

Home And Community-Based Services For Older People And Younger Adults with Physical Disabilities In Kentucky

Final Report

Prepared for:

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

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**Jane Tilly
The Urban Institute
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INTRODUCTION

Kentucky, a fairly small Southern state with about 4 million people in 1999¹, provides home and community services to a substantial number of aged and physically disabled adult beneficiaries through its Medicaid home health benefit and the Home and Community-Based Services (HCBS) waiver. In 2000, the state expects to serve over 18,000 beneficiaries through the home health benefit and over 15,000 beneficiaries through HCBS waiver. These two programs can be characterized as traditional in that they rely largely on an agency-based model for provision of services. The state also has a large, agency-based, state-funded Home Care program, along with several other smaller state-funded programs. Despite the size of Kentucky's home and community services programs, nursing home care dominates the state's long-term care system.

Kentucky has expanded its home and community services programs steadily over the years, including implementation of two new Medicaid waivers in 1999. Innovations, such as consumer-directed services and coverage of assisted living facilities, do not play a large role in Kentucky's system.

This paper analyzes the home and community-based service system for older persons and younger adults with physical disabilities in Kentucky, focusing on the state administrative structure for home and community services, eligibility and assessment, services covered by Medicaid and other programs, cost containment, and quality assurance. This report also summarizes government officials' and key stakeholders' opinions about how well the Medicaid and state-funded programs work.

Information was obtained from public documents, state of Kentucky web sites, and interviews with state officials, consumer representatives and provider associations. Interviews were conducted in person in Frankfort, Lexington, and Louisville, Kentucky, during July 2000. Questions were asked using a structured, open-ended interview protocol. To encourage candor

¹ www.census.gov

in their answers, respondents were told that they would not be quoted by name or identified by type of respondent within a state (e.g. home health industry representative in Kentucky).

THE LONG-TERM CARE SYSTEM IN KENTUCKY

Kentucky has a slightly higher-than-average supply of nursing home beds and a substantial number of home health agencies. The state had 326 nursing facilities with 27,000 beds in 1998—55 beds per 1,000 persons age 65 and over, compared with a national average of 52.5.² Nursing facilities in Kentucky are primarily small and family-owned. The few chains are not affiliated with large national corporations. In 1998, Kentucky had a relatively low supply of nonmedical residential facilities —506 licensed residential facilities with a total of 7,678 beds—15.6 beds per 1,000 persons age 65 and over compared to the national average of 25.5.³

In fiscal year 2000, state officials report that 124 home health agencies were enrolled as Medicaid providers with 108 also participating in the HCBS waiver. According to the Kentucky Home Health Association, about half of the agencies in the state are part of state or national chains and every county has a minimum of two to three agencies from which beneficiaries can choose.

State officials report that Kentucky's Medicaid long-term care expenditures (nursing facility, intermediate care facilities for the mentally retarded (ICF/MRs), home and community-based services waivers, and home health) totaled \$710 million in fiscal year 1998, 11.25 percent of which were for home and community-based waiver services and home health.

PROGRAMS AND ADMINISTRATIVE STRUCTURE

Charts 1-3 summarize the characteristics of Kentucky's home and community service programs. The state has three large programs that provide the bulk of publicly-funded home and community services in the state. Medicaid's home health benefit served about 18,000 beneficiaries who had skilled or personal care needs in state fiscal year 2000. In the same time

² Harrington C, Swan JH, Wellin V, Clemena W, Carrillo HM, *1998 State Data Book on Long-Term Care Program and Market Characteristics*, University of California at San Francisco, January 2000.

³ Ibid.

period, the HCBS waiver served about 14,000 aged and disabled beneficiaries who would have otherwise been eligible for nursing home care. Administration of the Medicaid home health benefit is split between the Division of Long-Term Care and the Division of Physical Health, which are housed in the Cabinet for Health Services. The former pays home health agencies and the latter handles policy matters and day-to-day operations of the home health benefit. All responsibility for the HCBS waiver rests in the Division of Long-Term Care. There is no role for local government in managing the two Medicaid programs, which operate completely independently of the state-funded home and community services programs.

The Office of Aging Services, also located within the Cabinet for Health Services, administers three state-funded programs and two new Medicaid waivers, which are similar in structure to the state-funded programs. The largest program—the state-funded Home Care Program for the Elderly—provided personal care, home maker, and chore services to 12,200 beneficiaries age 60 and over in state fiscal year 1999. The Office also manages two much smaller programs. The Personal Care Attendant Program for Physically Disabled Adults (PCAP) had 270 participants age 18 and over in state fiscal year 1999. The Adult Day/Alzheimer’s Disease Respite Program (AD/ADR) served 1,400 persons in the same time period. The Office of Aging Services allocates funding for the three state-funded programs to Area Agencies on Aging, which reside within Area Development Districts.

