South Carolina Legislative Audit Council

LAC

Report to the General Assembly

March 1993

A Limited-Scope Review of Long Term Care and Related Services for the Elderly

Legislative Audit Council

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A Limited-Scope Review of Long Term Care and Related Services for the Elderly was conducted by the following audit team.

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A Limited-Scope Review of Long Term Care and Related Services for the Elderly

March 1993

In March 1992, members of the General Assembly requested that we review long term care and related services for the elderly. We focused primarily on the long term care and related services provided by South Carolina state government agencies. We found that:

- The elderly comprise the greatest portion of persons needing long term care.
- A significant number of persons need long term care and related services but do not receive them.
- Planning and delivery of long term care and related services are fragmented among different organizations.
- Elderly, blind, and disabled persons receive fee and tax exemptions regardless of financial need. To focus assistance on those who cannot afford needed services, it would be more effective to reduce fee and tax subsidies to high-income individuals and use those funds to increase assistance to low- and moderate-income individuals who need long term care services.

What Long Term Care Services Are Provided by State Agencies?

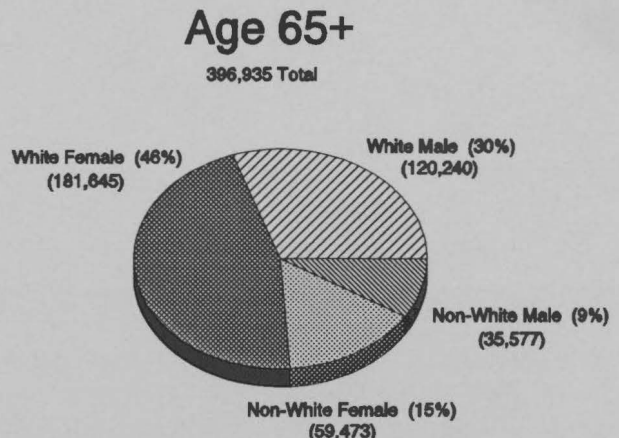
FY 90-91 Expenditures on the Elderly by Six State Agencies (in Millions)

Agency	State Funds	Federal and Other Funds
COA	$3.0	$10.5
Finance Commission	$88.5	$237.4
DHEC	$2.3	$28.4
DSS	$8.3	$38.6
DMH	$27.4	$14.1
DMR	$4.8	$7.0
Total	$134.3	$336.0

Examples of services include home-delivered meals, case management, homemaking and personal care, transportation, adult protective services, home health care, and institutional care. Some services are provided by these agencies directly; some are funded by state agencies but provided by other organizations.

What are the Characteristics of the Long Term Care Population?

Approximately 92% of nursing home residents and 65% of community long term care clients are 65 and older. Persons 65 and older made up 11% of the state's population, according to the 1990 census. The number of elderly in South Carolina by sex and race are:



The 1990 census also showed that 20.5% of South Carolinians 65 and older lived below poverty, a rate almost twice the national average for this age group.

Based on projections made by the State Budget and Control Board Division of Research and Statistical Services, South Carolina's aged 65+ population is expected to grow 25% from 1990 to 2000. The number of South Carolinians aged 85 and older is expected to more than double.

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What are the Unmet Long Term Care Needs of the Elderly?

The elderly who need long term care and related services sometimes do not receive them.

- About 500 persons 65 and older are waiting for medicaid-funded nursing home beds.
- About 2,500 persons, the majority of whom are 65 and older, eligible for community long term care are waiting for services.
- 29 of the state's 46 counties did not have licensed adult day care available.
- Hundreds more are on waiting lists for services, such as home-delivered meals, funded by the Commission on Aging.

Waiting lists for specific programs are only one indication of an unmet need. The 1990 *Panel Study of Older South Carolinians* estimated that 55%, or 217,000, of South Carolinians aged 65 and older were dependent on others' help in one or more of the routine activities of daily living.

While 59% of the elderly receive help from friends or family, about 15% in the panel study sample reported not receiving any help for their needs.

Is Planning of Services Coordinated?

Three interagency groups are involved in planning for long term care services. These groups have related goals and overlapping members. We concluded that planning could be more efficient if coordinated by a single interagency group.

Responses to our audit begin on page 41.

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Are Home and Community Based Services Coordinated?

Planning and delivery of services are fragmented among different state agencies and organizations. Gaining access to long term care services may be confusing and time-consuming. For example, a number of agencies provide similar services such as homemakers and personal care aides. Obtaining these services becomes a complex process. Some disabled elderly must be served by multiple programs and agencies in order to get the level of service they need. The fragmentation of long term care programs means that the elderly may have to contact numerous state agencies before connecting with the services they are eligible for.

Are Fee and Tax Exemptions Based on Financial Need?

Property taxes, retirement income taxes, and various state fees are reduced for the elderly, blind, and disabled. Persons with high incomes receive the same tax and fee exemptions as those with low or moderate incomes. For example:

- In 1993, elderly, blind and disabled households making $50,000 or more will receive a $5.3 million subsidy from the state to help pay their local property taxes.
- Individuals aged 65 and older do not pay South Carolina income taxes on the first $10,000 of retirement income.
- In addition, camping fees in state parks and motor vehicle registration fees are reduced for the elderly and disabled.

We did not suggest what the state's long term care funding priorities should be. However, $4.4 million annually in state funds would be sufficient to provide long term care services to an additional 2,500 elderly and disabled community long term care clients per month.

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Report to the General Assembly

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LAC/92-2

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Executive Summary

We conducted a limited-scope review of long term care and related services provided by South Carolina state government. We made the following findings:

- The elderly comprise the greatest portion of persons needing long term care in South Carolina. For example, approximately 92% of nursing home residents and 65% of community long term care clients are 65 and older. The number of South Carolinians 65 and older is expected to increase 25% from 1990 to 2000 and the number 85 and older is expected to more than double. Also, South Carolinians 65 and older have a poverty rate almost twice the national average (see pp. 5-8).

- There is a significant number of persons who need long term care and related services but do not receive them. Approximately 500 persons 65 and older are waiting for medicaid-funded nursing home beds. There are approximately 2,500 persons on the community long term care waiting list eligible for services based on need criteria, the majority of whom are 65 and older. Hundreds more are on waiting lists for services funded by the Commission on Aging (see pp. 9-14).

- Planning and delivery of long term care and related services are fragmented among different organizations. A number of agencies provide similar, and in some cases the same, services. As a result, the steps clients take to receive services and the steps agencies take to coordinate and deliver services may be more complicated than necessary (see pp. 15-29).

- Finally, elderly, disabled, and blind persons receive exemptions from fees and taxes which are not based on need. Persons with high incomes receive the same tax and fee exemptions as those with low and moderate incomes. For example, in 1993, elderly, blind, and disabled households making $50,000 or more will receive a $5.3 million subsidy from the state to help pay their local property taxes. We do not suggest what the state's long term care funding priorities should be. However, $4.4 million in state funds annually would be sufficient to serve an additional 2,500 elderly and disabled community long term care clients per month (see pp. 31-33).

We recommend greater integration of long term care services. We also recommend that fee and tax exemptions be frozen, reduced, or eliminated for elderly, blind, and disabled persons with high incomes. The savings could be used to increase long term care services for elderly, blind, and disabled persons with low and moderate incomes.

Introduction

Audit Objectives

In March 1992, members of the South Carolina General Assembly requested that we review long term care services for the elderly. We conducted a limited-scope review of long term care and related services provided by South Carolina state government. Our objectives were:

- Determine whether client needs are being met.
- Examine coordination of planning and service delivery by state agencies.
- Identify tax and fee exemptions which are not based on need.

Most of the long term care and related programs we reviewed serve elderly and non-elderly clients. For those programs, the recommendations in this report will affect all clients regardless of age.

Scope and Methodology

The United States General Accounting Office (GAO) defines long term care as the:

> . . . array of medical, social, and support services needed by individuals who, because of chronic illness or disability, need another person's help in caring for themselves over an extended period of time.

Our review focused primarily on long term care and related services provided by the Commission on Aging, the Health and Human Services Finance Commission, the Department of Health and Environmental Control, and the Department of Social Services. To a lesser extent, our review included the Department of Mental Health and the Department of Mental Retardation. Our review did not focus on long term care services provided to persons by family members.

The time frame covered by our review was primarily July 1990 through July 1992. We examined agency records, procedures, and state and federal laws. We also interviewed government and private agency officials in South Carolina, other states, and the federal government.

We obtained self-reported expenditure data from state agencies. We also compared client lists in four counties and inspected a random sample of client records in two counties.

We found no consistent age at which people are considered "elderly." When we refer, in this report, to the elderly, we will sometimes refer to persons 60 and older and sometimes persons 65 and older.

This review was conducted in accordance with generally accepted government auditing standards.

Background

Below is a description of the long term care and related services provided by six state agencies in South Carolina. Estimates of expenditures on the elderly were provided to us by the agencies.

