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ADMINISTRATION ON AGING

More Federal Action Needed to Promote Service Coordination for the Elderly



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Human Resources Division

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April 23, 1991

The Honorable Brock Adams
Chairman, Subcommittee on
Aging
Committee on Labor and
Human Resources
United States Senate

The Honorable Thomas J. Downey
Chairman, Subcommittee on
Human Services
Select Committee on Aging
House of Representatives

National polls show that elderly Americans, fearing institutionalization in nursing homes, express strong preferences for living in their own homes and communities as long as possible. To maintain their independence, the dependent elderly need an array of home and community-based services such as meal preparation; home health care; house-keeping; adult day care; and assistance with bathing, toileting, and other personal needs. Currently, about 6 million elderly Americans need these services and this population is expected to increase to about 10 million by 2020.¹ Family and friends are the largest providers of these services, but demographic changes affecting these informal caregivers will likely diminish their ability to provide care in the future.² Moreover, demand for government funded programs for services could increase as a result of such changes.

Federal, state, and local agency officials as well as other experts agree that the nation's elderly often have serious problems obtaining the package of health and social services they need when responsibilities for these services are shared by multiple state and local agencies. This sharing of responsibility frequently results in fragmented service delivery, which in turn creates difficulties in coordinating the timing, availability, and appropriateness of services from multiple providers.

¹Numbers derived from data in Kenneth G. Manton, "Epidemiological, Demographic, and Social Correlates of Disability Among the Elderly," The Milbank Quarterly, Vol. 67, Suppl. 2, Pt. 1, 1989, pp. 13-58.

²Trends toward smaller family size, frequent divorces, more women in the labor force, and greater geographic dispersal of families may tend to diminish the ratio of informal caregivers to elderly persons who need health and social services.

The literature is replete with examples of concern about service fragmentation and the need to improve coordination of home and community-based care for the elderly.

Acknowledging that the ad hoc arrangement of health and social services often impedes access to services for the elderly, the Older Americans Act of 1965 and subsequent amendments emphasized coordination as a means to deliver services for the elderly more efficiently. The Congress expected the Administration on Aging (AOA) to play a major role in promoting service coordination. In subsequent amendments, the Congress broadened AOA responsibilities to include organizing and administering grants through state and local agencies for nutrition services, social services, multipurpose senior centers, and other home and community-based services. Best known among these services are the meals-on-wheels and other nutrition programs.³

Objectives, Scope, and Methodology

The purpose of this report is to inform the Congress on the status of AOA coordination efforts as it deliberates reauthorization of the Older Americans Act. We reviewed AOA operations regarding activities central to promoting coordination. Those operations involved (1) technical assistance to state and local governments, and (2) dissemination of information from research and demonstration projects. We also examined available information on varying state experiences in coordinating services. (See app. I for a more detailed discussion of our objectives, scope, and methodology.)

Although we did not obtain written agency comments, we discussed the contents of this report with cognizant agency officials and incorporated their views as appropriate. We performed our work between May 1989 and August 1990 in accordance with generally accepted government auditing standards.

Results in Brief

Despite its mandate under the Older Americans Act to promote better coordination of services for the elderly, AOA efforts in the 1980s did not keep pace with growing coordination needs. Management decisions and cuts in federal resources reduced technical assistance and information dissemination necessary for AOA to foster coordination at the state and local level. In effect, AOA withdrew from the "aging network" it helped create. As a result, AOA's knowledge base, largely acquired through

³AOA administered a fiscal year 1990 budget of about \$748 million for a variety of home and community-based services and research and demonstration projects.

direct contact with state and local agencies, eroded and its capacity to provide assistance weakened.

Improving the efficiency and quality of services provided through stronger coordination will continue to be important in the 1990s as an aging population increases the demand for home and community-based services. The federal government has a direct stake in strengthening coordination because it shares in the cost of financing these services. Using AOA, which is uniquely positioned to provide leadership through central and regional office staff, the federal government can better achieve its mandate to promote coordination through the existing infrastructure of state and area agencies on aging.

We believe that AOA can contribute significantly to service coordination in the 1990s through more effective use of its resources. For example, AOA can improve central office dissemination of research and demonstration results on coordination and use regional offices to provide more technical assistance about service coordination to state and local agencies. Moreover, AOA can maximize the impact of its scarce resources by targeting states and communities most likely to benefit from federal support.

Expansion of Services for the Elderly Increases Need for Coordination

Consistent with the growth in the elderly population over the last decade, programs serving the elderly have expanded rapidly. Many states now offer home and community-based services for the elderly through their Medicaid programs. Other federal programs, such as those authorized by the Older Americans Act and Social Services Block Grant, provide a greater variety of such services than before. In addition, about two-thirds of the states operate programs providing home and community-based services that are exclusively state funded. Finally, the number of private service providers and programs has also increased.

The numerous programs for the elderly have many disparate funding sources, program objectives, eligibility requirements, and administering agencies that make obtaining services more complex, as shown in figure 1. In many states the same service provided by Medicaid, the Older Americans Act, and a state-funded program, for example, is not uniformly accessible because of different eligibility requirements. Likewise, the same or related services are administered by different agencies, including departments of social services, health, aging, transportation, and others. Agencies also have diverse arrangements with local service providers.