The two new Medicaid waivers are called the Home Care and the Personal Care Assistance Waivers. The state is using a portion of the funding previously devoted to the state-funded Home Care and PCAP programs as the state’s Medicaid matching funds for the new waivers. In fiscal year 2000, the new Home Care Waiver had approval to serve 990 unduplicated participants age 60 and over and the new Personal Care Assistance Waiver had approval for 82 adults age 18 and over. The new waivers are designed to reduce waiting lists for the state-funded Home Care and PCAP programs. Observers noted that implementation of these waivers has been slow but state officials say that Area Agencies on Aging have begun enrolling the providers who will provide services to participants.

Chart 1: Kentucky Medicaid Programs, Cabinet for Health Services

	Mandatory Home Health Benefit	Home and Community-Based Services Waiver
Year program started		Existing Statewide in 1987
Administrative responsibility	Division of LTC sets overall policy and oversees HHAs' and PRO's activities. Home health agencies (HHAs) do assessment, case management and service delivery. No level of care criteria or prior authorization necessary. Peer Review Organization (PRO) reviews service delivery.	Division of LTC sets overall policy and has oversight responsibility. Home health agencies (HHAs) do assessment, case management and service delivery. Peer review organization determines whether applicants meet the nursing home level of care criteria for waiver services and does prior authorization of services.
Functional eligibility	Physician must order services. People with personal care needs only receive services.	Physician must make referral to program and sign care plan. Adult Day Health Care requires a physician's signature. Nursing home level of care – on a daily or intermittent basis a person: 1) needs high intensity nursing or rehabilitation services or services, 2) the complexity of services requires supervision of technical or professional personnel, 3) has an unstable medical condition, or 4) needs continuous personal care or supervision.
Financial eligibility	Categorically or medically needy.	Categorically or medically needy or 300% rule for income test. Spousal impoverishment protections available including \$87,000 protected assets; amount is indexed for inflation.
Number of beneficiaries	FY99 – 18,000 participants FY00 - 18,418 participants	FY99 unduplicated participants 11,561 FY99 slots by age 0-22 653 23-45 1,184 46-65 2,667 65+ 7,260 FY00- 13,835 unduplicated participants of home and community-based services, with an additional 1661 participants of adult day health care.
Funding source	Medicaid	Medicaid
Expenditures (FY00)	FY00 - \$56.6 million	FY00 - \$39.8 million on home and community-based services, with an additional \$12.4 million on adult day health care.
Covered services	Skilled services Personal care services Services can be delivered in personal care homes.	Assessment. Case management. Attendant care not to exceed 45 hours a week for those with stable conditions, whose informal support is unable to provide services during working hours, and who need 6-8 hours of service a day with supervision. People receiving attendant care cannot also receive personal care, adult day health care, or homemaker services. Personal care. Homemaker services. Adult day health care. Home adaptations not to exceed \$500 a year. Respite (not available in institutions) not to exceed \$4,000 a year. Services must be received in a person's home or an adult day care center and cannot be delivered in personal care homes.

Chart 1: Kentucky Medicaid Programs, Cabinet for Health Services, continued

	Mandatory Home Health Benefit	Home and Community-Based Services Waiver
Consumer-direction	Not available.	Not available.
Cost containment mechanisms	<p>RN visits limited to twice a day.</p> <p>CON for HHAs.</p> <p>HHAs must demonstrate that they have been denied Medicare home health reimbursement for beneficiaries who might be eligible.</p> <p>HHAs have cost-based reimbursement limited to 130% of median HHA costs for each service.</p>	<p>Certificate of Need for HHAs.</p> <p>Aggregate cost cap of \$3,557 a year per recipient in FY99, \$3,778 in FY00.</p> <p>HHAs have cost-based reimbursement limited to 130% of median HHA costs for individual services.</p> <p>Personal care attendant services limited to \$11.50 an hour.</p> <p>Adult day care payments: level 1 limited to \$28 a half day and level 2 is \$34 a half day.</p> <p>The Peer Review Organization sends any care plans where costs exceed \$3,000 a month to the state for review and approval.</p>
Quality assurance mechanisms	<p>HHAs must meet Medicare certification standards.</p> <p>HHAs must have quality improvement councils.</p> <p>PRO pulls a random sample of cases and a subset of this sample receive home visits. The state occasionally reviews the PRO as it does its work.</p>	<p>Medicaid is revamping its quality assurance system to comply with HCFA's new protocol.</p> <p>PRO pulls a random sample of agencies' cases and a subset of this sample receives home visits. The agency receives several days advance notification of the audit and which records will be audited.</p> <p>The state receives a sample of 50 completed records monthly from the PRO and the state monitors them for problems. The state periodically reviews the PRO as it does its work.</p> <p>Adult day health care centers must have state licensure.</p> <p>HHAs must meet Medicare certification standards.</p> <p>HHAs must have quality improvement councils.</p> <p>Nurses make supervisory visits in a person's home every 60 days.</p> <p>Adult day care regulations are being rewritten. In the new system, the PRO will have responsibility for reviewing adult day health care centers, while Office of Aging Services will continue reviewing adult day care centers which fit the social model.</p>