FY 90-91 Expenditures on the Elderly by Six State Agencies (in Millions)		
Agency	State Funds	Federal and Other Funds
COA	$3.0	$10.5
Finance Commission	$88.5	$237.4
DHEC	$2.3	$28.4
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Total	$134.3	$336.0

Commission on Aging (COA)

The Commission on Aging provides funding and technical assistance to ten area agencies on aging (AAAs) across the state. The AAAs contract with a network of approximately 60 local service providers. The AAAs and local providers are not state agencies but consist of other public and private organizations.

Services provided through COA are targeted primarily at persons 60 and older. Examples of the services provided through this network include home delivered meals, congregate meals, homemaker services, recreational activities, transportation, and case management.

Commission on Aging records indicate that in FY 90-91 it spent approximately $3.0 million in state funds (including bingo tax revenue) and $10.5 million in federal (mostly through the Older Americans Act) and other funds on services to clients 60 and older.

Health and Human Services Finance Commission (finance commission)

The Health and Human Services Finance Commission sets standards and provides funding for programs in other public agencies and the private sector. Examples of long term care programs supported by the finance commission with medicaid funds include nursing homes, home health services, and community long term care (CLTC). Examples of programs supported by the finance commission with social service block grant (SSBG) funds include homemaker services, adult protective services, meals, and transportation.

CLTC is a medicaid-funded program operated by the finance commission to provide services to elderly and disabled persons, HIV/AIDS patients, and persons with mental retardation or related disabilities. Through CLTC, elderly and disabled clients receive case management, personal care assistance, and other services at home as an alternative to nursing home care. Personal care aides are provided under contract with other public and private agencies. Approximately 65% of CLTC clients are 65 or older.

The finance commission reports that in FY 90-91 it spent approximately $88.5 million in state funds and $237.4 million in federal and other funds on services to clients 65 and older. These totals have been reduced by the amount that finance commission expenditures overlap with expenditures by COA, DHEC, DSS, DMH, and DMR.

Department of Health and Environmental Control (DHEC)

The Department of Health and Environmental Control operates programs which provide health-related services.

DHEC's home health program provides skilled medical services, such as nursing and physical therapy, to homebound patients. Home health patients may also receive personal care services from "home health aides."

Through a separate program under contract with the finance commission, DHEC provides personal care services to CLTC clients. Staff who provide these services are called "personal care aides."

Approximately 66% of home health and personal care aide clients are 65 or older.

DHEC reports that in FY 90-91 it spent approximately $2.3 million in state funds and $28.4 million in federal (including medicare) and other funds on services to clients 65 and older.

Department of Social Services (DSS)

DSS operates social programs designed to protect the physical and financial well-being of clients. Adult protective services protects persons including those who are disabled, abused, or neglected. The optional state supplement program provides funding for elderly, blind, and disabled clients in residential care facilities. Other services DSS provides are homemaker services, family counseling, and food stamps.

The percentage of clients who are 65 and older in these DSS programs ranges from 33% to 64%.

DSS reports that in FY 90-91 it spent approximately $8.3 million in state funds and $38.6 million in federal and other funds on services to clients 65 and older.

Department of Mental Health (DMH)

The Department of Mental Health provides institutional and community services for persons with conditions including mental illness, alcohol and drug addiction, and alzheimer's disease. These services include clinical treatment as well as providing or securing housing, vocational opportunities, health care, social and recreational activities, economic assistance, and case management.

The percentage of DMH clients who are 65 and older varies. In DMH institutions, the percentage of clients 65 and older ranges from approximately 70% to 100%. By contrast, 6% of direct community service hours are provided to clients 65 and older.

DMH reports that in FY 90-91 it spent approximately $27.4 million in state funds and $14.1 million in federal and other funds on services to clients 65 and older.

Department of Mental Retardation (DMR)

The Department of Mental Retardation provides regional residential care, community residential care, and family support for persons with mental retardation.

The percentage of clients who are 65 and older in DMR programs ranges from 2% for family support to 7% for regional residential care.

DMR reports that in FY 90-91 it spent approximately $4.8 million in state funds and $7.0 million in federal and other funds on services to clients 65 and older.

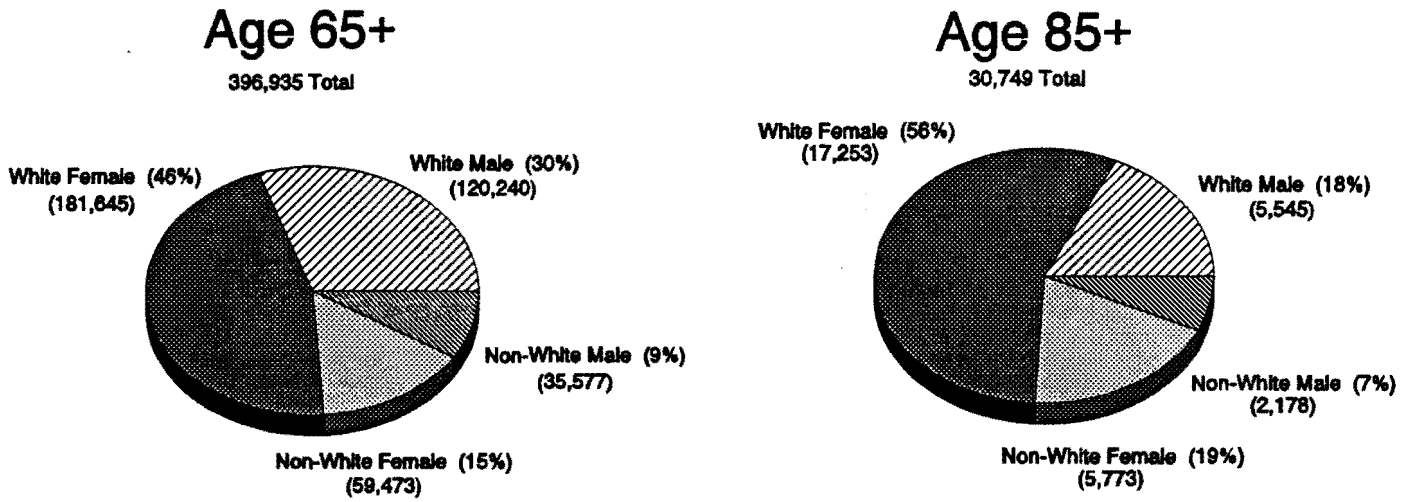
Demographic Profile of Older South Carolinians

South Carolinians aged 65 and older included 396,935 individuals, about 11% of the state's population, in the 1990 census. Information obtained from the 1990 census shows that:

- 62% were between the ages of 65 through 74; 30% were between ages 75 through 84; and 8% were 85 and older.
- 61% were female, and 39% male; 76% were white, and 24% black.
- The ratio of female to male increased as the population aged; 75% of those aged 85 and older were female (see Chart 1.1).
- 67% lived in households with family members, while 28% lived alone, 4% lived in institutions, and 2% lived with unrelated individuals and other group quarters.
- Women between the ages of 75 to 84 were the most likely to be living alone, especially compared to their male counterparts (45% vs. 18%).

The 1990 census also shows that South Carolinians aged 65 and older were poorer than the state as a whole; 20.5% lived below poverty compared to a statewide average of 15.4%. This was almost twice the national poverty rate of 11.4% for people age 65 and older. Almost 40% of South Carolina citizens 65 and older had annual incomes of less than $10,000. As shown on Table 1.1, race and type of living arrangement were related to poverty among older people.

Chart 1.1: Older South Carolinians by Sex and Race According to the 1990 Census



Source: 1990 census.
LAC graphics.

Table 1.1: Poverty Status of Older South Carolinians According to the 1990 Census

South Carolinians Over Age 65	Percent Living Below Poverty
Male	14%
Female	25%
White	14%
Black	42%
Married	9%
Not Married, Live With Family	21%
Live Alone	40%
Live In Non-Family Household	46%

Poverty status as determined by the 1990 census for those who reported income for 1989. Income of institutionalized persons not included.

Projections for the Future

Future projections of the number, type, income and disability rates of older South Carolinians are not precise. The level of migration into the state, the economy, marriage and divorce rates, birth and death rates, trends in health care and technology, and many other factors can have unpredictable demographic effects. Nationwide models, developed by Duke University, The Brookings Institution, and the Urban Institute have yielded varying results in projecting the size and status of the elderly population up to the year 2060.

The Division of Research and Statistics of the Budget and Control Board, in 1988, used census data to make some projections about South Carolina's aging population in the year 2000. Division of Research and Statistics officials expect to revise these projections in 1993.