Figure 1. Major Government Programs Supporting Home and Community-Based Care Services for the Elderly

Program	Objectives	Eligibility Requirements	Administering Agencies	
			Federal	State
Medicare/Title XVIII of the Social Security Act	To Pay for Acute Medical Care for the Aged and Disabled	Persons 65 Years and Over, Persons Under 65 Years Entitled to Federal Disability Benefits, and Certain Persons With End-Stage Renal Disease	Health Care Financing Administration/HHS	N/A
Medicaid/Title XIX of the Social Security Act	To Pay for Medical Assistance for Certain Low-Income Persons	Aged, Blind, Disabled Persons Receiving Cash Assistance Under SSI; Others Receiving Cash Assistance Under AFDC at State Option; Persons Who Qualify as "Medically Needy"	Health Care Financing Administration/HHS	State Medicaid Agency
Social Services Block Grant/ Title XX of the Social Security Act	To Assist Families and Individuals in Maintaining Self-Sufficiency and Independence	No Federal Requirements; State May Require Means Tests	Office of Human Development Services/HHS	State Social Services/Human Resources Agency in Some Cases, Other State Agencies May Administer a Portion of Title XX Funds for Certain Groups; e.g., State Agency on Aging
Older Americans Act	Foster the Development of a Comprehensive and Coordinated Service System to Serve the Elderly	Persons 60 Years and Over; No Means Tests, but Services Are Targeted to Those With Social or Economic Need	Administration on Aging/ Office of Human Development Services/HHS	State Agency on Aging
Supplemental Security Income/Title XVI of the Social Security Act	To Promote an Income Floor for Needy Aged, Blind, and Disabled Individuals	Aged, Blind, Disabled Persons Who Meet Federally Established Income and Resources Requirements. States May Make Payments to Other State-Defined Eligibility Groups	Social Security Administration/HHS	State Supplemental Payment Program May Be State or Federally Administered
State Only Programs	To Address "State-Identified" Needs	States Determine Eligibility Requirements	N/A	State Agencies

To further complicate state and local coordination efforts, Medicare, the largest source of federal funding for home health services, grew substantially in the 1980s. Medicare reimburses agencies providing services to the elderly but is not administered by state agencies. Other programs that are administered by state and local governments, however, may serve the same clients and pay for services provided by the same agencies.

Frequently, poor service integration in many states complicates obtaining services for the elderly and their families. For example, an elderly person recuperating from a broken hip may need physical therapy; transportation to therapy; and help with meals, dressing, and shopping. Access to these services, however, often requires contacting multiple agencies, each of which assesses eligibility and provides services differently. In most localities, these services are likely to be delivered piecemeal. In contrast, some states and localities attempt to simplify access to multiple services for their elderly clients through pooling funds from several programs for similar services, case management, colocation of social services, and other methods.

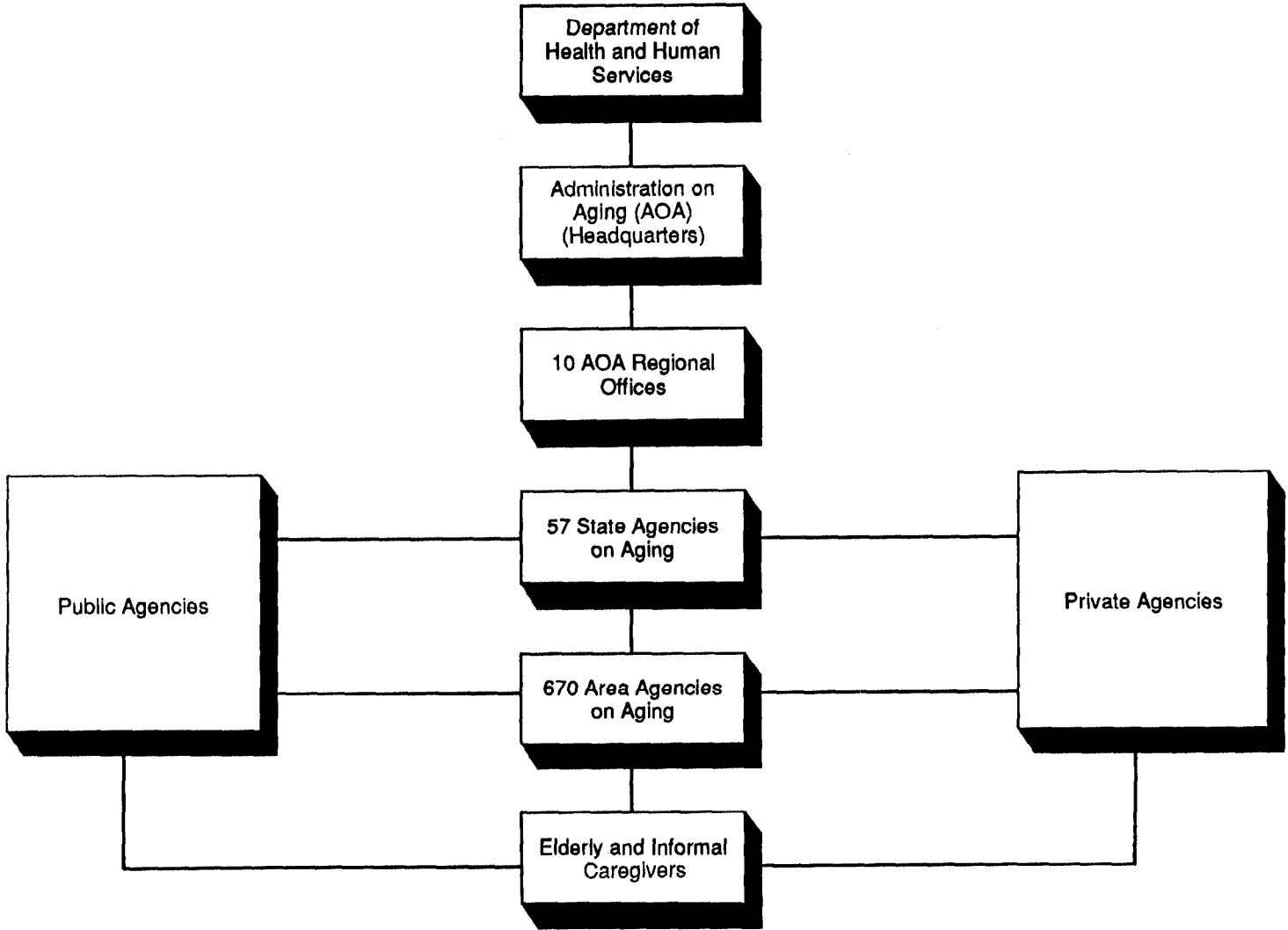
The Older Americans Act Established an Intergovernmental Infrastructure for Coordination

