state spending and continues as a major budget issue for states. As the numbers above suggest, Medicaid cost management strategies will likely produce more savings if the focus is on the elderly and disabled, because they generate more than 70 percent of Medicaid costs

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Types of Waivers

Since 1992, states have utilized Medicaid waivers to increase enrollment in managed care and to develop other innovative changes to their Medicaid programs. The federal government currently grants two kinds of Medicaid managed care waivers: Section 1915(b) waivers and Section 1115 demonstrations. In addition, states often use 1915(c) waivers to provide home and community based services as an alternative to institutional placement.

1915 (b) waivers

These waivers allow states to apply for exclusion from the requirement that recipients have freedom of choice in selecting health care plans, to waive the requirements of uniform statewide operation, and to waive the comparability requirement so that additional benefits can be provided for certain types of beneficiaries. In other words, Section 1915(b) waivers permit states to *require* beneficiaries to enroll in managed care plans. Section 1915(b) waivers are often used to establish primary care case management programs and other forms of managed care. There are 94 active Section 1915(b) waivers in 41 states. Under the 1997 Balanced Budget Act, states were given more flexibility in enrolling certain beneficiaries in 1915(b) waivers.

1115 waivers

States may seek 1115 waivers to implement a comprehensive, statewide reform or to expand program eligibility beyond traditional Medicaid populations. This type of waiver allows states to test new approaches to

benefits, services, eligibility, program payments, and service delivery. These approaches are aimed at testing innovative cost containment strategies.

1915 (c) waivers

This provision allows states to waive comparability requirements in order to provide certain medical and supportive services to a specific target population. States use 1915(c) waivers to provide a broad range of home and community based services to the elderly, disabled, mentally retarded, and other disabled and chronically ill persons. These services are provided as an alternative to more costly institutional placement that would be covered under Medicaid. Many states have incorporated managed care principles in their 1915(c) waivers.

State Experiences

Waivers allow states to provide a range of services in caring for the elderly, disabled, and special populations such as the mentally ill, individuals diagnosed with AIDS, and chronically ill children. Also, several states are involved in the Program of All-inclusive Care for the Elderly (PACE) demonstrations that provide comprehensive acute and long term care services to Medicare/Medicaid-eligible persons aged 55 and over, who are clinically eligible for nursing home-level care.

Programs for the Elderly/Disabled

The following highlights some of the programs that appear in greater detail in the appendix:

- Arizona's long term care system is an 1115 waiver that offers a complete array of medical care services for developmentally disabled and elderly or physically disabled persons under a capitated arrangement, saving an estimated $290 million between 1989 and 1993.
- Arkansas and the Robert Wood Johnson Foundation have a three year demonstration project, Independent Choices, designed to test the strengths and weaknesses of offering cash to Medicaid clients in lieu of services.
- Florida's Long Term Care Community Diversion Project provides care through licensed HMOs on a prepaid basis. Additionally, Florida has several 1915(c) waiver programs, is one of the EverCare

demonstration sites for Medicare eligible nursing home residents, and participates in the Medicare Choices Demonstration project designed to expand choices among types of managed care plans and extend managed care options to rural areas.

- Georgia has initiated development of a model for a comprehensive community based service delivery system called SOURCE (Service Options Utilizing Resources in a Community Environment). SOURCE expands the PACE model to include four levels of participation, from the most frail to those at risk of an acute episode resulting in institutional placement.

- The Illinois Community Care Program is a community based entitlement program that provides services to senior citizens at risk of entering a nursing facility. Illinois participates in the PACE demonstration and is implementing a supported living demonstration targeting frail elderly and developmentally disabled individuals aged 22 and over.

- The Missouri Care Options Program is a case managed program serving elderly and disabled adults qualified for Medicaid long term care in a nursing facility. Missouri also participates in the PACE demonstration for the frail elderly and has a managed care pilot project called Health Care Options Plus for individuals with disabilities and chronic illnesses.

- Montana has expanded home and community alternatives under a Medicaid waiver. In addition to a public education campaign aimed at retirees called "Your Future is in Your Hands", Montana also expanded the state income tax deduction for long term care insurance to include insurance purchased for parents or grandparents.

- Nebraska expanded home and community based services as an alternative to nursing home care and projects cumulative savings over a ten year period of $130 million.

- New Jersey has several 1915(c) waivers to provide

community based services to the following populations: aged or disabled persons with income above Medicaid eligibility but below the institutional cap for eligibility; developmentally disabled persons; and severely disabled persons.

- New York's Social HMOs pool premiums from Medicare, private insurance and, in some instances, Medicaid to create a managed health care system that integrates acute and long term care services. New York is also a PACE demonstration site and is testing the efficiency and effectiveness of financing and delivery systems that integrate primary, acute, and long term care services under combined Medicare and Medicaid capitation payments. A law was passed to promote the development of a broader and more integrated continuum of long term care, financed by a range of private and public options. This law extends authority for the currently approved managed long term care demonstration programs (Commonwealth Project, Cooperative Home Care, Continuing Care Networks), and establishes authority for twenty-four new managed long term care plans through 2006.

- Pennsylvania has a 1915(b) Medicaid waiver that was expanded to include disabled, blind, and persons over 65. The state also has a managed care program for nursing facility eligibles.

- Utah has a waiver program for persons age 65 and over that provides home delivered meals, transportation, adult day care and other services.

- Wyoming has a 1915(c) waiver for home and community based services for the elderly.

Programs for Special Populations

Programs for special populations initiated by states include managed care programs for substance abuse, mental health, AIDS patients, and medically complex children. In most cases, the clients are served in community based settings.

The following highlights some of the programs that are detailed in the appendix:

- In Florida, monthly allowances are provided for parents with medically complex children so that care can be provided in home as opposed to a state operated facility. Florida also has two other programs, Prescribed Pediatric Extended Care and Medical Foster Care that are cost-effective and medically and "environmentally" beneficial for Medicaid eligible medically complex children under 21 years of age. Project AIDS Care is a 1915(c) waiver that provides a wide array of home and community based services for individuals diagnosed with AIDS who are at-risk of hospital or nursing facility placement and meet disability standards and certain financial guidelines. Florida also has a Medicaid Prepaid Mental Health Plan that uses a 1915(b) waiver to provide mental health services for certain populations and is part of a demonstration project for End Stage Renal Disease Management.

- The Illinois Family Assistance program for children with a mental illness or developmental disability provides an allowance to families equal to the amount of a monthly federal SSI payment to help defer the cost of keeping their special needs child in their home rather than in a state operated facility.

- Nebraska's managed care program for mental health/substance abuse is a capitated arrangement that saved $11 million.

- New Jersey has a 1915(c) waiver for providing home and community based services to severely brain injured persons aged 22-65. The AIDS Community Care Alternatives Program is a 1915(c) waiver for AIDS diagnosed or HIV and SSA disabled children and adults.

- New York will establish Special Needs Plans for providing managed care to Medicaid recipients who have HIV/AIDS or are seriously mentally ill. A pilot project will provide mental health and substance abuse services for indigent, non-Medicaid recipients receiving services funded by the Department of Mental Health and Substance Abuse Services.

- Pennsylvania's Department of Public Welfare implemented a policy that counties with above average cost per patient would be allocated 10 percent less funds or be reduced to the average cost per patient, whichever was higher. Counties are still expected to provide all necessary treatments and the cost for any individual is not limited to the average cost.

- Utah has a waiver that provides case management, respite, and other services for technology dependent or medically fragile persons from birth to age 20. The state also has a self determination project for developmentally disabled individuals that is funded by a Robert Wood Johnson grant and state funds.

Summary

Health care delivery systems are extremely complex. Managed care is one "efficiency" tool that policy-makers are using as they grapple with the larger questions about delivering care to those in need and the delivery systems for the acute care population and the long term care population. However, many sources report that managed care savings already have been realized and that health care costs will begin to rise in the near future.

As evidenced by the state initiatives highlighted in this brief, states are using waivers to serve the elderly, disabled, and special populations in community based settings. In addition to being cost effective, these settings are often preferred by clients. State experimentation with managed care and waivers are important steps toward ultimately altering the health care system and making it more efficient and effective for those receiving care.