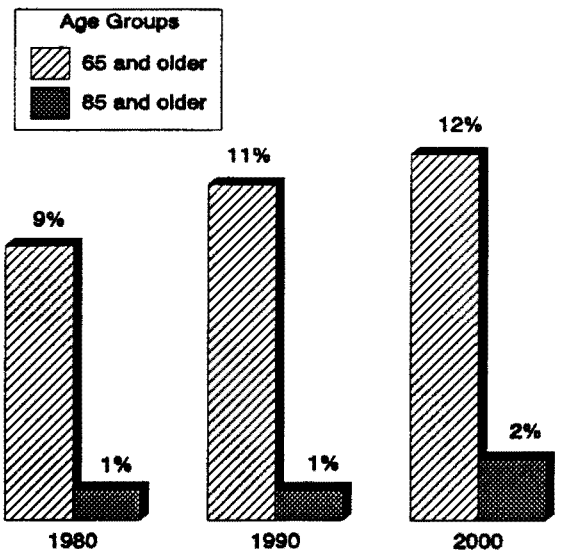
The number of South Carolinians aged 85 and older is expected to grow by 117% from 1990 to 2000.

From 1990 to 2000, South Carolina's total population is expected to increase by about 16%. The increase in persons age 65 and above is expected to be about 25%, and the number of South Carolina citizens aged 85 and above is expected to grow by 117%. By 2000 individuals aged 65 and above are expected to be 12% of South Carolina's population. The chart below shows the expected increases as a percent of the state's population for age 65+ and age 85+.

Nationally, South Carolina is ranked 29th in the number of age 65+ citizens, and ranks 38th in its number of older citizens as a percent of state population. South Carolina was sixth in the rate of growth of its elderly population from 1980 to 1989. However, even though South Carolina's older population is increasing faster relative to those of other states, by the year 2010 it is projected to still rank 37th among the states in its number of older citizens as a percent of total state population.[1.1]

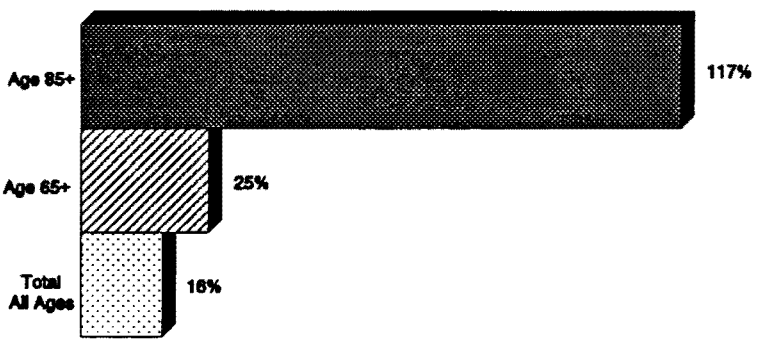
[1.1] Source of national data is *Aging America: Trends and Projections*, prepared by the U.S. Senate Special Committee on Aging, the AARP, the Federal Council on the Aging, and the U.S. Administration on Aging, 1991.

Chart 1.2: South Carolina's Older Population as a Percent of the Total Population



Source: Budget and Control Board Division of Research and Statistics.
LAC graphics.

Chart 1.3: Projected Increase For Different Age Groups in South Carolina from 1990-2000



Source: Budget and Control Board Division of Research and Statistics.
LAC graphics.

Unmet Needs

In our limited review of state agencies directly involved in long term care and related services, we found that South Carolina does not adequately meet its citizens' needs. Many individuals needing long term care are put on waiting lists; some are not receiving care at the level or frequency needed; and in some counties services do not exist. Some specific examples of these needs are cited below.

Waiting Lists

One method used by state agencies to measure the unmet need for long term care is through waiting lists for specific programs. Medicaid-funded programs and those administered by local councils on aging have waiting lists.

- As of September 1992, 559 individuals were waiting for a medicaid-funded nursing home bed, according to finance commission reports.

  The finance commission does not keep separate data on whether individuals waiting for services are aged 65 and over. The 1991 nursing home census conducted by DHEC shows that 92% of nursing home residents were age 65 and over. Projected to the current waiting list for nursing home beds, that means approximately 500 elderly clients are waiting for a bed. According to finance commission officials, individuals waiting for a medicaid-funded nursing home bed have been assessed and are eligible to receive this service.

  According to DHEC officials, as of October 1992 South Carolina had 13,499 community nursing home beds certified to receive medicaid clients. From 1987 to 1992, about 2,100 new medicaid beds were approved, the first major increases in new beds since 1979. Of these new medicaid beds, approximately 500 are not yet fully licensed and available for patients. Medicaid currently pays for approximately 75% of nursing home patients in South Carolina. The cost of maintaining a client in a nursing home with medicaid funds was $12,765 for federal fiscal year 1991 (the last year information is available), according to finance commission reports.

Approximately 500 persons 65 and older are waiting for medicaid-funded nursing home beds. Approximately 2,500 persons on the CLTC waiting list are eligible for services based on need criteria, the majority of whom are 65 and older.

- As of October 1992, there were 3,213 individuals waiting for community long term care (CLTC) services for the elderly and disabled according to finance commission reports. Approximately

65% of CLTC clients served in FY 90-91 were 65 and older. Those on the CLTC waiting list have not been formally screened and, therefore, might not be eligible for CLTC based on its financial and need criteria. The finance commission has estimated that approximately 2,500 of the persons on the waiting list are eligible for services based on need criteria. CLTC takes clients on a "first come, first served" basis, and does not distinguish between clients based on severity of need, although to be eligible all clients must need nursing home level of care.

As of October 1992, there were approximately 4,000 CLTC "slots." The number of CLTC clients served per year decreased by about 23% from 1989 to 1992. The cost of maintaining a client in the CLTC program with medicaid funds was $4,539 for federal fiscal year 1991 (the last year information is available).

- Local councils on aging, which receive partial funding through the state Commission on Aging, maintain waiting lists for services which are available to persons aged 60 and over. As of April 1, 1992, the largest waiting lists were for the following services:

Home-Delivered Meals	1,149
Home Care (Homemakers and Personal Care Aides)	929
Case Management	218
Transportation	135
Congregate Meals	231
Respite/Adult Day Care	109

1990 Panel Study of Older South Carolinians

In addition to waiting lists for specific state programs, general information on the number of South Carolina elderly with long term care needs was identified by the 1990 *Panel Study of Older South Carolinians*. This study was sponsored by the Long Term Care Council and conducted by the University of South Carolina.

The panel study indicated that elderly South Carolina citizens need more long term care services then they currently are getting. The need for long term care is determined by how many people need help with the activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The ADL index measures a person's ability to independently carry out six to seven basic functions of daily living, including feeding, dressing, bathing, and toileting. The IADL index measures the ability to carry out approximately nine activities such as preparing meals, balancing a checkbook, and walking or getting around without crutches, wheelchairs or the aid of another person.

Approximately 55%, or 217,000, of the population aged 65 and older who live in the community, needed help with ADLs and/or IADLs. About 10%, or at least 39,000 elderly individuals, needed help with one or two ADLs. About 4%, or at least 16,000 elderly individuals had dependencies with three or more ADLs, which can classify them as severely disabled. The older the individual, the greater the likelihood he or she had a dependency in an ADL or IADL. These data are illustrated by Chart 2.1.

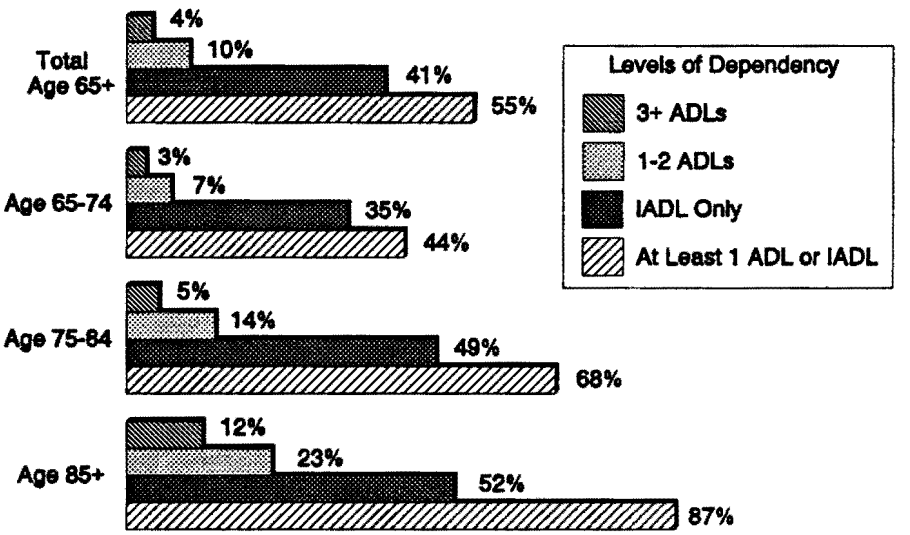
The panel study estimated that 55%, or about 217,000, South Carolinians aged 65 and older needed help with the routine activities of daily living. It also estimated that about 15%, or 32,500, received no help with those activities.