The Older Americans Act fostered the development of a unique infrastructure of agencies, headed by AOA, to help coordinate services for the elderly. The act charges AOA with federal responsibility for promoting service coordination among federal, state, and local government agencies as well as private agencies.⁴ The Congress chose to enhance service coordination through this aging network of federal, state, and local agencies on aging rather than compel coordination through a single federal agency. This approach has given states and communities considerable discretion in determining the content and organization of services to individuals.

Figure 2 shows the public and private components of the extensive aging network. AOA, state agencies on aging, and local area agencies on aging have the lead responsibility for coordinating, planning, and advocating elderly services at their respective governmental levels.

⁴Specifically, the act requires AOA to "coordinate, and assist in, the planning and development by public (including Federal, State, and local agencies) and private organizations of programs for older individuals, with a view to the establishment of a nationwide network of comprehensive, coordinated services." 42 U.S.C. 3012(a)(12).

Figure 2. The Aging Network



AOA Support to the States Declined

During the 1980s, despite the widely acknowledged and acute need for better coordination of services for the elderly, AOA substantially reduced information dissemination and technical assistance activities. Consequently, state and local governments were left largely on their own to develop ways to coordinate services. Because of the withdrawal of AOA regional office and headquarters staff from contacts in the rest of the aging network, AOA had difficulty maintaining its knowledge base about

state and local advances in coordination of services. This in turn compromised AOA's ability to foster replication of effective coordination strategies. Moreover, states reported needing better dissemination of information and more technical assistance to help improve their programs.

Operational Changes at AOA Adversely Affected Coordination Mission

During the 1980s, AOA management actions and resource constraints resulted in the detachment of central and regional office staff from the rest of the aging infrastructure. The central office instructed staff in regional offices not to interact with state and local agencies on aging, yet assigned no alternative duties.⁵ AOA staff and travel resources were significantly reduced during the same time.⁶ Between 1981 and 1989, the number of AOA staff, including the central office and regional offices, fell from 252 to 162—a 36 percent decrease, AOA officials reported. The five regional program directors we interviewed reported larger cuts than the AOA-wide reduction.⁷

Travel funds for AOA staff also fell during the 1980s from a peak of about \$238,000 in 1984 to a low of about \$45,000 in 1989. During this period, travel funding declined by 81 percent.⁸ Officials at four of the five regional offices with whom we spoke provided comparable information on their travel budgets in the 1980s. Overall, travel cuts at these regional offices were greater than the 81 percent reported agencywide and contributed to the growing regional office isolation from state and area agency officials.

Research and demonstration projects as well as subsequent dissemination also experienced significant budget reductions during the 1980s. Funding dropped from \$54 million in 1980 to \$26 million in 1990. AOA staff who administer title IV also were reduced during the 1980s, from 50 in 1983 to 25 full-time-equivalent employees in 1990, according to AOA staff estimates.

⁵The commissioner and her staff have been considering what the role of regional offices should be in the 1990s.

⁶The Department of Health and Human Services—including the Office of Human Development Services, which provides administrative and travel support for AOA—also experienced reductions in resources during this period.

⁷We selected 5 of AOA's 10 regions based on geographic diversity. AOA agreed that the 5 regions provided a fair assessment of the regional perspective.

⁸AOA travel funds increased to \$90,000 in fiscal year 1990.

Dissemination Needs Improvement

Disseminating information on successful coordination experiences is a key component of AOA promotion of coordination, but one which AOA needs to improve. During the 1980s, AOA substantially reduced its overall dissemination efforts under title IV of the Older Americans Act, including those relevant to coordination.⁹ Most notably, AOA eliminated its clearinghouse in 1981 because of budget cuts. Many state agencies and other experts attributed program improvements to AOA dissemination activities and told us that AOA could make several relatively minor changes in the way it disseminates information that would yield significant results at the state and local level.