Services for the Elderly and Disabled
Table A

State	Program Name	Type of Waiver or Program	Population	Services	Savings
Arkansas	ElderChoices	1915(c) waiver	Elderly, Disabled	Home and community based services.	ElderChoice services average cost

					one-third of the cost of nursing home care.
	Alternatives	1915(c) waiver	Elderly, Disabled	Home and community based services.	Not available.
	Independent Choices	Demonstration project	Medicaid clients over age 18 with chronic disabilities or elderly.	Cash in lieu of personal care services.	Not available.
Arizona	Arizona Long Term Care System	1115 waiver	Elderly, Disabled	Acute medical; institutional; home and community based services.	$290 million between fiscal 1989 and fiscal 1993.
Florida	Long Term Care Community Diversion Pilot Project	1915(c) waiver	Elderly	Community based managed long term care program.	$23.5 million reduction in 1997 for nursing home expenditures in anticipation of savings.
	Assisted Living for the Elderly	1915(c) waiver	Elderly	Home and community based services.	Waiver services average cost was $7,519 in fiscal 1996; average cost for persons with institutional claims was $17,184.
	Aged/Disabled Adult Services Waiver	1915(c) waiver	Elderly, Disabled	Home and community based services.	Waiver services average cost in fiscal 1996 was $5,853; average cost for persons with institutional claims was $18,148.
	Channeling	1915(c) waiver	Elderly	Home and community based services.	Waiver services average cost in fiscal 1996 was $6,538;

					average cost for nursing facility was $15,120.
Florida (continued)	Developmental Services Home and Community Based Waiver	1915(c) waiver	Disabled	Home and community based services.	Waiver services average cost in fiscal 1997 was $14,537; average cost for institutional care was $66,197.
	Eldercare	Frail/elderly portion of a Medicaid prepaid health plan.	Elderly	In home supportive services.	Services capitated at 92% of Medicaid fee-for- service in fiscal 1998.
	Evercare	Demonstration project	Elderly nursing home residents	Acute and chronic care.	Not available.
	Supported Living	1915(c) waiver	Disabled	Home and community based services.	Estimated waiver average cost in fiscal 1997 was $2,668 while ICF/DD average cost was $63,602.
	Developmental Services Program ICF/DD Reform	1915(c) waiver	Disabled	Home and community based services.	Savings of $33 million anticipated.
	Medicare Choices Demonstration	Demonstration project	Elderly	Managed medical care plan.	Not available.
Georgia	Services Options Utilizing Resources in a Community Environment (SOURCE)	Enhanced case management with a primary care approach.	Elderly,Disabled	Community based services in a day care setting with clients returning home at night.	Not available.
Illinois	Community Care Program	Entitlement program for senior citizens at risk of entering a nursing facility.	Elderly	Community based services: homemaker, case management,	Not available.

				adult day care.	
	Supported Living Program	Assisted living demonstration.	Elderly, Disabled	Emphasizes health monitoring, early detection, prevention and treatment of conditions that could cause nursing home placement if not detected and addressed.	Supported Living program provides services at a cost of no more than 75% of the Medicaid nursing home rates for the same population.
Illinois (continued)	Program for All-Inclusive Care for the Elderly (PACE)	Managed care demonstration project.	Elderly	Range of health care services emphasizing home and community based care.	Through a dual waiver process, Medicaid and Medicare will receive 5% savings in per capita health care expenditures.
Missouri	Missouri Care Options Program	Case managed program with fee-for-service reimbursement.	Elderly, disabled and in need of nursing home care.	Fee-for-service home and community based services case managed with monthly per client cost cap.	Since implementation in fiscal 1993, the cost avoidance estimate is $145.5 million.
	Program for All-Inclusive Care for the Elderly (PACE)	Managed care demonstration project	Frail elderly in need of nursing home care.	Full range of health care services emphasizing home and community based care.	Medicaid cost for nursing facility care is discounted by a small percentage (reimbursed on a per member per month capitated basis). Implementation expected in Fall 1998.
	Health Care Options Plus	Managed care demonstration project	Individuals under age 65 with disabling or	Full range of health care services	Not available; implementation expected in

			chronic illnesses.	emphasizing home and community based care.	Fall 1998.
Montana	Home and Community Alternatives	Medicaid waiver	Elderly, Disabled	Home and community based care	Each 1% decrease in nursing facility bed days saves about $1 million per year.
	State Income Tax Deduction for Long Term Care Insurance	Tax Deduction	Includes insurance purchased for parents or grandparents	Long term care services.	Not available.
	Your Future is in Your Hands	Public education campaign	Elderly, Retirees	Aimed at educating seniors and baby boomers about issues and planning for life as a senior citizen.	Not available.
Nebraska	Long Term Community Based Care	1915(c) waiver	Elderly, Disabled	Home and community based care.	Projected savings are $1 million in 1999; $130 million projected cumulative savings over 10 years.
New Jersey	Community Care Programs for the Elderly and Disabled	1915(c) waiver	Elderly, Disabled	Community based services.	Not available.
	Developmental Disabilities Community Care Waiver	1915(c) waiver	Disabled	Residential community services.	Not available.
	Model Waiver III	1915(c) waiver	Disabled	Community based long term care services, private duty	Not available.

				nursing.	
New York	Social HMOs	Managed care with pooled premiums from Medicare, Medicaid and private insurance.	Elderly	Acute and long term care.	Not available.
	Program for All-Inclusive Care for the Elderly (PACE)	Capitation fee from Medicare and Medicaid.	Elderly	Acute and long term care services.	Not available.
	Continuing Care Networks	Medicaid waiver using capitation payments from Medicare and Medicaid.	Elderly	Primary, acute, and long term care services.	Not available.
	The Commonwealth Project	Demonstration project for Medicare/Medicaid dual eligible persons.	Elderly	Long term care services.	Not available.
	Cooperative Home Care	Chronic care management demonstration program.	Disabled, Chronically Ill	Test various methods of service delivery and financing for long term care.	Not available.
New York (continued)	Long Term Care Integration and Finance Act of 1997	Extends authority for current long term care demonstration.	Chronically Ill	Promote development of broader, more integrated continuum of long term care.	Program guidelines require savings; however savings are not projected at this time.
	Managed Care Payment System for Waiver	1915(c) waiver	Disabled	Changing payment of services to managed care system from fee-for-service.	Not available.
Pennsylvania	Managed Care	1915(b) waiver	Disabled, Blind, Elderly	HMOs responsible for payment of up to 30 consecutive days of nursing home care or services in a community based waiver	No savings projected in the long term care appropriation.

				program.	
	Community Based Care Waiver Program	1915(c) waiver	Nursing facility eligibles.	Community based care for nursing home eligible clients.	Program cost in fiscal 1998 was $28.7 million; an equivalent number of new nursing home beds is $72 million.
	Long Term Care Capitated Assistance Program	Managed care	Nursing facility eligibles.	Nursing facility services, physician services, and pharmaceuticals	No savings projected in the long term care appropriation.
Utah	Aging Waiver	Demonstration project	Elderly	Capitates Medicaid long term care program.	Not available.
	Capitated Long Term Care Demonstration Program	Demonstration project	Medicaid long term care recipients.	Nursing homes, assisted living, community living arrangements.	Unavailable – program will be implemented in 1999.
	Developmentally Disabled/Mentally Retarded Waiver	1915(c) waiver	Developmentally disabled, mentally retarded.	Community based services.	Fiscal 1996 waiver average cost was $23,775; institutional care average cost was $51,383.
Wyoming	Elderly Home and Community Based Services Waiver	1915(c) waiver	Elderly	Home and community based services.	Fiscal 1997 savings totaled $4.6 million.

Services for Special Populations
Table B

Florida	Project AIDS Care	1915(c) waiver	AIDS diagnosis and certified at-risk of hospital or nursing facility placement.	Home and community based services.	Average waiver co in fiscal 1996 was $17,700; average cost for institutior claims wa $21,848.
	Katie Beckett Model Waiver	1915(c) waiver	Under age 21 diagnosed with degenerative spinocerebellar disease.	Home and community based services.	Average waiver co in fiscal 1997 was $3,900; average cost for hospital recipient was $14,465.
	Medicaid Prepaid Mental Health Plan	1915(b) waiver	Medipass recipients (AFDC, SSI without Medicare), OBRA, and foster children.	"Carve out" vs. integrated models of mental health managed care.	Not available.
	Prescribed Pediatric Extended Care	Title XIX	Under age 21 with medically complex condition.	Short or long term care at a non-residential center.	Not available.
	Medical Foster Care	Title XIX	Medically complex foster children.	Family based care.	Not available.
	End Stage Renal Disease Management Demonstration	Demonstration project	End Stage Renal Disease diagnosis and Medicare Part A and B as primary insurance.	Managed care approach for service delivery.	Not available.
Illinois	Home Services Program	Waiver	Disabled	In-home care.	Not available.
	Family Assistance Program	_____	Mentally ill or disabled children.	Monthly payments to help defer the cost of keeping the child at home rather than a state	Not available.

