ADULT DAY SERVICES: STATE REGULATORY AND REIMBURSEMENT STRUCTURE

DISSERTATION

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Although adult day services are acknowledged as a key component of community-based care, the availability of adult day programs is limited due to the disparity that exists in the funding and regulatory practices that govern their development and growth. The state agencies that administer regulations and funding for adult day care, and the state membership associations that influence them to varying degrees, create an organizational structure that either promotes or impedes adult day care availability and quality.

As the need for community care increases, complete and up-to-date information about organizational structure is crucial to making appropriate decisions about the expansion of adult day services. The absence of uniform national policies results in states and communities being relegated to balancing limited funds with the demand for adult day services, and in many areas, the lack of adult day centers altogether.

Characteristics of adult day centers have been described in a number of studies, but an organizational description of the variations in funding does not exist. Due to the lack of federal guidelines, wide variations exist in the

states' reimbursement methods and requirements for licensing and certification.

It is believed that certain states have greater availability of adult day care programs not only because of differences in demographic characteristics but also because of variations in state policies for community-based care. This study addresses this assumption by exploring the organizational structure of public financing and regulation of adult day services in Texas and comparing key variables to other select states. The study provides an overview of the types of state reimbursement, the availability of different funding sources, and the utilization of the sources in various states. The affects of funding policies on the number and characteristics of adult day centers in select states, along with the relationship of licensing and certification requirements, is described. Findings from the study reveal significant disparity in the states' organizational structure and availability of adult day centers, not only among states, but also within geographical regions of Texas. This information is important to policy-makers who are seeking and developing alternative funding practices at the state and federal level.

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GLOSSARY

ADULT DAY SERVICES--a structured, comprehensive program designed to meet the needs of adults with functional impairments by providing health, social, and related support services through an individualized plan of care, in a protective setting, during any part of a day.

ALZHEIMER'S GRANT FUNDING--a program available in a few states, typically administered by a state human services or aging agency, that provides funding for eligible adult day centers that provide services that support the physical and psychological needs of persons with Alzheimer's Disease or related dementia.

CERTIFICATION--a condition of eligibility for an adult day services program to receive government funding.

CHILD AND ADULT CARE FOOD PROGRAM (CACFP)--a program administered by the Food and Nutrition Service of the U.S. Department of Agriculture that provides federal funds and USDA-donated foods to non-residential child care and adult day centers to serve nutritious meals and snacks.

DISABILITY--restrictions or lack of ability to perform an activity in a manner or within the range considered normal for a human being.

FUNCTIONAL IMPAIRMENT--abnormalities of body structure and appearance and organ or system function, resulting from any cause (e.g., mental impairment, limitations in range of motion, loss of limbs).

HOME AND COMMUNITY-BASED SERVICES--non-institutional programs and services that originated as amendments to the Social Security Act beginning in the 1960s and the Older Americans Act beginning in the 1970s designed to provide health and social services in a community setting for the purpose of preventing or postponing institutionalization.

INDIVIDUAL PLAN OF CARE--a written plan which documents functional impairment or disability and the health, social, and supportive services required by an individual. The plan is developed jointly with and approved by the individual and/or responsible family member.

LICENSURE--a condition of operation in adult day services specifying criteria intended to protect the public.

MEDICAID--government funded health services for low-income individuals, people with disabilities, and the elderly authorized by Title XIX of the Social Security Act of 1965. Medicaid is funded jointly by federal and state governments; the federal matching rate is based on the state's average per capita income.

MEDICAID STATE HEALTH PLAN--optional Medicaid services specified by a state with direct payment to eligible providers; the services must be available statewide, comparable, and equal in amount, duration, and scope for groups of recipients.

MEDICAID WAIVER--permits states to offer an array of services with waivers of certain Medicaid statutory requirements (e.g., statewideness and comparability) as cost-effective alternatives to Medicaid-reimbursed institutional care.

MEDICARE--a social insurance program that provides benefits to persons that are 65 and older, blind, disabled, or have end-stage renal disease. The right to benefits is established primarily by payroll tax contributions and monthly premium payments.

MENTAL HEALTH FUNDING--funding provided to eligible adult day centers by a state agency that oversees mental health programs in the state; services are often targeted as respite for family caregivers of persons with physical disabilities or mental impairment.

MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES FUNDING--funding provided by a state agency to adult day centers who provide supervision and services for persons with developmental disabilities.

NATIONAL ADULT DAY SERVICES ASSOCIATION (NADSA)--a membership unit of the National Council on the Aging created in 1979 to promote program quality, legislative advocacy, and research in adult day services.

PRIVATE PAY--an adult day center that charges fees to its participants for services rendered.

REIMBURSEMENT--funds paid to an adult day center by a state agency for services rendered to eligible recipients of the program.

SOCIAL SERVICES BLOCK GRANT (SSBG)--funding designated in amendments to Title XX of the Social Security Act for a variety of approved community services.

STATE AGENCY--a state government agency responsible for assuring that community service programs under its jurisdiction are in compliance with applicable laws, regulations, and/or funding requirements.

STATE ASSOCIATION--a membership association of adult day services providers in the state.

TITLE III--a funding program of the Older Americans Act administered as either a grant or a contract by the state department on aging.

TITLE XIX--(same as Medicaid).

TITLE XX--(same as Social Services Block Grant).

VETERANS AFFAIRS--funding provided for eligible veterans receiving services at adult day health centers that contract with the Department of Veterans Affairs.

CHAPTER I

INTRODUCTION

Adult day services are increasingly acknowledged as a key component of community-based care (Weissert, Elston, Musliner & Mutran, 1991; Bradsher, Stuart, & Estes, 1993). Nevertheless, the availability of adult services is limited or nonexistent in many communities. According to the National Adult Day Services Association (NADSA), more than 3000 adult day centers are currently operating across the nation. This number falls short, however, of the need identified by NADSA for programs to be available in every community. States with the largest number of adult day centers include California with 181, Texas with 176, New York with 170, Florida with 145, and Pennsylvania with 135, but even these states report the lack of adult day services in many local communities. In Texas, for example, a high concentration of licensed adult day centers are located in the Rio Grande Valley region while licensed centers are scarce in the Dallas-Fort Worth metroplex, rural areas of West Texas, and the Panhandle.

One of the most dramatic changes occurring in the nation today is the aging of our population. Since the beginning of the century, the older population has become a larger and more influential segment of American

society. In addition to the increase in the size of the elderly population, the morbidity pattern has also shifted during the twentieth century with significant growth in the number of persons with chronic conditions. Considering the upcoming changes in the size and characteristics of the older population, and since chronic conditions lead to disabilities and functional impairment, a sharp rise is expected in the number of frail elderly in need of institutional and community-based care. As a result of these shifts, the current system is under strain and Americans are questioning the availability and quality of future health care and social services. With longer life spans, serious health problems are often deferred or extended, leading to medical and long-term care costs that are financially devastating for many older people and their families. The burden on state and federal funding is significant and policy-makers are continually searching for cost-effective options that permit older people to live independently in their communities as long as possible.

In addition to shifts in the size and demographic characteristics of the elderly population, the nation's economic status is influencing the future direction of aging policy in the U.S. Home and community-based services improve the living conditions and health status of older Americans, but considerations of cost, rather than concern for improving quality of life, will most likely influence future policy choices (Browne & Olson, 1983; Estes & Swan, 1993; Gill & Ingman, 1994; Weaver & Ingman, in press). These

services depend largely on state and federal public funding, administered by state agencies that strive to expand their efficiency and power by increasing the level of bureaucratization. In an environment of federal budget constraints, state agencies must use rational and efficient means for managing their programs. A number of programs and systems have developed in the U.S. that serve as models for both cost-effectiveness and quality care. These programs are designed to promote health and/or prevent disease or impairment while costing considerably less than institutional care. Adult day care is one such program.

Although the availability of adult day centers is limited, the program is known as one of the fastest growing options in community-based care. Whereas more than 3000 centers are currently operational, the number has increased significantly in recent years. Only 300 centers were known to exist in 1978 and by 1984, the number had increased to 1200 centers (Von Behren, 1986). Various factors have contributed to the rapid growth of adult day centers across the nation: (1) the older population in need of community care has increased; (2) the public knowledge of adult day services has increased; and (3) community-based services have expanded due to an underlying trend toward reducing the rate of growth in long-term institutional care. The growth in the number of adult day centers, however, has not been accompanied by a national policy initiative. In fact, the only national directive is the issuance of voluntary standards and guidelines through the

National Adult Day Services Association (NADSA), with no federal funds specifically allocated for these programs.

At the state level, adult day programs are often poorly defined and funding levels generally contend inequitably with program demands. In Texas, for example, providers express concern regarding whether the structural and organizational characteristics of adult day programs in the Rio Grande Valley result in the low costs reflected in annual cost reports for the entire state. Throughout the state, adult day services providers utilize a variety of methods to contain costs including shared staff, limited services, and in-kind contributions of staffing and services. Few facilities employ full-time registered nurses and social workers, if available, are typically shared by a number of adult day centers that are group affiliated. Services associated with activities of daily living for participants who require assistance with bathing, grooming, eating, toileting, and transferring are limited due to the extra staff time required to provide such services. The more time-intensive services, such as bathing, are almost never routinely offered. Two outcomes result from the lack of public funding or low reimbursement levels: (1) adult day programs are not available in areas where other revenue sources have not provided the supplemental funding needed to support a program and (2) the quality of adult day service provisions is adversely affected.