Chart 2: New Kentucky Medicaid Waivers

	Personal Care Assistance Waiver Services	Home Care Waiver Services
Year program started	1999	1999
Administrative responsibility	The Office of Aging administers the waiver through a memorandum of understanding with Medicaid. Fiscal agent pays the personal care coordinator and peer review organization determines whether applicant meets nursing facility level of care criteria.	The Office of Aging administers the waiver through a memorandum of understanding with Medicaid. Fiscal agent pays workers. Agencies doing case management cannot do service delivery. PRO determines if applicant meets nursing facility level of care.
Functional eligibility	Cognitively intact persons age 18 or older needing a nursing facility level of care and having a functional loss of two or more limbs. Annual reassessments.	Persons age 60 or older meeting a nursing facility level of care. Annual reassessments.
Financial eligibility	Categorically or medically needy or 300% rule for income test. Spousal impoverishment protections available including \$87,000 protected assets; amount is indexed for inflation.	Categorically or medically needy or 300% rule for income test. Spousal impoverishment protections available including \$87,000 protected assets; amount is indexed for inflation.
Number of beneficiaries	75 slots in 1999. 82 slots in 2000.	990 slots in 2000.
Funding source	Medicaid and Office of Aging Services general funds	Medicaid and Office of Aging Services general funds
Expenditures (FY00)		
Covered services	Case management; Personal care assistance; Personal care program coordination. Assistance is available outside the home. Services not available in group residential settings. Participants direct these services.	Case management; Homemaker; Personal care; Environmental accessibility adaptations of \$1,000 a year. Services not available in group residential settings.
Consumer-direction	Yes.	Not available.
Cost containment mechanisms	Payments to workers are the lessor of usual charge, or maximum hourly rates. Personal care limited to \$3.08 per ½ hour.	Payments to agencies are the lessor of usual charge, or maximum hourly rates. Personal care limited to \$9.75 per ½ hour.
Quality assurance mechanisms	Providers of case management and personal care must be certified to participate in Medicaid by the Office of Aging Services.	Workers must have at least 16 hours of training before providing services and 44 hours within first 6 months of employment. 6 hours of continuing education required. Providers must supervise workers on-site at least once a month. Providers must be certified to participate in Medicaid by the Office of Aging Services.

Chart 3: Kentucky State-Only-Funded Programs in Office of Aging Services, Cabinet for Health Services

	Personal Care Attendant Program for Physically Disabled Adults (PCAP) or Personal Care Assistance Services	Home Care Program for the Elderly	Adult Day and Alzheimer's Respite Program
Year program started	1982	1983	Late 1980s
Administrative responsibilities	<p>Office of Aging Services allocates funds to 10 Area Agencies on Aging, which contract with "provider agencies" via a competitive bidding process to provide program coordination and to pay attendants. 5 AAAs do not request funding from this program. Office monitors AAAs at least annually and reviews program activity monthly.</p> <p>The provider agencies recruit potential participants, assess their competence to manage services, provide 10 hours of initial training, and help arrange for emergency backup, and pay workers.</p> <p>Beneficiaries must recruit, hire, train, supervise, fire attendants and calculate payroll taxes.</p>	<p>Office of Aging Services allocates funds to 15 Area Agencies on Aging. Area Agencies must submit proposals that consist of an area plan that assures delivery of covered services and specifies relevant procedures.</p> <p>AAAs do assessment, case management, and service monitoring using procedures they devise themselves. They contract with providers using a competitive bidding process.</p> <p>The Office monitors the administration of programs annually, which includes a review of the Area Agencies on Aging monitoring, assessment, and case management.</p>	<p>Office of Aging Services allocates funds to 15 Area Agencies on Aging. Agencies must submit proposals that consist of an area plan that assures delivery of covered services and specifies relevant procedures. The Office annually monitors the Area Agencies' administration of the program and certifies adult day social care providers every two years.</p>
Functional eligibility	<p>Must be age 18+.</p> <p>Must have functional limitations in the use of two limbs.</p> <p>Need at least 14 hours of services a week or an attendant at night and need for services does not exceed 40 hours a week.</p> <p>Live in a non-institutional setting.</p> <p>Capable of directing attendants.</p> <p>Provider agencies do annual reassessments.</p>	<p>Must be age 60+.</p> <p>Have impairments in 2 ADLs or 3 IADLs, or have mental or emotional impairments if these impairments affect physical functioning; or</p> <p>Stable medical condition requiring an institutional level of care; or</p> <p>Currently residing in a nursing facility and can be maintained at home with supports.</p> <p>Twice yearly assessments.</p>	<p>Age 60+, physically-disabled, and in need of supervision; or</p> <p>Age 60+, mentally confused, and in need of supervision; or</p> <p>Age 60+, benefit from services; or</p> <p>Any age with a diagnosis of dementia.</p>
Financial eligibility	<p>Annual income test is 60% of median income for a family of one. Deductions from income include unreimbursed medical and disability-related expenses and \$1,260 a year for cost of living. Adjusted gross income is then divided in half and people cannot qualify for the PCAP if this figure exceeds 60% of median income.</p>	<p>The program has a cost-sharing schedule — single persons with incomes exceeding \$16,651 pay 100% of service costs. However, case managers consider extraordinary out-of-pocket expenses when determining a client's ability to pay for services.</p>	<p>The program has a cost-sharing schedule — single persons with incomes exceeding \$16,651 pay 100% of service costs. However, case managers consider extraordinary out-of-pocket expenses when determining a client's ability to pay for services.</p>
Number of beneficiaries	FY1999-270 participants. 300 slots available in 2000.	FY1999 – 12,200 persons served with 4,236,200 units of ½ hour services.	FY1999- 1,400 persons served with 1,069,200 units of 12 hour services.
Funding source	State funds.	State funds.	State funds.
Expenditures (FY2000)	\$2.36 million	\$15.5 million	\$2.67 million

