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A CRS Review of 10 States: Home and Community-Based Services — States Seek to Change the Face of Long-Term Care: Arizona

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Summary

Demographic challenges posed by the growing elderly population and demands for greater public commitment to home and community-based care for persons with disabilities have drawn the attention of federal and state policymakers for some time. In 2001, both public and private spending for long-term care services for persons of all ages represented 12.2% of all personal health care spending (almost \$152 billion of \$1.24 trillion). Federal and state governments accounted for almost two-thirds of all long-term care spending. By far, the primary payer for long-term care is the federal-state Medicaid program, which paid for almost half of all long-term care spending in 2001.

Many states have devoted significant efforts to respond to the desire for home and community-based care for persons with disabilities and their families. Nevertheless, financing of nursing home care, chiefly by Medicaid, still dominates most states' spending for long-term care today. To assist Congress in understanding issues that states face in providing long-term care services, the Congressional Research Service (CRS) undertook a study of 10 states in 2002. This report presents background and analysis about long-term care in one of those states, Arizona.

Arizona is the only state in the nation that uses a statewide mandatory managed care system to deliver long-term care services to low-income Medicaid populations. Arizona's Medicaid program, Arizona Health Care Cost Containment System (AHCCCS), through its Arizona Long-Term Care System (ALTCS), makes capitated payments to managed care organizations which are contracted to deliver long-term care services. The design of the contracts includes cost-effectiveness incentives to encourage managed care organizations to serve persons in home and community-based services when possible rather than in institutional settings.

Almost 22% of total AHCCCS expenditures in contract year (CY) 2002 paid for long-term care services for 4% of total enrollees. Of ALTCS long-term care expenditures in 2002, almost 51% was spent on home and community-based services, 5% was spent on case management, and 39% was spent on institutional care. In contrast, of all Medicaid long-term care spending in the U.S. as a whole in FY2002, 30% was spent on home and community-based services and almost 70% was spent on institutional care.

ALTCS staff, advocates and providers point to a number of issues, including challenges Arizona faces in attracting and retaining nursing and paraprofessional staff to provide Medicaid-covered long-term care services, the implementation of Medicaid eligibility rules, equity of access to services, and delays in eligibility determinations.

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The authors also gratefully acknowledge the excellent assistance of Rashelle Butts and Flora Adams in the production of this report.

Preface

Demographic challenges posed by the growing elderly population and demands for greater public commitment to home and community-based care for persons with disabilities have drawn the attention of federal and state policymakers for some time. Spending on long-term care by both the public and private sectors is significant. In 2001, spending for long-term care services for persons of all ages represented 12.2% of all personal health care spending (almost \$152 billion of \$1.24 trillion). Federal and state governments accounted for almost two-thirds of all spending. By far, the primary payer for long-term care is the federal-state Medicaid program, which paid for almost half of all U.S. long-term care spending in 2001.

Federal and state Medicaid spending for long-term care in FY2001 was about \$75 billion, representing over one-third of all Medicaid spending. Over 70% of Medicaid long-term care spending was for institutions — nursing homes and intermediate care facilities for the mentally retarded (ICFs/MR). Many believe that the current federal financing system paid through Medicaid is structurally biased in favor of institutional care. State governments face significant challenges in refocusing care systems, given the structure of current federal financing. Many states have devoted significant efforts to change their long-term care systems to expand home and community-based services for persons with disabilities and their families. Nevertheless, financing of nursing home care — primarily through the Medicaid program — still dominates most states' spending on long-term care today.

While some advocates maintain that the federal government should play a larger role in providing support for home and community-based care, Congress has not yet decided whether or how to change current federal policy. One possibility is that Congress may continue an incremental approach to long-term care, without major federal policy involvement, leaving to state governments the responsibility for developing strategies that support home and community-based care within existing federal funding constraints and program rules.

To help Congress review various policy alternatives and to assist policymakers understand issues that states face in development of long-term care services, the Congressional Research Service (CRS) undertook a study of ten states in 2002. The research was undertaken to look at state policies on long-term care as well as trends in both institutional and home and community-based care for persons with disabilities (the elderly, persons with mental retardation, and other adults with disabilities). The research included a review of state documents and data on long-term care, as well as national data sources on spending. CRS interviewed state officials responsible for long-term care, a wide range of stakeholders and, in some cases, members or staff of state legislatures.

The 10 states included in the study are: Arizona, Florida, Illinois, Indiana, Louisiana, Maine, Oklahoma, Oregon, Pennsylvania, and Texas. States were chosen according to a number of variables, including geographic distribution, demographic trends, and approaches to financing, administration and delivery of long-term care services. This report presents background and analysis about long-term care in Arizona.

A CRS Review of 10 States: Home and Community-Based Services — States Seek to Change the Face of Long-Term Care: Arizona

Since Medicaid's¹ enactment in 1965, most states have relied on the program as the primary payer for acute and long-term care services for low-income individuals. Unlike most states, however, Arizona did not begin participation in Medicaid until the 1980s. The state's emphasis on private market solutions to fiscal problems and support for decentralized government placed fiscal responsibility for health care largely on private payers and county governments. In addition, Arizona's enactment of the state's Howell Code in 1864 placed legal responsibility on counties to provide health care for unemployable persons without relatives capable of supporting them. Although Arizona's county-centered approach allowed local governments flexibility in program design, it also generated significant variation across county programs and growing fiscal pressure.²

Stressed county budgets, combined with a limited revenue base (tax increases in Arizona require citizen approval through ballot measures) through the 1970s, impelled the state to seek federal matching dollars through the Medicaid program.³ In 1982, Arizona gained approval from the Center for Medicare and Medicaid Services (CMS, then called the Health Care Financing Administration) to implement a Medicaid managed care system based on capitated contracts with health plans organized at the county levels for acute care services only. The state proposed this program under a Research and Demonstration waiver authorized by CMS under

¹ Medicaid is a federal-state matching entitlement program, established under Title XIX of the Social Security Act, that provides medical assistance to certain groups of low-income individuals, primarily children, adult members of families with children, pregnant women, and individuals who are aged, blind, or disabled.

² William G. Weissert, Timothy Lesnic, Melissa Musliner, and Kathleen A. Foley, "Cost Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program," *Journal of Health Politics, Policy and Law*, vol. 22, no. 6, Dec. 1997.

³ The federal government's share of a state's expenditures for Medicaid is called the federal medical assistance percentage (FMAP). The FMAP for each of the 50 states and the District of Columbia is determined annually based on a statutory formula that uses the average per capita income of each state and the United States for the 3 most recent calendar years for which data are available from the Department of Commerce. This formula is designed to pay a higher FMAP to states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes). For the first two quarters of FY2003, Arizona's FMAP was 67.25. For the second two quarters it will be 70.20 as a result of P.L. 108-027.

Section 1115 of the Social Security Act. Unlike the open-ended federal matching funds for service expenditures traditionally provided through the Medicaid program, AHCCCS receives a federal per capita matching payment for each eligible beneficiary. Under the Section 1115 waiver, the Arizona Health Care Cost Containment System (AHCCCS) was established as the state agency responsible for overseeing the Medicaid program. In the absence of other statewide managed care programs to serve as examples for Arizona's Medicaid program, AHCCCS modeled its managed care arrangements for acute care services largely on examples available in the private insurance market.

As AHCCCS was originally established to deliver acute care service, counties and private payers remained largely responsible for financing long-term care services for low-income individuals. Counties were the sole payers for nursing home care on behalf of low-income individuals, and major payers for residential board and care assistance, assessment, case management and other services provided in the home. A 1984 report by the Pritzlaff Commission on Long-Term Care forecasted that Arizona's population of low-income elderly with long-term care needs would continue to grow and that county and state budgets would become increasingly strained. The report also projected that the growth in the proportion of county and state budgets needed to pay for institutional care would be unsustainable. The Commission encouraged the state to enter into a new agreement with CMS to establish a program of AHCCCS that would arrange for and fund Medicaid long-term care services.⁴

In December 1988, the state amended its Section 1115 Medicaid waiver and established a program of AHCCCS called the Arizona Long-Term Care System (ALTCS). Through ALTCS, the state began obtaining federal matching dollars for long-term care services authorized under the Medicaid program.⁵ Medicaid is now the primary payer for long-term care services in Arizona. Arizona's ALTCS system provides services under a managed care approach, with services provided on a fee-for-service basis to Native Americans living on reservations. ALTCS is the only mandatory, statewide Medicaid managed care program for long-term care in the nation.

⁴ *Long-Term Care in Arizona: Final Report*, The Pritzlaff Commission on Long-Term Care, supported by the Flinn Foundation, July 1984.

⁵ In Dec. 1988, ALTCS provided services to persons with mental retardation and developmental disabilities (MR/DD). ALTCS extended services to elderly individuals and persons with physical disabilities in Jan. 1989.

Summary Overview⁶

Demographic Trends

- Arizona has one of the fastest growing elderly populations in the nation. Between 1990 and 2000 Arizona's population of persons age 65 and older increased by almost 40%, with the cohort of persons age 85 and older growing dramatically, by 82%. Growth of the older population will largely be fueled by more Arizonans aging-in-place than ever before.⁷

Administration of Long-Term Care Programs

- Arizona's service delivery system is centrally managed by ALTCS, a program of AHCCCS. AHCCCS finances Medicaid long-term care services for persons aged 65 and older and for persons with physical disabilities. AHCCCS pays capitated payments to the Arizona Department of Economic Security (DES) to arrange for services for persons with mental retardation and developmental disabilities (MR/DD);
- Arizona is the only state in the nation that uses a mandatory statewide managed care system to deliver long-term care services. Its managed care approach establishes incentives for managed care organizations (MCOs) to provide access to home and community-based services and reduce the traditional bias in the Medicaid program toward institutional care; and
- Arizona's long-term care system has demonstrated effectiveness in shifting persons away from institutional care and into home and community-based settings. This state could serve as one model for other states that wish to accomplish the same objective.

Long-Term Care Services

- According to state reports and CRS interviews, Arizona's guiding principles in long-term care include expanding access to home and community-based services; providing specialized care plans that are tailored to individuals' needs; supporting bounded consumer choice within the managed care system; and assuring quality of care.

⁶ Information is based on data provided to CRS by AHCCCS, national data, and interviews with state officials, advocates and providers. This report does not discuss programs for persons with mental illness. It also generally excludes discussion of programs for infants and children with disabilities, other than those serving persons with mental retardation and developmental disabilities.

⁷ John Stuart Hall, *The Coming of Age: A Research Report on Aging, Health and Arizona's Capacity to Care*, Arizona State University, St. Luke's Health Initiatives, May 2002. (Hereafter cited as Hall, *The Coming of Age*.)

- Services provided under ALTCS comprise the majority of the state's long-term care system. For most ALTCS recipients, care is provided in home and community-based settings.
- MCOs that contract with AHCCCS for the provision of long-term care services also contract for the provision of Medicaid-covered acute care services. The integration of acute and long-term care services in this way could serve as a model to states interested in developing a more seamless system of care delivery.

Long-Term Care Spending and Enrollment

The summary data below combine data for the elderly, persons with physical disabilities and persons with mental retardation and developmental disabilities.

Spending

- State and federal spending on the Medicaid program in Arizona is the second largest expenditure category of the state budget, representing almost 16% of total state and federal expenditures.
- Almost 22% (\$772 million) of total AHCCCS expenditures (\$3.6 billion) in contract year (CY) 2002 paid for long-term care services for 4% (35,450) of total enrollees (842,797). Of ALTCS long-term care expenditures in 2002, almost 51% was spent on home and community-based services, and almost 5% on case management. In contrast, of all Medicaid long-term care spending in the U.S. as a whole, spending on home and community-based services constituted 30%.
- Spending on institutional care in Arizona constituted 39% of ALTCS spending, most of which paid for nursing home care. In contrast, of all Medicaid long-term care spending in the U.S. as a whole, spending on institutional care constituted almost 70%.
- Arizona spent \$42 million on fee-for-service long-term care services. Most of this funding paid for home and community-based services for Native Americans living on reservations.

Enrollment

- Enrollment in ALTCS grew by 163% in the 12-year period from 1990 to 2002.
- Nearly three-quarters of all ALTCS enrollees received home and community-based services in 2002, including almost 73% of managed care enrollees and 65% of fee-for-service enrollees.
- Almost 56% of elderly and physically disabled program participants and almost 98% of MR/DD participants received home and community-based services in that year.

Issues in Financing and Delivery of Long-Term Care

- Arizona's substantial enrollment in home and community-based services may be partly a result of a number of cost containment initiatives integrated into its managed care system.
- Advocates, providers, and state officials raised a number of concerns pertaining to the implementation of eligibility rules, equity of access to services, and delays in eligibility determinations. Some barriers to enrollment may be partly due to federal and state laws as well as state program administration.
- Arizona faces significant challenges in attracting and retaining nursing and paraprofessional personnel, which threatens to impact the state's ability to provide quality care to the elderly and persons with disabilities.

Demographic Trends

Arizona experienced dramatic population growth in the decade of the 1990s, growing by 40%, from about 3.7 million in 1990, to 5.1 million in 2000. The most dramatic increase among the age 65 and older population occurred among the population of persons age 85 and older. This group grew by almost 82% during that period. The age cohort of persons 75 to 84 increased by almost 56%. The cohort of persons under age 65 grew by almost 40%. **Table 1** shows Arizona's population increase by age groups for 1990 to 2000.