About 15% of those with dependencies were covered by medicaid, according to the Division of Research and Statistics. Information from the panel study also showed that 59% of persons with dependencies received help from family and friends. About 6% were helped by programs funded through state, federal and other public funds or volunteer efforts. About 40% were helped by privately paid services. And about 15% received no help at all. If this percentage is applied to the total number of South Carolinians age 65 and over who had some IADL or ADL difficulty, that means about 32,500 individuals lack help for these dependencies.

The panel study was a telephone survey that gathered information on 6,473 South Carolinians age 55 and older who live in the community. It did not include those elderly living in nursing homes or in DMR and DMH facilities. Since the study was administered as a telephone survey, it did not include households where the elderly do not have a telephone—about 5%. It should also be noted that participants in the panel study assessed

their own needs and may not necessarily meet funding and level of need criteria to be eligible for certain state services.

Chart 2.1: Percent of Elderly With Dependencies in Daily Living Activities



Source: 1990 *Panel Study of Older South Carolinians.*
LAC graphics.

Access to Services

Waiting lists do not provide a complete picture of unfulfilled service needs. They reflect only the number of people who are aware of the services and have applied for them.

For example, based on panel study information, we estimated that there were 22,000 individuals aged 60 and older who may need but do not receive home-delivered meals, 27,000 who may need but do not receive case management, and 16,000 who may need but do not receive congregate meals. Thus, a greater number may need services than is shown by the waiting lists on page 10.

Waiting lists reflect only the number of people who are aware of the services and have applied for them. An estimated 22,000 individuals aged 60 and older may need but do not receive home-delivered meals.

Needy elderly, potentially eligible for long term care services, may not be applying for these services for several reasons. Some may not be able to access services because of lack of transportation. Based on panel study information, we estimated that 11,000 to 16,000 individuals aged 60 and older had transportation problems which hindered them from getting to meal sites and/or social services.

A lack of information about available services may also limit access to these services. Thirty-five percent of the respondents to the panel study said they would not know where to get information about services in the community. Also, a system with multiple service providers and criteria for eligibility may be confusing to elderly clients.

Cutbacks in Services

While individuals on waiting lists may not be getting the services they need, some who are receiving services may not be receiving them at the level or frequency needed. In two counties we found evidence that local agencies were cutting back on services such as homemakers and personal care aides because of budget reductions.

The policy of the CLTC program is for regional staff to authorize up to 15 hours of personal care services per week. More hours can be authorized only with special permission from central CLTC administration. In deciding the amount of personal care a client receives, agency officials have stated that budget considerations together with the client's needs are determining factors.

Services Not Offered

In addition to inadequate levels of existing services, some services are absent in some counties. For example, as of June 1992, there were 29 licensed adult day care centers in 17 counties. Twenty-nine of the state's 46 counties did not have licensed adult day care available. In an informal survey we sent to local councils on aging, 12 stated that adult day care was a major unmet need in their area.

A lack of housing suitable for frail elderly has been cited by Palmetto SeniorCare and the Commission on Aging. In addition, the allocation of social services block grant funds for adult day care and homemaker services was not based on the relative needs of each county, but rather was determined by traditional funding levels. As a result, some counties did not have these SSBG-funded services available for the elderly.

Conclusion

In our review, we did not determine what the state's funding priorities should be. However, in assessing the need for long term care, the following points should be considered:

- More dependent elderly reside in the community than in institutions.
- National surveys have shown that the elderly prefer to receive long term care in the home or community whenever possible.
- The waiting lists for in-home and community services are larger than that for medicaid nursing home beds.

In general, the demand for long term care services exceeds the current capacity of state and local agencies. The need for long term care services is expected to increase as the numbers of elderly in this state increase over the next ten years. In Chapter 5 of this report, we discuss possible funding alternatives that could be directed toward long term care.

Interagency Planning

We reviewed the extent to which planning of long term care services is coordinated among South Carolina state agencies. The Commission on Aging, Department of Social Services, Department of Health and Environmental Control, Department of Mental Health, Department of Mental Retardation, and the Health and Human Services Finance Commission provided us with their formal planning documents which relate to long term care services. We also reviewed interagency planning documents of the Long Term Care Council, the Human Services Coordinating Council, and the Commission on Aging Coordinating Council. In addition, we interviewed staff of the agencies and interagency planning councils.

We found that interagency planning groups overlap with each other, which could result in services which are not coordinated.

Role of the Commission on Aging

Federal law 42 U.S.C. §3025 requires that there be a state agency on aging. Federal regulation 45 C.F.R. §1321.7 requires that the agency:

> . . . carry out . . . functions relating to advocacy, planning, coordination, interagency linkages, information sharing, brokering, monitoring and evaluation, designed to lead to the development or enhancement of comprehensive and coordinated community based systems in, or serving, communities throughout the State.

South Carolina law designates the Commission on Aging to be this agency. Section 43-21-40 of the South Carolina Code of Laws directs the Commission on Aging to:

> . . . study, investigate, plan, promote, and execute a program to meet the present and future needs of aging citizens of the State, and it shall receive the cooperation of other State departments and agencies in carrying out a coordinated program.

In July 1992 the Commission on Aging published its most recent state plan. This four-year plan identifies strategies which the Commission on Aging will use to address concerns relating to the elderly. It also summarizes what other state agencies and interagency groups are doing in the field of aging.

Overlapping Planning Groups

Two interagency groups, the Long Term Care Council and the Human Services Coordinating Council, develop plans that address long term care services. The Commission on Aging Coordinating Council also addresses issues relating to long term care. The goals and membership of these interagency planning groups overlap.

The overlap in the planning groups' goals can be seen in a review of their enabling legislation:

- §129.25 of the Appropriation Act for FY 92-93 requires that the Human Services Coordinating Council "[p]rovide coordination between the council members and the State Health and Human Services Finance Commission in the development of the comprehensive State Health and Human Services Plan [and] . . . coordinate and oversee efforts to integrate services information among state agencies . . . ."

- The goal of the Long Term Care Council is similar. Section 43-21-140 of the South Carolina Code of Laws requires that the Long Term Care Council, "[t]hrough close coordination of each member agency's planning efforts . . . develop recommendations for a statewide service delivery system for all health impaired elderly or disabled persons . . . ."

Five agencies are members of all three interagency planning groups. Eleven agencies are members of two or more of the groups.

- Also similar, is the goal of the Commission on Aging Coordinating Council. Section 43-21-120 requires that the Commission on Aging Coordinating Council work with the Commission on Aging on the: ". . . programs related to the field of aging, and to advise and make pertinent recommendations to the [C]ommission [on Aging] . . . ."

In addition to having related goals, these interagency groups have overlapping memberships. Five agencies are members of all three groups. Eleven agencies are members of two or more of the groups. Appendix A on page 37 lists the membership of the interagency planning groups.

Interagency planning may be more efficient and better coordinated in a single interagency group. Some of the existing interagency groups could become subcommittees of this unified group. Lack of planning coordination can lead to a lack of coordination in the way services are provided.

Recommendation

1 The General Assembly may wish to consider merging the Health and Human Services Coordinating Council, Long Term Care Council, and Commission on Aging Coordinating Council into one interagency planning group. Any special tasks could be given to sub-committees within this interagency group.

Integration of Home and Community Based Services

We found that home and community based long term care services may not be adequately integrated among different organizations. In conjunction with this finding, we note that the finance commission's community long term care program is not in compliance with state law and that area agencies on aging could be streamlined.

While some innovations are being implemented to integrate services, additional operational changes are needed. Despite federal funding restrictions that shape the operation of these programs, state level changes can be made. Since the issues we address in this chapter are interrelated, our recommendations should be considered and implemented together.

Services Are Fragmented

Gaining access to long term care can be a complicated process. Fragmentation of home and community based long term care exists in South Carolina and in other states. According to the United States General Accounting Office (GAO), multiple programs with differing funding sources, largely federal, have produced a disjointed approach to service provision. In 1991, GAO reported:

> 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 . . . . Frequently, poor service integration in many states complicates obtaining services for the elderly and their families . . . . Access to these services . . . often requires contacting multiple agencies, each of which assesses eligibility and provides services differently.

Our review of community based long term care services in South Carolina supports the GAO findings. The Health and Human Service Finance Commission (finance commission), Commission on Aging (COA), Department of Health and Environmental Control (DHEC), and Department of Social Services (DSS) have programs with overlapping eligibility criteria and clients. We did not review the Department of Mental Health or the Department of Mental Retardation in this segment of the report because they serve special needs clients.

Officials in several South Carolina agencies told us that due to the number of long term care programs, clients can be confused about which agency is serving them. In addition to the impact on clients, poor service integration increases the need for agencies to communicate with each other.

Different Programs Perform Same Functions

DSS, DHEC, the finance commission, and local councils on aging in the COA network perform similar long term care services. For example, each agency has programs that employ or contract for personnel for housekeeping and personal care services. Housekeeping includes activities such as routine cleaning, shopping, and meal preparation. Personal care activities include bathing, dressing, hair care, and shaving. The job descriptions for these positions are fundamentally the same across programs with the exception that some put varying emphasis on personal care and on housekeeping.