The cost of adult day services varies from state to state and from

program to program. The National Adult Day Services Association found that the average per diem cost in 1986[1] was $31 with a median of $20 (Von Behren, 1986). The median total cost per participant day in a study by Weissert, Elston, Bolda, Zelman, Mutran, and Mangum was $29.50 (1990, p. 87). Although the cost of adult day services is frequently addressed in studies that focus on program and participant characteristics, little has been written about the variation in types and methods of public funding and how these variations correlate to the availability of adult day services in a given area. Payment or reimbursement for services comes from a variety of private and public sources including participant fees, Medicaid, Older Americans' Act funding, or local subsidies, and all of these vary by locale and state. In addition, the Department of Veterans' Affairs will, in select locations, reimburse for adult day services received by eligible veterans. The level of reimbursement by these sources varies significantly.

The types of public funding also varies considerably from state to state. Government contracts used most often by adult day programs include Medicaid, the Social Services Block Grant (SSBG), and Title IIIB of the Older Americans' Act. Medicaid funding for adult day care has increased significantly in recent years accounting for 41 percent of center revenues in

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[1]More recent information on the per diem cost of adult day services is not available. Chapter 2 provides additional details on the status and findings of adult day services research.

1989 (Burke, Hudson, & Eubanks, 1990, p. 34). Title XX of the Social Services Block Grant program allows states to provide home and community care services for eligible elderly or disabled individuals. SSBG requires cost sharing in some states and has traditionally been oriented toward the social model program although it may also support health components under certain specified conditions. Title IIIB monies are available in some areas for scholarship programs or for administrative overhead or specific services. Generally, Title IIIB supports transportation and social, recreational, educational, and nutritional services. Other public support is sometimes available through city or county funding. Medicare generally does not pay for adult day services although it may reimburse for medical services provided in an adult day center that is certified as a comprehensive out-patient rehabilitation facility. According to the study by Weissert et al. (1990), only 2.9 percent of the adult day centers surveyed were certified for Medicare.

In summary, adult day services, as an integral part of the community-based care system, have grown in number as a result of the increase in the population in need of such care and a trend to control the growth of institutional care. However, the number of adult day centers currently operating across the nation is far below that which is needed. The disparity that exists from state to state in bureaucratic funding and regulatory practices is believed to be responsible, in part, for the shortage. The absence

of uniform interstate and intrastate policies and regulations results in states and local communities being relegated to balancing the demand for adult day services with other priorities given limited funds, and in many areas, the lack of adult day services altogether. The purpose of this study is to explore the organizational characteristics of adult day care (e.g., the types, levels, and methods of public funding and regulation) in relationship to the availability of adult day services in Texas and to discuss how these factors compare in other select states. A general exploration of funding and regulation variables in select states will determine similarities and differences in regulatory and funding practices and how these factors affect the availability of adult day care. Organizational characteristics will then be examined extensively in Texas to describe the influences of the funding/regulatory agency, other state government agencies, and the state adult day care association on the development and location of adult day centers in Texas. This information can assist policy makers and adult day center developers in making needed decisions about the expansion of adult day services on the local, state, and national levels.

CHAPTER II

LITERATURE REVIEW

Shifts in the U.S. Population

The U.S. contains the second largest population of people age 65 and older in the world, numbering 31.6 million individuals[1] (U.S. Bureau of the Census, 1987). Since 1900, a shift in the proportion of older and younger individuals has occurred. At the beginning of the twentieth century, 4.1 percent of the total U.S. population was 65 and older and 40 percent of the population was comprised of people under age 18. By 1990, the elderly[2] comprised 12.6 percent of the total population, or 1 in 8 Americans, while the percentage of young people[3] decreased to 28 percent (U.S. Bureau of the Census, 1992). Between 1990 and 2030, the number of individuals 65 and older will double and the number of people 85 and older--as the fastest growing age group--will triple in size. Due to the aging of the "baby boomers" and people living longer, there will be proportionately more elderly than

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[1]China has the world's largest population of persons 65 and older with 63.4 million (U.S. Bureau of the Census, 1987).

[2]Throughout this chapter, the terms "elderly," "older individuals," "older population," etc. refer to persons 65 and older.

[3]Young people are defined throughout this paper as individuals 18 and under.

young people in the population by the year 2030.

During the years between 1946 and 1964, the U.S. experienced what has become known as the "baby boom" with the highest birth rates in its history. The large number of individuals born during these years will be 65 years old between the years of 2011 and 2029. During the first quarter of the next century, the population will not only contain a greater proportion of older people, but will also be comprised of more older people living longer. Between 1900 and 1990, life expectancy for whites increased from 48.2 years to 72.6 years for men and from 51.1 years to 79.3 years for women[4] (National Center for Health Statistics, 1990). By 2030, white men are expected to live 75.4 years and white women are expected to live 82.3 years (U.S. Bureau of the Census, 1989). But, not all of the years a person lives will be active and independent ones. In 1980, whites could expect health impairments in 11.4 of their 74.4 years of life expectancy[5] (U.S. Department of Health and Human Services, 1990).

In 1990, 14 percent of the 65 and older population was comprised of minorities. Although the nonwhite and Hispanic populations currently have a smaller proportion of elderly than the white population, the older minority

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[4]Life expectancy for nonwhites in 1990 was 68.4 years for men and 76.3 years for women.

[5]In 1980, 56 of the 68 years of life expectancy for blacks and 62 of the 75 years of life expectancy for Hispanics were expected to be healthy ones (USDHHS, 1990).

population is expected to increase more rapidly in the 21st century than the older white population. Between 1990 and 2030, the older white population will grow by 92 percent, compared with a growth of 247 percent for the older black population and people of other races and 395 percent for older Hispanics. However, the older white population will remain higher than the percentage of blacks and Hispanics in 2030 (USDHHS, 1991a).

One compelling disparity in health care for older people relates to socioeconomic status. In 1989, 11.4 percent of people over 65 were below the poverty level. The poverty rate of the oldest old (people who are 85 and older) was 18.4 percent in 1989--more than twice the 8.8 percent rate of the young old (ages 65 to 74) (U.S. Bureau of the Census, 1990). Women are substantially more likely to be poor than men: only 7.8 percent of men age 65 and older are below the poverty level, compared with 14 percent of the women. Poverty rates are also higher for people not living in families. Change in marital status, particularly due to the death of a spouse, is an important reason contributing to differences in income among the elderly. More than half of the population age 65 to 74 is married, while nearly three-quarters of those age 85 and older are widowed (U.S. Bureau of the Census, 1990). The greater the accumulation of these factors (age, gender, race/ethnicity, and living arrangements), the greater the risk of poverty. Poverty rates are much higher among minority elderly than among white elderly, and higher among people who are not living in families. The highest

poverty rates are among elderly black women living alone: 3 of every 5 have incomes below the poverty level (U.S. Bureau of the Census, 1990).

In addition to the change in the age of the U.S. population from young to old, the morbidity pattern has also shifted during the twentieth century. Whereas acute conditions[6] were prevalent at the beginning of the century, chronic conditions are now the predominant health problem for older individuals. The leading chronic conditions for the elderly in 1989 were arthritis, hypertension, hearing impairments, and heart disease (USDHHS, 1991a). Since chronic conditions lead to disabilities and functional impairment, a sharp rise is expected in the number of frail elderly in need of institutional and community-based care in conjunction with the upcoming changes in the size and characteristics of the older population.

Disability associated with chronic conditions is measured by determining limitations in major activities[7], activities of daily living[8], and

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[6]Scientific advances and public health efforts have largely conquered the high rate of acute conditions (e.g., life-threatening communicable diseases and injuries due to accidents) that were prevalent among the elderly a century ago.

[7]Major activities refer to the customary activity for one's age and gender group (e.g., housekeeping, working, going to school, or living independently as an older adult).

[8]Activities of daily living refer to walking and the five activities vital to personal care: bathing, dressing, using the toilet, getting in and out of bed or a chair, and eating.

instrumental activities of daily living[9]. The role of perceived health is also an important factor since knowledge of underlying disease, recognition of physical disabilities, and awareness of functional limitation all negatively affect individuals' perceptions of their health status (Johnson & Wolinsky, 1994). Since some individuals adapt better than others to chronic health problems and associated limitations, the relationship between disability and functional limitation is variable.

Older people are diverse in health and chronic conditions. The majority of elderly living in the community (71 percent) view their health as excellent or good (National Center for Health Statistics, 1990). People 65 and older tend to take better care of their health than the nonelderly. Although they exercise less, the elderly are not as likely as the nonelderly to smoke, be overweight, drink, or report that stress has adversely affected their health (USDHHS, 1991a).

The growth in the number of older persons with functional difficulties will have a dramatic impact on health care and social services in coming years. In 1988, 22.6 percent of people over 65 suffered a limitation in major activity. The 1987 National Medical Expenditure Survey (NMES) identified 19.5 percent of the noninstitutionalized population over the age of 65 that

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[9]IADL functions include activities that are necessary to adapt independently to the environment (e.g, shopping, transportation, housekeeping, meal preparation, ability to use the telephone).

reported either ADL or IADL limitations (USDHHS, 1991b). The likelihood of suffering a chronic condition increases rapidly with advanced age. While 5.9 percent of all persons aged 65 to 69 experience difficulty with at least one ADL, 34.5 percent of those 85 and older have ADL limitations (Leon & Lair, 1990). Gender differences are significant for all areas of functional status and increase with advancing age. Consistently higher proportions of women have ADL limitations in all age groups (Leon & Lair, 1990). Fewer elderly who live with a spouse have ADL/IADL limitations when compared to those who live alone or with other relatives. Almost 8 percent of the elderly living with a spouse experience one or more ADL limitations, compared with 13.3 percent of those who lived alone and 15.6 percent of those who live with other relatives (Leon & Lair, 1990).