AOA officials told us they are aware of shortcomings in the dissemination area and are considering ways to improve it. They told us the agency does not systematically disseminate title IV results or monitor how these results are used. AOA does publish the Compendium of Active Grants,¹⁰ but relies primarily on others to disseminate information¹¹ because staff spend most of their time preparing grant announcements, evaluating applications, and monitoring the progress of work.

To find out more about overall AOA dissemination of information we conducted a survey of state agencies on aging regarding dissemination of title IV results and their use by state agencies.¹² The results reinforce expert views that AOA disseminated little information on coordination during the 1980s and that greater dissemination by AOA would have helped state and local agencies better coordinate services.

⁹The Congress intended under title IV that a priority be placed on research and demonstration activities and on the dissemination of information related to these activities and effective practices in the field of aging. This was to be accomplished in part, through the "... dissemination of information on the aging ... acquired through such [title IV-supported] programs to public and private organizations or programs for older individuals." 42 U.S.C. 3030aa(4). The act further requires that "[a]ppropriate provisions for the dissemination of resulting information shall be a requirement of all [title IV research and development] grants ..." 42 U.S.C. 3035(a).

¹⁰The annual compendium contains listings and descriptions of projects underway and is generated through an automated productions system in which project descriptions and information are keyed in from grant award materials.

¹¹Specifically, AOA provides research and demonstration results to the Government Printing Office and to databases such as AGELINE, sponsored by the American Association for Retired Persons; the National Technical Information Service at the Department of Commerce; and Project Share, sponsored by the Department of Health and Human Services. AOA also relies on grantees to disseminate the results of their individual projects.

¹²We conducted our survey of state agencies in the 50 states and the District of Columbia during August 1990. The survey response rate was 100 percent. See Older Americans Act: Dissemination of Research and Demonstration Findings Could Be Improved (GAO/T-HRD-90-53, Sept. 11, 1990).

Our survey showed that state agencies on aging most frequently get their information from a private newsletter and national resource centers, partly funded by AOA. Of the 51 state agency officials we surveyed, 33 told us that they have used project results disseminated to them to make changes in their programs and 39 said that increased AOA dissemination would help in carrying out their programs. Several state agencies cited improvements they made in service coordination as a result of information they had received from title IV projects.

State agencies had several suggestions for improving AOA dissemination of information on coordination and other topics. For example, 29 state agencies on aging told us a published summary of completed title IV projects' results to supplement the compendium of ongoing activities would be very useful, and AOA officials agreed. State officials also reported that more AOA-sponsored conferences and seminars would help them better understand and apply research results in their states, and 9 states asked for increased contact with AOA's regional offices.

Technical Assistance Needs to Be Expanded

Technical assistance is an important tool for promoting service coordination by providing the on-site means to translate research and demonstration results into practice. During the 1970s, AOA regional offices were very active in promoting coordination through frequent on-site visits to assist state and area agencies on aging design their administrative structures and implement programs. Through these contacts, AOA also gained national perspective on state and local innovations in delivering and coordinating services for the elderly. AOA largely abandoned this role in the 1980s, however, and as a result eroded both its expertise and its capacity to promote coordination.

Simultaneously, the states began to face more complex home and community-based care developments that increased the need for coordinating services. Among these developments were financing and providing services like case management, cross-state information and referral systems, and broad-based eldercare programs that include the use of corporate or other private funding sources. States reported especially needing assistance with coordination of Medicaid waiver and other social service programs, design of common admission and assessment instruments for home and community-based services, and implementation of case management programs.

States sought to compensate for the lack of AOA staff assistance in several ways, but most were not successful in solving their fragmentation

problems. Some state officials reported that they tried to develop expertise on their own or with the informal help of officials from other states. Some states also reported using national resource centers for long-term care in the late 1980s.¹³ (See app. II for a description of the centers.)

AOA Can Promote Coordination More Effectively in the 1990s

AOA can maximize the effectiveness of its limited resources by using the positive experiences of about a dozen states to assist other states whose programs are not yet well coordinated. AOA site visits, conferences, workshops, and other face-to-face assistance can help bring information on successful coordination to state and local officials who need it and help them consider how to apply the information.

By using readily available information from the states that have progressed in service coordination and from aging experts, AOA can rebuild quickly and at low cost the knowledge base it needs to promote coordination throughout the infrastructure. Using this information, AOA could identify coordination strategies that work and promote their replication across the country. Two key elements AOA could use in developing a plan for promoting coordination with its existing resources are (1) how some states and communities have improved service coordination and (2) which states are most in need of and receptive to efforts for improving coordination.

The diversity of effective approaches underscores the importance of tailoring coordination to local delivery systems. For example, Oregon locates all relevant programs in the Senior and Disabled Services Division of its Department of Human Resources. Maryland convenes a state interagency committee of agencies administering relevant programs. Illinois coordinates local services for several state-administered programs through its Department of Aging contracts with Care Coordination Units.¹⁴

Despite state differences in program financing and administration (see app. III), some common principles, which may be useful for AOA promotion of coordination, can be derived from successful coordination approaches. Based on discussions with state officials and other experts

¹³The six national resource centers for long-term care, established in 1988, receive grants and contracts from AOA to perform research and policy analysis and to provide technical assistance for the Commissioner of AOA, policy makers, service providers, and the Congress. 42 U.S.C. 3032(a).