				facility.	
Illinois (continued)	Home Based Support Services	_____	Over age 18 with mental illness or developmental disability, living in own apartment without 24 hour professional care.	Services or tangible items that allow the individual to remain in their home. Skill enhancing services can also be purchased.	Not available.
Nebraska	Medicaid Managed Care for Mental Health/Substance Abuse	1915(b) waiver	Mentally ill or substance abuse clients that are Medicaid eligible.	Outpatient therapy, residential treatment.	Cost savings of $11 million.
New Jersey	Traumatic Brain Injury Waiver	1915(c) waiver	Severely brain-injured persons aged 22-65.	Intensive home and community based therapies.	Not available.
	AIDS Community Care Alternatives Program	1915(c) waiver	AIDS diagnosed or HIV and SSA disabled children or adults.	Medicaid services plus eight additional services as an alternative to nursing home care.	Not available.
New York	Managed Care Special Needs Plan	1115 waiver	HIV/AIDS diagnosis or seriously mentally ill.	Primary and specialized care, including full range or mental health and related support services.	Not available.
Oklahoma	Pilot Managed Care Project Initiative	Pilot managed care project.	Indigent, non-Medicaid and receiving services funded by the Department of Mental Health and Substance Abuse.	Mental health and substance abuse treatment.	Savings will be diverted t expand communi based car
Pennsylvania	Developmentally Delayed Children Services	Counties with above average cost per patient would receive 10% less funds or be reduced to the average cost per patient – whichever	Developmentally delayed children.	All necessary treatments.	$2.2 million in fiscal 199

		is higher.			
Pennsylvania (continued)	Mental Health and Mental Retardation Programs	1915(c) waiver	Clients served in institutional mental health or mental retardation facilities.	Continuum of care in family or community based settings.	Institutior costs average $120,00 per client/yea communi residentia costs average $100,000 per client/yea family based services average $30,000 annually.
Utah	Technology Dependent/Medically Fragile	_____	Birth to age 20 and medically fragile or technology dependent.	Case management, respite care, portable oxygen, respiratory care, etc.	In 1996, per capita program cost savings w $55,447. Waiver spending $25,117 while comparab institutior care is $80,564.
	Utah Self Determination Project	Foundation grant and state funds	Developmentally Disabled	Individuals identify services that meet their needs and goals.	Not available.

APPENDIX

Arizona	*Elderly/Disabled*
Arizona Long Term Care System	In 1987, the Arizona legislature passed legislation to include long term care services under the new Arizona Long Term Care System (ALTCS). An 1115 waiver

	Long Term Care System (ALTCS). An 1115 waiver, ALTCS was implemented on December 19, 1988 for the developmentally disabled population; the program for the elderly or physically disabled population was implemented on January 1, 1989. As of February 1, 1998, ALTCS served 24,321 members: 8,928 were developmentally disabled and 15,393 were elderly or physically disabled persons. ALTCS offers a complete array of acute medical care services, institutional services, behavioral health services, home and community based services, and case management services for all eligible persons. ALTCS is unique in that all covered services are integrated into a single delivery package, coordinated and managed by eight program contractors in the state. ALTCS provides services to persons who are either elderly, physically disabled, or developmentally disabled if the individual passes both a financial and medical screen for the program. Individuals must be financially eligible to qualify for ALTCS. The legislature has established ALTCS financial eligibility at the highest allowable income amount under federal law: 300 percent of Supplemental Security Income (SSI) or $1482 per month for an individual as of April 1, 1998. Allowable resources vary by eligibility group. Once financial eligibility has been established, a preadmission screen is conducted by a registered nurse or social worker to determine if the individual is at risk of institutionalization in either a nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR). A network of seven program contractors located throughout the state delivers ALTCS Services for the elderly or physically disabled population. By statute, AKTCS services for the developmentally disabled population are delivered by the Department of Economic Security/Division of Developmental Disabilities (DESDDD) under a capitation arrangement. DES/DDD operates in the same manner as other program contractors and additionally administers a 100 percent state funded program for developmentally disabled persons who are not eligible for ALTCS.

	The ALTCS program achieved estimated savings of $290 million between fiscal 1989 and fiscal 1993. Most of the savings were experienced in fiscal 1992 and fiscal 1993, with savings of more than $100 million per year.
Arkansas	*Elderly/Disabled*
ElderChoices	This 1915(c) home and community based services waiver is designed to provide an individualized care plan of support services to persons in their home to avoid or delay institutionalization and to de-institutionalize persons who could live in a less restrictive setting than an institution and desire to do so. To be eligible for the waiver, the individual must be 65 years of age or older, have resources of less than $2,000, incomes of less than 300% of SSI, require nursing home care, and receive in-home services costing less than institutionalization. Services include homemaker, chore, home-delivered meals, personal emergency response system, adult day care, adult foster care, and respite. The eligible client also receives all appropriate Medicaid services including personal care, prescriptions, and home health care. Currently, almost 6,000 persons receive ElderChoices. In state fiscal year 1997, almost $25 million was expended in waiver services. The average cost of a plan of care (including waiver and personal care services) was approximately 1/3 the cost of nursing home care. The average annual home-based service cost per client totaled $5,964, while annual nursing home cost totaled $18,000.
Alternatives	This home and community based services waiver provides services that maintain eligible persons at home. These services may prevent or delay institutionalization, optimize access to supportive community resources, remove obstacles to improving social and health services, and allow flexibility in the

	delivery of alternative services. Persons qualifying for this waiver have the option of selecting consumer driven attendant services and/or environmental adaptations. Eligibility criteria are as follows: 21-64 years of age, income of less than 300% of SSI, resources of less than $2,000, and medically eligible for admission to a nursing facility. The program was implemented in July, 1997 with a limit of 200 participants. Currently, over 100 persons receive Alternatives services. The projected budget for state fiscal year 1998 is $5 million. Cost of services in the home must be less than the cost of nursing home care.
Independent Choices	Independent Choices is a national demonstration project sponsored by the Robert Wood Johnson Foundation and the U.S. Department of Health and Human Services. The project will test the weaknesses and strengths of offering cash to Medicaid clients in lieu of personal care services. Eligible clients include Medicaid clients over age 18 with chronic disabilities or the elderly. Persons participating in the three year demonstration project must be willing and able to direct their own care or have a representative willing to accept the responsibility. Many positive outcomes are anticipated from the demonstration project, including increased consumer-satisfaction, services performed in a more cost-effective manner, or receiving more services for the same amount of money. Implementation is planned for spring 1998.
Florida	*Elderly/Disabled*
Long-Term Care Community Diversion Pilot Project	The 1997 Florida Legislature appropriated $22 million to implement the Long-term Care Community Diversion Pilot Project for an average monthly caseload of 2,300 eligible individuals. Medicaid nursing home expenditures were reduced by $23.5 million based on the anticipated savings of the pilot project. The pilot project, a Medicaid funded

	alternative to nursing home care, will be a three-year demonstration that provides a community-based managed long-term care program. Under the 1915(c) waiver, the state will contract with willing and qualified licensed health maintenance organizations (HMOs) on a prepaid basis. The HMOs will be placed at full financial risk for the delivery of comprehensive medical and long-term care services, including community-based waiver services and nursing home care, to a group of severely impaired and nursing home eligible elderly Medicaid recipients. Recipient enrollment is voluntary. Participants can choose to disenroll at any time. The project will be implemented in selected areas in central and south Florida. The sites are selected based on a number of factors, including the size of the elderly population, nursing home growth, the availability of community services and residences, and other factors important to the successful test of the project. The project is expected to be operational in early 1998.
Assisted Living for the Elderly	Assisted Living for the Elderly (ALE) is a 1915(c) waiver program of home and community-based services for recipients who reside in Assisted Living Facilities. The components of assisted living are: attendant call systems, attendant care, behavior management, chore, companion service, homemaker, intermittent nursing, medication administration, occupational therapy, personal care, physical therapy, specialized medical equipment and supplies, speech therapy, and therapeutic social and recreational services. Assisted Living services are limited to individuals who are 60 years old or older and meet one or more of the following: requires assistance with four or more activities of daily living, has a diagnosis of Alzheimer's Disease or another type of dementia, or be a Medicaid eligible recipient awaiting discharge from a nursing home who cannot return to a private residence. Average Medicaid expenditures for persons enrolled in the ALE Medicaid Waiver were $5,191 in fiscal 1995 and $7,519 in fiscal 1996. Medicaid expenditures for