Table 4.1, based on agency documents and interviews with staff, shows job titles of persons who provide housekeeping and personal care services. It also shows how they are funded, eligibility criteria for different funding sources, and mechanisms for accessing these similar services through the different providers.

Table 4.1: Similar Housekeeping/Personal Care Services Funded Through South Carolina State Agencies

Provider	Funding	Client Eligibility Criteria	Where Client Accesses Service
Homemaker Service			
Private organizations not affiliated with COA	•Federal social services block grant (SSBG) through finance commission contracts	•Need based requirement •Financial eligibility requirement •Target group requirement defined by grant, or •DSS adult protective service client status	•Private providers awarded SSBG contracts by finance commission (DSS would still assess the client and authorize the service) •DSS
DSS	•Federal SSBG through finance commission interagency contract with DSS •Appropriated state funds	Same as above	•DSS
Local councils on aging	•Federal SSBG through finance commission contracts	Same as above	•COA network service providers usually a council on aging (DSS would still assess the client and authorize service for clients served with SSBG funds) •DSS
	•Federal Older Americans Act through COA	•Age requirement among adults (60+ for most service) •No financial eligibility requirement (however, services to be targeted to greatest social or economic need)	•COA network service providers, usually a council on aging
	•State alternate care for the elderly (ACE) funds	Same as above, plus functional impairment requirements	Same as above
Personal Care Aide (PCA)			
Private organizations not affiliated with COA	•Federal medicaid through finance commission's CLTC program	•Need for nursing home level of care required •Financial eligibility requirement	•Finance commission's CLTC program which also refers the client to DSS for a financial eligibility determination
DSS	Same as above	Same as above	Same as above
Local councils on aging	Same as above	Same as above	Same as above
DHEC	Same as above	Same as above	Same as above
Home Health Aide			
DHEC	•Fee for service program; clients' or their medical coverage (usually medicare) pays for service	•Need for home based, "skilled" (usually a nurse's) care from DHEC's home health program	•DHEC home health

Similar Clients and Eligibility Requirements

In two counties, we reviewed files of clients aged 60 and older from COA, DHEC home health and personal care aide programs, DSS adult services, and the finance commission's CLTC program. We also conducted a four-county comparison of client lists. We noted that poor, elderly, and disabled clients may be served by multiple agencies and programs. An elderly person who is poor, ill, disabled, and homebound may meet the eligibility criteria of all four of the agencies we reviewed. See Table 4.1 for comparison of the eligibility criteria associated with the housekeeping/personal care aide services previously discussed.

A four-county comparison of July 1992 client lists revealed that many clients were served by more than one agency.

Table 4.2: Percent of Agency Clients, Aged 60 and Older, Served by at Least One Other Agency's Programs

	DSS[a]	DHEC	CLTC	COA
County A	47%	51%	48%	11%
County B	27%	27%	65%	10%
County C	33%	47%	46%	8%
County D	39%	34%	51%	5%

a Excludes clients who receive only transportation services.

We found the client list provided by county D's local council on aging did not include clients served using local funds only. This same list also included a number of inactive cases. In reviewing county B's files we found no material problems. We did not check the accuracy of client lists in counties A and C, but due to this indication of data problems, Commission on Aging percentages should be viewed as estimates.

Although we found multiple agencies providing services to the same client, it should not be assumed that services provided by each agency were not needed by the client. Under the system's resource limitations, some clients receive services from more than one agency to meet their needs. For example, an extremely disabled CLTC client with no family support might require more than the maximum hours of personal care aide

service per week that CLTC can provide. To meet the client's needs, DSS adult services may provide an additional ten hours a week of homemaker service.

Client Characteristics

When considering the effects of this fragmented system on clients it is important to remember the traits of those served. The 1990 *Panel Study of Older South Carolinians* estimated that 12% of South Carolinians aged 60 and older were functionally disabled in at least one activity of daily living. About 39% had a serious, chronic health problem, 3% lacked transportation to medical services, 40% had less than a high school education, and 35% were unsure who they would need to contact to obtain services. In addition, about 19% (according to the 1990 census) were below the poverty level. A 1992 independent assessment of CLTC performed by the University of South Carolina found that elderly and disabled CLTC clients are not self-advocates.

Effects of Fragmentation

Service fragmentation can make enrolling and obtaining service a complex process. Clients may have to contact numerous individuals at several agencies. For example, to enroll in the finance commission's CLTC program, a client or his family must go through the following process:

- The client is referred to CLTC by himself, a hospital, a state agency he is already involved with, or other source.
- Finance commission staff visit and assess the client's level of care needs.
- DSS staff determine if the client is financially eligible for medicaid.

Once enrolled in CLTC, that client may have several individuals coming into his home:

- The client is provided a personal care aide whom he may select from DHEC, DSS, a local council on aging, or a private agency.
- The finance commission service manager visits and monitors the case on an ongoing basis.

- The personal care aide's supervisor visits the client every 60 days to review the aide's performance.

If the client receives additional services, the level of complexity increases. This same CLTC client could also be receiving:

- A home-delivered meal from a local council on aging in which case the council on aging would also do an assessment of the client and possibly provide case management.

We found a number of clients served by three or four state agencies.

- A home health nurse and home health aide from a home health agency, possibly DHEC.

- A homemaker provided either by the Commission on Aging, DSS, or a private provider contracted by the finance commission and authorized by DSS.

As the number of service providers increases, the client may be less sure whom to call if a service provider does not come as scheduled. We observed a situation in which a client called a local council on aging about missed visits by a personal care aide who was not from the council. The client knew the personal care aide by name, but did not know which agency employed the aide. Officials in several agencies confirmed that this is not an unusual occurrence.

The complexities of the system also affect agency staff. Each agency's staff must coordinate and communicate with other agencies to adequately serve the client and avoid unnecessary service duplication. According to officials from different agencies, in some counties, interagency coordinating councils have been set up to ensure that services among the agencies complement each other and are not unnecessarily duplicated to the same clients.

CLTC Service Delivery Not Consistent With Law

Through its community long term care program (CLTC), the finance commission provides case management services to clients. However, as we noted in our 1992 cost savings report, §44-6-30 (4) of the South Carolina Code of Laws prohibits the finance commission from ". . . engaging in the delivery of services."

Finance commission staff perform case management for all clients in the CLTC program with 135 staff operating out of 13 regional offices. The CLTC program defines case management as assessing the client's condition, determining the client's care needs, and planning, coordinating, and monitoring service. The CLTC program is subject to federal law. According to federal law, 42 U.S.C §1396n(g)2 and §1396d(a)(19), case management is a service.

Currently professional literature and several officials with different agencies have conflicting ideas about what is the best system for case management service delivery. In some other states, either a state agency separate from the medicaid agency or individual service providers perform case management.

Increased efficiency and better client service could result from case management provided by a service providing organization with existing local offices. For example, the finance commission estimates that approximately 80% of its CLTC clients get personal care aide services. DHEC provides personal care aide service in all 46 counties; as noted earlier, many DHEC clients are CLTC clients. On the other hand, better service and increased efficiency might also result from service providers, public and private alike, case managing the clients they serve. This could increase control and contact between the case manager and the workers providing other services.

CLTC staff support in-house case managers to assess clients and arrange and monitor service. CLTC officials feel CLTC employed service managers exercise greater independence and fiscal control than other organizations would.

Resources for Area Agencies on Aging

The federal Older Americans Act is the largest funding source for the Commission on Aging's network of service providers. This act requires that the state designate planning and service areas within the state and establish an area agency on aging (AAA) for each. The Commission on Aging has designated ten planning and service areas and funds a AAA in each. Six AAAs are operated by regional councils of government (COGs), and four are operated by other organizations.

South Carolina AAAs rarely serve clients directly. The AAAs contract with and monitor approximately 60 local service providers, usually called local councils on aging. For FY 92-93, the ten AAAs have been allocated approximately $11.8 million in Older Americans Act, state, and local funds. This total includes $1.4 million for planning and administration and program development.

Redirection of Resources

Two studies have identified potential administrative savings and opportunities for improving AAA staff skills by designating fewer and larger planning and service areas. In 1985, a Commission on Aging study estimated annual savings of up to $400,000 would occur if four or five AAAs were operated instead of ten. A private consulting firm conducted a second 1985 study which estimated the change would yield administrative annual savings of $900,000 from all funding sources, not just the Older Americans Act. The study states that economies of scale would reduce total administrative costs while increasing the resources for the remaining AAAs. In 1986, the Governor's office questioned the Commission on Aging and consultant studies' conclusions that consolidation of AAAs would significantly reduce costs.

In 1985, a Commission on Aging study estimated annual savings of up to $400,000 would occur if four or five area agencies on aging were operated instead of ten.