¹⁴For a discussion of coordination strategies in six states, see Diane Justice and others, State Long Term Care Reform: Development of Community Care Systems in Six States (Washington, D.C.: National Governors' Association, 1988).

we interviewed, the experiences of states show that strategies to promote coordination are most successful when (1) policies stress state and local agency accountability for service coordination; (2) planning is done jointly by service providers, community leaders, and the elderly to identify access and delivery problems and services needed; (3) services are developed and implemented jointly by related state and local agencies; (4) interagency agreements specify the services each agency will provide; and (5) communities have clearly designated points of entry for service and well-defined agency responsibilities for client assessment and case management.

AOA Federal Initiatives Show Promise

AOA has several initiatives underway to promote service coordination at the federal level. These initiatives include AOA written agreements with the Social Security Administration (SSA), the Health Care Financing Administration, the Department of Transportation, and the Department of Housing and Urban Development signed in the late 1980s.¹⁶ These agreements formally establish staff groups to work on issues of mutual interest to the agencies involved. Although these AOA efforts show promise, it is too early to assess their overall impact in promoting coordination at the service delivery level.

Conclusions

AOA did not make sufficient efforts to promote service coordination at the state and local level in the 1980s. AOA is in a unique position, however, to promote coordination in the 1990s through the aging network. We believe AOA can promote service coordination by using its existing regional and central office staff to disseminate research and demonstration results and to provide technical assistance to states and communities. Judicious use of scarce resources would require targeting those states and communities most in need of and receptive to assistance. In addition, AOA can strengthen its efforts to promote coordination at low cost by tapping existing sources of information on successful state coordination methods.

¹⁶One result of these agreements, for example, is that AOA is carrying out a demonstration project with SSA. This project places area agency on aging staff in an SSA office in each of AOA's 10 regions for the purpose of providing information on a broad range of programs to those accessing SSA offices.

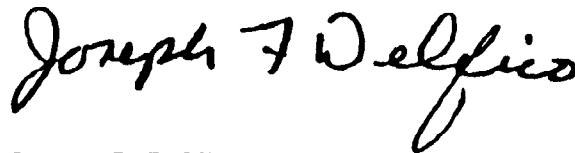
Recommendations

We believe that AOA can improve its promotion of service coordination if it more effectively uses its scarce resources. To accomplish this, we recommend that the Commissioner of AOA:

- expand the role of AOA regional offices in (1) disseminating research and demonstration results and (2) providing technical assistance to state and area agencies on aging by targeting communities where assistance is likely to have the greatest effect and
- compile and disseminate a directory of research and demonstration results to state and local agencies.

As requested by your offices, unless you publicly release its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services, the Commissioner of AOA, and the directors of the state agencies on aging. We will also make copies available to other interested parties upon request.

Please call me on (202) 275-6193 if you or your staffs have any questions about this report. Other major contributors are included in appendix IV.



Joseph F. Delfico
Director, Income Security Issues

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Abbreviations

AOA	Administration on Aging
IHPP	Intergovernmental Health Policy Project
HHS	Department of Health and Human Services
SSA	Social Security Administration

Objectives, Scope, and Methodology

Objectives

The objective of this report is to inform the Congress on the status of AOA efforts to promote coordination in preparation for reauthorization of the Older Americans Act. We reviewed AOA operations central to promoting coordination that:

- disseminate information from research and demonstration projects and
- provide technical assistance to state and local governments.

We also examined information on varying state experiences in coordinating services.

Scope

The scope of our work included federal, state, local, and private programs that fund or deliver home and community-based services. Our focus was on programs for persons 60 years of age and older, since this is consistent with how older individuals are defined in title III of the Older Americans Act. Most other programs serving the older population are targeted to slightly different cohorts or specifically to no particular age group at all. To the extent possible, we focused on the elements of those programs relevant to the population 60 and over. These programs include Medicare; Medicaid; the Social Services Block Grant; Social Security; Supplemental Security Income; other income security, housing, and transportation programs; and programs funded entirely by state governments.

Methodology

We collected information for this study by (1) reviewing documents and literature, (2) interviewing experts, (3) analyzing data from a survey of state agencies on aging on their use of Older Americans Act research and demonstration project results, and (4) analyzing data from a survey of all cognizant state agencies on their financial and administrative responsibilities for home and community-based services for the elderly.

Review of Documents and Literature

We reviewed (1) the Older Americans Act and its legislative history, (2) AOA regulations related to coordination, (3) reports from AOA research and demonstration projects, (4) internal AOA administrative documents, and (5) several state agency on aging service plans submitted to AOA. AOA also provided us with data on changes in its staff size and travel expenditures, but could only provide this information for selected years. We examined documents and data provided from other federal agencies, states, communities, and other aging experts concerning AOA, state, and

local efforts to provide coordination. In addition, we reviewed the literature on the coordination of home and community-based services to examine lessons learned from studies of coordination attempts in various states and communities.