**Chart 3: Kentucky State-Only-Funded Programs in Office of Aging Services,
Cabinet for Families and Children, continued**

	Personal Care Attendant Program for Physically Disabled Adults (PCAP) or Personal Care Assistance Services	Homecare Program for the Elderly	Adult Day and Alzheimer’s Respite Program
Covered services	Program provides a “subsidy” or financial reimbursement through the contracting agency to the beneficiary. The participant must use the subsidy to pay a personal care attendant to assist with ADLs, IADLs, ambulation, and emergency procedures. Assistance is available outside the home. Services are available in acute care settings but not in group residential settings.	Assessment, case management, homemaker, home health aide, chore, home-delivered meals, escort, home repair, respite, & personal care services including ADLs & IADLs. Services cannot replace available informal support. Services not available in group residential settings.	Adult day care includes self-administration of medications, personal care, self-care training, social activities, and recreational opportunities. In-home respite services available for those with a dementia diagnosis.
Consumer-direction	All participants direct their services.	Not available.	Not available.
Cost containment mechanisms	Office of Aging Services establishes a \$7 maximum hourly rate and \$16 nightly rate for attendants. Maximum hours per week are 40. Area Agencies on Aging receive a fixed budget for PCAP. Program has a waiting list of about 600 for services.	AAAs put out an RFP for agency services and agencies must bid on a 30 minute visit rate. Program has a 3,000 person waiting list.	
Quality assurance mechanisms	Provider agencies must monitor services at least quarterly.	Case managers monitor participants monthly and visit them bi-monthly. Case manager caseload limited to 100 participants.	Social model adult day care centers must meet state certification criteria set by the Office. The health model adult day care centers must meet state licensing standards. One staff person must be available for every 5 participants.

ELIGIBILITY CRITERIA AND ASSESSMENT

Eligibility criteria for the programs vary. The Medicaid home health benefit simply requires that a physician order services. Home health beneficiaries generally start off with a skilled need but often, over time, receive only personal care services. Medicaid contracts with the peer review organization to periodically review a random sample of beneficiaries to determine whether they need services.

To receive services under any of the Medicaid waivers, an applicant must meet a nursing facility level of care, which involves 1) daily or intermittent nursing or rehabilitation services, 2) complex services delivered under the supervision of professionals, 3) a complex medical condition, or 4) need for continuous personal care or supervision. The new PCAP waiver requires participants need a nursing facility level of care as well as have functional loss of two or more limbs. In the opinion of some stakeholders, the nursing facility level of care criteria rely too heavily on professional judgement.

Home health agencies conduct the assessment, do the case management, and usually provide the services in the HCBS waiver. However, in the new PCAP and Home Care waivers, agencies cannot do assessments for and provide services to the same participants. The peer review organization examines home health agencies' assessments and care plans to determine whether beneficiaries meet the level of care criteria and are receiving the appropriate number of units of service. The peer review organization's review activities are designed, in part, to address the possible conflict of interest on the part of home health agencies in their dual role of both authorizing and providing services.

Stakeholders stated that the peer review organization began interpreting the level of care criteria more strictly in 1996 and, as a result, four or five people were discharged from nursing homes or lost waiver services. Their plights received a great deal of media attention and the legislature held several hearings about the problem. The regulations had not changed but the peer review organization's interpretations of them had. Stakeholders attributed the discharges to the Medicaid program asking the organization to tighten up its eligibility reviews and to some assessors not providing sufficient documentation of applicants' medical needs. In response to

media and legislative attention, the state modified its existing appeals process by developing an explicit mechanism for contesting level-of-care decisions.

Categorically eligible or medically needy individuals may receive the Medicaid home health benefit, while the Medicaid waivers allow persons with countable income at or below 300 percent of Supplemental Security Income levels to receive services. Unlike some states, Kentucky extends spousal impoverishment protections to waiver participants' spouses.