The consulting firm's study expects the larger AAAs to have increased staffing flexibility. In 1985, after observation of the existing AAAs in the state, the consulting firm found that larger AAAs had more specialized and better educated staff. The firm's assessment was that an agency with a larger budget can offer more competitive salaries to attract skilled staff. Also, an agency with more staff can allow staff to develop specialized skills rather than forcing employees to be "jacks of all trades." Currently, some AAAs have only two or three full-time equivalent employees. Concentration of available administrative funds into fewer AAAs might allow each unit additional professional staff giving them the

flexibility to allow staff to specialize and to competitively recruit the best staff.

Other states have reviewed reducing their number of AAAs as a way to combat shrinking resources. In 1991, West Virginia reduced its number of AAAs, and Michigan has been reviewing that option. In West Virginia, AAA costs went from 8.7% to just over 5.7% of total funds after the number of AAAs was reduced from nine to four. This savings occurred despite increased funding of each of the four remaining AAAs to cover their enlarged service areas. In Michigan, state-level staff support reducing their number of AAAs, but according to one official, most of their AAAs are extremely resistant even though more funds would be freed for direct service.

In 1989, the South Carolina Commission on Aging noted:

> . . . it is important to emphasize that we do not project any savings in current outlays of administrative costs that could be allocated to direct services. The major rationale for consolidation into fewer, larger regions would be more effective utilization of current administrative outlays. We do believe that we can avoid some future increases in administrative costs by redistributing current funding among fewer Area Agencies on Aging (AAA).

However, South Carolina Commission on Aging staff report that they experienced strong resistance that same year to a proposal to reduce the number of AAAs. The commission director does not support reducing the number of AAAs because she believes the estimated savings in administrative costs are outweighed by the disruptive effect on working relationships in the network. However, the annually recurring nature of the savings make them increasingly significant over time.

Officials with the South Carolina Commission on Aging are also concerned that expansion of planning and service areas outside the boundaries now shared with the councils of government (COG) might keep COGs from functioning as AAAs. According to COA staff, some COGs have historically performed well, and it would not best serve the network to keep them from continuing in that role. Under §6-7-110, COGs would probably be prohibited from performing this function outside their boundaries unless the General Assembly chose to amend the statute to allow different boundaries for the AAA function.

In Some Programs Better Integration Has Occurred

Better integration of long term care and related services is possible and has begun in some programs. The finance commission has reduced some fragmentation in the social services block grant (SSBG) program. The current SSBG contract with COA for home-delivered meals is the first to eliminate COA and client interaction with DSS. In the past, SSBG home-delivered meal contracts with COA's local councils on aging required that DSS determine the eligibility of clients the councils had identified as eligible.

In some counties DHEC has begun to integrate home health and personal care aide services. A DHEC official reports that for clients served by DHEC through the home health and CLTC programs, the same employee can perform both services. DHEC plans to expand consolidation of personal care aide and home health aide services.

Conclusion

Opportunities for further integration of long term care and related services at the state level may exist. Service integration could involve agency operational changes and possibly restructuring of services across agencies. Since different organizational structures have different strengths and weaknesses, a consensus on desirable attributes should be developed. This may be best determined through an interactive process including the General Assembly, state and local agencies, the Joint Legislative Committee on Aging, care providers, and clients.

Recommendations

2 The Joint Health Care Planning and Oversight Committee should determine ways to better integrate long term care and related services and report back in one year with specific recommendations and an action plan. This process should involve participation by state and local agencies, the Joint Legislative Committee on Aging, service providers, and clients.

3 The Health and Human Services Finance Commission should assist with this effort to integrate long term care and related services and comply with state law by discontinuing in-house service provision in its community long term care program.

4 The General Assembly may wish to amend state law to allow regional councils of government to perform area agency on aging functions outside their boundaries. Also, as part of the effort to integrate long term care, the Commission on Aging should redesignate planning and service areas to reduce the number of area agencies on aging. Administrative savings should be targeted for direct service when possible.

Fee and Tax Exemptions

In a limited review, we identified South Carolina state government fees and taxes which are reduced or eliminated for elderly, blind and disabled individuals. We noted exemptions in property taxes, retirement income taxes, camping fees at state parks, and vehicle registration fees. We were able to obtain estimates of the costs of reduced fees and taxes by income group only for the property tax exemption.

The four tax and fee exemptions and reductions we describe in this chapter are granted regardless of a person's income. The state grants high-income citizens the same exemptions and reductions as citizens with low and moderate incomes. If the goal of the General Assembly is to assist those who cannot afford long term care services, it would be more effective to reduce subsidies to high-income individuals and increase assistance to low- and moderate-income individuals whose long term care needs are not being met.

Property Tax Exemption

Section 12-37-250 of the South Carolina Code of Laws and Article 10, Section 3(i) of the South Carolina Constitution allow state residents 65 and older to deduct $20,000 from the fair market value of their homes when determining county, municipal, school and special assessment property taxes owed. This exemption also applies to permanently disabled and legally blind citizens. The state reimburses each county, municipality, school district, and special district for property taxes not realized.

In 1993, elderly, blind, and disabled households making $50,000 or more will receive a $5.3 million subsidy from the state to help pay their local property taxes.

We obtained estimates of the projected 1993 cost of this homestead exemption from the South Carolina Tax Commission. In 1993, approximately 223,300 homeowners who are 65 and older, blind, and disabled, will request the property tax exemption for a reduction of $40.9 million in taxes. The tax savings will average $183 per homeowner. Approximately 66,500 exemptions will go to homeowners whose annual income is $30,000 or greater while 27,600 exemptions will go to homeowners whose annual income is $50,000 or greater. The total cost to the state for homeowners whose income exceeds $30,000 will be approximately $12.6 million, while the cost for those making more than $50,000 annually will be $5.3 million (see Appendix B on page 38).

According to a 1992 National Conference of State Legislatures study, 44 states have some form of property tax exemption. These exemptions are

primarily targeted to the elderly and the disabled. Eighteen states required recipients to meet income eligibility requirements.

Georgia and North Carolina place income limits on their property tax exemptions. In Georgia, homeowners' annual income cannot exceed $10,000. In North Carolina, the annual income cannot exceed $11,000. Both states require that persons declare their incomes before receiving an exemption. There are criminal penalties in both states for providing false information.

Pension Exemptions

An amendment to §12-7-435 of the South Carolina Code of Laws allows retired individuals who have reached the age of 65 to receive their first $10,000 per year of retirement income tax free. Taxpayers under age 65 who receive retirement income may exempt up to $3,000 of this income from state taxes annually but may not increase this exemption when they reach the age of 65. This amendment takes effect in taxable year 1993.

Prior to taxable year 1993, any taxpayer who received retirement income could exempt up to $3,000 of retirement income annually. According to estimates provided by the South Carolina Tax Commission and the Office of the Comptroller General, in FY 92-93 approximately 137,000 people 65 and older will claim this exemption, which will cost the state approximately $14.9 million. For retirees of all ages, the total cost of the exemptions to the state will be approximately $33.7 million.

Discount Camping Fees

Section 51-3-60 allows South Carolina residents who are 65 and older, disabled, or blind to receive a 50% discount off camping fees in state parks. The Department of Parks, Recreation and Tourism estimates that in FY 91-92, 147,993 of South Carolina's elderly citizens took advantage of this discount at an estimated cost of $339,110. We did not obtain totals for handicapped residents.

Discount Vehicle Registration Fees

Section 56-3-620 allows South Carolina residents who are 65 and older and the handicapped to pay $10 to register a private passenger vehicle. For non-handicapped people under age 65, the fee is $12. The Department of Highways and Public Transportation estimates that during FY 91-92 approximately 250,000 people 65 and older registered vehicles. The total cost of the $2 per vehicle fee reduction was approximately $500,000. We did not obtain totals for handicapped residents.

The Effect of Fee and Tax Exemptions

If it is the intent of the General Assembly to increase the financial well-being of all elderly, blind, or disabled citizens because they are elderly, blind, or disabled, the exemptions and reductions in place will accomplish that goal. However, if the General Assembly seeks to focus assistance on those who cannot afford needed services, it would be more effective to reduce subsidies to high-income individuals and use these funds to increase assistance to low- and moderate-income individuals who need long term care services.

As noted in Chapter 2, there are waiting lists for long term care services. We do not suggest what the state's funding priorities should be. However, the finance commission's community long term care program for elderly and disabled clients is an example of how additional funds could be used. In February 1993, the finance commission estimated that it would cost an additional $15,880,000 per year to increase the number of CLTC clients served per month from 4,000 to 6,500. This increased service could be accomplished with $4,446,000 in additional state funds which would generate federal matching funds of $11,434,000.

Recommendation

5 The General Assembly may wish to consider freezing, reducing or eliminating fee and tax exemptions and reductions for elderly, disabled, and blind persons who have high incomes. The General Assembly may wish to consider using the resulting savings to provide increased long term care services needed by elderly, blind, and disabled persons with low and moderate incomes.