Interviews of Experts

We interviewed federal and state officials and other aging experts in the home and community-based services field. This included AOA central and regional office staff, participants in some of AOA's current research and demonstration projects, and directors or assistant directors of five state agencies on aging. The AOA regional offices contacted were in Atlanta, Boston, Chicago, Philadelphia, and San Francisco. AOA's central office agreed that these offices would provide a fair representation of regional office perspectives. The state agencies on aging contacted were California, Florida, Massachusetts, Mississippi, and Ohio. We also interviewed aging experts in universities and research organizations.

Analysis of Survey Data

We conducted a telephone survey of state agencies on aging in the 50 states and the District of Columbia. We analyzed their responses regarding the accessibility of the Older Americans Act's title IV results and the use made of the material disseminated. The response rate was 100 percent.

We also analyzed financial and administrative responsibilities for home and community-based services at the state level using survey data collected by the Intergovernmental Health Policy Project (IHPP) at George Washington University.¹ We extracted from these data information on the home and community-based services aspect of long-term care. We added information on Older Americans Act expenditures for nutrition services from a United States Senate Special Committee on Aging report.² These data were not included in the George Washington survey. We did not verify all the data but did verify some individual state data and compared control totals for spending nationwide against the sum of spending reported for all states. On the basis of these checks and the views of experts with whom we talked, we believe that the data provide an accurate picture of home and community-based services spending

¹Debra J. Lipson, Elizabeth Donohoe, and Constance Thomas, *State Financing of Long-term Care Services for the Elderly: Volume II State Profiles* (Washington, D.C.: Intergovernmental Health Policy Project, George Washington University, 1988).

²*Developments in Aging: 1986*, Report of the United States Senate Special Committee on Aging, Mar. 13, 1986.

**Appendix I
Objectives, Scope, and Methodology**

administered by the states. Data on administrative responsibilities of state agencies on aging were coded from the narratives in the HPP study and verified by an independent coder. These data are discussed in detail in appendix III.

National Resource Centers for Long-Term Care

In 1988, AOA awarded 3-year grants for the establishment of six national resource centers on long-term care. These centers have the potential to be an important force in helping states and communities to improve the coordination of home and community-based services for the elderly.

AOA funded the long-term care resource centers to provide training and technical assistance, syntheses of research papers, and dissemination of current information about their prescribed subject areas. Center staff are to provide expert consultation and assistance to state and area agencies on aging, other agencies providing services to the elderly, and AOA. The mission and potential products of each center are described below.

**Brandeis University, Bigel
Institute for Health Policy,
(Waltham, Massachusetts)**

Mission: Support (1) policymaking, (2) program planning, and (3) program implementation by state and area agencies on aging that manage long-term care delivery. The topical areas covered by the center are: (1) integrated delivery systems, (2) home-care personnel and quality issues, and (3) cultural diversity among elderly clients and the aging services workforce.

Products: (1) National training workshops, (2) training manuals, (3) on-site technical assistance, (4) "best practice" materials, and (5) periodic letters to the state agency on aging directors.

**University of California at
Los Angeles, Department
of Medicine and Geriatrics,
(Los Angeles, California)**

Mission: To work in collaboration with the University of Southern California Andrus Gerontology Center to (1) promote stronger linkages between the aging network, hospitals, and residential long-term care facilities; (2) decrease fragmentation; and (3) encourage more appropriate utilization by providers and consumers of the full range of options available to older persons to remain independent. Topic areas to be covered by the center are: (1) geriatric assessment programs, (2) discharge planning, (3) respite care, and (4) supportive housing and home modifications.

Products: (1) Annotated bibliographies, (2) training manuals and videotapes, (3) case analyses on model programs, (4) policy papers, (5) a newsletter, and (6) consumer booklets.

Heartland Center on
Aging/National Center for
Senior Living Indiana
University (Indianapolis,
Indiana)

Mission: Support state agencies and others in the areas of long-term care planning and data analysis.

Products: (1) Technical assistance guides; (2) state, regional, and national training sessions; (3) a practitioner fellowship program; (4) special data analysis; and (5) other products to orient aging network personnel in providing the planning and management of long-term care service delivery.

University of Minnesota,
School of Social Work
(Minneapolis, Minnesota)

Mission: Improve long-term care decisions made by the elderly and those working with and for older persons, especially staff of state and area agencies on aging. Topic areas covered by the center include: (1) assessment, (2) case management linkages between community level care and nursing home and acute care facilities, and (3) ethics of long-term care. The center brings together faculty from the University Schools of Public Health, Social Work, Public Affairs, and the Center for Biomedical Ethics.

Products: (1) Training conferences, (2) telephone and selected long-range on-site assistance, (3) information synthesis and dissemination, and (4) periodic papers and training products, including a quarterly newsletter.

National Association of
State Units on Aging
(Washington, D.C.)

Mission: (1) Assist state aging networks to integrate discrete community long-term care program components into comprehensive systems of care; (2) enhance states' capacities to develop quality assurance initiatives for community long-term care systems; and (3) increase the ability of states to better link their community long-term care systems with other delivery systems providing older people acute, primary, and institutional care. The center will provide information on multiple approaches to each of these system functions so that states can choose the ones most applicable to their own local context.