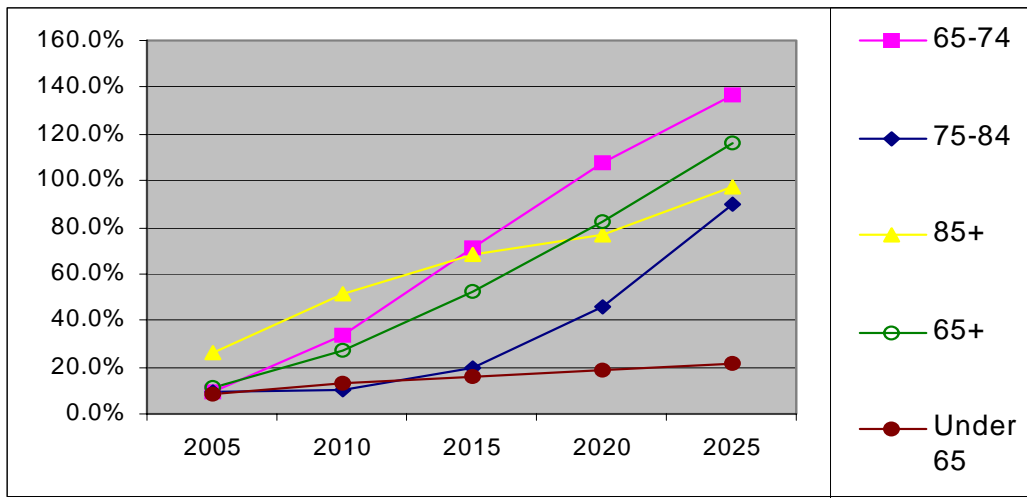
Table 1. Arizona Population Age 65 and Older, 1990 and 2000

Age	1990		2000		Percent change 1990-2000	2000 Population rank in U.S. (based on percent)
	Number	Percent of total population	Number	Percent of total population		
65+	478,774	13.1%	667,839	13.0%	39.5%	22 nd
65-74	290,044	7.9%	363,841	7.1%	25.4%	10 th
75-84	151,013	4.1%	235,473	4.6%	55.9%	21 st
85+	37,717	1.0%	68,525	1.3%	81.7%	38 th
Under 65	3,186,454	86.9%	4,462,793	86.9%	40.1%	30 th
Total	3,665,228	100%	5,130,632	100%	40.0%	20 th

Source: U.S. Census Bureau, Profile of General Demographics for Arizona: 1990. 2000: [http://www.census.gov/census2000/states/az.html]. Percentages may not sum to 100% due to rounding.

Arizona has a large population of older persons, with about 668,000 persons age 65 or older in 2000. Arizona's older population is predicted to increase by 115.6% by 2025 (See **Figure 1**). In 2025, 21.3% of Arizona's population will be 65 years or older, compared to 18.5% for the nation (**Table 2**).

Figure 1. Projected Percent Population Increases in Arizona Over 2000 by Population for Selected Years



Source: CRS calculations based on data from the U.S. Census Bureau, Population Division, Population Projections Branch. Detailed. Projections: [http://www.census.gov/population/www/projections/st_yrby5.html]; analyzed data from State Population Projections: Every Fifth Year.

Table 2. Elderly Population as a Percent of Total Population, Arizona and the United States, 2025

Age	Percent of total population in 2025 in Arizona	Percent of total population in 2025 in U.S.
65+	21.3%	18.5%
65-74	12.5%	10.5%
75-84	6.7%	5.8%
85+	2.2%	2.2%
Under 65 pop.	78.7%	81.5%

Source: CRS calculations based on data from U.S. Census Bureau. Projections released in 1996. See **Appendix 1** for information about projections, their methodology and limitations.

At the heart of these anticipated increases is the aging of the baby-boom generation (those persons born between 1946 and 1964) who will begin turning 65 in 2011. Growth will also be fueled by more Arizonans aging in place than ever before. Arizona is also a popular location for older retirees, from all parts of the nation, partly due to its year-round warm weather and relatively low income tax rate.

According to a report on Arizona's aging population, *The Coming of Age*, women will be expected to comprise the majority of Arizona's 65-plus population.

The report also states that older persons will be more ethnically diverse in the future than they are today, with a higher proportion of Hispanics and immigrants.⁸

Demand for Long-Term Care. As the population ages and working age persons with disabilities live longer, the demand for long-term care will likely increase significantly in Arizona in the upcoming decades. *The Coming of Age* report predicts that this demand will be particularly significant in Arizona's rural counties.⁹

Older Persons with Disabilities. Table 3 presents estimates of the number of persons aged 18 and over who have limitations in two or more activities of daily living (ADLs) in Arizona. These estimates were derived from data generated by The Lewin Group, Inc. and combine national level data on persons with disabilities with state-level data from the U.S. Census Bureau on age, income, and broad measures of disability. Persons aged 85 and over with two or more limitations in ADLs will likely increase by 37% by 2010.¹⁰ This growth will place pressure on public and private long-term care resources.

Table 3. Estimated Number of Persons with Two or More Limitations in Activities of Daily Living (ADLs), by Poverty Status, in Arizona, 2002, 2005 and 2010

Percent of poverty	2002			2005			2010		
	Persons with 2+ ADLs by age and income								
	18-64	65+	85+	18-64	65+	85+	18-64	65+	85+
up to 100%	3,266	2,753	559	3,449	2,959	638	3,634	3,378	766
up to 150%	5,329	5,981	1,503	5,627	6,448	1,715	5,929	7,324	2,060
up to 200%	6,904	8,992	2,327	7,290	9,695	2,654	7,682	10,961	3,187
All income levels	12,331	20,364	6,438	13,022	22,044	7,345	13,721	24,923	8,820

Source: CRS analysis based on projections generated by The Lewin Group through the HCBS State-by-State Population Tool on-line from [http://www.lewin.com/cltc]. Lisa M.B. Alexih, and Ryan Foreman, *The Lewin Group Center on Long Term Care HCBS Population Tool*, (2000).

For many older persons, needed assistance can be obtained through informal caregivers, such as spouses, adult children, neighbors, and other friends. Census data show that in 2000, 24.9% of Arizonans age 65 and older lived alone. Women

⁸ Hall, *The Coming of Age*.

⁹ Ibid.

¹⁰ CRS analysis based on projections generated by The Lewin Group through the HCBS State-by-State Population Tool on-line from [http://www.lewin.com/cltc]. Lisa M. B. Alexih, and Ryan Foreman, *The Lewin Group Center on Long Term Care HCBS Population Tool*, (2000). (Hereafter cited as Alexih and Foreman, *The Lewin Group Center on Long Term Care HCBS Population Tool*.)

comprise 72.8% of these persons living alone.¹¹ Those without access to informal supports may be able to purchase supportive services from private providers. However, income of elderly women, the primary consumers of long-term care services in the state, is only about one-half that of their male counterparts.¹² This disparity in income suggests that older women in Arizona are less likely to be able to afford to pay out-of-pocket for their long-term care needs.

Access to affordable housing in the community is a major component of community-based long-term care in Arizona as well as in the nation. With housing in Arizona's urban areas costing more than most other areas in Arizona (with the exception of Yuma and Tucson),¹³ older persons with long-term care needs may need to spend more on housing, resulting in less ability to pay for long-term care services.

Persons with Physical Disabilities and with Mental Retardation and Developmental Disabilities (MR/DD). Improved medical technology and research has enabled more persons with disabilities to live longer and more independent lives. As of 2002, there were approximately 32,000 persons with MR/DD aged 18 and over in Arizona, about 3,000 (9%) of whom were age 65 or older. The number of persons with MR/DD aged 18 and over residing in Arizona is expected to increase by 12.5%, to about 36,000 by 2010.¹⁴

Arizona's Native-American Population. Of the 2.6 million Native Americans¹⁵ residing in the United States as of 2000, about 10%, or 256,000, lived in Arizona. Among Native American Arizonans, about 5%, or 14,000, were aged 65 and over. Native Americans comprise the fastest growing ethnic group in the United States. According to the Indian Health Service (IHS), life expectancy at birth for Native Americans is about 71.1 years. This is lower than the average life expectancy for all races combined, which was 75.4 in 1995.¹⁶

¹¹ CRS calculations based on data by state from the U.S. Bureau of the Census, Census 2000, Summary File 1, p. 30: Relationship by Household Type (including Living Alone) for the Population 65 Years and Over.

¹² In 2000 the median income in Arizona for a single male 65 years of age or older was \$19,168 versus a single women at \$10,899. (Arizona's Community Based Services and Settings Report, May 2002.) The 2000 federal poverty level (FPL) in the 48 contiguous states and the District of Columbia was \$8,350 for one person, or \$696 per month. (HHS Poverty Guidelines, *Federal Register*, v. 65, no. 31, Feb. 15, 2000. pp. 7555-7557.)

¹³ *Statewide Economic Study: How Does Arizona's Cost of Living Compare?*, July 2002. Prepared for the Arizona Department of Commerce by Marshall J. Vest, Director of Economic and Business Research, University of Arizona.

¹⁴ CRS analysis is based on data from Alecxi and Foreman, *The Lewin Group Center on Long Term Care HCBS Population Tool*.

¹⁵ For the purposes of this report, Native-American refers to American Indian and Alaskan Natives as defined by the Census Bureau and does not include Native Hawaiians and Pacific Islanders.

¹⁶ U.S. Department of Health Service, Indian Health Service, Office of Public Health Program Statistics Team, Trends in Indian Health, Chart 4.57, 1998-1999; U.S. Census (continued...)

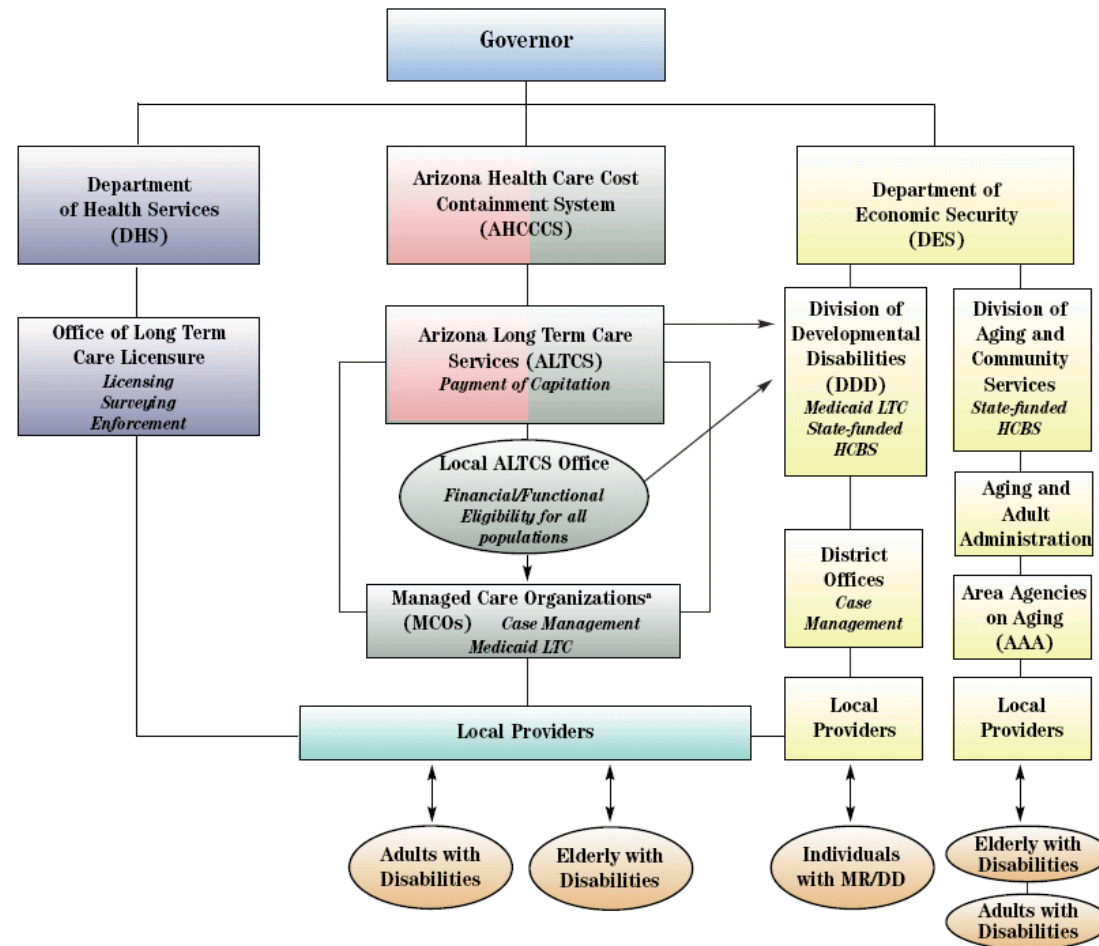
Administration of Long-Term Care Programs

Responsibility for the administration and management of long-term care services for the elderly and persons with disabilities in Arizona is spread across three state agencies — Arizona Health Care Cost Containment System (AHCCCS), Arizona Department of Economic Security (DES), and the Arizona Department of Health Services (DHS). ALTCS, a program of AHCCCS, administers the long-term care services funded by Medicaid. **Figure 2** displays an organizational chart of these state agencies and programs, including private, for-profit and not-for-profit managed care organizations.