The state-funded PCAP program requires that a person have limitations in the use of two limbs, be age 18 or older, and be mentally capable of directing workers. In addition, beneficiaries must need at least 14 hours of services a week. The state-funded Home Care Program requires that people age 60 and over have impairments in two activities of daily living or three instrumental activities of daily living, or mental impairments that affect physical functioning. To receive services in the AD/ADR program, people must be at least age 60 and have a physical disability or need supervision, but the respite program allows people of any age to receive services if they have a diagnosis of Alzheimer's disease or related dementia.

The state-funded programs have no income or asset test; rather they impose an income-related cost-sharing schedule, which is periodically changed by regulatory action. Currently, single persons, with a countable annual income of \$16,500 a year or more, must pay 100 percent of costs. Certain expenses, such as those that are medical in nature, can be deducted from a person's gross income to determine countable income for the purposes of the cost-sharing schedule. The majority of state program beneficiaries have incomes below \$8,000 a year and do not have any cost-sharing responsibility.

CASE MANAGEMENT AND SERVICE PLANNING

Home health agencies provide case management for Medicaid's home health benefit and the HCBS waiver. In contrast, under the two new Medicaid waivers, Area Agencies on Aging can apply to be certified as case management providers. For the state-funded Home Care Program, all but two of the 15 Area Agencies on Aging conduct assessments and provide case management.

Opinions about case management in Kentucky vary. Some observers say that state and home health agency case managers are good at coordinating care and maximizing use of services, such as those from charitable organizations that are available in the community. Others say that expenditures for case management services are too high and that case managers do not attend to participants' preferences for services. According to these observers, case management is "another way to control participants' lives." One stakeholder pointed to two advantages of having case management reside within home health agencies: 1) agency case managers can easily coordinate beneficiaries' home and community services with health services, and 2) case managers, who generally are social workers, participate in the agency team meetings about beneficiaries.

In the state-funded PCAP program, participants direct their own services, rather than rely on case managers. Area Agencies on Aging contract with agencies (generally independent living centers) to provide program coordinators to help participants find attendants or train participants about their management responsibilities on an as-needed basis. The new Medicaid personal care assistance waiver requires that program coordinators pay attendants because federal rules for home and community-based services waivers prohibit beneficiaries from receiving their benefits in cash.

SERVICES

Kentucky's Medicaid home health benefit covers skilled and personal care services in beneficiaries' homes or in personal care homes. The HCBS waiver covers personal care, attendant care, homemaker services, adult day care, home adaptations and respite care to people living in their own homes. Waiver services are not available outside of the home with the exception of the adult day care benefit. Services in both programs, as well as the new waivers, can include getting a beneficiary ready to go to work or school. Under the state-funded PCAP and new Personal Care Assistance Waiver programs, participants can receive attendant services outside of their homes.

The state-funded Home Care Program services are assessment, case management, personal care, homemaker, home health aide, escort, minor home repair, chore, respite and meals. Beneficiaries generally must receive services in their homes. Also, the program is

designed to be gap filling; that is, the program is a last resort for those who cannot get their needs met elsewhere. The state-funded AD/ADR program covers services in adult day care centers that follow either the health or social model and provides some in-home respite for the caregivers of participants with dementia.

Some government staff believe that current home and community services programs meet most needs. However, others consider the scope of current Medicaid services to be too limited. For example, Medicaid does not cover transportation unless it is necessary for receipt of Medicaid services. Some observers say that this is a barrier to employment because people with disabilities cannot get to work without transportation. In addition, some observers stated that Medicaid home health agency services are medically oriented and skilled care is not always necessary. An example given was that of a nurse coming every two weeks to take a beneficiary's temperature and blood pressure, even when the person had a stable condition.

The number of persons using adult day care under the HCBS waiver has grown rapidly over the last several years because a number of large, national adult day care companies have undertaken aggressive marketing campaigns directed at younger persons with cerebral palsy, mental retardation, and developmental disabilities. As a result, in FY98-99, 1,489 Medicaid HCBS waiver participants attended such centers. Transportation to these centers is considered medically necessary and thus Medicaid's transportation benefit pays the costs.

Waiver services cannot be delivered in personal care homes because these facilities are prohibited by state regulations from serving people who meet a nursing home level of care. This is in contrast to the Medicaid home health program where agencies can deliver services in personal care homes because beneficiaries do not have to meet the nursing facility level of care criteria and these facilities are considered to be the beneficiary's home.

Observers reported that assisted living facilities and personal care homes serve different clientele. People who live in personal care homes are largely younger people with mental impairments, while assisted living facilities' residents are largely wealthy, older persons with disabilities. Views were mixed about whether Medicaid should cover services in assisted living facilities. While some said that such facilities are "ideal because residents have choice over

living arrangements, meals, and the services they use,” others viewed assisted living facilities as equivalent to nursing homes.