Although the diversity of the population has come to be recognized as a national strength, health care programs in the U.S. are characterized by unacceptable disparities linked to racial and ethnic groups[10] (USDHHS, 1990). Changes in informal care of the dependent elderly in the U.S. (i.e., unpaid care that is typically provided by family members) is also characterizing health care and affecting demands on community services. Because people are living longer and have fewer children, the "elderly

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[10]These disparities are summarized in the 1985 *Report of the Secretary's Task Force on Black and Minority Health* (USDHHS, 1985).

support ratio"[11] has increased significantly. In 1900, there were about 7 elderly people for every 100 people of working age. By 1990, the number of elderly had increased to 20 for every 100 people of working age, and by 2020, the ratio will be 29 to 100 (U.S. Bureau of the Census, 1989). Elder caregiving has already become a normative life event of middle age (Brody, 1985; Bengston & Achenbaum, 1993). The "middle-generation squeeze" experienced by persons caring for both dependent elderly and dependent children, and possibly grandchildren, will become a pattern for even more individuals in coming decades (Bengston & Achenbaum, 1993, p. 19).

Since women have traditionally provided most of the care for dependent children and elders, issues of gender equity arise. The issue of the feminized structure of family caregiving is raised since women must often forego the freedom to make choices about their responsibilities--an outcome that may be critical to their well-being (England, Keigher, Miller, & Linsk, 1991). Thus, community support services are often designed to assist the dependent elder as well as the family caregiver. Policies to support or encourage informal caregiving, however, largely ignore the issue of gender. Usually, such policies are framed in reference to the need to reduce or control public expenditures and assume that the associated outcomes are gender neutral. However, present community care policies, grounded in traditional

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[11]The "elderly support ratio" is defined as the ratio of support by people of working age (18 to 64 years) to people 65 and older.

concepts about family and women, generally support a laissez-faire approach to informal caregiving (England et al., 1991).

For minorities, additional issues relating to current policies are significant. American society has responded to social forces involving increased industrialization, urbanization, and bureaucratization of modern life. The large-scale organizations that have resulted from these forces, with their hierarchy of authority, division of labor, and emphasis on efficiency, have restructured family life and culture in dramatic ways (Williams, 1990). The feminization of caregiving becomes more complex when diverse issues relating to race and ethnicity are considered in conjunction with different belief systems among age cohorts within a specific group. In the case of Mexican Americans, for example, the romanticized view of the extended family caring for their elderly is, according to many researchers, a myth (Weeks & Cuellar, 1981; Lacayo, 1980, 1992; Markides & Krause, 1986). Whereas a few studies (Starrett, Mindel, & Wright, 1983; Rosenthal, 1986) suggest that formal social services are under-utilized by Mexican American elders because needs are already being met informally by family members, other researchers (Sanchez, 1992; Weeks & Cuellar, 1981; Yeo, 1991) strongly challenge this assumption (Dietz, 1995). The experience gained from these opposing views should result in policies that adopt a universal social service package that empowers disadvantaged persons to participate in decision-making relating to their own care needs and to the creation of

community-based programs to assist impaired elders (Williams, Himmel, Sjoberg, & Torrez, 1995).

Implications for Community-Based Services

Care for the elderly in the U.S. has taken a slow start in comparison to other countries with comparable levels of socioeconomic development. Social Security was not established until 1935 and Medicare, Medicaid, and the Older Americans Act did not appear until the 1960s. In comparison to the limited social support, income, and services provided for the elderly in the U.S., countries such as Sweden, Denmark, and Holland have a long history of providing high levels of income support, medical care, sheltered housing in a variety of forms, and social services designed to prevent social isolation for their older citizens (Gill & Ingman, 1994). Support services in the U.S. are not available or accessible in many communities to elderly individuals in need of such services.

With the advent of Medicare in 1965, persons 65 and older experienced improved access to medical care and hospitalization. Medicare is a federal health insurance program for the aging that is divided into two basic components: Part A, hospital insurance and Part B, supplemental medical insurance. Part A pays for hospital care and for restricted amounts of skilled nursing care and home health care. All individuals who are eligible for

Social Security benefits are automatically eligible for Medicare, Part A[12]. Part B, the supplemental medical insurance portion of Medicare, covers physician services, hospital outpatient services, additional home health care, diagnostic laboratory and x-ray services, and a variety of miscellaneous services. All individuals who are eligible for Part A are also eligible for Part B by paying a monthly premium.

A number of disadvantages associated with the costs and benefits of the Medicare system persist. Several important health expenses are either excluded or given limited support by Medicare. Social services and most community-based care services (e.g., adult day care and respite care) are not covered and the eligibility requirements on home care strictly limits its accessibility. Prescription drugs are also excluded requiring many elderly persons to pay substantially for their medications. Additional excluded services include eye glasses, hearing aids, dentures, and routine dental care (Lammers, 1983).

In addition to limited coverage, the cost of Medicare, for both the government and the consumer, has not been contained. Medicare costs continue to escalate and the share of the Gross Domestic Product (GDP) allocated to health care continues to rise. In 1990, 12.2 percent of the GDP

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[12]Individuals who are recipients of railroad retirement benefits, have been disabled for more than 24 months, or have end stage renal disease are also eligible for Medicare.

($666 billion) was spent on health care with the elderly population averaging more than three times the annual medical expenditures of persons less than age 65 (USDHHS, 1991b). For consumers, although approximately 70 percent of those on Medicare also have supplemental private insurance policies, the elderly spent $67 billion out-of-pocket for health care in 1991 (Rubin & Koelln, 1993).

Hospital discharge practices thrust elderly persons back into the community sicker and poorer than they were previously. The Prospective Payment System (PPS), implemented in 1984, has resulted in earlier hospital discharge and sub-acute care by nursing homes and community care agencies. Long-term and community-based care systems are maligned with an increasing demand for services and an increase in the number of elderly requiring care (Estes & Swan, 1993).

The Medicaid program, enacted by Congress in 1965, represented a major expansion in federal contributions to the states for the provision of health care to needy persons of all ages. Individuals whose income and assets are below a designated level established by the federal government are eligible for Medicaid. They are also eligible for Supplemental Security Income (SSI), a means-tested cash assistance program, and in-kind programs such as food stamps and subsidized housing (Browne & Olson, 1983). Under Medicaid, the states are responsible for providing numerous services including inpatient services, outpatient hospital services, physician care, x-

ray and laboratory services, nursing home care and optional services[13] (Lammers, 1983, p. 149). Consequently, access to long-term and community-based care has improved, but individuals must either already meet poverty level criteria or "spend-down" their resources in order to qualify.

The Older Americans Act (OAA) of 1965, and its Comprehensive Service Amendments of 1973 and 1978, represent an attempt to establish a system of coordinated social services for elderly citizens (Browne & Olson, 1983). The Act created the Administration on Aging (AoA), which serves as a national focal point for the needs and concerns of the older population. The AoA's functions include the dissemination of information and technical assistance, and the distribution of grants to states and organizations for more effective utilization of available resources on behalf of the elderly. The OAA involves the aging network[14] which includes the AoA, state aging commissions, and the area agencies on aging.

Aging activities within each state are presented in the state's annual aging plan. The plan includes a series of commitments for the aging network

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[13]Each state may choose which optional services will be covered. Options may include prescription medications, emergency hospital services, adult day care, primary home care, hospice, ambulance services, outpatient psychological counseling, physical therapy, case management, mental health rehabilitation, and others.

[14]The term, "aging network," refers to the totality of agencies, organizations, interest groups, service providers, and management and professional staff that is broadly concerned with aging policy, services, and program development.

within the state to respond to the needs of older citizens. The state unit on aging serves as a management linkage between the AoA and the area agencies and assists in prioritizing and coordinating the state aging plan. The state unit is also responsible for facilitating the flow of fiscal and program resources to the area agencies (Browne & Olson, 1983).

The future direction of aging policy is being influenced not only by shifts in the size and demographic characteristics of the elderly population, but also by the nation's economic status. Existing programs have improved the living conditions and health status of older Americans through retirement income security, health care, and social services. However, considerations of cost, rather than concern for improving quality of life, will most likely influence future policy choices (Browne & Olson, 1983; Estes & Swan, 1993; Gill & Ingman, 1994, Weaver & Ingman, in press). Public support for aging programs is being debated around such issues as the sustainability of the Social Security system and the economic consequences of government funding for various services. Future policy decisions will most likely reduce or eliminate benefits of existing programs and emphasize the need to direct limited resources to older persons with demonstrable needs (Browne & Olson, 1983). Service providers and policy makers, meantime, will need to continue to develop improvements in the efficiency and organizational methods of providing care. Strategies will include coordinating the delivery of care and applying cost-sharing formulas for

individuals who can afford to pay.