¹⁶ (...continued)

Bureau, Census 2000 Summary File 2, Matrices PCT3, PCT4, PCT5, PCT8, and PCT11. Counts of persons on the U.S. Census include Alaska Natives in the count of American Indians.

Figure 2. Arizona's Long-Term Care System



Source: Prepared by CRS.

^a Managed Care Organizations do not conduct eligibility determinations.

Arizona Health Care Cost Containment System (AHCCCS). The state Medicaid agency, AHCCCS, funds all Medicaid-covered services provided in the state. Within AHCCCS are two programs, the acute care program and the long-term care program, also called Arizona Long Term Care System (ALTCS). Most of the services provided under AHCCCS are arranged through a managed care system in which AHCCCS contracts with managed care organizations (MCOs) and the Department of Economic Security (DES) to arrange for Medicaid covered services.¹⁷ On a much smaller scale, AHCCCS also pays for services that are delivered on a fee-for-service basis to certain Medicaid beneficiaries.

Under contract with AHCCCS, MCOs provide a continuum of acute and long-term care services to elderly individuals and persons with physical disabilities who meet the state's functional eligibility criteria for long-term care services.¹⁸ AHCCCS contracts with DES to provide long-term care services exclusively for persons with MR/DD who meet the state's functional eligibility criteria for long-term care. ALTCS manages the provision of these services. Acute care services for persons with MR/DD are managed by AHCCCS' acute care program.

The state establishes fixed, prospective, monthly, per person rates referred to as "capitation" payments to pay MCOs for these services. (The Long-Term Care Spending and Enrollment section of this paper contains a discussion about the rates paid to MCOs.) Contracts with MCOs and DES are risk-based, meaning that the organization is fiscally responsible for the provision of all services agreed upon in the contract, regardless of actual use by beneficiaries. AHCCCS offers limited reinsurance coverage to MCOs for certain high-risk beneficiaries.

Elderly and Persons with Physical Disabilities. In 2002, ALTCS had contracts with seven MCOs across the state to administer services for older persons and persons with physical disabilities. Five of the MCOs were managed by county governments, one was for-profit and another was not-for-profit. One county (Maricopa) provided enrollees with a choice of plans (the county-based plan and two private plans). **Table 4** shows a summary of Arizona's seven MCOs responsible for providing long-term care services to the elderly and younger persons with disabilities.

¹⁷ About 14.6% of Medicaid recipients aged 65 and older and many working age Medicaid enrollees with disabilities are also enrolled in the Medicare program. These individuals are considered "dual eligibles." In general, Medicare pays most of their acute care services and Medicaid pays for their long-term care services and prescription drugs. Medicaid also often pays for their Medicare cost sharing charges.

¹⁸ MCOs may be run on a profit or non-profit basis, as well as be county-run.

Table 4. Managed Care Organizations that Contract with ALTCS for Services Provided to the Elderly and Persons with Physical Disabilities,^a June 2002

Managed care organization responsible for administering long-term care services	Description	Approximate number of enrollees eligible for long-term care services
Maricopa Long-Term Care Plan	Public, managed by county	7,500
Pima Health Systems	Public, managed by county	3,400
EverCare Select	For-profit, statewide	3,000
Cochise Health Systems	Public, managed by county	900
Mercy Care Plan	Not-for-profit	2,800
Pinal/Gila Long-Term Care Plan	Public, managed by county	1,000
Yavapai County Long-Term Care Plan	Public, managed by county	1,000

Source: ALTCS, Oct. 2002.

^a MCOs do not provide long-term care services to persons with MR/DD.

MCOs subcontract with local providers to supply long-term care services to older persons and persons with physical disabilities who qualify for ALTCS. The capitated payments they receive are used to pay for a range of long-term care services, from nursing homes to home and community-based care. (These services are described later in this report.) Payments to each MCO vary by service mix (e.g., nursing home utilization rates versus home and community-based service utilization rates) and geographic region (e.g., MCOs serving urban areas receive higher payments than MCOs serving rural areas), and account for differences in severity levels of Medicaid long-term care enrollees. Although MCOs assume most of the financial risk for exceeding their aggregate revenue, ALTCS reinsures the MCOs for costs incurred on behalf of certain Medicaid recipients with very high medical expenses.

ALTCS requires MCOs to design and implement quality management plans to oversee both institutional and community-based providers. Case managers, hired by MCOs, are required to assist in monitoring the quality of services offered by providers. They must also investigate complaints, track and log monitoring activities, and conduct consumer surveys.

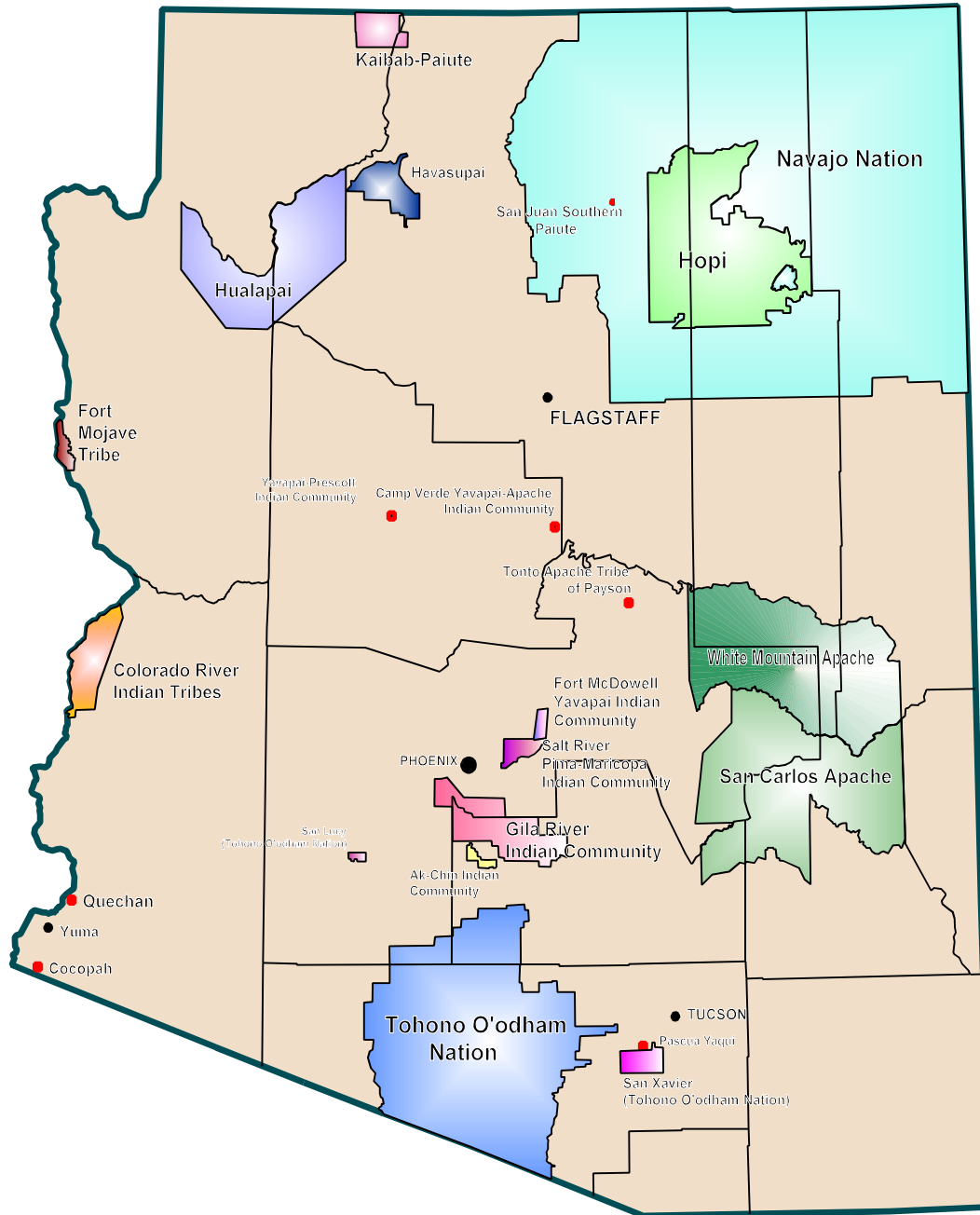
Case managers also are responsible for coordinating the acute and long-term care services for all enrollees, and they assist enrollees and their families in designing care plans, including selecting between nursing home care or home and community-based services. They assign enrollees to appropriate provider agencies, authorize services, and review and approve provider claims. Case managers are required to review the care plans of in-home service recipients every 90 days, and of institutional service recipients every 6 months.

American Indians and Native Alaskans Age 65 and Older or with Physical Disabilities Residing on Reservations. There are approximately 21 tribes in Arizona. ALTCS provides care to Native Americans residing on reservations under a fee-for-service system.¹⁹ ALTCS contracts directly with service providers — usually individuals rather than agencies — on reservations to provide in-home services to ALTCS elderly and physically disabled enrollees. ALTCS has intergovernmental agreements with six tribes for the direct delivery of case management services by tribal employees.²⁰ For the remaining tribes, AHCCCS arranges to have their case management services provided by the not-for-profit agency, Native American Community Health Center (NACHC), based in Phoenix, Arizona.²¹ For case management services, ALTCS makes capitated payments to tribes and NACHC. Care provided by institutions and in group-living arrangements is primarily available to tribal ALTCS enrollees off the reservations. See **Figure 3** for a map of the Native American Reservations in Arizona.

¹⁹ Fee-for-service is a payment system in which Medicaid-certified providers are paid retrospectively for the services they provide Medicaid beneficiaries.

²⁰ These tribes are Gila River, Navajo Nation, Pascua Yaqui, San Carlos Apache, Tohono O'Odham Nation, and White Mountain Apache.

²¹ These tribes are Ak Chin, Camp Verde Yavapai Apache, Cocopah, Colorado River Indian Tribe (CRIT), Fort Mohave, Fort McDowell, Havasupai, Hopi, Hualapai, Kaibab Paiute, Quechan, Salt River Pima - Maricopa, San Juan Southern Paiute, Tonto Apache, and Yavapai Prescott.

Figure 3. Native American Reservations in Arizona

Source: Map provided to CRS by ALTCS, 2002.

Persons with Mental Retardation and Developmental Disabilities ALTCS makes capitated payments to DES to provide long-term care services for persons with MR/DD.

Department of Economic Security (DES). Two divisions within DES are responsible for long-term care services. The DES Division of Developmental Disabilities (DDD) coordinates Medicaid and non-Medicaid home and community-based services for persons with MR/DD. The DES Aging and Adult Administration manages the state's non-medical home and community-based programs, provided through contracts with the Area Agencies on Aging (AAAs). These programs are funded by state dollars, Title III of the Older Americans Act and the Social Services Block Grant (SSBG). Services are provided to persons age 60 and older and, for certain services, persons with physical disabilities.

Division of Developmental Disabilities (DDD). AHCCCS provides capitated payments on a per person basis to the DES' Division of Developmental Disabilities to administer acute and long-term care services for enrollees with MR/DD. The capitated payment levels are adjusted to reflect service utilization and Medicare payments for services provided to dual eligibles.²² For the delivery of long-term care services, DDD contracts directly with service providers.²³

DDD has six district offices. District staff are responsible for provider billing and payment, quality monitoring, and case management, among other functions. In addition, there are approximately 60 local offices that report to the district offices. These offices are responsible for assisting in the oversight of the state-run long-term care facilities and group homes; coordinating service delivery to clients; and assisting in quality oversight activities.

Case managers, employed by district offices, are responsible for coordinating the acute and long-term care services for all enrollees. Like the case managers who work with the elderly and persons with physical disabilities, DDD case managers also assist enrollees and their families in designing care plans. For DDD clients, they assist them in selecting between in-home services, group homes, adult or child developmental homes, or ICF/MRs. They also assign enrollees to appropriate provider agencies, authorize services, and review and approve provider claims. Case managers are required to review the care plans of in-home service recipients every 90 days, and group home or institutional service recipients every 6 months.²⁴

²² The term "dual eligibles" refers to individuals who qualify for both Medicare and Medicaid. Persons qualify for Medicare because they have paid the Medicare payroll tax and are either age 65 or older, or have a disability and have been receiving Social Security Disability Insurance (SSDI) for a minimum of 2 years. The majority of dual eligibles are entitled to Medicare and are also eligible for full Medicaid benefits as determined by the state within federal guidelines. Medicare beneficiaries qualify for Medicaid because they meet the income and asset requirements established by each state within federal guidelines.

²³ Behavioral health services for persons with MR/DD are provided by the DHS Division of Behavior Health Services through an intergovernmental agreement.

²⁴ Case managers are required to review the care plans of individuals living in group homes (continued...)

DDD also administers the state-only funded non-Medicaid home and community-based services for persons with MR/DD who are ineligible for Medicaid. Case managers in district offices are responsible for providing assistance in the design of these care plans and for coordinating enrollees' services.

Native Americans with Mental Retardation Residing on Reservations. Like ALTCS, DDD arranges home care for persons with MR/DD on reservations. DES contracts on a fee-for-service basis with providers on reservations — most of whom are individuals certified by ALTCS — to provide in-home care. Case management is provided by DDD on all reservations except the Navajo Nation. DDD contracts directly with the government of the Navajo Nation to provide case management on this reservation. As in the DES-managed care program, district staff members in the local offices serve as case managers and assist enrollees in developing care plans and monitoring quality of care.