Medicare’s home health reimbursement changes have not affected the Medicaid home health benefit or the industry to any great degree; there have been no unusual increases in the numbers of Medicaid participants served and few agencies have gone out of business. Certificate of need for home health agencies has kept provider supply under control so Kentucky did not experience the same level of growth in agencies as did the rest of the country in the late 1990s. As a result, existing home health agencies have sufficient beneficiary volume to remain in business.

CONSUMER DIRECTION

Three of Kentucky’s programs are consumer-directed, but they are quite small. In the state-funded PCAP program and the Medicaid personal care assistance waiver, participants must be cognitively intact and have the capacity to recruit, hire, and manage workers. In the state-funded PCAP program, participants must also pay employment taxes. There also is a state-funded supported living program that gives small cash grants to people with disabilities, which they decide how to use.

Views about consumer-direction were mixed. Some government staff support the concept because they believe that beneficiaries who are in control have good self concepts and quality of life. In addition, they believe participants are able to take “nominal amounts of money and hire people to deliver skilled services.” Other staff had concerns about safety and believed that extending consumer-direction to those with cognitive impairment would be problematic because they are not capable of managing services. Currently, people who cannot manage services are not able to participate in the state’s consumer-directed programs.

Stakeholders’ views also were mixed. Some observers contended that people want to control their services and are capable of managing the money and purchasing services efficiently. However, in order for consumer direction to work effectively, they argued that older beneficiaries need access to supportive services such as those available to younger persons with disabilities through independent living centers. In addition, they noted that families would like

the ability to arrange services and maintain control even when beneficiaries cannot do so. On the other hand, since Kentucky does not require training for individual workers, some stakeholders thought beneficiaries would be more vulnerable to quality problems under consumer-direction.

COST CONTAINMENT

In recent years, Kentucky's Medicaid program has emphasized cost containment. The current administration was quoted as saying that any new money for home and community services will have to come from the current funding devoted to institutions. In a related action, in 2000, the General Assembly passed a bill to study the state's long-term care system, including the allocation of resources across provider type.

Kentucky currently uses several methods of containing costs under its home and community services programs, including aggregate caps on waiver spending, limits on payments to some providers, competitive bidding for providers participating in the state-funded programs and waiting lists for those programs, and strong certificate of need laws for nursing homes and home health agencies.

Kentucky uses aggregate cost caps for the waiver; the average cost per participant was limited to \$3,778 in fiscal year 2000. The state does not impose individual limits on the cost of beneficiaries' waiver services, but one stakeholder asserted that it is very difficult to receive waiver services exceeding 2.0–2.5 hours a day. The average annual per beneficiary waiver expenditure is \$3,500, well below the cost of nursing home care. Kentucky does not have waiting lists for its largest waiver program because whenever the number of applicants approaches the cap on unduplicated participants, the state requests an amendment to the waiver to increase the cap.

Home health agencies delivering Medicaid home health and HCBS waiver services receive cost-based reimbursement limited to 130 percent of median home health agency costs for each service. For example, the maximum allowable payment for personal care is \$19.32 for a half-hour visit in fiscal year 2000. As a cost containment incentive, Medicaid allows home health providers to keep a portion of the difference between the reimbursement limits and agency costs. Medicaid payments to home health agencies, although not as high as Medicare

reimbursement, are generally thought to be adequate and have increased over time. Medicaid also maximizes Medicare payments by denying a home health agency's claim for skilled services under Medicaid's home health benefit unless the agency demonstrates that it has already tried to obtain Medicare reimbursement.

In January 2000, nursing homes began receiving prospective payment based on 34 casemix categories. Although the overall system design is considered a good one, one stakeholder asserted that payment rates are lower than the cost to providers of delivering care. Adult day health care centers began receiving prospective payment in July 2000, with different rates for adult day health centers and adult day social care.

Cost containment mechanisms for the state-funded programs differ from those of the Medicaid home health and waiver programs. Area Agencies on Aging select providers using a competitive bidding process, accepting bids from home care agencies that want to participate in the Home Care program. The bids are for the price of half-hour units of service and bidding agencies must provide assurances that their services will be available to beneficiaries. One stakeholder expressed concern about competition for the Home Care contracts because the resulting prices do not enable agencies to meet the state's Medicare-related licensure standards, raising quality assurance issues.

Area Agencies on Aging can receive state PCAP program funds, but one third of the 15 Agencies do not want to administer the program and do not seek its funding. Thus, people in these Agencies' areas must access the program through a neighboring Agency.

The state-funded PCAP services are capped at 40 hours a week per beneficiary and the maximum payment rate for individual workers was \$7.00 an hour with a \$16 night rate in 2000. Most Area Agencies on Aging do not allow beneficiaries to pay workers at the maximum rate and require beneficiaries to pay the minimum wage. However, some urban agencies allow payment at the maximum rates because of the higher prevailing wage rates in these areas. Home care agency workers in the state-funded Home Care program receive about the same hourly pay as individual workers, generally minimum wage.