Products: Continuing education and skill building for aging network personnel working at multiple levels of expertise through (1) training, (2) technical assistance, and (3) peer consultation. Indirect technical assistance in the form of (1) training curricula, (2) resource directories, (3) guidebooks, (4) educational videotapes, (5) a compendium of tools, (6) special issue manuals and papers, (7) focus groups, (8) published proceedings, and (9) state profiles of expenditures and other community-based long-term care data.

**University of South
Florida Suncoast
Gerontology Center,
(Tampa, Florida)**

Mission: Respond to the needs and priorities identified by state agencies on aging as they plan, develop, and implement programs and services for Alzheimer's disease victims and their family caregivers, with a special focus on the needs of elderly minorities. The center provides state agencies with (1) information; (2) national and regional training sessions; and (3) technical assistance in establishing effective, comprehensive, and coordinated statewide services systems and programs to recognize, diagnose, and provide short-term treatment and long term management to Alzheimer's disease patients and meet the needs of their family caregivers.

Products: (1) A computerized knowledge base, (2) a quarterly newsletter and applied research publications, (3) "best practice" guides for educating minority caregivers, and (4) providing information on respite care and dementia-specific care units.

Diversity in State-Administered Home and Community-Based Services

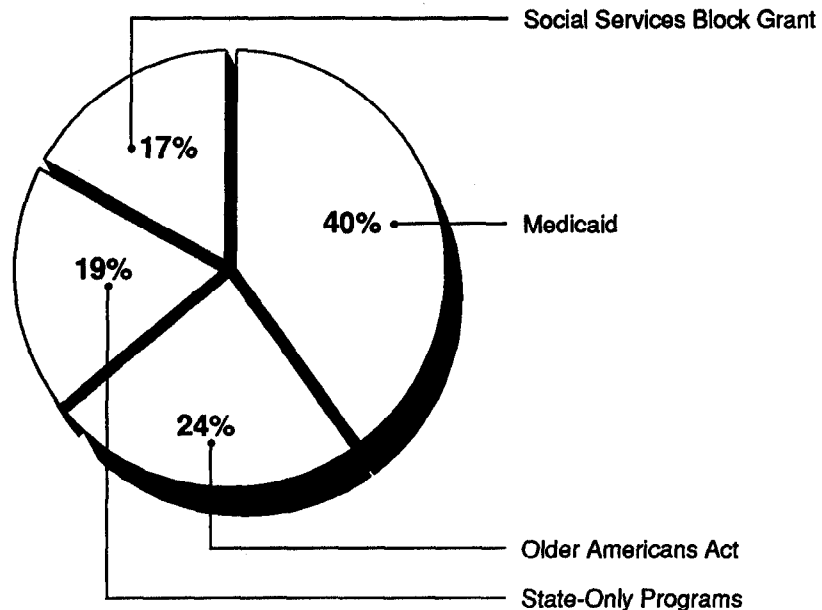
States have diverse financing and administrative arrangements for home and community-based services for the elderly. This means that there is considerable variation by state in the types and amounts of these services available to the elderly and in the way that services are accessed and used. States organize and provide these services primarily through three federal programs: (1) Medicaid, (2) the Older Americans Act, and (3) the Social Services Block Grant, and through programs funded exclusively by state revenues, often referred to as state-only programs. The Medicaid and Older Americans Act programs are partly funded by state governments through required matches to federal funding. Though Medicare is the largest source of government funding for home and community-based services, it is not included in this analysis because states do not administer it. All these funding sources can pay for identical or similar services for the elderly though eligibility criteria vary.

Older Americans Act Is the Largest Source of Funds in Most States

Overall Picture Understates Importance of Funding

Medicaid is the largest funding source for home and community-based services overall among state-administered programs, as figure III.1 shows. Among the four state-administered programs, Medicaid accounted for 40 percent of the total. The Older Americans Act program was the second largest source of funds at 24 percent, followed by state-only programs at 19 percent, and then by the Social Services Block Grant at 17 percent.

Figure III.1 State-Administered Spending
for Home and Community-Based
Services for the Elderly, Fiscal Year 1986



Source: Calculated from data reported in Debra J. Lipson, and others, *State Financing of Long-Term Care Services for the Elderly: Volume II State Profiles* (Washington, D.C.: Intergovernmental Health Policy Project, George Washington University, 1988); and *Developments In Aging: 1986*, Report of the United States Senate Special Committee on Aging, March 13, 1986.

Note: Data do not include all state-matching funds for the Older American Act, therefore, the Older Americans Act share is slightly understated.

The overall funding picture, however, understates the importance of Older Americans Act funding for home and community-based services. In fact, if New York is excluded, the Older Americans Act is the largest overall funder of these services because New York accounted for more than one-half of Medicaid spending for these services nationwide in fiscal year 1986. This fact is frequently overlooked, partly because funding for home and community-based services is often aggregated with total long-term care spending, where Medicaid spending, especially for nursing home care, clearly dominates.