Aging and Adult Administration. DES also houses the Aging and Adult Administration (sometimes known as the State Agency on Aging).²⁵ Programs administered by this department include the state-funded home and community-based services program for certain persons aged 60 and older who are ineligible for Medicaid; services funded through Title III of the Older Americans Act for persons age 60 and older; and the Social Services Block Grant (SSBG) for certain persons age 18 and older. The Aging and Adult Administration provides funding and oversight to eight Area Agencies on Aging (AAAs), located in various counties across the state.²⁶ AAAs serve as the single point of entry for Arizona's non-medical home and community-based program. Case managers that contract with AAAs are responsible for providing assistance in the design of care plans and for coordinating clients' services. (A list of services can be found later in this report.)

AAAs in Arizona are either public or private non-profit entities and cover large geographical areas, often requiring contracting with case managers and other providers to drive long distances to offer services. Each AAA is given the flexibility to tailor its programs to meet the needs of its local communities. According to some advocates, AAAs sometimes authorize services that are not provided due to lack of provider availability, which is particularly salient in rural areas.

²⁴ (...continued)

with very high medical needs every 90 days.

²⁵ Title III of The Older Americans Act authorizes grants to state and area agencies on aging to act as advocates on behalf of, and to coordinate programs for, older persons. Nationwide, the program supports 56 state agencies on aging, 655 area agencies on aging, and 29,000 service providers. The Act currently authorizes six separate service programs. States receive separate allotments of funds for supportive services and centers, family caregiver support, congregate and home-delivered nutrition services, U.S. Department of Agriculture (USDA) commodities or cash-in-lieu of commodities, and disease prevention and health promotion services.

²⁶ For more information on Arizona AAA offices, see [<http://www.de.state.az.us/links/aaa/regions.asp>].

Department of Health Services (DHS). The Arizona Department of Health Services (DHS) is responsible for ensuring that long-term care service providers are in compliance with both federal and state standards. The Office of Long-Term Care Licensure, a department of DHS, licenses and monitors Arizona's nursing homes, intermediate care facilities for the mentally retarded (ICF/MRs), and home health agencies. It also licenses assisted living facilities and monitors their compliance with state regulations.

Eligibility Determinations for Long-Term Care Services²⁷

Medicaid is a federal-state matching program, established under Title XIX of the Social Security Act. The program covers medical assistance for certain groups of low-income individuals, including individuals who are aged, blind, or disabled.²⁸ Eligibility for Medicaid is means-tested. To qualify, applicants' income²⁹ and resources,³⁰ or assets, must be within certain limits defined by states and within federal parameters. Arizona, like all other states, provides Medicaid coverage to individuals who meet minimum income and resources eligibility standards and meet certain categorical definitions of aged, blind, or disabled, among others. For Medicaid long-term care services, persons must also meet certain functional criteria for the level-of-care needed. The criteria used in Arizona are shaped in part by estimates of spending that will occur as a result of these standards.³¹

ALTCS Eligibility Requirements for Functional Level of Care.

Arizona's Medicaid-funded home and community-based long-term care services are restricted to individuals who require a level of care provided in a nursing facility, intermediate care facility for the mentally retarded (ICF/MR), or hospital. Arizona has designed a tool known as the PreAdmission Screening (PAS) assessment that is used to determine functional eligibility for ALTCS. The PAS for the elderly and persons with physical disabilities assesses a person's ability to perform basic types of daily activities, referred to as activities of daily living (ADLs). ADLs include bathing, dressing, toileting, transferring from a bed or a chair, eating, and getting

²⁷ For more information on Medicaid eligibility, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

²⁸ Medicaid also covers certain low-income children, and adult members of families with children and pregnant women. States have the option to cover many other groups as well, including, women with breast or cervical cancer, individuals with tuberculosis, and working individuals with disabilities.

²⁹ Two types of income are generally considered: earned and unearned. Earned income includes wages, net earnings from self-employment and earnings from services performed. All other income that is not derived from current work, such as Social Security benefits, other government and private pensions, veterans benefits, workers' compensation and in-kind support and maintenance, is considered "unearned."

³⁰ Resources, also referred to as assets, generally refer to liquid assets such as money in bank accounts, stocks and bonds, mutual fund investments, and certificates of deposit.

³¹ Arizona uses its Section 1115 research and demonstration waiver to require enrollment in managed care for most of its beneficiaries. For eligibility purposes, the state complies largely with eligibility rules defined in Medicaid law and regulations.

around inside the home. Also included are measures of applicants' continence, sensory abilities, orientation, behaviors, and medical conditions.

The state uses four age-specific PAS tools for the MR/DD population. These PAS tools are also used for non-MR/DD children under age 6. These tools assess developmental milestones in children under 6 years old, motor and independent living skills, cognitive and communication skills, behaviors, medical conditions and medical stability.

ALTCS Financial Eligibility. To qualify for Medicaid long-term care services, an applicant's income must not exceed 300% of the maximum Supplemental Security Income (SSI) payment. In 2003, this limit is \$1,656 per month. Persons with income in excess of this special income level may place it in a special trust, or Miller Trust, and still receive Medicaid coverage for their care. Once funds are placed in this trust, they are applied toward the cost of the individuals' Medicaid coverage and are not available for personal use by the individuals. Following an individual's death, the state becomes the beneficiary of amounts in the trust. Between 5% and 10% of total ALTCS beneficiaries have Miller Trusts.³²

In addition to income criteria, applicants may not have countable resources that exceed \$2,000 for an individual. Countable resources generally refer to liquid assets, such as money in bank accounts, stocks and bonds, mutual fund investments, and certificates of deposit. Certain resources, however, are excluded, such as applicants' homes of any value; up to \$2,000 in household goods and personal effects; and resources set aside to fulfill a plan to achieve self-support; among others. Under a waiver authorized by the Secretary of the U.S. Department of Health and Human Services (DHHS), Arizona also excludes in-kind support and maintenance from unearned income.

State Programs. Eligibility for the *state-funded* home and community-based services program for the elderly and persons with physical disabilities is restricted to persons with limitations in two or more activities of daily living (ADLs), such as bathing, dressing, toileting, or two or more limitations in instrumental activities of daily living (IADLs), such as light housework, meal preparation, grocery shopping, and transportation. Eligibility for these services is not means-tested.

To qualify for the state-funded DDD-administered non-Medicaid home and community-based services program, persons with MR/DD must meet the state's statutory definition of a developmental disability. Under Arizona Revised Statutes (ARS) 36-551, developmental disability is defined as "either a strongly demonstrated potential that a child under the age of six years is developmentally disabled or will become developmentally disabled, as determined by a test performed pursuant to ARS Section 36-694 or by other appropriate tests, or a severe, chronic disability which: (a) is attributable to mental retardation, cerebral palsy, epilepsy or autism, (b) is manifest before age eighteen, (c) is likely to continue indefinitely, (d) reflects the need for a combination and sequence of individually planned or coordinated special,

³² Personal communication with ALTCS staff, Dec. 2002.

interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration, and (e) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency.” There are no income or resources tests for this program.

Administration. ALTCS local offices are responsible for conducting all financial and functional eligibility determinations. There are 14 local offices across the state. In some local ALTCS offices, designated individuals are responsible for conducting financial and functional eligibility determinations. This often requires many applicants, or their authorized representatives, to make at least two appointments with ALTCS eligibility workers before eligibility can be confirmed. Most interviews that assess applicants’ financial eligibility are held on site at local offices; however, many of these interviews are conducted with an authorized representative of the applicant. Upon written request, ALTCS workers will visit the homes of applicants to conduct financial eligibility determinations. Interviews to determine functional eligibility are conducted at the residence of the applicant. Under certain circumstances, ALTCS’ PAS assessors may conduct financial eligibility determinations for applicants. In addition, eligibility workers often travel to Native American reservations to conduct determinations.

Once eligibility is established, ALTCS assigns elderly individuals and individuals with disabilities to appropriate MCOs. Persons with MR/DD are assigned to DES. Native Americans living on reservations are assigned directly to one of the six tribes or NACHC for case management and coordination of services.

Arizona’s Long-Term Care Services for the Elderly and Persons with Disabilities

The establishment of the ALTCS program in 1989 came less than a decade after Congress amended the Medicaid statute to provide opportunities for states to expand home and community-based services to persons who would otherwise require institutional care. In 1981, Congress enacted Section 1915(c) of the Social Security Act, authorizing the Secretary of DHHS³³ to waive certain requirements of Medicaid law in order to allow states to cover a range of home and community-based services for persons who would otherwise be eligible for Medicaid-funded institutional care. It also corresponded with nationwide advocacy concerning the reduction of state reliance on institutional care as the primary means of caring for frail elders. The design of the ALTCS program reflects a response to these activities as well as the state’s interest in relieving fiscal pressure on its counties.

The ALTCS managed care model attempted to shift the service bias in the Medicaid program away from institutionalized care and toward home and community-based care. Yet it did so within certain limits imposed by the Centers for

³³ The program is administered by states and the Centers for Medicare and Medicaid Services (CMS).

Medicare and Medicaid Services (then the Health Care Financing Administration, HCFA). When ALTCS was established, CMS placed a 5% cap on total expenditures for home and community-based services for elderly individuals and persons with physical disabilities. CMS imposed this cap to deter possible excessive new enrollment and expenditures in ALTCS home and community-based services.³⁴ The cap was intended to constrain the rate of growth in ALTCS' home and community-based services. Despite CMS concern about possible increased costs, research conducted by Weissert on commission to HCFA, in 1998,³⁵ found no evidence of utilization large enough to offset the savings from the substitution of home and community-based care for nursing facility care. CMS changed its policy and raised the cap on home and community-based care incrementally over the years. On October 1, 1999, CMS lifted the cap entirely. Without a limit on access to services, AHCCCS expects that participation in home and community-based services will grow. There is currently no waiting list for home and community-based services under ALTCS.

According to state reports, Arizona's guiding principles in long-term care are to provide: member-centered case management, consistency of services, accessibility to services, care in the least restrictive settings available, and collaboration with stakeholders to continuously improve the range of services available in the state.³⁶ State staff identified goals of the Arizona long-term care system — expanding access to home and community-based services; allowing the free market to determine nursing home bed growth or decline; providing specialized care plans that are tailored to individuals' needs; supporting bounded consumer choice within the managed care system; and assuring quality of care.³⁷

Trends in Institutional Care

Arizona began to regulate nursing homes in the 1970s. In 1971, Arizona required approval for the construction or acquisition of nursing homes. Then, in 1975, the state created a certificate-of-need (CON) requirement and established a law mandating licensure of nursing home administrators. Shortly thereafter, in 1977, Arizona established in-service training programs for staff and three levels of nursing

³⁴ This is often referred to as the “woodwork effect,” as more persons may choose to apply for ALTCS if more services would be provided in the community.

³⁵ William Weissert, Ph.D., Michael Chernew, Ph.D., and Achamyeleh Gebremariam, M.S., *Cost-Effectiveness of Home and Community Based Services in the Arizona Long-Term Care System: An Update*, a report to the U.S. Health Care Financing Administration, Oct. 21, 1998.

³⁶ Arizona's Community Based Services and Settings Report (3rd Biennial), May 2002. Published by AHCCCS [<http://www.ahcccs.state.az.us>], ADES [<http://www.de.state.az.us>], and ADHS [<http://www.hs.state.az.us>].

³⁷ Materials collected from the state's documents and personal communications with state staff.

care institutions, similar to those established by Congress in 1972. These levels consisted of skilled, intermediate, and personal care.³⁸

By the 1980s, the legislature began to be concerned about the effect of some of the regulations and repealed Arizona's certificate of need program. Investment in bed growth by private industry flourished in that decade. A 1983 survey conducted by the Pritzlaff Commission on Long-Term Care identified 900 licensed nursing home beds in Arizona. Between 1982 and 1985, the number of nursing home beds increased by over 4,000. Despite the growth in supply of institutional care, Arizona had a lower bed ratio to the elderly population (2.5 beds per 100 persons aged 65 and older) in the early 1980s, compared to the national average (5 beds per 100 persons aged 65 and older).³⁹

The American Health Care Association (AHCA) reported that from 1999 to 2000, 153 nursing homes in Arizona served 13,459 residents.⁴⁰ The number of beds per 1,000 elderly persons in Arizona is significantly lower than the national average. In 1999 to 2000, there were about 26.4 beds per 1,000 persons aged 65 and older, 57.9 beds per 1,000 persons aged 75 and older and 256.8 beds per 1,000 persons aged 85 and older, as compared to 52.7, 111.1, and 434.8 respectively for the United States (**Table 5**). According to state officials, this is in part due to the number of nursing home closures in recent years due to bankruptcies. The occupancy rate was 76.5% for 1999-2000, slightly lower than the national average of 80.8%.

Table 5. Nursing Home Characteristics in Arizona and the United States

(data are for 1999-2000)

Characteristic	Arizona	United States
Number of facilities	153	17,023
Number of residents	13,459	1,490,155
Number of beds	17,600	1,843,522
Number of Medicaid beds	5,416 ^a	841,458
Number of beds per 1,000 pop. aged 65 and older	26.4	52.7
Number of beds per 1,000 pop. aged 75 and older	57.9	111.1
Number of beds per 1,000 pop. aged 85 and older	256.8	434.8
Occupancy rate	76.5%	80.8%

Sources: American Health Care Association (AHCA), Facts & Trends: The Nursing Facility Sourcebook (2001).

a. According to ALTCS this number underestimates total Medicaid-certified beds.