	non-waiver persons with institutional claims were on average $17,635 in fiscal 1995 and $17,184 in fiscal 1996.
Aged/Disabled Adult Services Waiver	The Aged/Disabled Adult Services Waiver (ADA) is a 1915(c) waiver program provides a wide array of home and community-based services including adult day health care, case management, chore services, consumable medical supplies, environmental modifications, home delivered meals, homemaker and personal care services, and physical therapy. Aged/Disabled Adult services are limited to individuals who are 65 years or older or are determined disabled according to Social Security Administration standards. If an individual is under 65 years of age, Supplemental Security Income (SSI) or Institutional Care Program (ICP) income and asset guidelines and level of care determination must be met for eligibility. Aged/Disabled Adult Services Waiver is a fee-for-service program, which operates using specific managed care mechanisms. Medicaid expenditures for persons enrolled in the ADA Medicaid Waiver were on average, $5,147 in fiscal 1994, $5,631 in fiscal 1995, and $5,853 in fiscal 1996. For non-waiver persons with institutional claims, the average Medicaid expenditure in fiscal 1994 was $15,378, in fiscal 1995 it was $17,016, and in fiscal 1996, it was $18,148.
Channeling	Channeling is a 1915(c) waiver program that provides a wide array of home and community-based services, including adaptive equipment, adult day health care, case management, home based nursing, home delivered meals, home health aide, homemaker/personal care, mental health services, respite care, and physical therapy. Channeling services are limited to individuals who reside in Dade or Broward counties, are age 65 or older, meet financial guidelines for the Institutional Care Program (income at or below 300% of the Federal Benefit Rate); and are assessed as at risk of nursing facility placement. Channeling operates as an organized health care

	delivery system and receives a prospective payment for each enrolled recipient based on a negotiated per diem rate. This delivery system incorporates specific managed care principles. For example, prior authorization by case managers via a written plan of care is required for all home and community-based services provided under Channeling. Cost savings can be demonstrated by the following comparisons of total Medicaid expenditures among waiver and non-waiver Medicaid recipients. In fiscal 1995, average program expenditures under the Channeling program were $6,173 per recipient; for nursing facilities, average expenditures in fiscal 1995 were $13,932. In fiscal 1996, average Channeling program expenditures were $6,538, while average nursing facility expenditures were $15,120.
Developmental Services Home and Community-Based Waiver	The Developmental Services Home and Community Based Waiver (DS Waiver) is a 1915(c) waiver that provides services as an alternative to more costly institutional placement that would be covered under Medicaid. The DS Waiver provides a wide array of home and community based services including adult day training, behavioral services, child day training, environmental modification, homemaker services, in-home support services, physical therapy, private duty nursing, psychological services, respite services, skilled nursing services, speech, language, and hearing therapy, and transportation services. DS waiver services are limited to individuals with a diagnosis of developmental disabilities who meet level-of-care criteria for intermediate care facilities for the developmentally disabled (ICFs/DD), meet income and asset requirements for SSI-related Medicaid or the Institutional Care Program, are clients of the Developmental Services Program and are enrolled in the DS Waiver. The DS Waiver operates as a fee-for-service program that uses specific managed care mechanisms. For example, all home and community-based services provided under the DS Waiver require prior authorization by support coordinators via a written plan of care. Average expenditures per recipient for persons enrolled in the DS Waiver were

	$15,037 in fiscal 1996. For non-waiver persons with institutional claims, the average expenditure was $67,338. In fiscal 1997, average expenditure per recipient under the waiver was $14,537, compared to $66,197 for those persons receiving institutional care.
Eldercare	The purpose of the ElderCare program (a frail/elderly portion of a Medicaid prepaid health plan) is to manage services for the frail and elderly who are at risk of institutional placement. This program is currently offered by United Health Care, Inc. and is available to nursing home certifiable SSI Medicaid recipients in three counties. The plan operates the frail/elderly program in a manner consistent with the Medicaid prepaid health plan contract, with the addition of the frail/elderly portion of the contract as outlined below. The plan provides at least the following services as part of the frail/elderly program: coordination of services, adult day health care, homemaker/personal care, adaptive equipment, and supplies. The plan is encouraged to provide other supportive services as deemed necessary. The plan is capitated to provide service at 92% of Medicaid fee-for-service in fiscal 1998.
EverCare Demonstration	EverCare is a managed care approach to financing and delivering acute and chronic care for long term nursing home residents eligible for Medicare. HCFA has contracted with United HealthCare to replicate the Minnesota EverCare model in five sites. Florida's Tampa Bay area is one of these sites. EverCare members in Florida are exempt from paying premiums, deductibles, and co-insurance. In 1995, representatives of United HealthCare invited Florida Medicaid's participation in the EverCare project. They requested a Medicaid capitation payment for dual eligible members of EverCare. The state Medicaid office has reviewed this option and will present to EverCare the terms and conditions for Medicaid participation in the demonstration. Florida's Medicaid demonstration project will extend for a period of 18 months. According to HCFA officials, a Medicaid waiver is not

	required, because the demonstration is limited in time, scope, and geographical area.
Supported Living Waiver	The Supported Living Waiver is a 1915(c) waiver program of home and community-based services provided to individuals with a diagnosis of developmental disabilities who are at risk for institutionalization in an intermediate care facility for the developmentally disabled (ICF/DD), but have sufficient abilities to live in the community. They must also meet income and asset requirements for SSI-related Medicaid or the Institutional Care Program, be clients of the Developmental Services Program and be enrolled in the Supported Living Waiver. The Supported Living Waiver operates as a fee-for-service program that uses specific managed care mechanisms. For example, the home and community-based services provided under the Supported Living Waiver require prior authorization by support coordinators via a written plan of care. While specific comparisons to an identical institutionalized population are not available, preliminary data for fiscal 1997 indicates average expenditures per recipient for the Supported Living Waiver are $2,668, compared to an average expenditure per recipient of $63,602 for the ICF/DD.
Florida Developmental Services Program ICF/DD Reform	The 1996 Florida Legislature enacted legislation eliminating the Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) optional Medicaid service in anticipation of transferring the individuals to the more cost effective home and community based services waiver. The legislature believed that the change would remove the state from the costly institutional services arena into one that is consumer directed and driven. In addition to believing that the state could save considerable money, approximately $33 million, it also believed that built-in cost escalators perpetuated under the Boren Amendment would cease to drive up costs of serving individuals with developmental disabilities. Due to delays in federal approval of amendments to

	the state's 1915(c) waiver, the federal Protection and Advocacy Agency filed suit in federal court, halting all action on August 28, 1996. The state is still under federal court injunction. Under one of several lawsuits, the state is now faced with a federal court ruling based on interpretation of existing federal law and policy that all individuals who are eligible and seek placement in an ICF/DD are entitled to the provision of that service within 90 days
Medicare Choices Demonstration Project	The Medicare Choices demonstration is designed to give Medicare beneficiaries expanded choices among types of managed care plans, to extend managed care options to rural areas, and to test new ways to pay for managed care. In December 1996, Florida Hospital Healthcare System was awarded final approval for a Medicare Choices Demonstration Project from HCFA. The Florida Hospital Healthcare System is a community-based provider-sponsored organization with a Medicare contract. The service area for the demonstration includes three counties in central Florida. Enrollment began in February 1997, and had 2,367 members as of March 1997.
Georgia	*Elderly/Disabled*
Services Options Utilizing Resources in a Community Environment (SOURCE)	The Department of Medical Assistance initiated a project to develop a model for a comprehensive community based service delivery system. The resulting model, Services Options Utilizing Resources in a Community Environment (SOURCE) has been implemented in four sites around the states. Recipients in twelve counties are included in the project enrollment. SOURCE evolved from discussions related to the PACE projects operating under a national waiver granted from HCFA and targeting the most frail elderly. The PACE model is designed to provide services in a day care setting with individuals returning to their homes at night. The SOURCE model expands the PACE model to include four levels of participation from the

	most frail to those who are at risk of an acute episode and subsequent placement in an institution. A major emphasis of the design of the program is the ongoing involvement of the client and the client's significant others in the development and adjustment of the client's care plan and a life plan to address long term social, emotional, and medical goals. The model provides enhanced case management with a primary care approach. The sites are approved to provide service to the elderly (individuals 65 years or older) and the disabled (individuals under 65 years) who receive Medicare and Medicaid and are otherwise exempt from participation in Georgia Better Health Care (GBHC). Participation in the project is voluntary, and clients may disenroll at any time.
Illinois	*Elderly/Disabled*
Community Care Program	The Community Care Program is not a managed care program, but an entitlement program that provides services to senior citizens at risk of entering a nursing facility. All services are community based, and provided through vendors contracted with the Illinois Department on Aging. The three main components of the Community Care Program are homemaker services, case management, and adult day care. Homemaker services assist the client with household tasks including cleaning, laundry, errands, meal preparation, and personal care. Adult day care serves to keep the elderly in the community and helps to provide respite for caregivers, and socialization for the elderly. Health monitoring, personal care, medication supervision, and recreational/therapeutic are an example of the services provided by adult day care. Case management service is the most integral part of the Community Care Program. A statewide network of Case Coordination Units provides this service. Case managers screen all nursing home applicants, and those referrals that they receive from within the