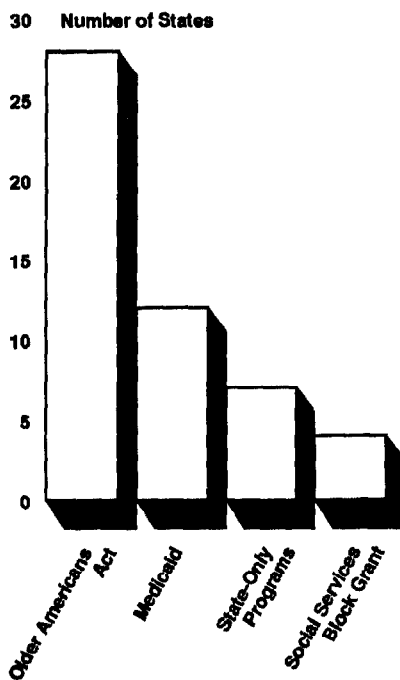
On a state-by-state basis, the Older Americans Act was the largest funder of home and community-based services for the elderly in 28 states in fiscal year 1986, the most recent for which comprehensive data are available (see fig. III.2).¹ The act was the second largest sources of funds in 17 other states. By contrast, Medicaid was the largest source of

¹In these 28 states, Older Americans Act funds, as a percentage of state-administered home and community-based services funding, ranged from 38 to 100 percent.

**Appendix III
Diversity in State-Administered Home and
Community-Based Services**

funds in only 12 states, state-only programs in 7 states, and the Social Service Block Grant in 4 states. These numbers suggest that the Older Americans Act is a major payer for home and community-based services in all but a few states.

Figure III.2 Largest Sources of State-Administered Funding for Home and Community-Based Services for the Elderly, Fiscal Year 1986



Largest Funding Sources

Source: Calculated from data reported in Debra J. Lipson, and others, *State Financing of Long-Term Care Services for the Elderly: Volume II State Profiles* (Washington, D.C.: Intergovernmental Health Policy Project, George Washington University, 1988); and *Developments In Aging: 1986*, Report of the United States Senate Special Committee on Aging, March 13, 1986.

Note: Data do not include all state-matching funds for the Older Americans Act, therefore, the Older Americans Act may be the largest source of funds in more states than indicated.

States Are Major Source of Funding

States were important funders of home and community-based services in the 1980s. The overall fiscal importance of the states is demonstrated by the fact that state governments accounted for \$1.3 billion or 45 percent of state-administered home and community-based services spending in fiscal year 1986. Accounting for the bulk of these expenditures were state matches to Medicaid and programs funded exclusively

**Appendix III
Diversity in State-Administered Home and
Community-Based Services**

by state governments.² Both Medicaid and state-only programs increased significantly in the 1980s, but the role of state-only programs is not as well known.

In the 1980s, many states established or expanded state-only programs for home and community-based services for the elderly. Increases in the elderly population and strategies to avoid the high costs of institutional care contributed to expansion of many of these programs. In some cases, states opted for their own programs rather than relying solely on matching federal Medicaid funds because the flexibility gained was worth the loss in potential federal dollars to them.

Total spending for state-only programs was \$578 million in fiscal year 1986. A total of 33 states reported having state-only programs in that year, but state-only program dollars were heavily concentrated in a smaller number of states. Ten states accounted for 90 percent of all these program expenditures (see table III.1). In 3 states—Pennsylvania, Massachusetts, and New Jersey—over one-half of all home and community-based services spending came from state-only programs.

Table III.1: Ten States With the Largest State-Only Program Expenditures for Home and Community-Based Services for the Elderly (Fiscal Year 1986)

State	State-only programs
Pennsylvania	\$154,077,000
Massachusetts	105,400,000
New Jersey	85,075,000
Illinois	69,982,100
Florida	35,514,500
Washington	23,035,100
New York	13,816,300
Minnesota	12,726,200
Colorado	12,616,500
Wisconsin	11,214,100
Total	\$523,456,800

^aDoes not include all state matching funds.

Source: Data on state-only program expenditures from Debra J. Lipson and others, *State Financing of Long-Term Care Services for the Elderly: Volume II State Profiles* (Washington, D.C.: Intergovernmental Health Policy Project, George Washington University, 1988).

²State matches to Older Americans Act funds also contribute to total state spending. States are required to match 15 percent of Older Americans Act funded services, and many states overmatch.

**Wide Range in Per Capita
Spending Among the
States**

In fiscal year 1986, funding for state-administered home and community based services for the elderly was as much as 12 times higher per capita in some states than in others. Higher spending may indicate a greater range and quantity of services because states can increase the resources available for these services by choosing additional options under Medicaid and by funding their own state programs. This is important because states with varying levels of service availability may have very different coordination needs.

Per capita spending for each elderly person ranged from \$323 to \$27 per capita among the states. Three states—New York, Alaska, and Massachusetts—had per capita expenditures above \$200. After these three states, the next highest expenditure rate was \$157 per capita in Washington, D.C. Nationwide, average state expenditures were \$83 per capita. In fiscal year 1986, states with high, moderate, and low amounts of spending were found in each major region of the country.

**State Agencies on
Aging Administer the
Largest Program in
Most States**

In fiscal year 1986, state agencies on aging administered or shared in the administration of the largest home and community-based program in 38 states.³ In addition to the Older Americans Act, many state agencies on aging also administered Medicaid, the Social Services Block Grant, and state-only programs. State agencies on aging administered at least one program other than the Older Americans Act in 42 of the states.

³Data on administrative responsibilities of state agencies on aging were derived from narratives for programs in each state in Debra J. Lipson, and others, State Financing of Long-Term Care: Volume II State Profiles.

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