³⁸ *Long-Term Care in Arizona: Final Report*, The Pritzlaff Commission on Long-Term Care, supported by the Flinn Foundation, July 1984.

³⁹ *Ibid.*

⁴⁰ This count includes residents paying out-of-pocket for care, persons covered under the Medicare skilled nursing facility benefit and persons covered under Medicaid.

Arizona's policies include a number of strategies that affect institutional care utilization. Among the more prominent policies is an ALTCS requirement that managed care organizations apply a cost-effectiveness test to determine the most appropriate care settings for ALTCS clients. The test requires MCOs to compare the total cost of the array of services that would be needed to keep an individual in the community to the ALTCS' nursing home rate in that area for the individual. If the total cost is equal to or less than the nursing home rate, an MCO is expected to keep an individual in the community — provided that the services an individual needs are available, the home or community-based setting is safe, and the services are covered by ALTCS or can be provided through another program. If the total cost exceeds the nursing home rate, then the MCO is expected to place an individual in a nursing home.⁴¹ Waivers for this test are subject to ALTCS approval.⁴²

According to ALTCS staff, advocates, and some providers, disability levels of patients in nursing homes have increased in recent years. This may be attributed to greater use of home and community-based services that delays entry into nursing home care.

Trends in Home and Community-Based Care

Arizona has a multi-layered approach to the provision of care for the elderly and persons with physical disabilities in home and community-based settings. Although services provided under ALTCS dominate the state's long-term care system, Arizona's Medicaid acute care program covers limited home health services for these individuals as well as for all acute care program enrollees, provided the services are ordered by a physician under an approved plan of care. Among the services offered are part-time nursing services provided on an intermittent basis by a home health agency or, under certain circumstances, a registered nurse.⁴³

On a much smaller scale, Arizona also provides non-medical home and community-based services to a limited number of persons whose financial and/or functional status do not meet the ALTCS eligibility requirements and, in some cases, for persons who choose not to enroll in Medicaid. Another source of funding for services offered by the state is Title III of the Older Americans Act. The Area Agencies on Aging (AAA), funded by this Act, provide home care, congregate meals, case management, and the long-term care ombudsman program to a variety of elderly persons across the state. Some AAAs also provide additional supportive services, such as emergency food and shelter services. There are also a number of private pay assisted living facilities, congregate housing alternatives, home care aides and other supportive services available to persons who can afford to pay out-of-pocket for care

⁴¹ States that provide home and community-based services under Section 1915(c) home and community-based waivers are also subject to certain cost-effectiveness requirements. See CRS Report RL31163, *Long-Term Care: A Profile of Medicaid 1915(c) Home and Community-Based Services Waivers*, by Carol O'Shaughnessy and Rachel Kelly.

⁴² Interviews with ALTCS officials.

⁴³ Also included are home health aide services, medical supplies, equipment, and supplies for use at home and at the option of the state, physical and occupational therapy, or speech pathology and audiology services.

or who have purchased long-term care insurance policies. Together all these programs and services make up the state's home and community-based long-term care system.

The following describes the home and community-based services covered under ALTCS and services paid for by the state-only funded non-medical home and community-based services program. It also describes the categories of assisted living facilities in Arizona, as specified through state statute.

ALTCS Home and Community-Based Services. ALTCS provides a wide range of services to the approximately 9,843 elderly and physically disabled enrollees receiving home and community-based services.

These services⁴⁴ include:

Medically-Related Services:

- *Home Nursing.* Includes in-home intermittent skilled nursing services, including health maintenance, continued treatments, or supervision of a health condition.

Supportive Services:

- *Home Health Aide.* Includes in-home services, including intermittent health maintenance, continued treatments or monitoring of a health condition, and supportive care for activities of daily living;
- *Adult Day Health Care.* Includes planned care and supervision, recreation and socialization, personal living skills training, group meals, health monitoring and various preventive, therapeutic and restorative health care services;
- *Attendant Care.* Includes homemaker services, personal care, coordination of services, general supervision and assistance, companionship, socialization and skills development. Services are provided by a trained attendant for members who reside in their own homes;
- *Housekeeping/Chore.* Includes heavy indoor cleaning and may include designated outdoor tasks;
- *Home Delivered Meals.* Delivers meals containing at least one-third of the federal recommended daily allowance;
- *Personal Care.* Includes assistance with personal physical needs, such as washing hair, bathing and dressing;

⁴⁴ Descriptions of services are those found in Arizona's Community Based Services and Settings Report (3rd Biennial). The Arizona Health Care Cost Containment System, The Arizona Department of Economic Security, and the Arizona Department of Health Services, May 2002.

- *Respite Care.* Includes short-term care and supervision to relieve primary caregivers for up to 24 hours per day. Respite may be provided in groups or in an individual's home;
- *Home Modification.* Includes funds for certain building specification or items which allow individuals to function as independently as possible in their own homes;
- *Augmentative Communication Devices.* Includes funds to purchase devices that help a person communicate, such as a notebook or a computer system; and
- *Habilitation.* Includes habilitative therapies (e.g., occupational, physical and speech or audiology), special developmental skills, behavioral intervention, sensory-motor development designed to increase the person's skill and functioning.

Residential Services:

As of June 2003, the state had about 250 adult foster care homes, 192 assisted living centers, and 1,225 assisted living homes. ALTCS covers services provided to many ALTCS enrollees residing in these residences.⁴⁵ (See below for additional information on assisted living.)

Case Management Services:

All participants are assigned case managers upon their enrollment in ALTCS. Case managers assist clients and their families in making informed decisions about care settings, e.g., home, assisted living, state-run homes, or nursing homes. They also assist ALTCS enrollees in addressing problems in service delivery and modifying care plans to reflect changes in clients' health status or the availability of informal supports. When necessary, they investigate complaints and advocate on behalf of their clients. Case managers are required to visit in-home ALTCS recipients every 90 days, and nursing home ALTCS recipients every 6 months.

State-Only Funded Program. The non-medical home and community-based services (NMHCBS) program is intended to provide assistance to persons with long-term care needs who are ineligible for ALTCS. By providing supportive long-term care services to persons who are at risk of becoming ALTCS eligible, NMHCBS may delay or prevent individuals from depleting their income and assets on health care related services, and thus qualifying for ALTCS. Unlike ALTCS, there are no income or resources tests to qualify. There are, however, functional eligibility requirements. (See section on eligibility for state programs of this report for more information.)

Services are statewide and are more limited in scope than those provided under ALTCS. They include adult day care/adult day health care, home delivered meals, home health aide, housekeeping, personal care, respite care and home nursing. Many NMHCBS participants remain in the program until death or until they become eligible for ALTCS. Once enrollment in ALTCS begins, the services provided under

⁴⁵ Arizona Department of Health Services, June 2003.

MNHCBS cease. Persons may still remain eligible for AAA's nutrition services as well as other services administered by AAAs.

Participation in the state-funded NMHCBS program is capped according to the amount of general revenue funding appropriated annually by the state legislature. As a result, as of May 2003, there was a statewide waiting list of 625 persons.⁴⁶

Assisted Living. Arizona has a variety of assisted living homes that provide long-term care services, primarily on a private pay basis or, for those who meet eligibility requirements, through ALTCS. It is one of just a few states that has enacted legislation to regulate assisted living facilities. The legislature acted partly as a result of a number of media reports in the late 1990s that identified some assisted living homes that were providing poor quality services to elderly persons. In 1998, the state legislature established rules pertaining to the health and safety of residents; management of residents' personal funds; abuse, neglect and exploitation; staff training and qualifications; activity requirements; food services; and building requirements; among other purposes.

In November 1998, the Department of Health Services published regulations that established three levels of care that can be provided in assisted living residences and the minimum staff training hours required. The regulations address homes serving ten or fewer residents, 11 or more residents, and adult foster homes that serve one to four residents.⁴⁷

- *Supervisory Care Services:* Residents must be able to direct their own self-care. Facilities may receive nursing services or health-related services from a licensed home health agency, licensed hospice service agency or private duty nurse. Forty hours of staff training are required;
- *Personal Care Services:* Residents living in these facilities must be able to direct their own self-care. In addition to 60 hours of staff training, managers and caregivers must complete a minimum of 2 hours of ongoing training in providing personal care services every 12 months. Limited personal care services may be provided, including certain skin maintenance services, hydration, medication administration, and assistance with incontinence;
- *Directed Care Services:* Facilities may provide services to persons who cannot direct their own self-care, including direct supervision, coordination of communications, cognitive stimulation activities to maximize functioning, encouragement to eat meals and snacks, an assessment of a resident who is unable to direct self-care by a primary care provider and ensure medication requirements are met, among other services. In addition to 72 hours of staff training, each manager and caregiver must complete a minimum of 4 hours of ongoing training service every 12 months.

⁴⁶ Aging and Adult Administration, June 2003.

⁴⁷ See Arizona Revised Statute (A.R.S.) §36-401.

Arizona's Long-Term Care Services for Persons with Mental Retardation and Developmental Disabilities

The early history of services for persons with mental retardation in the United States is characterized by the development of large state institutions or training schools begun during the latter part of the 19th century and continuing through the first part of the 20th century. Between 1920 and 1967 institutions quadrupled in size and the number of residents peaked at almost 200,000 individuals nationwide in 165 free-standing state-operated institutional facilities.⁴⁸ Arizona, on the other hand, did not establish its first institution until 1952, when it opened the Coolidge facility for persons with MR/DD. Three more institutions were opened in the 1970s. During these years, institutional care comprised the bulk of care provided to persons with MR/DD in Arizona. (See **Appendix 2** for facility populations, and opening and closures dates.)

Pressure from advocacy groups and legal action taken by advocates against some states encouraged the development of alternative care systems that are intended to promote self-determination, independence, and a higher quality of life for persons with MR/DD. The ALTCS program's investment in home and community-based services combined with increasing pressure from advocacy groups resulted in the closing of three large state institutions in 1988, 1994, and 1995 and the downsizing of Coolidge. (See **Appendix 1**.)

Trends in Institutional Care

According to Braddock et. al., 445 individuals with MR/DD in Arizona, or 23% of all persons with MR/DD in residential settings, were living in Arizona in institutions of 16 or more beds in 1990. By 2000, Arizona had reduced this number by 42%, to 258 individuals, or 7% of all residents. During this decade, the number of persons living in group homes of six or fewer individuals grew by 128%, from 1,445 in 1990 to 3,298 in 2000. In that year, nearly all (92%) residents lived in small facilities with six or fewer residents (**Table 6**).

⁴⁸ For a detailed history of the development of services for persons with developmental disabilities, see David Braddock, Richard Hemp, Susan Parish, and James Westrich, *The State of the States in Developmental Disabilities*, University of Illinois at Chicago, American Association of Mental Retardation, Washington, 1998. (Hereafter cited as Braddock, et. al., *The State of the States in Developmental Disabilities*, 1998.)

Table 6. Persons in Arizona with Developmental Disabilities and Mental Retardation Served in Residential Settings by Type and Size of Residential Setting, 1990, 1995, and 2000

Persons served by residential setting			
	1990	1995	2000
Setting by size	1,938 (100%)	2,694 (100%)	3,598 (100%)
16+ persons	445 (23%)	372 (14%)	258 (7%)
Nursing Facilities	48	76	57
State Institutions	366	248	166
Private ICF/MR	16	48	35
Other Residential	15	0	0
7-15 persons	48 (2%)	44 (2%)	42 (1%)
Public ICF/MR	48	44	42
Private ICF/MR	0	0	0
Other Residential	0	0	0
≤6 persons	1,445(75%)	2,278 (85%)	3,298 (92%)
Public ICF/MR	0	0	0
Private ICF/MR	0	0	0
Other residential	1,445	2,278	3,298

Source: *Disability at the Dawn of the 21st Century and the State of the States*, David Braddock, editor, with Richard Hemp, Mary C. Rizzolo, Susan Parish, and Amy Pomeranz, American Association on Mental Retardation, Washington, D.C., 2002.

Note: Percentages may not sum to 100 due to rounding.

Trends in Home and Community-Based Care

Arizona has made a significant effort to provide home and community-based care options to persons with MR/DD. Similar to ALTCS services for the elderly and persons with physical disabilities, DDD's case managers conduct a cost-effectiveness test. Under the test, case managers are required to compare the total cost of the array of services that would be needed to keep an individual with MR/DD in the community to the ALTCS' ICF/MR rate in that area. If the total cost is equal to or less than the ICF/MR rate, then the case manager must try to keep the individual in the community. If the case manager's calculation shows that the total cost to serve an individual in the community would exceed the ICF/MR rate, then the case

manager would recommend placement in an institution.⁴⁹ In 2003, 98% of the ALTCS MR/DD population reside in home and community-based settings.

The following programs and services make up the majority of the long-term care system for persons with MR/DD in Arizona. AHCCCS provides home health services to qualifying individuals and a range of home and community-based long-term care services for persons who meet the eligibility criteria. The state also provides state-funded services to persons who do not meet the eligibility requirements for ALTCS.

ALTCS Home and Community-Based Services. Under contract with AHCCCS, DDD provides managed care services to all ALTCS enrollees with MR/DD. Case managers assist clients and their families in designing care plans and making informed decisions about care settings. In general, the case management services provided to persons with MR/DD are similar to those provided to the elderly and persons with disabilities (see section above).