	community. The managers within these agencies determine eligibility, assess needs, develop care plans, and monitor ongoing needs of clients. Eligibility for the Community Care Program is determined by the following: age 60 or over, a U.S. citizen or legal alien, a resident of Illinois, non-exempt assets totaling less than $10,000, and an assessed need for long term care. Spending in fiscal 1997 was approximately $132 million with an average monthly caseload of 32,906.
Supported Living Program	The Supported Living Program is an assisted living demonstration program set for implementation in February 1998. Savings will be achieved by providing supportive services to "light need" nursing home residents or potential residents in independent living apartments that cost no more than 75 percent of the Medicaid nursing home rates for the same population. The program is a health/medical model that emphasizes health monitoring and promotion by the provider as a means of early detection, prevention and treatment of conditions that could cause deterioration that would require nursing home or hospital placement if not detected or addressed. The Supportive Living Program would serve one of two populations in each location selected to participate. The two populations are the frail elderly age 65 and over and persons with disabilities age 22 and over (not developmentally disabled or chronic mentally ill).
Program for All-Inclusive Care for the Elderly *(PACE)*	The Program for All-Inclusive Care for the Elderly (PACE) program is a national Managed Care demonstration project that replicates On Lok of San Francisco. On Lok is a model of health care, which coordinates health and health-related social and support services for the chronically ill or impaired elderly under one provider organization. Services are provided at the program's adult day health center and in the participant's home. Providers on contract furnish acute care services with the PACE program.

	The program cost for fiscal year 1997 was $1.3 million, with payments made on a monthly basis via a prepaid, Medicaid-only capitation rate. Cost savings are realized through more appropriate utilization of services and careful management and coordination of care. As this program grows to its cap of 300 clients, Medicare and Medicaid through a dual waiver process will realize five percent savings in per capita health car expenditures.
Missouri	*Elderly/Disabled*
Missouri Care Options Program	Missouri Care Options Program (MCO) is the name given to the 1992 legislative initiative intended to ensure that adults facing decisions regarding state-funded long-term care have information sufficient to exercise choice. Under the auspices of the MCO program, the Division of Aging (DA) has revised pre-admission screening policies, enhanced public awareness of options for long-term care, received additional funding for in-home services, and expanded the quality, quantity, and availability of Home and Community based service options across Missouri.
	MCO is a case managed program based on informed choice by potential service users. Reimbursement remains fee-for-service with prior authorized service unit amounts for home and community based care within a monthly per client cost cap. The population served includes elders and adults with disabilities who have medical and functional need equal to those qualifying for Medicaid long-term care in a nursing facility. Comprehensive assessments lead to service plans of care which are largely consumer directed. The MCO initiative has shifted the balance of Medicaid payments for long-term care in Missouri from nursing facility payments toward increased home and community based care. The share of the Medicaid long-term care dollar spent on home and community

	care has gone from 8.8 percent in 1992 to 15.2 percent in 1996. In fiscal 1998, it is projected that the number of Medicaid long-term home and community care recipients will equal (or exceed) the number of nursing facility recipients at a projected Medicaid cost of about 1/5 the cost of nursing facility care. The total cost for home and community based care is not entirely Medicaid, however. Residential care involves the Supplemental Nursing Care cash grants and home car uses some Social Service Block Grant/General Revenue and Older Americans Act funds. Costs and cost savings (cost avoidance) are calculated by the Department of Social Services and are based on actual costs for all home and community services and what the same number of days of care would have cost in a nursing facility based on the statewide average daily Medicaid reimbursement for the previous fiscal year. Since implementation of the program in 1993, the program has cost $40 million. The cost avoidance estimate is $145.5 million.
Program for All-Inclusive Care for the Elderly *(PACE)*	PACE (Program for All-Inclusive Care for the Elderly) is a model of care delivery designed specifically to meet the needs of the very frail elderly. A complete range of health care services is available based on the needs of the individual, with a heavy emphasis on home and community based care. Enrollment in PACE will be strictly on a voluntary basis. The state will contract with health care systems which have had a successful feasibility study conducted by the National PACE Association. Programs may be implemented as pre-paid health plans where the provider is at risk for only a selected range of services in order to build capacity. Once adequate census is achieved, the PACE program will receive a monthly capitation payment from both Medicaid and Medicare. The population served includes Medicaid eligible individuals 55 and older who require nursing facility care. Individuals may be eligible only for Medicaid, or for both Medicare and Medicaid. A single PACE provider can effectively serve up to 300

	enrollees. The PACE provider is responsible for all medically necessary care required by the individual. Many services are available at the PACE site, such as primary and preventive care, rehabilitative services, nursing services, nutrition, social and recreational services. Home care, such as personal care, homemaker, respite care, nurse visits, and any home and community-based service that might prevent or delay institutionalization are included in PACE. The PACE provider is also responsible for all other services the individual might require, including: inpatient hospitalization, primary and specialty care, prescriptions, emergency services, durable medical equipment, mental health services, dental care, optical care, audiology, medical transportation, and nursing facility care. Monthly capitation rates are established for both Medicaid and Medicare services. The Medicaid rate is based on the state's expenditures for the eligible population discounted by a small percentage to demonstrate cost savings.
Health Care Options Plus	Health Care Options Plus (HCO+) is a pilot project to enroll individuals with disabilities and chronic illnesses into a managed care program designed specifically to meet their needs. Enrollment in HCO+ is strictly on a voluntary basis. All services will be provided by the HMO for a monthly capitation payment. The population served includes Medicaid eligible individuals under age 65, with physical disabilities or disabling chronic illnesses. Individuals may be eligible only for Medicaid, or for both Medicare and Medicaid. The HMO will provide all medically necessary care required by the individual, including but not limited to: inpatient hospitalization, outpatient care, primary and specialty care, prescriptions, emergency services, durable medical equipment, personal care, hospice, skilled nurse visits, rehabilitation, mental health services, dental care, optical care, audiology, family planning, prenatal care, medical transportation, and up to 90 consecutive days in a nursing home. While enrolled in the program, the individual may also

	receive specified services on a fee-for-service basis, including transplants, community psychiatric rehabilitation, adult day health care, and nursing facility care greater than 90 days. Capitation rates will be established using a diagnostic-based Disability Payment System. This methodology is based on case mix adjusted diagnostic rate cells determined by region, age, gender, Medicare status, and length of Medicaid eligibility.
Montana	*Elderly/Disabled*
Home and Community Alternatives	Home and community alternatives under the Medicaid waiver program have been expanded without making those services an entitlement. A portion of the proceeds from the Lien and Estate Recovery program is directed toward community alternatives. The Lien and Estate Recovery program is expected to recover about $1.2 million in fiscal 1998. Nursing home bed days and Medicaid expenditures for nursing home care have decreased each of the past two years and the trend appears to be continuing. The expanded Medicaid community services cost about $2.0 million per year in each year of the next biennium. Fewer Medicaid funded nursing home days of care are projected in fiscal 1998; each 1% decrease in nursing facility bed days saves about $1 million per year.
State Income Tax Deduction	The state income tax deduction for long term care insurance was expanded to include insurance purchased for parents or grandparents.
Your Future is in Your Hands	This statewide public education campaign known as "Your Future is in Your Hands" is aimed at educating seniors and baby boomers about the issues associated with, and the need to plan for life as a senior citizen. The campaign includes print material, a cable

	television show titled " Aging Horizons" and a series of town forums on public television entitled "Your Future is in Your Hands" that discusses a variety of long term care issues. The public education campaign was developed in fiscal 1996 for about $100,000.
Nebraska	*Elderly/Disabled*
Long-term Care Community Based Care	With a 1915(c) waiver, the state will expand home and community-based services as an alternative to nursing home care. Assisted living and various in-home services will be provided. The program will serve 2,000 Medicaid-eligible elderly and disabled persons shifted from nursing home care to home and community-based services. The projected cost in fiscal 1999 is $253 million. Savings of $1 million are projected in fiscal 1999, while the cumulative savings over a ten year period are projected to be $130 million.
New Jersey	*Elderly/Disabled*
Community Care Programs for the Elderly and Disabled (CCPED) Waiver	This 1915(c) Medicaid waiver provides 3,300 slots for aged or disabled persons with income above Medicaid eligibility but below the institutional cap for eligibility. Services are limited to seven community based services, including case management, home health, homemaker, medical day care, non emergency medical transportation, respite care, and social day care. The program cost in fiscal 1997 was $43.6 million (50% state funding, 50% federal funding).
Developmental Disabilities Community Care Waiver	This 1915(c) Medicaid waiver provides 5,900 slots for developmentally disabled persons needing residential community services. The services provided include supervised adult day activities in the community and residential programs. The cost of the program in fiscal 1997 was $160 million, (50% state funding, and 50%