Appendices

Membership of Interagency Planning Groups

Health and Human Services Coordinating Council	Commission on Aging Coordinating Council	Long Term Care Council[a]
Department of Mental Health	Department of Mental Health	Department of Mental Health
Health and Human Services Finance Commission	Health and Human Services Finance Commission	Health and Human Services Finance Commission
Department of Health and Environmental Control	Department of Health and Environmental Control	Department of Health and Environmental Control
Department of Social Services	Department of Social Services	Department of Social Services
Office of the Governor	Office of the Governor	Office of the Governor
Commission for the Blind	Commission for the Blind	Joint Legislative Health Care Planning and Oversight Committee
Department of Education	Superintendent of Education	Joint Legislative Committee on Aging
Commission on Aging	State Department of Labor	Commission on Aging
Department of Mental Retardation	Development Board	Department of Mental Retardation
Commission on Alcohol and Drug Abuse	Commission on Alcohol and Drug Abuse	
Vocational Rehabilitation	Vocational Rehabilitation	
Continuum of Care for Emotionally Disturbed Children	Clemson University Extension Service	
Children's Foster Care Review Board	Department of Parks, Recreation, and Tourism	
ETV Commission	Retirement System	
Guardian Aid Litem Program	SC Municipal Association	
Department of Corrections	SC Association of Counties	
Department of Probation, Parole, and Pardon Services	Employment Security Commission	
Housing Authority	Commission on Women	
John De La Howe School		
SC School for the Deaf and Blind		
Department of Veteran Affairs		
Will Lou Gray Opportunity School		
Department of Youth Services		

a The Governor annually appoints one representative of the following groups to the Long Term Care Council: long term care providers, long term care consumers, and the insurance industry.

Estimated Cost to the State of the $20,000 Property Tax Exemption in 1993

Home Values	Income Levels									
	Under $10,000	$10,000–$14,999	$15,000–$19,999	$20,000–$24,999	$25,000–$29,999	$30,000–$34,999	$35,000–$39,999	$40,000–$49,999	$50,000 and Over	Total
Under $16,388	$1,390,192	$595,797	$309,445	$226,310	$152,413	$96,990	$64,660	$60,042	$64,660	$2,960,509
$16,388–$32,773	4,139,036	1,876,256	1,199,837	805,260	620,050	410,683	338,209	418,735	410,683	10,218,749
$32,774–$49,160	2,520,464	1,578,310	1,368,942	877,733	716,681	491,209	314,051	475,103	491,209	8,833,702
$49,161–$65,547	1,272,311	684,471	732,787	789,155	644,208	499,261	475,103	547,577	531,472	6,176,345
$65,548–$81,934	620,050	547,577	555,629	434,840	531,472	257,683	281,841	442,893	773,050	4,445,035
$81,935–$98,321	305,999	289,894	305,999	257,683	177,157	305,999	281,841	346,262	668,366	2,939,200
$98,322–$131,096	217,420	249,631	201,315	201,315	281,841	233,525	152,999	362,367	1,030,733	2,931,146
$131,096–$163,870	104,684	40,263	72,473	48,316	72,473	32,210	40,263	136,894	426,788	974,364
$163,871–$245,806	40,263	32,210	32,210	16,105	24,158	48,316	64,421	80,526	595,892	934,101
Over $245,807	32,210	8,053	16,105	16,105	24,158	24,158	24,158	16,105	281,841	442,893
Total	$10,642,629	$5,902,462	$4,794,742	$3,672,822	$3,244,611	$2,400,034	$2,037,546	$2,886,504	$5,274,694	$40,856,044

Source: Information provided by the South Carolina Tax Commission.

Abbreviations

CLTC — Community Long Term Care

SSBG — Social Services Block Grant

DHEC — Department of Health and Environmental Control

DSS — Department of Social Services

DMH — Department of Mental Health

DMR — Department of Mental Retardation

ADL — Activities of Daily Living

IADL — Instrumental Activities of Daily Living

GAO — General Accounting Office

COA — Commission on Aging

ACE — Alternative Care for the Elderly

AAA — Area Agency on Aging

COG — Council of Government

Agency Comments

South Carolina Commission on Aging

400 Arbor Lake Drive • Suite B-500 • Columbia, South Carolina 29223 • 803 735-0210

March 5, 1993

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

The Commission would like to make the following response to the final draft report entitled, "A Limited-Scope Review of Long Term Care and Related Services to the Elderly":

While we agree with most of the recommendations in the report, we cannot concur with Recommendation #4 on page 29, which states in part, "...the Commission on Aging should redesignate planning and service areas to reduce the number of area agencies on aging". We are disappointed that you did not reconsider this recommendation, based on the five pages of comments and over sixty pages of supporting documents that we submitted in response to the draft report. Since we are limited to only two pages of comments, we will attempt to summarize our arguments.

- This recommendation may be conceptually appealing, but has not been received as politically acceptable within South Carolina. Similar proposals have been attempted without success in 1986 and in 1989, at a substantial cost in time, money and damaged relationships. The LAC report does not contain new data nor compelling new arguments that would justify reopening this issue for a third time, unless the legislature wishes to undertake this activity under their purview.

- Rather than saving money, it is likely that consolidating AAAs could cost the State an additional $300,000 in matching funds that are now provided from local sources. While the law could be amended to allow COGs to provide services outside their boundaries, representatives of COGs and local governments have indicated that they would be opposed to using their local funds to serve counties outside of their boundaries. Furthermore, counties added under an expanded jurisdiction would expect representation on the COG board, thus requiring a complete restructuring of the board and per capita funding.

- In the report, West Virginia is used as an example of a State reducing the number of AAAs, but the fact that this had to be accomplished through a legislative mandate and successful defense of a lawsuit is omitted. Legislative support for a reduction in the number of AAAs was not present in South Carolina, when this was attempted in 1986 and 1989.

- The redesignation of planning and service areas must be done as a part of the State Plan on Aging, which must go through a public comment process and ultimately be approved by the Governor. Governor Riley disapproved such a plan in 1986. In 1989, the plan was changed after almost all of the 57 people commenting at public hearings opposed the consolidation recommendation. Written comments opposed to the recommendation were received from 38 members of the General Assembly and 17 local government officials. No one expressed strong support for the idea of reducing the number of AAAs. The report presents no new information to suggest that local government leadership would respond any differently in 1993.

- The potential damage to the Aging Network that could result from reopening this issue goes beyond disruption of relationships. Past experience has shown that the upheaval could have a serious impact on productivity and service to consumers. We feel it is not feasible to reopen this issue, risking the disruption of the Aging Network, especially since assumptions of cost savings are now outdated and the past studies have been considered as discredited.

- The Commission on Aging wishes to go on record that such a recommendation cannot be implemented without a clear legislative mandate, as well as the Governor's approval. The Commission on Aging continues to support its current policy on this issue.

In summary, we believe that the report, with the exception of this one recommendation, appropriately addresses the current condition of community-based long-term care in South Carolina. The report is particularly relevant to current efforts to restructure state government by recommending more comprehensive reform of the long-term care system. Within that context, it is more appropriate for the Commission on Aging to focus its energy on state-level restructuring rather than disrupting the local delivery system. To that end, we pledge our cooperation and support in working with other agencies and the General Assembly toward true long-term care reform.

Sincerely,

Helen D. Brawley

HELEN D. BRAWLEY
Chairperson

Ruth Q. Seigler

RUTH Q. SEIGLER
Executive Director

RQS/WLW/kmm

South Carolina
DHEC
Department of Health and Environmental Control
Robert Mills Complex, Box 101106
Columbia, SC 29211

March 8, 1993

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, SC 29201

Dear Mr. Schroeder:

The following statements are my comments on your report on long term care services for the elderly.

As I stated in my preliminary comments, the report is accurate with respect to the facts it presents. Its recommendations are well reasoned and appropriate.

State Agencies are sometimes accused of duplicative and poorly integrated services. In the case of the specific services reviewed by the Legislative Audit Council, it is true that different agencies perform "similar" services. What is lacking in the report is that the review found no instances of clients receiving the same or "too much" service from different agencies. The services provided by DSS, DHEC, CLTC, and COA are distinctly different and often targeted at different needs and different clients. The single exception to overlapping services is the personal care aide services provided in all counties by DHEC and in some counties by DSS or COA. In no case does the same client receive the same PCA service from different agencies. This is well managed by CLTC.

Rather than <u>focusing</u> on the possibility that services may be better integrated (and they can), the report could have focused on the fact that there are insufficient levels of home and community based services to meet the need and demand. This service gap results in clients receiving inappropriate and expensive services in hospitals and nursing homes, and denies many citizens of our state the freedom to receive less costly care in their own homes.

I appreciate the opportunity to comment on this critical area of state policy. It is good that home and community based services are beginning to receive some attention, but the attention should be directed more toward meeting the neeeds of our elderly citizens.

Sincerely,

T E Brown

Thomas E. Brown, Jr.
Interim Commissioner

State of South Carolina

State Health And Human Services Finance Commission

P.O. Box 8206, Columbia, South Carolina 29202-8206

March 5, 1993

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear George:

Enclosed are the State Health and Human Services Finance Commission's comments to be published with the final report of "A Limited-Scope Review of Long Term Care and Related Services for the Elderly." If you or your staff would like to discuss our comments, please feel free to contact me at 253-6100.