Other services for persons with MR/DD are the same as those for older persons and working age persons with physical disabilities (described above), but they provide broader coverage of day services and habilitation. Day services include day treatment and training, such as supervision, therapeutic activities and support to promote skill development in independent living, self care, communication and social relationships. Habilitation includes therapies such as occupational, physical and speech or audiology therapy, special developmental skills, behavioral intervention, and sensory-motor development designed to increase the person's skill and functioning. These services are intended to assist individuals in coping more effectively with personal and environmental demands and in raising the level of physical, mental and social efficiency.

ALTCS' Housing Benefits with Services. Arizona's ALTCS program provides limited access to supported residential housing for persons with MR/DD. The state runs, or contracts with, group homes, training program facilities,⁵⁰ adult developmental homes, child foster care homes, and state-operated service centers. Each of the settings is described below:

- *Group Homes.* Residences for no more than six persons with developmental disabilities that are operated by a service provider under a contract with DDD. They provide room and board and daily habilitation in a shared living environment;⁵¹
- *Adult Developmental Homes.* Homes are residential family-like settings in which care, physical custody and supervision are provided 24-hours a day. Homes provide services for a group of siblings or up to three adults with developmental disabilities;

⁴⁹ Waivers for this test are subject to ALTCS approval.

⁵⁰ A state-operated institution for persons with developmental disabilities.

⁵¹ Group homes do not include an adult developmental home, a child developmental foster home, a secure setting or an intermediate care facility for the mentally retarded.

- *Child Developmental Foster Homes.* Homes are residential family-like settings in which care, physical custody, and supervision are provided 24-hours a day. These homes provide services for a group of siblings or up to three children with developmental disabilities. The state's long-term goal is to move children out of foster care into a permanent home;
- *State Operated Service Centers.* Centers are owned or leased by the state and operated by DES. They provide temporary residential care and space for child and adult services which include respite care, crisis intervention, and diagnostic evaluation.

State Program. DDD's state-only funded program provides home and community-based long-term care services statewide to approximately 8,000 Arizonans with MR/DD. Although the majority of persons in the program receive housekeeping and personal care, other services offered include respite, in-home nursing, and cash assistance of up to \$400 per month for specified purposes. This program also covers care for program enrollees living in certain group homes and adult and child developmental homes.

The state maintains a waiting list for the state-funded program. Many participants remain in the program until death or until they become eligible for ALTCS. Once enrollment in ALTCS begins, the services provided under this program cease. By providing supportive long-term care services to persons who are at risk of becoming ALTCS eligible, DDD's state-only funded program may delay or prevent individuals from depleting their income and assets on health care related services, and thus qualify for ALTCS.

Long-Term Care Spending and Enrollment

In Arizona, as in most states, Medicaid is the largest single payer for long-term care services in the state. Arizona's Medicaid program is jointly funded by state, county, and federal dollars.⁵² State general revenue funds are also used to pay for non-Medicaid long-term care services in home and community-based settings for older persons, persons with physical disabilities and persons with MR/DD. Other services are funded through the Older Americans Act (Title III), Social Services Block Grant (Title XX of the Social Security Act), and local and private funds.

Medicaid Spending and Enrollment in Arizona

Medicaid is a significant part of state budgets. After elementary, secondary and higher education spending, Medicaid spending was the largest share of state budgets in 2001. According to data compiled by the National Association of State Budget Officers (NASBO), *federal and state* Medicaid spending represented almost 20% of state budgets for the United States as a whole in 2001.

⁵² Arizona's Community Based Services and Settings Report (3rd Biennial), May 2002.

In Arizona, Medicaid was the second largest single category of *federal and state spending combined* in 2001, after elementary and secondary education. Of the state's \$17.4 billion budget in 2001, federal and state Medicaid spending represented almost 16%. Spending for Medicaid increased from almost 11% in 1990 (**Table 7**). The increase in spending for Medicaid is largely attributed to an increase in federal spending. State spending for Medicaid services contributed from state funds *only* (excluding federal funds)⁵³ remained fairly constant during the 1990s. As a percent of spending for all categories of state spending, state Medicaid spending rose from 6.2% in 1990 to 7.7% in 1995, and then declined to slightly more than 6% in 2000 and 2001 (**Table 8**).

Table 7. Federal and State Spending Combined for all Categories of the State Budget, Arizona and the United States, 1990, 1995, 2000, and 2001

Expenditure category	Arizona				U.S. total
	1990	1995	2000	2001	2001
Total expenditure (in millions)	\$5,985	\$9,923	\$15,366	\$17,351	\$1,024,439
Medicaid	10.7%	15.7%	13.5%	15.9%	19.6%
Elementary and Secondary Education	23.6%	21.2%	19.0%	23.1%	22.2%
Higher Education	14.7%	11.5%	13.5%	12.4%	11.3%
Public Assistance	2.2%	3.0%	0.8%	0.7%	2.2%
Corrections	4.3%	4.1%	4.5%	4.1%	3.7%
Transportation	12.2%	8.0%	10.7%	9.4%	8.9%
All other expenses	32.2%	36.5%	37.9%	34.4%	32.1%

Source: CRS calculations based on National Association of State Budget Officers (NASBO), *State Expenditure Reports*, 1990-2001.

Notes: Data reported are for state fiscal years. Percentages may not sum to 100% due to rounding. Data from NASBO differ from data provided to CRS by AHCCCS for these years.

⁵³ Federal and state governments share the costs of Medicaid spending according to a statutory formula based on a state's relative per capita income (Federal Medical Assistance Percentage, or FMAP). In FY2001, the federal share for Medicaid in Arizona was 65.77%.

Table 8. State Spending for Medicaid (Excluding Federal Dollars), Arizona and All States, 1990, 1995, 2000, and 2001
(in millions)

State spending	Arizona				All states
	1990	1995	2000	2001	2001
Total state spending for all categories of the state budget (millions) ^a	\$4,337	\$6,738	\$11,821	\$13,600	\$760,419
State funded Medicaid spending (millions)	\$267	\$522	\$721	\$864	\$85,141
State funded Medicaid spending as a percent of the state budget	6.2%	7.7%	6.1%	6.4%	11.2%

Source: CRS calculations based on data from the National Association of State Budget Officers (NASBO), State Expenditure Reports, 1990-2001. Data reported are for state fiscal years.

Notes: Data reported are for state fiscal years. Percentages may not sum to 100% due to rounding.

Federal, State and County Financing. The federal government matches Arizona's contribution to Medicaid at a federal medical assistance percentage (FMAP) of 67.25% for the first 2 quarters of federal fiscal year 2003.⁵⁴ To provide temporary fiscal relief to states, the budget reconciliation Act (P.L. 108-27) provided \$10 billion to state Medicaid programs. Under the Act, FMAPs for the last 2 quarters of FY2003 and the first 3 quarters of FY2004 are held harmless for declines from the prior year, and FMAPs are increased by 2.95 percentage points. Arizona's FMAP will increase from 67.25% in FY2003 (first 2 quarters) to 70.2% for the last 2 quarters of FY2003, and 70.21% for the first 3 quarters of FY2004. The FMAP will fall to 67.26% in the last quarter of FY2004. FMAP payments are based on aggregate AHCCCS expenditures.

Counties pay significantly more for the ALTCS program than for the acute care program. Arizona requires counties to contribute 78% of the state share for ALTCS, the balance is paid with state dollars. In comparison, counties pay 24% of the state's share of AHCCCS' acute care program, and the state pays the remaining 76%.

⁵⁴ The federal government's share of a state's expenditures for medicaid is called the federal medical assistance percentage (FMAP). The FMAP for each of the 50 states and the District of Columbia is determined annually based on a statutory formula that uses the average per capita income of each state and the United States for the three most recent calendar years for which data are available from the Department of Commerce. This formula is designed to pay a higher FMAP to states with lower per capita income relative to the national average (and vice versa for states with higher per capita incomes).

Medicaid Long-Term Care Spending for All ALTCS Beneficiaries.

Almost 22% (\$772 million) of total AHCCCS expenditures (\$3.6 billion) in contract year (CY) 2002 paid for long-term care services for 4% (35,450) of total enrollees (842,797). Of ALTCS long-term care expenditures in 2002, almost 51% was spent on home and community-based services, 5% was spent on case management, and 39% was spent on institutional care. In contrast, of all Medicaid long-term care spending in the U.S. as a whole in FY2002, 30% (\$24.7 billion) was spent on home and community-based services and almost 70% was spent on institutional care.⁵⁵ Expenditures delivered on a fee-for-service basis on reservations constituted 5.4% of ALTCS spending (**Table 9**). **Table 10** shows ALTCS spending trends from 1999 to 2002 (estimated data).⁵⁶

Table 9. Total Medicaid Long-Term Care Expenditures for All ALTCS Participants in Arizona, Contract Year 1999-2002
(in millions)

	1999	2000	2001	2002 (est.)	Percent change 1999-2002
Total Medicaid (total AHCCCS expenditures)	\$2,266.9	\$2,450.8	\$2,828.9	\$3,585.5^a	58.2%
Total ALTCS Long-term care	\$542.9	\$589.7	\$698.1	\$771.7^a	42.2%
Total ALTCS managed care	\$511.7	\$557.0	\$660.1	\$730.3	42.7%
Total institutional care	\$244.6	\$254.8	\$280.4	\$301.5^b	23.3%
Nursing home services	\$233.5	\$243.2	\$268.3	\$287.6 ^b	23.2%
ICF-MR	\$11.1	\$11.5	\$12.1	\$13.9 ^b	25.5%
Total HCBS	\$244.4	\$276.2	\$349.4	\$393.7^b	61.1%
Total Case Management ^c	\$22.7	\$26.0	\$30.3	\$35.1 ^b	54.5%
Total ALTCS fee-for-service	\$31.2	\$32.7	\$37.9	\$41.5	33.0%

Source: Data provided to CRS by AHCCCS, Dec. 2002.

Note: Table includes expenditures for elderly, persons with physical disabilities, persons with MR/DD, and managed care. CY1999, 2000 and 2001 contain expenditures for fee-for-service delivery to ALTCS beneficiaries. Numbers may not add to totals due to rounding.

a. CRS analysis of data provided by AHCCCS, Dec. 2002.

b. Number does not include ALTCS payments for fee-for-service.

c. For capitated expenditures only.

⁵⁵ CMS 64 data for FY2002, Office of State Agency Financial Management, Centers for Medicare and Medicaid Services.

⁵⁶ Data provided to CRS by AHCCCS, Dec. 2002.

Table 10. Medicaid Long-Term Care Spending in Arizona on All Beneficiaries, Contract Year 1999-2002

	1999	2000	2001	2002 (est.)
Long-term care (LTC) spending as a % of Medicaid spending	23.9%	24.1%	24.7%	21.5%
MCO spending as a % of long-term care spending	94.3%	94.5%	94.6%	94.6%
Institutional care spending as a % of LTC spending	45.1%	43.2%	40.2%	39.1%
Nursing home spending as a % of LTC spending	43%	41.2%	38.4%	37.3%
ICF/MR* spending as a % of LTC spending	2%	2%	1.7%	1.8%
Total home and community-based services spending as a % of LTC spending	45%	46.8%	50.1%	51%
Case management as a % of LTC spending	4.2%	4.4%	4.3%	4.5%
Total fee-for-service as a % of LTC spending	5.7%	5.5%	5.4%	5.4%

Source: CRS analysis of data provided by AHCCCS, Dec. 2002.

Note: Table includes expenditures for elderly, persons with physical disabilities, persons with MR/DD, and managed care. CY1999, 2000 and 2001 contain expenditures for fee-for-service delivery to ALTCS beneficiaries. Percentages may not add to 100% due to rounding.

Enrollment in Medicaid Long-Term Care. Enrollment in ALTCS grew by 162.6% in the 12-year period from 1990 to 2002. Nearly three-quarters of all ALTCS enrollees received home and community-based services in 2002, including almost 73% of managed care enrollees and 65% of fee-for-service enrollees. Almost 56% of elderly and physically disabled program participants and almost 98% of MR/DD participants received home and community-based services in that year. **Table 11** shows ALTCS enrollment from 1999 through 2002.

**Table 11. ALTCS Enrollment
(Managed Care and Fee-For-Service), 1999-2002**
(as of September 30 for each year)

	1990	1999	2000	2001	2002	Percent increase (1990 to 2002)
Total AHCCCS (all populations)	334,498	NA	533,724	668,196	842,797	152%
Total ALTCS (includes managed care and fee-for-service)	about 13,502	27,438	29,700	32,482	35,450	162.6%

	1990	1999	2000	2001	2002	Percent increase (1990 to 2002)
Institutional	NA	9,534	9,750	9,582	9,784	—
Home/community	NA	17,904	19,950	22,900	25,666	—
Total ALTCS managed care (MC)	13,102	26,352	28,464	31,170	33,879	158.6%
Institutional	6,652	9,154	9,317	9,123	9,234	38.8%
Home/community	6,450	17,198	19,147	22,047	24,645	282.1%
Elderly and physically disabled (MC)	8,299	15,983	17,119	18,717	20,251	144%
Institutional	6,556	8,950	9,090	8,874	8,961	36.7%
Home/community	1,743	7,033	8,029	9,843	11,290	547.7%
MR/DD (MC)	4,803	10,369	11,345	12,453	13,628	183.7%
Institutional	96	204	227	249	273	184.4%
Home/community	4,707	10,165	11,118	12,204	13,355	183.7%
Total ALTCS Fee-for-Service (FFS)	about 400	1,086	1,236	1,312	1,571	292.8%
Institutional	NA	380	433	459	550	—
Home/community	NA	706	803	853	1021	—

Source: Data provided to CRS by AHCCCS, Dec. 2002.