Due to limited state appropriations, the state-funded programs maintain waiting lists. There is a 600 person waiting list for the PCAP program and 3,000 persons waiting for the Home Care program. The PCAP program uses a “first-come-first-served” rule in moving people off its list and some people have been on the list for four or five years. The list moves slowly because program participants generally have stable medical conditions and remain on the program for long periods of time. Observers asserted that participants in the Home Care program tend to leave this program relatively quickly because of their age and frailty so that the Home Care waiting list moves faster than PCAP’s list. Area Agencies on Aging set their own priorities for moving people off the Home Care waiting lists but for the AD/ADR program, Agencies are supposed to set priorities for moving people off waiting lists that relate to beneficiary need and access to informal or community support.

Kentucky has a strict certificate of need program for nursing home and home health agencies. The state’s certificate of need system sets statewide nursing home bed limits rather than imposing them at the regional level, making it difficult to obtain approval for more beds. Some stakeholders view restrictions on the number of providers and the number of beds as a method of controlling long-term care expenditures. These stakeholders believe, that when beds are built, they become occupied by people who will eventually qualify for Medicaid. Others believe that certificate of need programs protect poor quality nursing homes by reducing competition from new, potentially better facilities.

QUALITY ASSURANCE

Kentucky’s quality assurance system for home health agencies is medically oriented. All providers delivering services under the Medicaid home health benefit and the HCBS waiver must be licensed according to standards that follow the Medicare model. Nurses from the agencies must make supervisory visits every 60 days to clients’ homes in the HCBS waiver and agencies must have quality improvement councils. Agencies are not required to conduct criminal background checks on workers unless they are serving participants in programs managed by Area Agencies on Aging.

The peer review organization has responsibility for monitoring home health agencies’ compliance with Medicaid quality standards and the Medicaid program integrity unit also

monitors Medicaid home health providers. When examining home health agencies, the peer review organization pulls a random sample of home health and HCBS waiver records and a portion of this sample population receives home visits. The home visits include asking consumers about their satisfaction with services. The peer review organization's paper review of case files addresses quality and billing practices. State nursing staff sometimes follow behind the peer review organization to review its work.

Remedies for quality problems include fines through the licensure system and terminating providers from Medicaid, although disenrollment has not occurred in practice. The licensure staff and peer review organization staff cross-refer problem agencies. Medicaid staff conduct annual provider workshops for home health agencies that cover changes in quality assurance and billing practices.

Adult day health care centers that offer services under the Medicaid HCBS waiver must be licensed by the Cabinet for Health Services and the Office of Aging Services certifies the adult day care centers operating under a social care model for the state-funded AD/ADR program. Existing adult day health care licensure regulations are oriented toward the social model and they are being rewritten to better address centers that provide health services. Reported problems have included inadequate infection control and lack of alarm systems for centers serving people with cognitive impairment. The state is trying to review all adult day health care centers annually with on-site visits. Although the state currently has responsibility for all quality assurance activities related to adult day care centers, it is negotiating with the peer review organization to review licensed adult day health care centers.

Medicaid staff are incorporating HCFA's new quality assurance protocol for HCBS waivers into a redesign of the quality assurance system. This process has just begun.

The Office of Aging Services contracts with Area Agencies on Aging to review each state-funded Home Care provider on-site at least annually and each client's services are monitored monthly. Area Agencies on Aging develop their own mechanisms for monitoring, which generally consist of administrative, fiscal, and quality reviews, based on a state monitoring guide. Some Area Agencies on Aging pull a random sample of files and others do site visits with participants. Office of Aging Services staff visit home care agencies to provide additional

monitoring of their services and also review the Area Agencies' monitoring activities by conducting an on-site, paper review of each Agency's plan. Area Agencies on Aging are supposed to monitor PCAP providers and participants at least annually and the new Medicaid personal care assistance waiver will meet federal waiver requirements for quality assurance. The Office of Aging Services monitors Area Agencies on Aging administrative activities annually.

One stakeholder contended that home health agencies serving Medicaid participants receive more scrutiny than agencies providing services under the state-funded Home Care program. The former must meet Medicare-related quality standards while the latter do not. For example, Medicaid's home and community services programs require that home health aides demonstrate competency before delivering services. In contrast, the state-funded Home Care program requires that agency workers only receive 16 hours of training, which can occur at any time during the first year of employment. Reportedly, personal care workers in the state-funded program are entry level and hard to retain because of the demanding nature of their job. Thus, continuity of care and emergency back up for beneficiaries can be a problem.

Some observers were critical of quality assurance mechanisms in long-term care. For home and community services, some stakeholders believe that quality assurance activities primarily involve paper review and that there is too much attention to issues of safety rather than quality of life. For residential care, one stakeholder complained that nursing home surveyors were becoming too strict and not consultative enough and that the separation of responsibility for nursing homes from that for assisted living facilities in Kentucky had resulted in "regulatory fragmentation."