	federal funding).
Model Waiver III	This 1915(c) Medicaid waiver provides 150 slots for severely disabled persons. In fiscal 1997, the program cost was $13 million (50% state funding, 50% federal funding) for providing community based long term care services plus private duty nursing.
New York	*Elderly/Disabled*
Social HMOs	This health care model was initiated under the Omnibus Budget Reconciliation Act of 1984, with state participation beginning within the same year. The model is designed to test integration of acute and long term care services. Social Health Maintenance Organizations (SHMOs) pool premiums from Medicare, private insurance and, in some instances, Medicaid to create a managed health care system. SHMOs provide all services which are reimbursable under Medicare and, for members who meet nursing home criteria, community based long term care services including: personal care, skilled nursing and therapies, adult day care and certain supportive services. Currently there are approximately 5,000 Medicare eligibles enrolled in the SHMO (Elderplan). Of these, approximately 225 are also eligible for Medicaid. Eligibility for this program is limited to persons who are aged 65 or over who are eligible for Medicare. Most of the persons enrolled are "well elderly" with only a small percentage considered in need of long term care, based on measures of activities of daily living (ADLs). Authorization for these programs was extended until 2003 under New York State's Long Term Care Integration and Finance Act of 1997.
Program for All-Inclusive Care for the Elderly *(PACE)*	This federal demonstration was established under OBRA 1986, with sites beginning operation in 1990. This demonstration is a model that provides comprehensive acute and long term care services to

	comprehensive acute and long term care services to Medicare/Medicaid-eligible persons aged 55 and over, who are clinically eligible for nursing home-level care. In effect, PACE enrolls frail older persons who are certified eligible for nursing home care. The programs receive a monthly capitation fee from both Medicare and Medicaid. During the first three years of operation, financial risk is shared between the PACE provider and the State. Risk is phased-in over the three year period, until the provider assumes full risk for all services. Persons once enrolled in the PACE program, unless they voluntarily disenroll, remain enrolled until death. Authorization for these programs was extended until 2003 under New York State's Long Term Care Integration and Finance Act of 1997. There are now two PACE sites operational, with two "pre-PACE " sites – those where Medicare is not yet capitated – also in operation. Of the two that are fully operational, Beth Abraham's Comprehensive Care Management in the Bronx has a current enrollment of 290 and Independent Living for Seniors in Rochester has a current enrollment of 240. The rates for these two programs represent 96 percent and 92 percent, respectively, of the local average Medicaid expenditures for nursing facility level individuals. In addition, the two PACE programs receive a monthly Medicare capitation rate based on local average Medicare costs, adjusted for frailty. No specific savings are tied to this initiative. A study of the programs is anticipated to begin in 1998.
Continuing Care Networks(CCN)	Continuing Care Networks (CCN) is designed to test the efficiency and effectiveness of financing and delivery systems that integrate primary, acute, and long term care services under combined Medicare and Medicaid capitation payments. This demonstration, operating in Monroe County, is intending to enroll at least 10,000 Medicare and Medicare/Medicaid eligible persons within the county. This will include over 1,500 persons who meet a level of functional impairment qualifying them for nursing home placement and who

	live in the community or a nursing home. Enrollees will be both frail and well older persons, residing in the community or in nursing homes, and enrollment is voluntary. Both the Medicare/Medicaid dually eligible as well as the Medicare-only will be enrolled, with a benefit package that includes a full range of primary, acute and long term care services. The demonstration is still seeking federal waiver approval, and enrollment is anticipated to begin in June 1998.
The Commonwealth Project	In 1994, the Department of Health received a planning grant from the Commonwealth Fund to design and implement a demonstration of capitated managed care programs for Medicare/Medicaid eligible persons requiring long term care services. The goals of the project are to provide greater flexibility; to increase client satisfaction; to improve health status and delay decline in functioning; to test the effectiveness of capitation as a way to constrain growth in costs; and to enable providers to develop expertise with partial capitation leading towards integration of Medicare and Medicaid. Enrollment in the Commonwealth program is voluntary. Persons eligible for the program must be twenty-one or over, nursing home certifiable, living in the community upon enrollment, and in need of the long term care services in the benefit package. The benefits include case management, home care, nursing home care, medical and social day care, meals, drugs, dentistry, optometry, podiatry, transportation, medical equipment and supplies, and other social and environmental supports. Physician, hospital, laboratory, radiology, mental health and substance abuse services are outside the benefit package, but may be reimbursed on a fee for service basis through Medicare or Medicaid. Case managers are responsible for arranging and/or coordinating such services with the services covered by the program. The Commonwealth Fund has awarded a contract to the Urban Institute to conduct an independent

	evaluation of the program to determine the impact of capitation of long term care services on Medicaid and Medicare, health status of enrollees, client satisfaction, choice, and autonomy. The evaluation will also determine the impact of the contractor's organization on the outcomes cited and monitor the contractor's planning, implementation, and administration of the demonstration. In response to the request-for-proposals issued on March 15, 1996, the Department received seventeen proposals from which six programs and two alternates were selected in August 1996. The Medicaid contract with the sites has been drafted and sites are expected to start marketing and enrolling in December 1997.
Cooperative Home Care	This chronic care management demonstration program was authorized in law in 1997 through December 31, 2001, and is designed to test various methods of service delivery and financing for long term care. The Department of Health is authorized under this legislation to enter into a contract with Cooperative Home Care Associates, Inc. in conjunction with the Home Care Associates Training Institute, Inc. to develop chronic care management demonstration programs in order to test methods of coordinating the arrangement and provision of chronic or long term care services. Cooperative Home Care Associates received a promise of grant funding from various foundations in order to test capitated payments for disabled and chronically ill persons, but needed this enabling legislation in order to proceed. Enrollment in this demonstration is voluntary.
Long Term Integration and Finance Act of 1997	Enacted in 1997, this bill is designed to promote the development of a broader and more integrated continuum of long term care, financed by a range of private, public, and public/private options. Among other things, this bill extends authority for the currently approved managed long term care demonstration programs (Commonwealth Project, Cooperative Home Care, Continuing Care Networks), and establishes

	authority for twenty-four new managed long term care plans through 2006. Hospitals, nursing facilities, home care agencies, HMOs, and certain not-for-profit groups are all eligible to operate managed long term care programs. To be approved, applicants must demonstrate the program's relative cost effectiveness compared to other plans serving comparable populations. Plans must achieve full risk – become fully responsible, with no state liability – for all enrollees' comprehensive health and long term care benefit package as soon as feasible, and nor more than eight plans can be operating at one time which are not at full risk. Enrollment is voluntary, and plans are authorized to enroll, in total, 25,000 chronically ill and 25,000 non-chronically ill persons. Although the program guidelines require savings compared to other care delivery models, no actual savings are being projected at this time.
Managed Care Payment System for Waiver	The Developmental Disabilities Services Division of the Department of Human Services is planning a managed care system for payment of services to those citizens with developmental disabilities. The 1915(c) Home and Community Based Services Waiver is currently providing services on a fee for service basis. The services provided include residential, such as assisted living, foster care, group home, etc.; vocational; case management; assessment; communication; habilitation; behavior supports; respite; homemaker; health care; and accessibility, such as architectural modifications, assistive technology and mobility services. The annual waiver budget is in excess of $106 million. Information regarding potential cost savings as a result of the managed care initiative is not available.
Pennsylvania	*Elderly/Disabled*
Managed Care	Using a 1915(b) Medicaid waiver, mandatory managed care was implemented in the five southeastern counties