A number of home and community-based programs and services have developed in the U.S. that serve as models for quality care. These programs are designed to promote health and/or prevent disease or impairment at lower costs. The quality of life for frail older adults is related to what has been called a "trinity" of factors: housing, income, and good health (Billings, 1982, p. 4). Studies indicate that "the quality of life for elderly people who remain in the community and receive care is better than for those who enter long-term care facilities" (Billings, 1982, p. 2). Housing is a key factor in the quality of life for older people since "it provides a secure and meaningful old age or magnifies the disability and isolation that too often accompany advanced years" (Redfoot & Gaberlavage, 1991, p. 35). Chronic health problems or disabilities are often exacerbated by substandard housing conditions and inadequate services combined with limited income (Billings, 1982). A number of housing options are available for older people in the U.S. including public housing[15], rent supplements, mortgage assistance, and special programs such as Community Development Block Grants for neighborhood preservation. But in addition to appropriate housing, older

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[15]Public housing is available in a number of forms including single dwelling units and multiple unit structures that provide independent living, assisted living, or congregate living opportunities.

people sometimes require support services[16] within a continuum of care to remain in their homes and communities. Case management or care coordination is often used to determine the support services necessary to assist the person. Case management involves two basic objectives: (1) multidisciplinary involvement and a holistic approach toward meeting the client's needs and (2) a capacity for obtaining the entire range of services that might be needed by persons with multiple problems (Lammers, 1983, p. 188). Often, it is adult day services that case managers recommend since these objectives are achieved in the adult day care setting.

Development of Adult Day Services in the U. S.

Adult day care began as a response to a growing need for non-institutional but supportive environments. In the late 1960s, the U.S. Senate Special Committee on Aging began to investigate whether federal funds were being utilized to support substandard long-term care. By 1971, "the cost of institutional care was enormous, and there were dubious benefits to the patient beyond serving purely physical needs" (Boykin & Lamy, 1978, p. 683). As a result of these and other opinions, adult day health models began to emerge for the purposes of experimental demonstration.

The day care concept was adapted from geriatric day hospitals appearing as early as the 1940s in what was then the Soviet Union and the

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[16]Examples of support services include a range of nutrition programs, homemaker and chore services, adult day care, and home health care.

United Kingdom and from psychiatric day treatment centers in the United States. A physician, Dr. Lionel Cosin, known by many as the "father of adult day care," initiated the first British geriatric day hospital in 1950 and, in the late 1960s, transplanted his model to the Cherry State Hospital in Goldsboro, North Carolina (Kelly & Webb, 1989, p. 9-10). By the early 1970s, experimental day programs began emerging as non-institutional service models for evaluating alternatives to nursing homes. At that time, the annual cost of nursing home care was $3.2 billion, with 61 percent provided by public funds (Boykin & Lamy, 1978). As these costs continued to increase, Congress identified the need to plan alternatives to long-term care and authorized the Department of Health, Education, and Welfare (HEW) to design and conduct demonstration projects that would provide the basis for future changes in Medicare and Medicaid policy (Boykin & Lamy, 1978). In 1973, the passage of amendments to Title XX of the Social Security Act and Title III of the Older Americans' Act resulted in funding for community and home-based care alternatives including adult day services, case management, counseling, foster care, nutrition, homemakers, information and referral, recreation, and transportation (Kelly & Webb, 1989). HEW agreed to make Medicaid funds available to the states for adult day services in 1974, thus encouraging alternatives to nursing home placement. Congress further facilitated Medicaid funding for expanded use of alternative long-term care by authorizing state waivers for community-based services in the Omnibus

Budget Reconciliation Act of 1981 (Billings, 1982).

The number of adult day centers increased gradually at first from about a dozen in 1973 to approximately 1200 in 1986 (National Council on the Aging, 1987). It is currently estimated that more than 3000 adult day programs are operating in all 50 states (National Adult Day Services Association, 1992).

General Description of Adult Day Services

Adult day care[17] is a generic term describing programs that provide daytime health care and social services for individuals in need of rehabilitation or health maintenance. Prior to 1984, practitioners attempted to separate and classify health and social models, but since that time, a number of centers have developed a much broader range of both types of services as dictated by the needs of program participants. In response to this trend, the National Adult Day Services Association (NADSA) developed its standards as generic guidelines for quality care and good practice, respective of focus, and revised earlier standards which advocated separate models (NADSA, 1990). In the 1990 revision of the standards, NADSA "rejected the idea of discrete models perpetuated by a long-standing tradition of separation of social and health services in state licensing agencies and state/federal

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[17]Throughout this paper, the terms "adult day care" and "adult day services" will be used interchangeably. Most adult day providers prefer the more contemporary concept of offering services as opposed to providing care since the former term connotes individual participation and choice.

funding sources" (NADSA, 1990, p. xiv). NADSA's more recent position is based on the concept that specifically defined models might limit the center's ability to adapt to the changing needs of its participants.

Most of what is known about adult day services nationally is found in selected studies. The National Adult Day Services Association sent out questionnaires to all 1200 adult day care centers known to exist in 1985 and received responses from 874 of them (Von Behren, 1988). The purpose of the NADSA study was to examine differences in program and participant characteristics and to investigate relationships between licensing categories and funding sources. Another study, the Adult Day Care Assessment Procedure (ADCAP) (Conrad, Hanrahan, & Hughes, 1990), measured structural components, process issues, and the population characteristics of 834 centers located throughout the U.S. A third study, conducted by Weissert and his colleagues (1990), involved sixty adult day care centers in different geographic locations in the U.S. All of these studies present data collected in 1985-1986. The only nationwide studies since that time have been the 1989 National Adult Day Care Census (NADC) (Zawadski, Von Behren, & Stuart, 1992) and the Adult Day Health Care (ADHC) Evaluation Study conducted between 1987 and 1989 (Hedrick, Rothman, Chapko, Inui, Kelly, & Ehreth, 1993). The NADC examined organizational structure, general revenue sources, and participant characteristics of 1,157 centers. The ADHC Evaluation Study investigated the effects of adult day health care

on health status, utilization, and cost of care in adult day programs in or contracted by the Department of Veterans' Affairs. Among the findings of these studies are that a large number of day centers are housed in multipurpose centers such as senior centers, nursing homes, hospitals, or churches. Other programs are free-standing. Typical staffing for these centers includes a director, often trained as a nurse or social worker, and an assistant plus some or all of the following: nurses, therapists, social workers, case managers, recreation/activity aides, nursing assistants, custodial workers, van drivers, administrative/clerical personnel, and office staff (Weissert, Elston, Musliner, & Mutran, 1991). Consultant agreements are often utilized for the services of physicians, therapists, or dieticians and in-kind staffing is sometimes available for fiscal managers or bookkeepers. Overall, the conclusions of these studies support the concept that adult day care is a program containing a range of both basic and professional services.

One of the primary attractions of adult day services is the fact that older participants may remain in their community while, at the same time, receiving needed health, social, and support services. The monthly income of these participants averaged $557 in 1986 (Conrad, Hanrahan, & Hughes, 1990) emphasizing the need for assistance to individuals who are unable to pay privately for health and social services. Studies suggest that the quality of life for elderly people who remain in the community and receive care is better than for those who enter long-term care facilities, but findings vary on

whether community-based care is more or less expensive than institutional care. Current and complete financial information is crucial to the future financing and expansion of adult day services. Although several focused studies have been undertaken (e.g., Weissert, 1976; Von Behren, 1988; Zelman, Elston, & Weissert, 1991; Estes, 1993), a comprehensive examination of the relationships that exist among funding sources, licensing categories, participant and center characteristics, and demographic features has not yet occurred.

Adult day services are important options in the continuum of care for chronically ill or otherwise impaired individuals for two reasons: (1) they provide necessary health care and social support for individuals who prefer to remain in their homes and (2) they are more cost-effective than traditional institutional care. These comprehensive programs match the participants' needs with appropriate levels of support in order to enhance their ability to live in a community setting. Older adults with health problems and declining economic resources often require modifications and adaptations in living arrangements. The diverse services that are incorporated into community care programs may provide the opportunity for these individuals to enjoy an acceptable level of functioning within the community and avoid institutionalization.

Specific services in adult day care centers tend to vary in accordance with participant needs and facility resources. Indeed, it is precisely this

flexibility that makes adult day care a viable alternative. Most centers, however, offer recreational therapy, exercise, a midday meal, morning and afternoon snacks, assessment, and social services. In addition, many centers provide medical supervision, nursing care, personal care, counseling, education, rehabilitation, and transportation. The range of services provided by adult day care is representative of an underlying philosophy directed at improving each participant's quality of life. Key elements in the treatment program for each person include the therapeutic milieu and the individualized, interdisciplinary plan of care.

Each service plan is based on an assessment of an individual's physical, mental, and social status, which includes an evaluation of functional skills, support systems, and financial resources. The community, as well as the individual participant, benefits from this approach since service mobility within the adult day care system allows each center to respond appropriately when individuals' needs change. Thus "the opportunity exists for exploration and implementation of services unique to the profile of a specific community" (Kelly & Webb, 1989, p. 16).

Potential users of adult day services exhibit the same heterogeneous characteristics as the population in its entirety. As Soldo and Brothman (1981) point out, the elderly population differs not only by age and historical, cultural, and educational experiences, but also in family-friendship networks, interests, financial status, and health characteristics. A diversity

of living arrangements and housing accommodations are utilized, often based on the person's health, personal resources, and degree of dependency. In general, adult day participants have at least minimal limitations in independent functioning, although "community-based elderly tend to be somewhat younger, in better health, with greater financial resources and larger kin networks than those residing in some type of long-term care facility" (Soldo & Brothman, 1981, p. 37). According to the study by Weissert, et al. (1990), the average age of adult day participants is almost 78 years, with just under 20 percent being older than 84 years; most are unmarried Caucasian females who live with a relative or other caregiver. Further, more than half the participants are functionally impaired and almost 40 percent suffer from a mental disorder. The growing population of older individuals with various forms of dementia has resulted in the expansion of adult day services to accommodate the care of persons with Alzheimer's Disease and related disorders.