Another stakeholder argued that quality could be improved by providing state funds for a home health aide training program that meets state regulatory requirements. The current state-funded training program is specific to regulatory requirements for nurse aides working in nursing homes. In practice, people who graduate from this program cannot immediately provide home health aide services.

According to most government officials and stakeholders, Kentucky has a statewide shortage of long-term care workers. Two stakeholders contended that the biggest problem in recruiting long-term care workers is lack of fringe benefits. They also alleged that minimal

staffing causes workers in nursing facilities to be overburdened and leads to employee turnover. Reportedly, recruiting home health agency workers is somewhat less difficult than finding nursing home workers. Wages for home care workers are considered too low with experienced aides making \$8 an hour, much less than the \$60 a visit that Medicaid home health agencies charge. According to some stakeholders, the labor shortage is affecting quality in that home health agencies sometimes do not have enough workers to deliver services to beneficiaries. Worker turnover and recruitment are also problems for the state-funded PCAP program, which uses individual workers, with geographic variation in the severity of the problems based on local unemployment rates.

FEDERALISM ISSUES

All stakeholders who had an opinion on the topic characterized relationships between state government and HCFA staff as generally good. For example, regional HCFA staff are willing to consult with states and do pre-review of waivers. Another stakeholder observed that states already have a great deal of flexibility under Medicaid and “if a state Medicaid program wants to do something, it can, but approval can take a long time.” This observer said that “much of the approval process involves paper compliance with HCFA’s standards.”

Some government staff stated that the Medicaid structure works very well as it is, but other staff and observers did have a number of suggestions for increasing the flexibility of Medicaid.

- Some observers said that home and community services should be an optional service that could be added or changed by amending the Medicaid state plan. In the observers’ opinions, changing the state plan is simpler than amending a home and community-based services waiver. Others were concerned that this step would increase demand for care because exercising the option would create an entitlement to home and community services.
- The use of unduplicated client counts in the waiver is considered problematic because, if people are short-term users of waiver services, their place cannot be used the rest of the year.

- The prohibition against giving waiver beneficiaries cash is viewed as an obstacle because some consumers would like the flexibility of not having to use a fiscal agent to pay workers.
- A problem with the PCAP waiver is the prohibition against hiring relatives as attendants because, a relative often is the only person from whom a participant would be comfortable receiving services.

Other comments related to the waiver application process:

- HCFA should clarify the meaning of some of the terms used in the waiver application check off lists.
- HCFA's 90 day deadline for making decisions is "mysterious" in that people do not know what stops and starts the "clock". For example, HCFA's questions about a waiver application come back toward the end of the 90-day period thus limiting the ability to meet relevant state deadlines.

Not all issues were related to federal laws and regulations; some issues that observers brought up involved the state's interpretation of these regulations. For example, Kentucky Medicaid interprets the federal prohibition on hiring family members to include virtually all family members and relatives, thus limiting the number of family members who might be available to provide services to beneficiaries.

ISSUES FOR THE FUTURE

Kentucky's home and community services system is characterized by large programs, with traditional agency-based services. Kentucky is one of the few states with a large Medicaid home health benefit and the state is unusual in the degree to which it relies on home health agencies to perform functional assessments and case management for Medicaid beneficiaries. Some observers recommended separating case management from service delivery because of concerns about conflict of interest.

Another recommendation by some observers was to combine administrative responsibility for all long-term care services under one agency. This was in reaction to the fact

that the state appears to operate its Medicaid programs separately from its state-funded home and community services programs. Locally, home health agencies manage the former and Area Agencies on Aging the latter. One of the state's challenges is to integrate its Medicaid and state funded programs at the state and local levels.

Kentucky also appears to have relatively generous payment for home health agencies, with some observers recommending changes to the states' cost-based reimbursement system. Another challenge for the state is to determine how best to contain cost growth for home health agency services.

Views about the equity of Medicaid services across populations differed. Some observers said that all Medicaid populations are treated equitably. Others asserted that children are the first priority for receiving services with the older population coming next. The neglected group is those age 18 - 64 because this group has access to fewer services than children or the older population. Urban areas are said to be better served than rural areas because urban areas have more potential employees and better transportation systems for workers. The state may have to address these perceived inequities.

No government staff or stakeholders had a clear picture of what the state's reaction to the Supreme Court's *Olmstead* decision, which requires states to serve persons with disabilities in the community when appropriate, would be, since a work group has just been formed to consider the decision. Some staff suggested an assessment to determine which nursing home residents could go back to the community.

State staff said that Kentucky is likely to continue its gradual expansion of the number of waiver participants and will revamp its quality assurance system. From the perspective of government staff and stakeholders, the future evolution of Kentucky's long-term care system largely depends on two policy questions. First, should the home and community service system increase flexibility, most likely by expanding the use of consumer-directed options? Second, will the state be willing to increase funding of home and community services to improve access to them?