	care was implemented in the five southeastern counties of the state beginning in February 1997, with AFDC and the Healthy Beginnings eligibility groups. The remaining population, which includes disabled, blind, and persons over sixty-five, was added in September 1997. The HMOs are responsible for the payment of up to thirty consecutive days of nursing home care or service in a community-based care waiver program. Total cost for the program is $1.5 billion (state and federal) in 1997-98 which includes all benefits/services of the program. No savings are projected in the long term care appropriation. Mandatory managed care will be phased-in statewide with the next phase (ten counties in the Southwest corner of the state) beginning in January 1999.
Community-Based Care Waiver Program	The 1915(c) community-based care waiver program for people who are nursing home eligible was implemented in 1995-96 in Philadelphia County. The program was expanded in 1996-97 to 12 additional counties. Currently, there are 2,000 slots available to service individuals who require nursing facility level of care in the community. The cost of the program is $28.7 million in state and federal funds in 1997-98. No savings are projected in the long term care appropriation. These waivers were in counties that had a shortage of nursing home beds and in theory, prevented the construction of new beds. The cost of an equivalent number of new beds is $72 million in state and federal funds. Funds have been provided, beginning in 1997, for a two-year study of incentives to take nursing home beds off-line through the use of community options. No savings are budgeted as yet but each bed eventually closed has the potential of saving at least $7,200 per year.
Long Term Care Capitated Assistance Program	The program replicates the "On Lok" model in San Francisco, which provides managed care for nursing facility eligibles. Beginning in 1997-98, three demonstration sites will begin in Philadelphia and Allegheny counties. Services include nursing facility

	services, physician services, and pharmaceuticals. Total cost in 1997-98 is $779,000. No savings are projected in the long term care appropriation.
Utah	*Elderly/Disabled*
Aging Waiver	This program serves persons age 65 and over and provides home delivered meals, transportation, emergency response, adult day care, case management, respite care, homemaker, and supportive maintenance. In fiscal 1996, cost savings (program costs per capita are $22,466. Services under the Aging Waiver cost $4,720, while comparable institutional care cost $17,746.
Capitated Long-Term Care Demonstration Project	The Division of Health Care Financing (DHCF) in Utah is seeking proposals to implement a three-year capitated long-term care demonstration project in fiscal 1999. The goal of the program is to demonstrate the feasibility of capitating Utah's Medicaid long-term care program and providing quality services in a more holistic fashion to clients at a moderated cost to the division. The aim of the DHCF is to provide greater flexibility to contractors and allow them to furnish quality care to clients in the most appropriate and cost-effective setting through coordinated, innovative approaches. The project will focus on what efficiencies can be gained from capitating a program that has long been funded through fee-for-service arrangements. Contractors are expected to provide long-term health care in a variety of settings including nursing homes, assisted living, and other community living arrangements. Contractors will have complete responsibility for the day-to-day coordination and management of all client services beyond financial and medical eligibility. The state will retain the role of determining financial and medical eligibility, client education and choice of enrollment options, compliance monitoring and assisting, and if

	appropriate, development of the delivery system.
Developmentally Disabled/Mentally Retarded Waiver	This 1915(c) waiver serves the developmentally disabled and mentally retarded population. Services provided include community residential (day and hour), day treatment habilitation, supported employment, family support, respite care, waiver case management, pre-vocational day treatment. Cost savings in fiscal 1996 (program costs per capita were $27,608. Costs under the waiver were $23,775, while comparable institutional care cost $51,383.
Wyoming	*Elderly/Disabled*
Elderly Home and Community Based Services Waiver	Wyoming is not pursuing any managed care initiatives to control costs for long term care or special populations. Having the smallest population in the nation and being a frontier state does not lend itself to managed care economies of scale. However, several Medicaid waivers have been granted by Health Care Financing Administration in the last six years. Although cost savings was one reason for seeking the waivers, providing community based services was also an important factor. The elderly home and community based services 1915(c) waiver began in fiscal 1994. State general fund savings in fiscal 1994 totaled $0.9 million, fiscal 1995 savings totaled $2.3 million; fiscal 1996 savings totaled $2.2 million; and fiscal 1997 savings totaled $4.6 million. These "savings" are monies the state avoided paying because the waiver clients would probably have received nursing home care if waiver services were not available. While Medicaid expenditures have not decreased, they would have been higher without this waiver. Savings are achieved by serving clients in their homes instead of nursing homes or state institutions.

Florida	*Special Populations*
Project AIDS Care (PAC)	Project AIDS Care (PAC) is a 1915(c) waiver program that provides a wide array of home and community-based services, including adaptive equipment, adult live-in care, case management, chore service, day health care, education and support, home-based substance abuse treatment, home-delivered meals, homemaker, personal care, physical therapy, respite care, skilled care, and specialized personal care for foster children. PAC services are limited to individuals who have a medical diagnosis of AIDS, are determined disabled according to Social Security Administration standards, meet financial guidelines for the Institutional Care Program (income at or below 300% of the Federal Benefit Rate), and be certified as at-risk of hospital or nursing facility placement. PAC is a fee-for-service program that operates using specific managed care mechanisms. For example, all home and community-based services require prior authorization by case managers via a written plan of care. On average, Medicaid expenditures for persons enrolled in the PAC Medicaid waiver were $14,360 in 1994, $16,226 in 1995, and $17,700 in 1996. By comparison, Medicaid expenditures for non-waiver persons with institutional claims were $19,340 in 1994, $21,180 in 1995, and $21,848 in 1996.
Katie Beckett Model Waiver	The Katie Beckett Model Waiver is a program of home and community–based services provided under the authority of Section 1915(c) of the Social Security Act. This provision allows the State Medicaid Agency to waive comparability requirements in order to provide certain medical and supportive services to a specific target population. These services are provided as an alternative to more costly institutional placement that would be covered under Medicaid. The Katie Beckett Model Waiver provides case management and respite care. Services are limited to individuals under 21 years of age who have been

	diagnosed as having degenerative spinocerebellar disease, meet financial guidelines for the Institutional Care Program (income at or below 300% of the Federal Benefit Rate); and who have been determined at risk of hospital placement. This waiver is a fee for service program that operates using specific managed care mechanisms. For example, prior authorization of services is required by case managers via a written plan of care. While specific comparisons to an identical institutionalized population are not available, preliminary data comparing a similar population of medically complex children for fiscal 1997 is as follows: for the model waiver, the average expenditure per recipient is $3,900, while the average expenditure per recipient in the hospital is $14,465.
Medicaid Prepaid Mental Health Plan	The Medicaid Prepaid Mental Health Plan (PMHP) is a pilot project that uses a 1915(b) waiver with goals of improving access to care; developing acceptable care alternatives; promoting preventive care; reducing federal and state Medicaid mental health care spending; and testing 'carve out' vs. integrated models of mental health managed care. The contract was awarded to Florida Health Partnership. Covered services include mental health related inpatient and outpatient, physician services, community mental health services, and targeted case management. Recipients who are assigned to MediPass for physical health care are assigned to the Florida Health Partnership for behavioral health care. Eligibility groups include AFDC, SSI without Medicare, OBRA, Foster Children (including Emergency Shelter and Adoption Subsidized).
Prescribed Pediatric Extended Care (PPEC) and Medical Foster Care (MFC) Programs	These two programs (each described separately below) were established through Medicaid in the early 1990's under the authority of Title XIX of the Social Security Act. They have proven to be very cost-effective as well as "environmentally" and medically beneficial to the

	Medicaid eligible medically complex children under 21 years of age in Florida. Many of the children receiving these services are presently enrolled in Medipass, a primary care physician program and neither PPEC nor MFC has required that a recipient be linked to a managed care program. The purpose of prescribed pediatric extended care services is to enable children with medically complex conditions or the need for acute medical care to receive medical care at a non-residential pediatric center.
Prescribed Pediatric Extended Care (PPEC) Program	PPECs provide a cost effective and less restrictive alternative to institutionalization and reduce the isolation that homebound children may experience. A PPEC is a rehabilitative facility that serves three or more children under the age of 21 who require short or long term continual medical care due to medically complex conditions or the need for acute medical care. A PPEC offers services that meet the child' physiological, developmental, physical, nutritional and social needs. Medicaid reimburses a PPEC with a per diem rate for providing medically necessary services such as nursing, personal care, developmental therapies, and caregiver training. In fiscal 1997, Medicaid reimbursed approximately $6 million for $35,000 days of PPEC services.
Medical Foster Care (MFC) Program	The Medical Foster Care Program is a coordinated effort between the Florida Medicaid program in the Agency for Health Care Administration, the Division of Children's Medical Services in the Department of Health, and the Foster Care program in the Department of Children and Families, Family, Safety, and Preservation, to provide family based care for medically complex children who cannot safely receive care in their own homes. The Medical Foster Care program establishes and supervises the oversight, recruitment, training, and selection of licensed foster parents to provide medical foster care services for children with specialized medically complex needs. The medical foster parents are responsible for