Adult day care offers obvious advantages over some of the other long-term care options. These advantages include a possible reduction in feelings of isolation and the creation of a supportive yet flexible temporary living environment. Social interaction and support by peers are benefits that are not experienced in other care alternatives, particularly home care. Adult day care services are also seen as a significant advantage for family caregivers since it provides respite from their 24-hour care responsibilities and permits

continued participation in the workforce while allowing close familial relations to continue.

A 1986 study by Zimmerman identified the primary areas of family functioning that were helped by participation in adult day care. Positive aspects of participation reported by caregivers included not only the obvious attention to the needs of the participant, but also the attention to the needs of the caregiver. Among the more important of these latter needs was the fact that participation allowed the caregiver the opportunity to perform usual household chores, spend time with family, do shopping, visit with friends, engage in recreational activities, and attend to the needs of other family members (Zimmerman, 1986).

Public Funding and Regulation

Findings from the National Adult Day Care Census survey (Zawadski, Von Behren, & Stuart, 1992) provide only general fiscal information about state funding, licensing, and certification. The relationship of licensing and certification to funding was examined in NADSA's 1991 Survey of State Agencies/Contacts (Von Behren, 1992) and in the Intergovernmental Health Policy Project conducted by George Washington University (Folkemer, 1994). These surveys produced only fragmentary information regarding funding sources, reimbursement level, and people served and did not correlate licensure and/or certification to state reimbursement. A 1991 study by Weissert, Elston, Musliner, and Mutran examined variations among centers

according to their regulatory status. The study found significant differences between regulated and unregulated centers in staffing, services, facilities, and attendance and found certification to be associated with a greater likelihood of employing medical and nursing personnel and of offering particular services. Reference was not made, however, to interstate regulatory or funding variations and the effects of these differences on the availability of adult day services in a given state.

The 1989 National Adult Day Care Census (Zawadski, Von Behren, & Stuart, 1992) describes the types and characteristics of adult day care centers and their participants but a compilation of the many variations in funding availability, sources, and reimbursement methodology does not exist. Due to the lack of federal guidelines, wide variations in reimbursement methods and levels and differences in state requirements for licensing and certification are prevalent. Currently, funding for adult day services comes from a variety of sources including Title XX of the Social Security Act, Title III of the Older Americans Act, and Medicaid. Medicaid funding is administered either as part of the state health plan[18] or in the form of a waiver. Providers in states that do not have adult day services as part of their state health plan commonly apply for the Home and Community-Based, 1915-C (HCBS)

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[18]States may select which services and programs to include as part of the state health plan.

waiver[19] which was initiated in 1981 as an amendment to Title XIX of the Social Security Act. The waiver permits states to offer an array of home and community-based services, including adult day services, as cost-effective alternatives to Medicaid-reimbursed institutional care. Typically, adult day centers that utilize public forms of reimbursement must meet specified licensing and/or certification criteria.

Child and Adult Care Food Program

The Child and Adult Care Food Program (CACFP), a federally funded program administered by the United States Department of Agriculture, promotes the service of nutritious meals and snacks to children and adults in child care centers, after-school programs, family day homes, and adult day centers. The CACFP is an expansion of the Child Care Food Program (CCFP) authorized in 1968 under Section 17 of the National School Lunch Act to provide funds for meals served to children in nonresidential day care facilities. In 1987, an amendment to the Older Americans Act mandated that the CCFP be expanded to allow eligible adult day centers to participate. A 1989 amendment to the Child Nutrition and WIC Reauthorization Act resulted in the name change to reflect the two populations served (CACFP,

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[19]The 1915(c) provisions allow a number of Medicaid statutory requirements to be waived including statewideness (i.e., waiver services may be limited to specific geographic areas) and comparability (i.e., home and community-based services not otherwise available through the Medicaid State Plan may be provided to a certain subset of the Medicaid eligible population).

1992).

Adult day centers are eligible for participation in the CACFP if they operate as public agencies, private, non-profit organizations, or for-profit organizations that receive compensation under Title XIX or XX of the Social Security Act for 25 percent or more of their enrollment. Participating centers must be licensed or approved by federal, state, or local authorities to provide services on less than a 24-hour basis to adults with disabilities or chronic functional impairments or to persons 60 years of age or older (CACFP, 1992).

Institutions participating in CACFP are reimbursed for meals and snacks based on participants' household size and income. Participant eligibility falls into one of three categories: free, reduced, or paid. Adult day centers are reimbursed at the free level for participants whose family income is at or below 130 percent of the poverty level; the reduced category is paid for adults whose family income is between 130 percent and 185 percent of poverty[20]; and the paid category is reimbursed for adults whose family income is above 185 percent of the poverty level (CACFP, 1992). Based on these categories, reimbursements are 18.75, 64.5, and 94.5 cents respectively for breakfast; 16.25, 129.5, and 169.5 cents for lunch; and 4.25, 23.25, and

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[20]For a family of four, 130 percent of the poverty level in 1992 was $1,512 per month and 185 percent of poverty was $2,151 per month (CACFP, 1992).

46.5 cents for snacks[21]. Congress appropriated $1.3 billion for the CACFP in fiscal year 1993 (CACFP, 1992).

Theoretical Framework Explaining Funding and Regulatory Practices

The most prominent sources of sociological theory relating to public funding and regulation of human service organizations have been discussions on bureaucratic theory, organizational structure, regulatory theory, and the relationship between organizations and society. Such discussions have addressed both the function and the structure of organizations. Functional aspects (i.e., the interrelationships and behaviors of the individuals and groups that comprise organizations) are typically viewed as a separate area of inquiry or a subfield of organizational theory commonly referred to as organizational behavior (Heffron, 1989). Structural aspects, on the other hand, focus on the structure, goals, technology, and environment of the organization itself.

Organization theory has emerged as an academic and practical field as organizations have assumed an increasingly important role in capitalist societies and management has recognized a basic need to maximize organizational rationality. The earliest theoretical approaches emphasized an ideal type of structure, arguing that if a perfect structure could be determined, developed, and utilized, individual worker behavior could be

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[21]Reimbursement levels for the period of July 1, 1992 through June 30, 1993 (CACFP, 1992).

controlled to produce a high level of efficiency (Heffron, 1989). Max Weber's writings that define and describe classic bureaucracy provide the foundation for these developments. Understanding the nature of bureaucracy and the increasing bureaucratization of twentieth century society, as described by Weber, are essential to a basic comprehension of public funding and regulatory systems in human service organizations.

Weber considered his analysis of "ideal type" bureaucracy, based on legal-rational authority, to be the most efficient form of organization, destined to dominate over all other forms:

> From a purely technical point of view, a bureaucracy is capable of attaining the highest degree of efficiency, and is in this sense formally the most rational known means of exercising authority over human beings. It is superior to any other form in precision, in stability, in the stringency of its discipline, and its reliability. It thus makes possible a particularly high degree of calculability of results for the heads of the organization and for those acting in relation to it. It is finally superior both in intensive efficiency and in the scope of its operations and is formally capable of application to all kinds of administrative tasks. (Weber, 1921/1968, p. 223)

For Weber, increasing bureaucracy was a manifestation of formal and technical rationality and the rationalization process in the West.

The modern bureaucratic organization, according to Weber, has several distinctive characteristics. An official jurisdictional area or office is designated, bound by specified administrative rules and arranged hierarchically. The bureaucrats' activities are regarded as duties for which they have been specially trained and are qualified to perform. Bureaucrats do not own the means of production associated with the offices, and, to assure that all clients are treated in the same manner, the ideal bureaucrat is impartial and disinterested. Clients are not treated as individuals, but rather as members of categories. All items necessary to perform the specified tasks, including official files and records, are provided and maintained by the office. Administrative acts are formulated and recorded in writing (Zeitlin, 1990). These features of an ideal bureaucracy are intended to increase the efficiency and reduce the cost of production in a complex organization.

The increasing expansion of bureaucracy in modern society has resulted from considerations of efficiency and power. In both the private and public spheres, bureaucratization has been promoted by power politics, warfare, the creation of large military forces, social welfare policies, and the immense budgets, enormity, and complexity that contribute to the administrative apparatus of these enterprises (Zeitlin, 1990). Bureaucracy is necessary to facilitate the control of a large number of people. At the same time, its challenges are formidable, especially as they relate to human services. While recipients and providers of social services advocate personal

choice and participatory decision-making, ideal type bureaucracy prohibits individual freedom.

As Weber predicted, bureaucracy became a dominant form of organizational structure in the industrialized world. Since Weber, organization theorists have continued to examine both the advantages and the dysfunctions of bureaucracy. Classic organization theorists (e.g., Frederick Taylor, Lyndall Urwick, Luther Gulick, James Mooney, Alan Reilly, and Henri Fayol) took a management approach to bureaucracy. They believed that organization management was a science and that uniformly applicable laws and principles could be identified that would result in the best and most efficient organization (Heffron, 1989). In *The Principles of Scientific Management* (1911/1967), for example, Taylor emphasized the analyses of work processes, time and motion studies, selection and training of employees, and other means for assuring best performance within the organization. Other classicists[22] focused on principles of organizational structure such as span of control, unity of command, division of labor, or delineation of organizations by purpose, process, place, or clientele (Heffron, 1989).