Sincerely,

Eugene A. Laurent, Ph.D.
Executive Director

EAL/pcwa

Enclosure

State Health and Human Services Finance Commission's
Response to Recommendations from
"A Limited-Scope Review of Long Term Care and Related Services for the Elderly"

I. Recommendation #1 (page 17):

The Long Term Care Council (LTCC) has previously discussed the consolidation of the Human Services Coordinating Council (HSCC) and the LTCC. The LTCC concluded that long term care will remain a critical concern to South Carolina as the numbers of persons who are elderly and the non-elderly disabled continue to increase. Long term care services required by these two populations have a broad economic impact on the State's health and social service system. Because of the vital impact of long term care on the state, the LTCC determined that long term care should be addressed in a subject specific arena.

The Long Term Care Council also has representatives from two Legislative Committees and three gubernatorial appointees, which the HSCC does not have. The gubernatorial appointees represent consumers, the long term care insurance industry and the long term care provider industry. The Council believes that these individuals provide a critical link with the private sector to create a balance between public agencies and the private sector. One of the gubernatorial appointees has been elected chairman for 1993.

If the General Assembly should decide to reconfigure the existing councils to serve several purposes, it is recommended that provisions be made for representation of these other sectors that are not currently represented on the other Councils.

II. Recommendation #3 - page 29

The Legislative Audit Council's recommendation above is based upon two concepts: 1) that case management is a direct service and therefore its provision by the Finance Commission is in conflict with the agency's enabling legislation; and, 2) that the effort to integrate long term care services would be furthered by the provision of case management in a direct service provision agency. We strongly disagree with both of these concepts and respond to each separately below.

A. The Categorization of Case Management as a Direct Service: In arguing that case management is a direct service, the LAC is in disagreement with prevailing definitions of case management. Rather than being a direct service, authorities emphasize that case management is a means to link clients to direct services (JCAH, 1976); a method to control expenditures, costs, and service utilization (Polich et al., 1993); and a means to work within financial restraints while meeting the preferences of clients (Melemed, 1985).

The dual role of meeting the needs of the client while remaining within the fiscal demands of the system is particularly appropriate for Community Long Term Care (CLTC), as case managers are called upon to act both as planners for their clients and as administrators of a program with limited funding. In order to provide waiver services for as many people as possible with a limited budget, case management activities must control costs of services as well as work to meet clients' needs. The utilization of case management in this regard is strictly administrative, and includes targeting services to specific groups of clients, limiting services to stay within budgeted amounts, and channeling people into the most efficient long term care option.

The Finance Commission has always utilized the CLTC program as a gatekeeper for Medicaid-sponsored long term care services. Specifically, this agency has relied on case management for such administrative functions as: 1) determining that a potential client qualifies for and can benefit from home care, and then once enrolled, assuring continued eligibility; 2) controlling the amount, duration, and scope of waiver services; and 3) integration of Medicaid preadmission screening functions for both institutional and home-based care.

It is also worth noting that private industry in the United States is turning to case management to help contain health care costs. Case management is used by employers not as a direct service, but rather as an "effective tool for reducing health care costs, improving the quality of health care services, and raising the health status of program participants" (Miller and Miller, 1988).

B. Integrating Long Term Care Services: The model of case management used by CLTC is referred to as the brokerage model, also called a lead agency model. The brokerage model's emphasis is on negotiating and coordinating services, but does not provide any services directly. This model explicitly separates the role of service provision from service authorization, thereby ensuring that decisions are made for the benefit of the client and the cost effectiveness of the program, and not for the benefit of the service providing agency. "Locating case management in a freestanding agency provides a measure of autonomy and may avoid conflict of interest problems that can arise when case management and direct services are offered by the same agency. Case managers employed by a disinterested, freestanding agency are not pressured to incorporate their own agency's services into the care plan." (Applebaum and Austin, 1990).

C. Conclusion: From the Finance Commission's perspective, case management is critical to our role in planning for and financing an efficient long term care delivery system and allows us to allocate scarce resources to those who are most in need. Case management is **not** a direct Medicaid service like hospital care or prescription drugs, but instead is an administrative function that allows us to plan for and authorize the provision of services in a cost effective, efficient manner. As such, the provision of case management is **not** in conflict with the Finance Commission's enabling legislation. Since the Finance Commission is independent of direct service provision, it is the ideal location for a case management system designed to care for clients with long term care needs. Since Medicaid is the primary payor for all long term care services, both home and community-based and institutional care, it is logical that the program should continue to be administered by the Finance Commission.

III. References

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Melemed, B.B. "Issues related to private geriatric case management," p.9. Presentation to the First Annual Meeting of the National Association of Private Geriatric Care Managers, New York, 1985.

Polich, Cynthia, Marcie Parker, Margaret Hottinger, and Deborah Chase. Managing Health Care for the Elderly. New York. John Wiley and Sons, 1993.

DMH South Carolina Department of Mental Health

Commissioner's Office
2414 Bull Street/P.O. Box 485
Columbia, SC 29202
(803) 734-7780
Information: (803) 734-7766

Joseph J. Bevilacqua, Ph.D.
State Commissioner

March 2, 1993

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, SC 29201

Dear Mr. Schroeder:

Thank you for sharing the draft final report entitled **A Limited-Scope Review of Long Term Care and Related Services for the Elderly.** The report highlights many of the critical resource and planning issues that confront South Carolina as we strive to provide better care for our older citizens.

Although DMH provides services to specialized sub-populations, we are deeply involved in the same shift of emphasis toward local, preferably in-home services for the elderly. We have worked closely with Palmetto Senior Care, for example, and are developing an innovative replication of the An-Loc model for geriatric psychiatric patients.

The final arena in which DMH is happy to play a lead role is that of research and education in geriatric issues. Paul Eleazer, MD, has recently been named to fill a joint position as Director of our Byrnes Medical Center as well as Director of Geriatrics for the USC School of Medicine. Staff at our Tucker/Dowdy-Gardner Nursing Care Center are deeply involved in both training and research related to the elderly. We are intimately involved in plans for a Geriatric Institute which would further focus on the integration of service, research and training.

Thanks to you and your staff for this report.

Sincerely yours,

Joseph J. Bevilacqua, PhD
State Commissioner

JJB:jam

South Carolina Department of Mental Retardation

3440 Harden Street Extension
P. O. Box 4706
Columbia, South Carolina 29240

803/737-6474

February 17, 1993

George L. Schroeder
Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for providing us an opportunity to comment on the Legislative Audit Council's draft report on long term care services for the elderly. We have reviewed the report and offer the following general comments related to the population we serve:

Persons with mental retardation who are elderly are the fastest growing segment of the population the Department of Mental Retardation serves. The Department of Mental Retardation continues to face the challenge of providing integrated and age appropriate activities and services to this population.

Persons with mental retardation or related disabilities who are elderly need coordinated services from health, social, and long term care service agencies. They also need additional special services based on their individual needs. These special services do not duplicate services. Rather they are essential services which complement what other agencies provide. It is only when these essential, special services are combined with the services of other agencies that the state truly meet the needs of elderly persons with mental retardation. There is a need for better integration of elderly individuals with mental retardation or related disabilities in the planning, coordination, and provision of long term care and related services in South Carolina.

Training of personnel is essential. Staff serving the elderly individual with mental retardation or related disabilities need specialized training based upon existing research and program models.

Projections of the state's needs for long term care services should consider the fact that many individuals with mental retardation or related disabilities age faster than the general population. This population's needs for long term care and related services may occur much earlier than for the general population. The LAC report only considered those individuals with mental retardation who are 65 and older (page 5). Using the age break off of 65 and older may underestimate the need for long term care and related services for this special population.

Should you have questions and/or need additional information, please call Mrs. Deborah McPherson at 737-6470.

Sincerely,

Philip S. Massey, Ph.D.
Commissioner

SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES
Post Office Box 1520, Columbia, South Carolina 29202-1520
Public Information Telephone (803) 734-6179 Fax Number 734-5597

J. SAMUEL GRISWOLD, PH. D.
INTERIM COMMISSIONER

February 12, 1993

Mr. George L. Schroeder, Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for sending me a draft copy of your report on long term care services for the elderly.

As requested, an original, signed affidavit of confidentiality is being returned with this letter. Mr. Tim Cash, Division Director for Adult Services, is the agency contact for this assessment.

The findings and recommendations have been reviewed. The contents of the report relative to the Department of Social Services appear to be accurate and we have no comments or suggested revisions.

Thank you for the opportunity to review the data.

Sincerely,

Sam Griswold

J. Samuel Griswold, Ph.D.
Interim Commissioner

JSG/s

Enclosure

This report was published for a total cost of $907.50; 400 bound copies were printed at a cost of $2.27 per unit.