	performing most of the day-to-day functions necessary for the child's care. This program is a cost-effective alternative to hospitalization and skilled nursing facilities and is part of the continuum of care for medically complex children. Medicaid reimbursed medical foster care parents/providers for their role in helping meet the goals of this program: to enhance the quality of life for medically complex and medically fragile foster children, allowing them to develop to their fullest potential; and to provide a family-based, individualized therapeutic milieu of licensed medical homes to reduce the high cost of long term institutionalization of medically complex and medically fragile foster children. Medical Foster Care expenditures for fiscal 1997 totaled approximately $3.2 million dollars for 4,500 days of care. Although information that would demonstrate a cost savings is not readily available, Florida Medicaid has been satisfied that both programs have significantly reduced the possibilities of hospitalization/long term care in many instances, which, naturally affects the reduction of expenditures to those types of facilities. Additionally, these services have allowed medically complex children to function in less restrictive and more family and community based settings while continuing to receive child specific medically necessary services.
End Stage Renal Disease Management Demonstration	In September of 1996, Health Options, a subdivision of Blue Cross/Blue Shield of Florida was one of four sites that awarded a HCFA grant for the End Stage Renal Disease Management Demonstration program (a Social HMO's carve-out). The program is to develop a managed care approach in health care service delivery for persons with kidney failure. The Health Options demonstration service area includes three counties in south Florida. The demonstration will run for a three year operational period and Health Options expects to begin enrolling members with end stage renal disease in early 1998. To be eligible to join this program, a person with end

	stage renal disease must have Medicare Parts A and B as their primary insurance. HCFA is requiring that the End Stage Renal Disease Management demonstration programs develop an agreement with Medicaid for a capitation payment to cover items covered by Medicaid only for the dual eligible individuals.
Illinois	*Special Populations*
Home Services Program (HSP)	The Home Services Program (HSP) is a Medicaid waiver program that offers individuals with disabilities who are at risk of premature or unnecessary institutionalization the alternative of in-home care when the cost of home care does not exceed the cost of a health care facility. State-employed Rehabilitation Counselors and Coordinators perform eligibility determinations and reassessments, are responsible for service delivery and case management issues, develop customer service plans, maintain documentation in customer case files, advocate and perform other duties related to the provision of services to customers. Eligibles include people under the age of 60 who, at the time of application unless applying for the AIDS waiver program have a severe disability that will last for at least twelve months or the duration of life; must apply for Medicaid and not be receiving services from other Medicaid waiver programs; have at least the minimum score on the Determination of Need (DON); have physical approval as to the appropriateness and safety of the service plan; are able to live at home with services which cost the same or less than the cost of nursing home care; have less than $10,000 in non-exempt assets if age 18 or older, or less than $30,000 in family assets if under age 18; and are a resident of Illinois and a U.S. citizen or legally admitted. In fiscal 1997, spending was approximately $109 million for 152,216 client months.
Family Assistance Program	The Family Assistance Program serves children with a mental illness or developmental disability who are in

Program	danger of being placed out of their homes. The child must reside with his/her natural, adoptive, foster or legal family and the family must have a federal taxable income less than $50,000. This program provides an allowance to families equal to the amount of a monthly federal SSI payment to help defer the cost of keeping their special needs child in their home rather than placing the child in a state operated facility or a community residential setting. The monthly payments may be used for childcare, purchase of special equipment, family counseling and home remodeling to meet the needs of the child. All major expenditures must be pre-approved. The applicant families must reapply each year and detail how the previous year's funding was spent. Spending for fiscal year 1997 was $2.7 million.
Home Based Support Services	Home Based Support Services serves adults with a mental illness or developmental disability over the age of 18 who reside in Illinois. These individuals must live in their own apartment and not require 24 hour professional care. The individual receives funding based upon their service needs, but the funding level cannot exceed 200% of a monthly federal SSI payment if the adult is in school or 300% of a monthly federal SSI payment if the adult is not in school. The individuals may choose services that will allow them to stay in their home, enhance their skills or even purchase tangible items that are necessary to remain in their home. Spending for home based support services was $5.3 million in fiscal 1997.
Nebraska	*Special Populations*
Medicaid Managed Care for Mental Health/Substance Abuse	The managed care program for mental health/substance abuse, a 1915(b) waiver, served 98,000 Medicaid eligible recipients in fiscal year 1997. Services provided include therapy services through clinics, inpatient psychiatric facilities, and residential treatment centers. The cost of capitation payments for the program in fiscal 1997 was $39 million with cost

	savings of $11 million.
New Jersey	*Special Populations*
Traumatic Brain Injury Waiver	The traumatic brain injury waiver is a 1915(c) Medicaid waiver for severely brain injured persons aged 22-65. The services include intensive home and community based therapies as an alternative to institutional placement. The program cost for 150 slots in fiscal 1997 was $8.8 million, with the state paying half and the federal government paying half.
AIDS Community Care Alternatives Program (ACCAP)	The AIDS Community Care Alternatives Program is a 1915(c) Medicaid waiver for AIDS diagnosed or HIV and SSA disabled children or adults. Services include all Medicaid services plus eight additional services as an alternative to nursing home care. The cost for 1,000 slots in fiscal 1997 was $7.5 million, with the state paying half and the federal government paying half.
New York	*Special Populations*
Managed Care Special Needs Plan	Under its 1115 Medicaid managed care waiver, approved in July 1997, New York will establish Special Needs Plans (SNPs) to provide managed care to Medicaid recipients who have HIV/AIDS or who are seriously mentally ill. These plans will offer comprehensive, targeted case management services to address the unique circumstances of these populations. Voluntary enrollment in these programs is expected to begin in 1998-1999 with mandatory enrollment occuring after general health HMOs are established. State legislation limits the number of SNPs statewide to 12 HIV/AIDS SNPs and 6 adult mental health SNPs that likely will cover multi-county areas. The HIV/AIDS SNPs will provide primary and specialized care for persons who are HIV-positive or

	have symptomatic AIDS. Mental health SNPs will be responsible for a full range of mental health and related support services and will coordinate with recipients' regular managed care primary health care providers. The fiscal parameters of the SNP program model are under development.
Oklahoma	*Special Populations*
Pilot Managed Care Project Initiative	Plans for a pilot managed care project for indigent, non-Medicaid consumers who receive services funded by the Department of Mental Health and Substance Abuse Services were finalized in fiscal 1997. Services will include substance abuse and mental health treatment services; emergency, prevention, and domestic violence services are not included in the pilot program. Cost savings are not expected; resources will be diverted to expand community based care.
Pennsylvania	*Special Populations*
Developmentally Delayed Children Services	Services are provided through grants to counties that have a wide variance in treatment practices and costs. Often treatment plans were provider or family driven. To increase efficiency and reduce the occurrence of unnecessary treatments, the Department of Public Welfare implemented a policy that any county with above average cost per patient would be allocated 10% less funds or be reduced to the average cost per patient - whichever was higher. Counties are still expected to provide all necessary treatments and the cost for any individual is not limited to the average cost. The current average cost of Early Intervention is $7,100 per patient per year. The program was implemented in 1996-97 with cost savings of $2.8 million and estimated savings of $2.2 million for 1997-98.

Mental Health and Mental Retardation Programs	Under a 1915(c) waiver, clients are being moved from large mental health and mental retardation institutions to family or community settings. Institutional costs average $120,000 per client/year. Family based services average $30,000 annually. Community residential services can exceed $100,000 so savings are modest. The full savings cannot be realized during the transition process. Nevertheless, the large, old institutions have high maintenance costs and most would require significant capital investments that have been avoided. Since 1994, nine institutions have been closed.
Utah	*Special Populations*
Technology Dependent/Medically Fragile Waiver	This waiver serves persons from birth – 20 who are dependent on technology or medically fragile. Services provided include case management, respite care, respiratory care, nutrition evaluation, nutrition treatment, portable oxygen, family counseling. For fiscal 1996, cost savings were $55,447 (program costs per capita). Spending under the waiver is $25,117, while comparable institutional care is $80,564.
The Utah Self-Determination Project	Over a three-year period, the Division of Services for People with Disabilities through the Utah Self-Determination Project is transforming the design and delivery of its services from a system driven by professionals to a system of self-determination by the people who receive services. The goal is to have at least one third of the people served by the division exercising self-determination, and a majority of the divisions staff and "provider" agencies functioning under the self-determination model by the end of the three year period. The project is funded by a grant from the Robert Wood Johnson Foundation and Utah state funds. It is implemented in all regions of Utah and in partnership with people with developmental disabilities, families, advocates, private

	agencies or "providers" that work with people with developmental disabilities. The self-determination approach to service delivery includes: • Identifying lifetime goals and the help needed for achieving them within the community • Assistance by a "circle of support" which includes families, friends, and selected professionals to decide the service options that meet the individual's needs and goals • Providing opportunities to participate in the community similar to others • Carrying out a number of formal processes and mechanisms, including person-centered planning, person-centered budgeting, self and peer advocacy • Using third parties to provide assistance in identifying, obtaining, providing and coordinating desired services and supports.

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