As organization theory evolved, theorists began to examine characteristics that are invaluable to bureaucracy (i.e., the specialization, the

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[22]For example, see Gulick's and Urwick's 1937 publication, *Papers on the Science of Administration.*

rules, the impersonality, and the chain of command) but that frequently result in dehumanizing red tape that is rigid, inflexible, monotonous, and unsatisfying. When bureaucracy degenerates to this level, "its rationality and efficiency are diminished" (Heffron, 1989, p. 5). The task of theory, at this stage, is to discover remedies to the inherent difficulties experienced by bureaucracy. Among the first theorists to take a human relations approach to organization theory were Elton Mayo, Fritz Roethlisberger, and William Dickson. Rather than viewing the organization as a machine bureaucracy, like Weber and the classic organization theorists, the Human Relationists regarded organizations as "social systems composed of individuals whose attitudes, values, beliefs, and behaviors are shaped by forces and factors external to the organization and by the informal associations and groups internal to the organization" (Heffron, 1989, p. 5).

Since the 1940s, a variety of approaches to organization theory have emerged. Human relations theories narrowed their focus to a more humanist approach with an emphasis on the individual worker. Work by Chris Argyris, Rensis Likert, Warren Bennis, and others concentrated on the deficiencies of bureaucracy[23] and emphasized the importance of job satisfaction, job enrichment, and democratic management. These efforts led

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[23]See, for example, Bennis' chapter in *American Bureaucracy* (1970) in which he discusses ten ways that the bureaucratic form of organization is becoming "less and less effective and out of joint with contemporary realities" (1970, p. 3).

to a multimethod approach known as Organization Development that sought to create organizations that emphasize an equal concern for productivity and people (Heffron, 1989). The tactics used in Organization Development include team building, intergroup problem solving, confrontation meeting, strategic planning, goal setting, and third-party facilitation (Sherwood, 1978; Heffron, 1989).

The New Management Science paralleled the development of Organization Development as a new example to an old approach. The foremost theorist of New Management Science, Herbert Simon, recognized the basic nonrationality of individual human beings and, once again, the focus shifted to the organization and the need to create an organizational structure that controls and manipulates the individuals in the organization. The "administrative man" in Simon's organization is facilitated in his rational decision-making through a carefully designed and computerized management information system (Heffron, 1989, p. 7). "Management defines the objectives and tasks of the organization, gives the orders downward, rewards, penalizes, and trains--or indoctrinates, as critics suggested--employees" (Argyris, 1973, p. 255).

Two new theoretical approaches to organization theory have evolved since the 1970s: the cultural school and the power and politics school. The cultural school views organizations as micro-level societies with distinct cultural values, norms, and socialization processes. According to cultural

theorists, these deeply rooted aspects of culture are more significant to the structure of an organization than its formal, rational aspects (Heffron, 1989). The power and politics school views organizations as "political systems permeated with conflict and power struggles to determine who gets what, when, and how" (Heffron, 1989, p. 7). The winner of the power struggle is the participant with the highest level of resources and skills. "Formal authority does not guarantee success in organizational politics. The rational, mechanical aspects of organization are considered clearly less important in determining organizational behavior than the formal aspects [of] political games and strategies" (Heffron, 1989, p. 8).

Two contemporary theories that differ significantly from other organization theories are open systems theory and contingency theory. Unlike the rationality vs. humanist debates that fail to recognize the complexity of relationships between organizations and their employees, these approaches emphasize situational analysis of multiple variables that affect organizational effectiveness (Heffron, 1989). The open systems theory views organizations as "entities that exist in a dynamic and interdependent relationship with their environment, receiving resources from that environment, transforming those resources into outputs, and transmitting them to the environment" (Heffron, 1989, pp. 8-9). An open systems approach notes that there is no one best way to achieve a goal and adheres to the principle that "systems use diverse sets of inputs, transforming them in

different ways to attain outputs" (White & Vroman, 1982, p. 11). Systems adapt to their environment and cope with external forces by "ingesting them or acquiring control over them. . . . Social systems will move towards incorporating within their boundaries the external resources essential to survival. . . . [T]he steady state becomes one of preserving the character of the system through growth and expansion" (Katz & Kahn, 1966, p. 25). Open systems theory acknowledges both the similarities and the differences in organizations. Organizations share certain similarities whether they represent private business, government, quasi-governmental entities, or nonprofit organizations, but they exist in different environments, have different goals, utilize different inputs, and vary significantly in size, structure, and production.

Contingency theory emphasizes the differences among organizations and seeks to identify the variables that affect organizational structure and effectiveness. A number of theorists (e.g., Thompson, Laurence, Lorsch, Perrow, Burns, Stalker, Fiedler, and Vroom) have identified and examined external variables such as organizational environment[24] and technology[25] and

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[24]See, for example, Thompson's work on environmental stability and homogeneity as described in *Organization in Action* (1967, p. 39).

[25]The impact of organizational technology (e.g., basic work flow, methods, and the variability of tasks) has been examined by Charles Perrow (1970).

internal variables such as leadership style[26], worker motivation, and the personality types of subordinates[27]. Contingency theory incorporates a complex and critical process. In its application, managers must master the principles of contingency theory along with the skills of situational analysis. "The complexity, untidiness, and almost 'untheoretical' nature of contingency theory are its greatest weaknesses" (Heffron, 1989, p. 11). However, it provides a critical link enabling organization theories developed for private organizations to apply to the public sector.

A pervasive feature of public sector organizations, especially as they relate to human services such as adult day care and to the American economic system, is government regulation. Assigning the responsibility of writing rules to a government agency for the purpose of constraining certain kinds of private economic decisions and using a quasi-judicial administrative process to develop these rules is "a method of control over market processes that is uniquely American" (Noll, 1985, p. 9). The organizational objective specified in theories of regulatory agencies is usually based on three assumptions about the motives of regulators: "either they seek to serve the public interest; they try to serve the interests of particular client groups,

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[26]For example, see Fiedler's description of successful leadership style (1967).

[27]Victor Vroom characterized subordinates and described what motivates them in his 1967 publication, *Work and Motivation.*

often by creating a legally enforceable cartel arrangement in an industry that would otherwise be competitive; or they attempt to maximize their own economic rewards or some measure of the success of their bureau" (Noll, 1985, p. 18).

For the most part, regulatory theories adhere to traditional sociological ideas developed by Weber. A major segment of inquiry has been directed toward justifying Weber's assertions about the optimal characteristics of bureaucratic structures. In addition, an enormous amount of literature has developed on how and why regulatory organizations become structured as they do and on differences in agencies' performances based on structure. Another body of literature has derived from the assumptions described by Blau and his followers: (1) organizations are goal-directed and attempt to achieve efficient operation; (2) individuals have limited capacity for receiving communications and controlling subordinates; and (3) increasing specialization of jobs leads to increased worker productivity (Blau, 1970; Blau and Schoenhen, 1971; Noll, 1985). Almost none of the literature, however, is focused on regulation per se.

Overall, general theories of regulation face conceptual and empirical problems. They are difficult to separate from theories of representative democracy and the inherent inefficiencies of regulation that flow from these theories have no natural normative consequence. Regulation affects both economic efficiency and the distribution of income making it typical of

government policy: "well-organized groups are affected by these outcomes and the regulatory process is carried out by a bureaucracy" (Joskow & Noll, 1977, p. 39). Empirical tests of regulatory theories are problematic since the data used to test the theory are also the information available to identify the successful interest group. The variables associated with these theories (e.g., comparisons of the economic stakes, the degree of organization, the resources of the interest groups) are difficult to measure (Joskow & Noll, 1977). Because of these problems, a number of theorists (Joskow & Noll, 1977; Noll, 1985; Wilson, 1985) are encouraging scholarly research on how regulatory agencies actually work and what factors influence their performance in order to discern the theoretical models that are most effective.

Although adult day care is a publicly funded and regulated program in many states, it is relatively new as a human service organization and its scope in the home and community based care continuum is limited. However, research on adult day care, grounded in organization and regulatory theory, will be important to policy makers as they develop more cost efficient methods for meeting the needs of the older population.

CHAPTER III

METHODOLOGY

Although adult day care is known as one of the fastest growing options in long-term care, the 3000 centers that are known to be currently operational across the nation fall short of the number required for programs to be available in every community (Reifler, 1995). It is believed that certain states have a greater availability of adult day programs because of differences in demand associated with demographic characteristics and public awareness. An additional, and perhaps more significant, reason for the greater availability of adult day services in certain states is that public funding is more available and accessible in these states. In other words, assuming that public awareness and demographic features are similar, and assuming that regulatory practices do not restrict growth, states that provide more funding options and/or higher levels of reimbursement for adult day services have a greater number of adult day centers than states with limited funding availability.

Research Questions and Objectives

The assumption that the greater the availability of public funding for adult day services, the higher the number of adult day centers in the state is

being used as the guiding principal for this study. The following research questions serve as the major points of inquiry to explore this principal:

1. How many adult day centers are operational in select states?
2. What funding sources are utilized for adult day services in the selected states?
3. How many different funding sources are used by the selected states?
4. What is the reimbursement level for each source utilized by the selected states?
5. How do these factors present in Texas?
6. What factors have influenced the organizational structure and development of adult day services in Texas?

In addition, the following questions guide minor points of inquiry:

1. Is licensing mandatory in the selected states?
2. Is certification mandatory in the selected states?
3. How are reimbursement levels structured?
4. What specific services are covered by the reimbursement amount?
5. How do these variations in funding structures affect program types and development?
6. Do licensure and certification requirements by state agencies that monitor adult day services affect program types and development?
7. Do demographic and geographical characteristics affect the availability of adult day services in Texas?

Objectives of the project include:

1. To identify and describe the funding sources, reimbursement levels, and regulatory practices for adult day services in select states.
2. To compare adult day services' funding sources and regulatory policies to the availability and types of adult day centers in select states.
3. To compare funding sources and demographic characteristics to the availability and types of adult day centers in Texas.
4. To develop an information base system[1] to be used by NADSA and by state and federal agencies that monitor adult day services to better inform policy makers in the future.