Notes: Includes only those enrollees in ALTCS managed long-term care. Table includes managed care and fee-for-service enrollees. The exact number of FFS enrollees in 1990 is not available. Estimate is provided to CRS by AHCCCS.

NA = Not available. CRS has not obtained this data.

Medicaid and Other State Spending on Services for Elderly and Persons with Physical Disabilities

Table 12 shows a breakdown of total expenditures for long-term and acute care services, including capitation payments made to MCOs, other payments on behalf of beneficiaries, and payment adjustments. Between CY1999 and CY2002, administration was the fastest expenditure component of AHCCCS payments on behalf of elderly and physically disabled persons enrolled in ALTCS, followed by home and community-based services. Institutional care grew by 23.8%. According to Arizona's Community Based Services and Settings Report, growth in AHCCCS payments has consistently been lower than the sum of annual enrollment and inflationary trends.

Table 12. Long Term Care Expenditures for Managed Care by Category for the Elderly and Physically Disabled, Contract Years 1999-2002
(in millions)

Payments by service category	CY1999	CY2000	CY2001	CY2002 (est.)	Percentage change 1999-2002
Total expenditures	\$382.1	\$409.8	\$487.2	\$557.2	45.8%
Institutional	\$230.2	\$239.6	\$263.9	\$284.9	23.8%
HCBS	\$66.9	\$70.1	\$103.4	\$133.9	100.1%
Case management	\$11.0	\$12.8	\$15.7	\$16.4	49.1%
Acute care	\$56.0	\$66.7	\$76.9	\$85.0	51.8%
Administration	\$18.1	\$20.6	\$27.3	\$36.9	103.8%

Source: Data provided to CRS by ALTCS Officials, Dec. 2002.

Capitation Payments Per Capita. As described above, capitation rates are determined on a per person basis and thus vary by MCO and case mix. **Table 13** presents an example of the components of the capitation payments for various components of Arizona's long-term care program for CY1995-CY2002. The average total capitation rate for CY2002 was \$2,451.34. The rate is devised by summing the following payment rates: net nursing facility (row 4); net home and community based services (row 7); acute care (row 8); administration (row 9); case management (row 10); and risk, profit and contingency costs (row 11). The resulting amount — \$2,750.95 in CY2002 — is then reduced by the individual enrollee's share of the cost (row 12) to equal the total capitation rate for the year.

Following is a detailed description of the components of the capitation rates. **The first three rows pertain to nursing facility payments:**

- *Expected nursing facility rate* (row 2). This rate is the average amount ALTCS expects to pay for total nursing facility services. It is adjusted to account for expected utilization, geographic region and MCO contract agreements.
- *Nursing facility placement rate* (row 3). This rate refers to the percentage of people ALTCS expects will use nursing home care in a given year. MCOs that place fewer individuals in nursing facilities than ALTCS expects may apply the savings they incur to other spending categories or keep the savings for profit.
- *Net nursing facility payment* (row 4). This percentage is the actual amount paid to the MCO. It equals the product of rows 2 and 3.

The following three rows in the table pertaining to home and community-based services (HCBS) can be described using a similar logic.

- *Expected home and community-based placement percentage* (row 5). This is the average amount that ALTCS pays for the total cost of home and community-based services. It is adjusted to account for expected utilization, geographic region, and MCO contract agreements.
- *Expected home and community-based placement percentage* (row 6). This refers to the proportion of MCO enrollees ALTCS expects will use home and community-based services.
- *Net home and community-based services* (row 7). This payment is the product of rows 5 and 6. MCOs that pay less for home and community-based services than the ALTCS allotment, may apply their savings toward other spending categories or keep them for profit.

The capitation rate also includes a payment by AHCCCS to cover the acute care services provided to ALTCS recipients (row 8). These services include all other Medicaid-covered services, such as prescription drugs, physician visits, therapy services, hospitalization, etc. Administrative costs (row 9) and case management (row 10) include payments for the administration and coordination of services for all Medicaid covered long-term and acute care provided to ALTCS beneficiaries. The row referring to risk, profit and contingency (row 11) refers to extra payments made to the MCOs for potential liability for unexpected costs.

There are two ways in which members may be required to contribute toward the cost of their care (row 12, **Table 13**), depending upon whether they use institutional care or care provided in home and community-based settings. After enrollment in ALTCS, beneficiaries receiving home and community-based services may become responsible for paying some portion of the costs of their care, after deductions (or income disregards) are made for their living expenses in the community. Arizonans enrolled in the home and community-based services program may retain income up to the maintenance needs allowance, or \$1,656 per month in 2003, to be used by beneficiaries receiving home and community-based services in the community. This money may be used to cover living expenses, such as housing, personal items, transportation, among other items. Beneficiaries that have income exceeding the monthly maintenance needs allowance — such as income in a Miller Trust — must apply this money toward the cost of their care. For persons in nursing homes or other institutions, Medicaid requires states to reserve a personal needs allowance from a beneficiary's income. This amount may be used to cover various personal care items not included in the institution's basic charge, such as clothing, individual preferences on personal care items (e.g., hair products or cosmetics), social support (telephone, stationary, etc.), and occasional outings. As of 2003, Arizona's personal needs allowance is \$82.80 per month. The remainder of nursing home residents' income must be applied to the cost of their care.

Table 13. ALTCS Capitation Rates Per Capita; Weighted Average for Elderly and Physically Disabled by Component Contract Years 1995-2002, Selected Years

Rate component	CY1995	CY1997	CY1999	CY2001	CY2002
	Per member per month				
1. Total capitation^a	\$2,075.74	\$2,165.64	\$2,233.32	\$2,323.42	\$2,451.34
2. Expected nursing facility	\$2,525.17	\$2,703.79	\$2,811.67	\$3,040.02	\$3,243.73
3. NF placement percent (target)	69.52%	62.79%	58.26%	52.58%	48.03%
4. Net NF payment	\$1,755.50	\$1,697.71	\$1,638.08	\$1,598.44	\$1,557.96
5. Expected HCBS	\$685.13	\$709.31	\$772.98	\$924.13	\$1,048.01
6. HCBS placement percent (target)	30.48%	37.21%	41.74%	47.42%	51.97%
7. Net HCBS	\$208.83	\$263.93	\$322.64	\$438.22	\$544.65
8. Acute care	\$276.20	\$294.40	\$344.83	\$360.85	\$376.52
9. Administration	\$111.27	\$138.85	\$149.22	\$146.56	\$162.94
10. Case management	\$48.00	\$55.17	\$58.94	\$66.14	\$72.65
11. Risk, profit, and contingency	\$8.56	\$38.08	\$39.15	\$38.02	\$36.23
12. Member share of cost	(\$332.61)	(\$322.50)	(\$319.54)	(\$324.81)	(\$299.61)

Source: Data provided to CRS by AHCCCS, Dec. 2002.

a. Total capitation refers to the per capita weighted average across MCOs.

Other Long-Term Care Programs for the Elderly and Physically Disabled

Funding for non-medical home and community-based services (NMHCBS) system for elderly and physically disabled individuals with income and assets that exceed Medicaid eligibility thresholds is provided by a state appropriation, Older Americans Act, and the Social Services Block Grant, as well as other local funding sources. Total expenditures for all services were \$28.6 million in state fiscal year (SFY) 2001.⁵⁷ State and local funds made up more than one-half of the total dollars spent on the NMHCBS system in Arizona (**Table 14**).

⁵⁷ Arizona state fiscal year is from July 1 to June 30.

Table 14. Non-Medical Home and Community Based Services System Arranged by the Arizona Department on Aging, State Fiscal Year 2001
(in millions)

Source	Amount	Percent of total
Total funding for NMHCBS	\$28.6	100%
Total state government allotment	\$7.9	27.6%
Older Americans Act	\$4.0	14%
Social Services Block Grant	\$4.0	14%
Local funds	\$7.1	24.8%
Other federal funds	\$5.6	19.6%

Source: Arizona's Community Based Services and Settings Report, May 2002.

Medicaid and Other State Spending on Services for Persons with MR/DD

ALTCS spending for persons with mental retardation and developmental disabilities in managed care totaled an estimated \$388.4 million in 2002. This amount includes payment for long-term care services as well as other Medicaid costs for this population, including acute care, case management, and administration. Slightly more than two-thirds of expenditures in CY2002 were used to pay for home and community-based services, with a much smaller amount (4.3% in CY2002) used to pay for institutional services. Managed care expenditures for persons with MR/DD also included acute care, case management, other medical services and administration (**Table 15**).

Table 15. ALTCS and Other Managed Care Expenditures for Persons with MR/DD, Contract Years 1999-2002
(in millions)

Service category	CY1999	CY2000	CY2001	CY2002 (est.)
Total expenditures for ALTCS and other services	\$264.7	\$311.8	\$361.1	\$388.4
Total institutional expenses	\$14.3	\$15.2	\$16.5	\$16.6
Skilled nursing	\$3.3	\$3.7	\$4.4	\$2.7
ICF-MR	\$11.1	\$11.5	\$12.1	\$13.9
Total HCBS expenses	\$177.5	\$206.1	\$246.0	\$259.8
State operated group homes	\$4.2	\$4.4	\$4.5	\$5.2
Vendor operated group homes	\$92.9	\$105.0	\$123.1	\$124.8
Assisted living center	\$6.8	\$7.2	\$8.0	\$9.5
Other	\$73.5	\$89.6	\$110.4	\$120.3
Acute care	\$34.9	\$46.7	\$47.5	\$54.6
Case management services	\$11.7	\$13.2	\$14.6	\$18.6
Other medical services	\$3.0	\$3.4	\$3.8	\$8.0
Administration	\$23.2	\$28.1	\$32.7	\$30.8

Source: CRS analysis of data provided to CRS by AHCCCS, Dec. 2002.

Note: Numbers may not add to totals due to rounding.

AHCCCS' average capitation payment for persons with MR/DD was \$2,623 per enrollee in CY2002. This is \$172 more than the average capitation payment (\$2,451) AHCCCS paid per aged or physically disabled enrollee in the same year. The components of the capitation payment for persons with MR/DD are shown in **Table 16**. Capitation payments covered expected use of HCBS and institutional services, Medicaid covered acute care services, and estimated administration costs associated with service provision. AHCCCS also paid an amount for contingency costs to cover the risk that service costs for participants may exceed the expected payments. Payments for behavioral health services, a service provided through AHCCCS' acute care program, are also included.

Table 16. AHCCCS Capitation Rates Per Capita; Weighted Average for DDD Population by Component, CY1999-CY2002

	CY1999	CY2000	CY2001	CY2002
Total capitation	\$2,302.81	\$2,593.72	\$2,496.45	\$2,623
Home and community-based and institutional services	1,630.09	1,888.24	1,774.2	1,883.1
Acute care services	350.43	339.92	339.92	320.39
Case management services	99.57	104.66	104.66	108.58
Administration	174.37	195.87	184.16	210.48
Risk/contingency	22.54	37.93	36.04	37.84
Behavioral health services	25.81	27.10	57.46	62.63

Source: Data provided to CRS by AHCCCS, Dec. 2002.

State-Only Funded Home and Community-Based Programs for Persons with Mental Retardation and Developmental Disabilities. Arizona provides general revenue from an annual state appropriation for the non-medical home and community based services (NMHCBS) program for persons with MR/DD whose income and assets exceed Medicaid eligibility thresholds. The appropriation for SFY2002 was \$2.4 million. This is \$3.3 million less than the allotment of \$5.7 million in 2000, and \$300,000 less than the amount allotted in 2001. Despite the decrease in funding, enrollment grew by 6% between 2000 and 2002 (Table 17).

Table 17. Enrollment and Funding for Arizona's Non-Medical Home and Community Based Services Program, 1995-2002

Date	Number of enrollees	Funding allotment
June 1995	6,998	not available
June 1999	6,955	not available
July 2000	6,952	\$5.7 million
July 2001	7,190	\$2.7 million
July 2002	7,377	\$2.4 million

Source: DES state officials via telephone and email, Jan. 2002.

Issues in Financing and Delivery of Long-Term Care Services in Arizona

Selected issues raised by Arizona state officials, consumers, providers and other stakeholders as well as unique characteristics of the states' long-term care programs are discussed below. Concerns addressed through task forces developed by the Arizona legislature, such as the intra-agency committee on long-term care and the Elder Issues Task Force, are also identified.

Cost-Effectiveness of Home and Community-Based Services. For years, program administrators, state legislatures, governors, and Members of Congress have debated the cost-effectiveness of home and community-based care in lieu of institutional care. Broad disagreement persists among stakeholders concerning the savings that might occur if the Medicaid program were to invest in a broader array of home and community-based services for more individuals (Medicaid gives states the option to cover home and community-based services, but does not mandate them). Many assert that the per capita costs would decrease for persons living in the community with low care needs and increase for persons with very high care needs. Others claim that a larger investment in home and community-based services by Medicaid would encourage many more people to enroll in Medicaid and thus increase total expenditures.