Data Collection

Data on state funding policies, licensing/certification requirements, and adult day services program requirements were collected from state agencies that fund and monitor adult day services using the survey instrument that appears in Appendix A. The semi-structured questionnaire was developed in collaboration with the Community Care Division of the Texas Department of Human Services, who requested a comparative analysis of adult day care funding methodologies in other states, and with members of the National Adult Day Services Association's Publications and Research Sub-Committee. The instruments were tested in Texas and then

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[1]Procedures and survey instruments were developed for use by NADSA for annual data collection, analyses, and reporting to state agencies.

administered to the key informants in the fifty states who represent the funding and/or regulatory agencies.

Examples of agencies that monitor adult day services include state departments of health and human services, state departments of mental health, and state departments on aging. In some states, more than one agency is involved. The identification of key informants in each agency was provided by the National Adult Day Services Association[2]. A total of 68 funding or regulatory agencies that pertain to adult day services were contacted regardless of the extent to which that agency is involved. Of the 68 questionnaires mailed in December 1994, 32 were returned representing 31 states plus the District of Columbia. In December 1995 and January 1996, telephone interviews were conducted to collect information from state agencies that did not respond initially and to clarify information about select states. In addition, telephone interviews were used with state agency and state association representatives in Texas, California, Florida, Pennsylvania, and New Jersey to update earlier data. The combination of the two data collection methods resulted in a total of 40 responses (39 states plus the District of Columbia).

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[2]NADSA provided a list of 68 funding agencies that were contacted during the original data collection phase of the project. Appendix B provides an updated list containing the names of 98 contact persons in state agencies that monitor adult day care. This updated list was achieved through survey responses and/or telephone interviewing.

The qualitative methods used in this study included informant interviewing and content analysis. The data for content analysis was provided by state agency representatives as directed on the survey instrument. The documents requested included licensing standards, certification guidelines, and reimbursement methodology. In-depth telephone interviews were conducted with key informants representing the National Adult Day Services Association (NADSA), state adult day services associations, and state agencies. Key informants for NADSA included the program director at the NCOA office in Washington, D.C. and regional and at-large delegates in various states. Key informants for state adult day services associations are the association's executive director and/or officers and committee members. Key informants for state agencies include state directors for community care services divisions, program specialists, and reimbursement specialists. The semi-structured survey instrument that was mailed to state agencies served as the interview guide. Interviews were conducted after survey responses and attached documents were reviewed in order to identify pertinent topics and to discern the need to clarify data. The informational overlap that results from blending these data collection methods assures that adequate information is obtained and serves as a cross-check to increase validity.

Variables

The questionnaire used for the survey was designed to identify the two

categories of independent variables: those relating to funding and those relating to regulation. Funding variables include specific sources and types of funding available in the state, the level of reimbursement, and the utilization of more than one funding source. Regulation variables include licensing and certification requirements and mandated services. The dependent variable is the number of adult day centers in the state.

The funding categories are nominal variables designated as Medicaid State Health Plan, Medicaid Waiver, SSBG, Title III, Alzheimer's Grant, Developmental Disabilities/Mental Retardation, Mental Health, and others. The level of reimbursement (i.e., dollar amount per diem) is an ordinal variable. Regulation categories are nominal variables: licensing only; certification only; both licensing and certification; and neither licensing nor certification. The variables for services (listed on page 4 of the survey instrument) are nominally specified as either required or not required.

Data Analysis

Once all data were collected, the structural organization and the type of funding for adult day services in states that responded to the survey were examined and described using both quantitative and qualitative methods. Integrating the methods by combining survey analysis with informant interviews and unobtrusive measures (i.e., content analysis), strengthened the study by providing greater density of information and by clarifying meaning. This method of analysis incorporates three features: (1) defining

the units of analysis that are theoretically meaningful and that represent the perspectives of the informants; (2) crossing a sample of data sources--based on theoretical grounds and characteristics of funding and regulation in the state--with a sample of the units of analysis; and (3) creating a quantitative data set that consists of standardized codes for variables pertaining to each unit of analysis (McClintock, Brannon, & Maynard-Moody, 1983). Blending and integrating these various methods to examine the same dimension of the research problem assures a greater degree of external validity while the multiple comparison groups create greater reliability in the emergent theory (Jick, 1983). The specific information obtained from key informants representing different perspectives was analyzed and cross-checked with survey data and document information. These multiple viewpoints allow for greater validity in the interpretations about each phenomenon and the integration of methods assure internal reliability.

The quantitative segment of the data analysis was intended to enhance the reliability of the qualitative observations (e.g., the interview and document information), facilitate replication studies, and permit generalizations to larger populations (McClintock, Brannon, & Maynard-Moody, 1983). SPSS was used for the quantitative analysis (to perform descriptive statistics and crosstabulations), to explain the differences in growth patterns and availability of adult day centers in select states, and to quantitatively explore the assumption that increased funding enhances the

development of adult day services in any state. The number of adult day centers per state was used for crosstabulations between variables. The variable for number of centers required recoding to produce four value categories labeled "low number of adult day centers" (less than 25 adult day centers in the state); "moderate number of adult day centers" (25 to 49 centers in the state); "moderately high number of adult day centers" (50 to 99 centers in the state); and "high number of adult day centers" (100 or more centers in the state). The variable for number of centers was then crossed with the independent variables for the sources of funding available in the state (i.e, Medicaid State Health Plan, Medicaid Waiver, SSBG, and Title III) and the number of funding sources available. Frequencies were performed to determine the number of states that utilize the various funding sources, require licensure and/or certification, and mandate specific services.

Qualitative methods were used to clarify information obtained by the survey method and to provide a variety of perspectives. The goals of the qualitative analysis included: (1) to capture the frame of reference of each informant; (2) to define the situation for each variable; (3) to conduct detailed examination of the organizational process; and (4) to elucidate factors particular to each state and allow greater understanding of policies in that state (McClintock, Brannon, & Maynard-Moody, 1983). The procedure involved an analysis of the responses to open-ended questions on the survey instrument; content analysis of documents provided by state agencies (i.e.,

licensing standards, certification guidelines, and reimbursement methodology); and analysis of information obtained during informant interviews. These data sources were compared with one another to discern whether the varying perspectives produce the same or different responses. The responses provided by state association leaders, for example, were compared to those provided by state agency representatives to determine whether providers' perspectives adhere to those of funders and regulators. In states where more than one state agency monitors adult day services, responses of each agency's representative were analyzed and described to discern any differences between agencies. In addition, the details of each of the funding and regulation variables were summarized and described as expressed by each informant and in written policy.

Application of the Theoretical Framework

The structure of adult day care is grounded in organization and regulatory theory. State agencies that monitor adult day services, along with numerous other home, community, and institutional organizations, have developed as highly specialized bureaucracies responsible for overseeing human service organizations. Adult day care, as a small segment of the home and community based care system, depends on the public funding administered by these agencies for its growth and development. As complex organizations, state agencies strive to expand their efficiency and power by increasing bureaucratization. In light of upcoming changes resulting from

overarching federal budget constraints, states are being forced to increase their reliance on rational and efficient means for managing their programs and strategies.

The future role of adult day services in the state system will depend on the degree to which bureaucrats consider adult day services efficient and rational. The intent of this exploratory study is to examine and describe the manner in which state bureaucracies currently promote or inhibit the availability and accessibility of public funds for adult day care and to provide documentation on structural aspects of the program, incorporating the perspectives of state agency representatives, agency documents, and provider groups. This information should be considered a starting point for the much more extensive data required on cost factors and bureaucratic structure as researchers and policy-makers plan community care and support services for an expanding population of older Americans.

CHAPTER IV

ADULT DAY SERVICES IN THE U.S.

Home and community-based services have expanded in recent years in accordance with the increase in the elderly population and an underlying trend to reduce institutional care. Adult day care, as one of the fastest growing community service alternatives, has experienced increased public awareness and notice by policy-makers, funding agencies, and regulators. Since there is not a national policy, adult day services receive varying degrees of attention on the state level. Some states have highly structured funding and regulatory systems for adult day services while others provide minimal public funds and little or no regulatory oversight. As previously mentioned, the type and level of involvement by state agencies that fund or monitor adult day centers influence the development of adult day care in the state. States with large numbers of adult day centers are also states that help to promote the programs' growth through funding and monitoring. This chapter provides summary descriptions of certain organizational characteristics of adult day services in various states. Adult day services, like any publicly funded and regulated program, are typical of government policy that is grounded in bureaucratic theory (i.e., economic efficiency and a

regulatory process carried out by a bureaucracy affects the outcome of well-organized groups).

Since it is difficult or impossible to measure variables associated with these theories (e.g., economic comparisons, degree of organization, interest group resources), a description of how agencies and interest groups (i.e., provider associations) relate to adult day care is included to assist bureaucrats and providers to discern the models of adult day services in a given state that are most effective. Discussion will include the types, levels, and methods of public funding and regulation in select states and how these factors influence the number of adult day centers in the state.

As described in Chapter 3, the study began with a semi-structured survey of all state agencies that fund and/or regulate adult day services. The data collected from the survey were analyzed using both quantitative and qualitative methods. Quantitative analysis determined the number of adult day centers in each state and the number of these centers that utilize an array of public funding sources and regulatory mechanisms. Qualitative analysis included informant interviews and content analysis. The units of analysis were defined as individual states with one or more agencies that regulate and/or fund adult day programs. For states with more than one such agency, the variables were clarified through content analysis and telephone interviews with key informants. The dependent variable was the number of adult day centers in the state. The independent variables related

to funding and regulation.