At the time of ALTCS' inception, program administrators were committed to using home and community-based services as an alternative to nursing home care. Federal agency staff at CMS (then called the Health Care Financing Administration, HCFA), were concerned that clients would use home and community-based services as a complement to nursing home care rather than as a substitute, and that total program expenditures would increase due to an overall increase in utilization. CMS was also concerned that more Arizonans would be attracted to ALTCS' home and community-based service options, and substantial increases in enrollment would result. To contain ALTCS' growth, CMS capped total home and community-based service expenditures at no greater than 5% of the ALTCS budget for the elderly and disabled in 1989. This cap increased steadily over the years. By 1995, CMS had raised the cap to 45%. The cap was removed on October 1, 1999, partly as a result of a study commissioned by CMS.

A study by William Weissert, Ph.D. in 1997 found that the use of home and community-based services for individuals with a high risk of a prolonged stay in a nursing home resulted in substantial savings for ALTCS, even after subtracting the cost of the home and community-based services that were provided in lieu of nursing home care. He also found that the use of home and community-based services for clients with a low probability of a long nursing home stay may be even greater than what would otherwise have been spent for their care in nursing homes. Finally, Weissert's study did not find sufficient evidence of increased enrollment.⁵⁸

⁵⁸ William G. Weissert, Timothy Lesnick, Melissa Musliner, and Kathleen A. Foley, "Cost (continued...)"

Integration of Acute and Long-Term Care Services. Many states divide the responsibility of providing Medicaid-covered long-term care services and Medicaid-covered acute care services among different programs and/or agencies. Payment and management of services for these individuals are often further complicated for those dual eligibles that receive payment for many of their acute care services by Medicare. For these persons, the coordination of care and the payment sources for that care are divided across three programs and/or agencies. Several advocates and constituency groups have asserted that this division of responsibility in caring for dual eligibles has contributed to a fragmented health services delivery system, fraught with administrative inefficiencies and incentives to shift costs across programs.

Unlike other states, Arizona has arranged for the provision of Medicaid acute and long-term care services under a single agency, AHCCCS. Persons that are eligible for long-term care services and are enrolled in managed care, receive all of their Medicaid-covered services through a single MCO. According to state officials, centralizing the payment and administration for both categories of services allows the state to use its spending authority to uniformly apply certain Medicaid policies across all Medicaid-covered services provided to certain individuals and all providers of those services. The fact that a single MCO is responsible for coordinating all Medicaid-covered services may also simplify the program's coordination with Medicare for those beneficiaries who are dual eligibles. Arizona's integration of acute and long-term care services could serve as a model to states interested in developing a more seamless system of care delivery.

Despite this integrated system, some advocates expressed an interest in eliminating the administrative inefficiencies associated with using multiple payers and delivery systems between Medicare and Medicaid for dual eligibles. One suggestion pertained to the pooling of Medicare and Medicaid financing to promote financial and service integration. Another suggestion was to consolidate the program rules to promote improved administrative integration.

Cost-Containment Initiatives. The ALTCS system incorporates a number of cost-containment initiatives integrated into its managed care system. The following describes some of these initiatives:

- *Capitation Payments.* Capitation payments paid to MCOs are made on a per month, per beneficiary basis. Payments are adjusted to account for the number of clients ALTCS expects that the MCO will place in home and community-based settings versus institutional settings. By paying capitated payments to MCOs, AHCCCS shifts a lot of the risk for cost overruns away from the Medicaid agency onto the MCOs.
- *Provider Payments.* Rather than standardize provider reimbursement levels at the same level, MCOs have flexibility to

⁵⁸ (...continued)

Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program," *Journal of Health Politics, Policy and Law*, vol. 22, no. 6, Dec. 1997.

determine the amounts to pay providers. This flexibility allows MCOs the opportunity to adjust payment levels according to their needs to contain costs. Anecdotal evidence from state providers suggests that there is significant variation in the amounts paid to MCO providers.

- *Cost-Effectiveness Tests.* ALTCS requires that case managers apply cost-effectiveness tests when developing care plans. This test discourages placement in nursing homes or ICF/MRs for persons whose needs could be met in home and community-based settings at lower cost. State officials report that per capita spending on individuals enrolled in home and community-based services is often less than per capita spending on institutional care.
- *Profit Incentive.* State laws allow MCOs to keep excess funding not spent on the cost of care as profit. Some advocates raised concerns about the use of Medicaid dollars for profit. State officials interviewed contend that the incentive for MCOs to earn profits has contributed toward increasing home and community-based participation in ALTCS. AHCCCS administrators monitor profit margins of participating MCOs and may adjust payments for future years to MCOs to control for continued high profits.

ALTCS Eligibility. Advocates, providers and state officials raised a number of concerns pertaining to the implementation of eligibility rules, equity of access to services and delays in eligibility determinations. While Arizona's financial eligibility standards enable the state to contain ALTCS spending, they may also make the administrative process of applying for Medicaid difficult for some people. For example, persons whose income exceeds 300% of SSI may place excess income into a Miller trust (see eligibility section above). For many, the placement of funds in a trust may require paid assistance, such as by an attorney or accountant. In addition, persons may find the resources criteria particularly stringent, especially those who need assistance to remain in their homes. For example, qualifying for Medicaid would leave an enrollee without saved resources to pay for needed household expenses and emergencies.

Despite the fact that the long-term care system is centrally managed, advocates claim that inconsistencies in the implementation of the program exist across the state. For example, advocates and consumers asserted that not all ALTCS eligibility workers apply eligibility standards and income and resources counting procedures in the same way. They asserted that one individual may be found eligible in one county and denied coverage altogether in another county.

Advocates also have expressed concern about long delays in the eligibility determination process, especially for persons who require home assessment visits. Advocates assert that these delays are often too long to wait for persons with relatively urgent long-term care needs.

Lack of Presumptive Eligibility Authority. The Medicaid statute prohibits state Medicaid agencies from making retrospective payments to home and community-based providers that serve persons before they are enrolled in the Medicaid program. It does not, however, prohibit Medicaid agencies from making

retrospective payments to nursing homes for this purpose. Thus, home and community-based providers generally do not serve persons until their Medicaid eligibility is established, thus limiting their services to persons who can afford to pay out-of-pocket and persons who are enrolled in ALTCS. These providers are often hesitant to assume the financial risk of providing care to individuals pending ALTCS determination because providers generally do not have sufficient resources to recover the cost of uncompensated care.

In contrast, advocates explained that nursing homes are often the most reliable providers for persons who need services immediately and cannot wait until they receive notification of enrollment from ALTCS. Nursing homes can often assume the risk of ALTCS denial because denial would require the individual to spend down. Given the generally high price of nursing home care, the clients often deplete their income and resources within a predictable period of time, usually 6 months to a year. In addition, some Medicaid certified nursing homes facilitate the application process by assisting applicants in the filing of eligibility forms. Once enrollment in ALTCS is approved, federal guidelines require states to make retroactive payments for covered services up to 3 months prior to the day of application.⁵⁹ As a result, advocates assert that this difference in the ability of providers to assume risk creates excessive reliance on institutional care.

Eligibility for State-Only Funded Programs. Arizona, through its state-only funded programs for the elderly, persons with physical disabilities and persons with MR/DD have addressed some of the Medicaid financial eligibility barriers. These programs allow persons with functional impairments to qualify without undergoing financial tests. By providing services to persons before they deplete their income on care, non-medical home and community-based services may help delay or prevent persons from becoming eligible for ALTCS. State budget allocations, however, limit the amount of funding available to serve all of the persons needing assistance.

State-only funded programs may serve as models for other states that have the financial capacity to expand the pool of eligibles. They may also serve as examples for any federal initiatives that may be proposed to expand eligibility. The state maintains a waiting list for this program.

Long-Term Care Staffing. As in all states, the majority of long-term care in Arizona is provided by direct care providers, including registered nurses, licensed practical nurses and paraprofessionals (home health aides, nursing aides, personal care and home care aides). There have been widespread accounts across the nation of hospitals, nursing homes, home health agencies and other long-term care providers

⁵⁹ A state's Medicaid plan must provide that Medicaid eligibility is effective no later than the third month before the month of application if the individual (1) received Medicaid services, at any time during that 3-month retroactive eligibility period, or a type covered under the plan; and (2) would have been eligible for Medicaid at the time he received the services if he had applied (or someone had applied for him), regardless of whether the individual was alive when application for Medicaid was made. The state's Medicaid agency may make eligibility effective on the first day of a month if an individual was eligible at any time during that month. Medicaid Manual §14,703.

having great difficulty attracting and retaining nursing and paraprofessional personnel. Arizona faces this challenge as well.

Speculation by advocates suggest that a lack of sufficient child care and affordable housing contributes to the state's difficulty in hiring qualified staff. According to advocates, this problem is particularly acute in Arizona's rural areas that have high costs of living, such as Prescott in Yavapai County. The need for workers to travel long distances in rural areas between the homes of program participants, often navigating unpaved roads, magnifies the difficulty of retaining qualified staff. Advocates also explained that the relatively low wages, limited or no employee benefits, and insufficient opportunities for professional development (such as promotions and training opportunities) offered to paraprofessionals have magnified the problem.

State officials and advocates also explained that training of staff on reservations is often inadequate to meet ALTCS standards. Without a sufficient supply of providers on reservations, ALTCS occasionally requires Native Americans to leave their reservations to receive care. At the core of all these challenges are issues concerning quality of care and adequacy of the supply of those nurses and paraprofessionals who play a central role in providing long-term care services.

Arizona's task force on the future of long-term care made a number of recommendations to the state legislature. In response, AHCCCS raised rates in CY2001 by 10%. These rates were intended to pay for increased wages and benefits for nursing paraprofessionals. The following year, the state legislature passed an approximately 15% rate increase to be paid to MCOs. These increases were restricted for use toward higher wages and or benefits for nursing aides and became effective in CY2002.

Assisted Living as an Alternative to Nursing Home Care. Providers and advocates in Arizona expressed concern about increased disability levels of clients in community-based settings in recent years. Anecdotal evidence suggests that this increase is particularly apparent in assisted living facilities. Assisted living residents, as reported by advocates and providers, are looking increasingly more like nursing home residents of 5 years ago. Caring for persons with acute disabilities in assisted living settings, raises concerns about safety and quality of care. States have demonstrated significant variation in the degree to which they monitor the care that is provided in these facilities as well as the training that is offered to caregivers. Unlike most states, Arizona established rules in 1998 to oversee assisted living facilities. In addition, AHCCCS requires MCOs to oversee the care provided to ALTCS beneficiaries in assisted living facilities.

Other Issues. Other issues raised by advocates, providers and state officials are:

- *Consumer Choice.* One of Arizona's 15 counties offer participants a choice between MCOs (Maricopa County). Once enrolled in a MCO, ALTCS participants many select within the range of providers available. Consumer-directed care on a larger scale is not done formally in Arizona.

- *Estate Planning and Avoidance of Estate Recovery.* State officials reported that although there may be a small number of people sheltering assets in order to qualify for ALTCS sooner than they otherwise would, the number is growing. Many people shelter assets in trusts (i.e., Pooled Trusts), annuities and other financial instruments that are deemed “not available” to the Medicaid applicant to pay for long-term care. Anecdotal evidence was also presented about the growing incidence of persons who shelter assets so as to avoid Arizona’s Medicaid Estate Recovery program.
- *Provider Costs Liability Insurance.* Nursing home providers were unanimous in their concern about the increasing costs of liability insurance and the absence of state caps on punitive damages. This issue was raised by many of the provider groups who were interviewed for this study.
- *Affordable Housing.* State officials, advocates and providers raised concerns about limited access to affordable housing for older and working age persons with disabilities. They also expressed concern about the limited ability to use Medicaid dollars to cover room and board expenditures for ALTCS enrollees.
- *Uneven Distribution of Providers.* Advocates asserted that shortages of certain providers, such as adult day care agencies or nursing homes, were prevalent in some counties and available in only limited supply in other counties. Part of this problem may be attributed to MCOs’ flexibility in setting payment levels for local providers. Another reason is that the majority of the population lives in the Phoenix and Tucson metropolitan areas and thus fewer providers can be found outside of these areas. They explained that rural areas often experience a higher scarcity of providers than urban areas in the state.

Appendix 1. About the Census Population Projections

“The projections use the cohort-component method. The cohort-component method requires separate assumptions for each component of population change: births, deaths, internal migration (Internal migration refers to state-to-state migration, domestic migration, or interstate migration), and international migration. The projection’s starting date is July 1, 1994. The national population total is consistent with the middle series of the Census Bureau’s national population projections for the years 1996 to 2025.” (Paul R. Campbell, 1996, *Population Projections for States by Age, Sex, Race, and Hispanic Origin: 1995 to 2025*, U.S. Bureau of the Census, Population Division, PPL-47. For detailed explanation of the methodology, see same available at [<http://www.census.gov/population/www/projections/ppl47.html>].)

Appendix 2

Table A-2. Population in Large State Facilities for Persons with Mental Retardation/Development Disabilities, Closure Date, and Per Diem Expenditure

Large state MR/DD facilities or units operating 1960-2001	Year facility opened	Year closed	Residents with MR/DD on 6/30/01	Average daily MR/DD residents FY2001	Average per diem expenditures FY2001
Arizona Training Program (Phoenix)	1973	1988	—	—	—
Arizona Training Program (Tucson)	1970	1995	—	—	—
Arizona Training Program (Coolidge)	1952	—	158	160	\$270.23
Arizona State Hospital (Phoenix)	1978*	1994	—	—	—

Source: *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2001*, Research and Training Center on Community Living, Institute on Community Integration/UCEED. University of Minnesota (June 2002).

* estimate.