Content analysis involved systematic review of the documents provided by state agencies, state associations, and NADSA. These documents include a variety of licensing standards or guidelines, reimbursement methodologies, certification and/or funding criteria, program descriptions, and research reports. Other documents received include the survey instrument used by the state of Maryland for the long-term care survey conducted by the Maryland Health Resources Planning Commission and an information packet provided by South Carolina's state association informant that was developed in cooperation with the state's Health and Human Services Finance Commission. The Maryland Long Term Care Survey has been conducted routinely since 1984. It collects data on the operating characteristics of long term care facilities and services statewide. The South Carolina packet, entitled "From A to Z: Adult Day Care Start-Up Information for South Carolina," is issued to anyone interested in developing adult day care and provides basic information about licensing, needs assessment, financing, facility requirements, and operations. NADSA provided a number of historical and informational documents including the "North Carolina Adult Day Care/Day Health: Findings from the 1993 NCADCA Survey." NCADCA (North Carolina Adult Day Care Association) conducted the study in conjunction with the Center for Aging Research and Educational Services at the University of North Carolina, Chapel Hill and

the Adult Services Branch of the State Division of Social Services. A description of the study and a comparison of its findings to other information received about adult day services in North Carolina are discussed later in this chapter. NADSA also provided the executive summary of a study conducted by Mathematica Health Policy, Inc. on the adult component of the Child and Adult Care Food Program and *An Overview of State Regulations and Standards for Adult Day Care: 1993*, an unpublished report of the Intergovernmental Health Policy (IHP) Project conducted at George Washington University (Lipson, 1994). Findings from the IHP report, which concentrated on regulation of adult day services, were compared with relative findings in this study. All of these documents assisted in the analysis of the organizational structure of adult day services.

Telephone interviews were conducted with key informants representing state agencies, NADSA, and state adult day services associations. The primary purposes of the interviews were to validate information and to capture the perspectives of the various reporters. The multiple reports revealed a significant problem with the data: a lack of consensus among the key informants regarding the variables. For example, NADSA's Winter 1995 summary of the adult day care association survey reported 1,727 adult day centers operating in the 34 states plus the District

of Columbia that responded to the survey[1] (Ransom, 1995). When members of the NADSA delegate council adjusted the figure by adding the number of centers known to exist in states that did not respond to the survey, the total was calculated at 2,211 centers nationwide. This number falls significantly short of the 3000 to 3300 adult day centers reported in current literature (Reifler, 1995; Von Behren, 1994; Weaver, 1994). National studies (Von Behren, 1988; Conrad, Hanrahan, & Hughes, 1990; Weissert et al., 1990) fail to provide an accurate census of adult day centers since their samples have never spanned all fifty states and since the research was conducted more than five years ago. The national study of the Child and Adult Care Food Program conducted by Mathematica Policy Research, Inc. lists 2,837 adult day centers operating in the U.S. in 1991.

Once the data pertaining to dependent and independent variables were verified as accurately as possible by crossing the survey data with the information obtained through content analysis and interviewing reliable informants, descriptive statistics were applied. The number of adult day centers per state, as the dependent variable, was validated and summarized. The independent variables were separated into either funding or regulation

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[1]States that did not respond include Alaska, California, Connecticut, Georgia, Idaho, Kansas, Maine, Massachusetts, Michigan, Mississippi, Missouri, New Hampshire, New Jersey, Rhode Island, Vermont, and Wyoming.

variables. Funding variables include the types of funding, the number of different funding sources available, and the level of reimbursement per source. Regulation variables refer to mandates for licensing, certification, or required services.

Findings and Discussion

Number of Adult Day Centers

Table 1 lists the number of adult day centers reported in each state. These data were derived from responses to the survey mailed in December 1994 and to interviews conducted in December 1995 and January 1996.

Table 1

Number of Adult Day Centers in Each State

STATE	# ADCs	STATE	# ADCs	STATE	# ADCs	STATE	# ADCs
CA	181	KY	80	IA	32	RI	13
TX	176	MN	75	ME	30	AK	12
NY	170	NC	72	AZ	27	NM	12
FL	145	CT	56	MT	27	MS	10
PA	135	WA	53	AR	25	DE	8
NJ	100	GA	51	OK	19	ND	8
MA	100	VA	46	VT	16	UT	8
WI	98	MO	40	KS	15	WY	8
MI	96	NE	39	HI	15	DC	6
IL	95	SC	39	OR	15	WV	6
MD	93	AL	35	LA	14	NV	4
OH	85	TN	35	NH	14	ID	1
IN	81	CO	32	SD	14		

Of the 31 states plus the District of Columbia that responded to the initial survey in December 1994, the top five (California, Texas, New York, Florida, and Pennsylvania) plus states that reported data discrepancies were

contacted again in December 1995 to update or clarify information. Telephone interviews were conducted with state agency representatives, state association leaders, and regional representatives of NADSA to collect data from these states plus the 19 others that did not respond to the original survey.

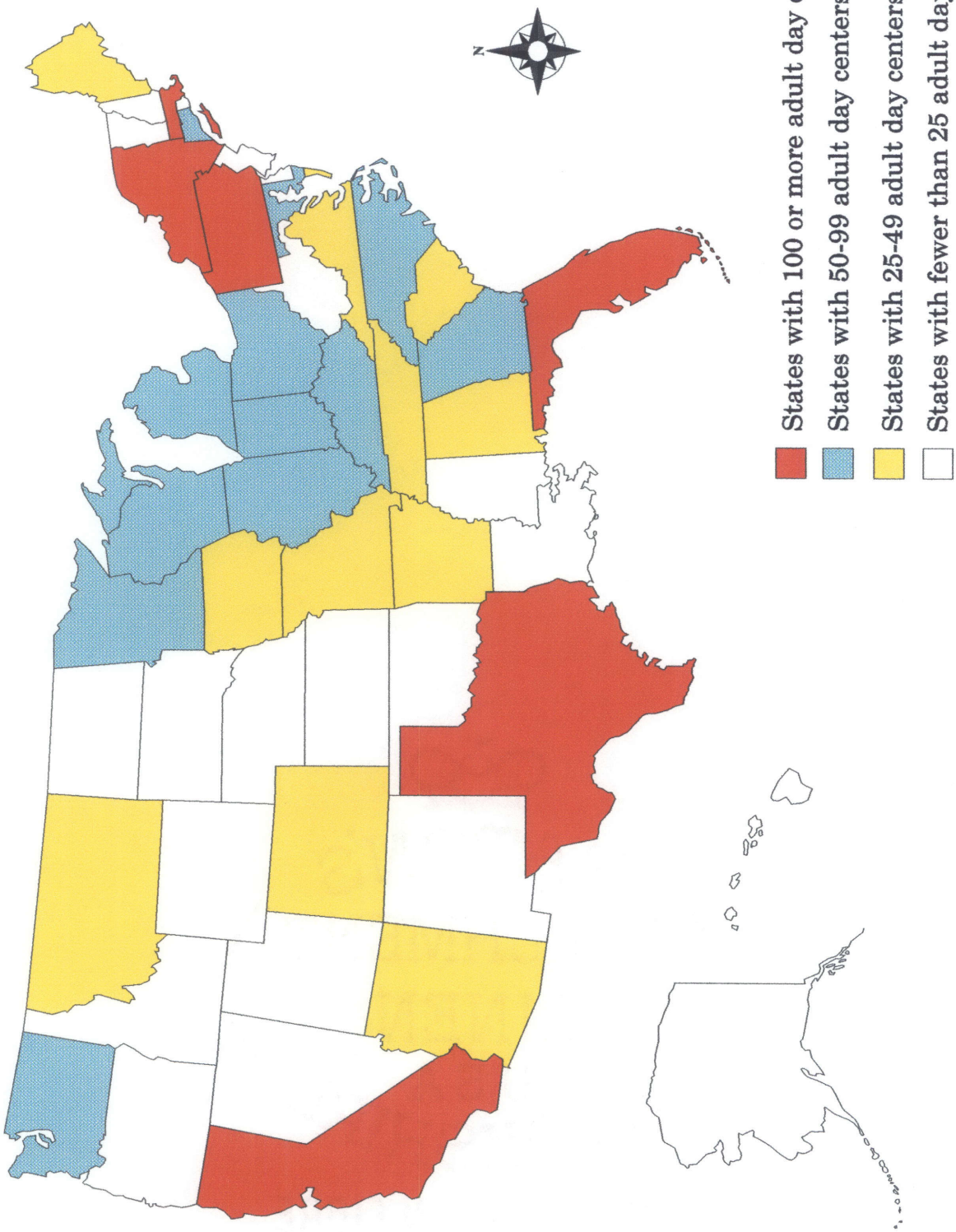
As previously mentioned, one problem with the data is the nonavailability of accurate information from a single source. In states where licensing is not mandatory or where more than one agency is involved, the precise number of adult day centers per state is either not known, or, at best, difficult to obtain. In California, for example, the Department of Social Services (DSS), Community Care Licensing Division reported 459 Adult Day Care (ADC) and 34 Adult Day Support Center (ADSC) facilities. They did not report on behalf of the California Department of Aging who administers the Adult Day Health Care (ADHC) program. The executive director of the California Association for Adult Day Services (CAADS) clarified the information provided by the DSS, reporting that a total of 181 adult day facilities (90 ADCs or ADSCs and 91 ADHCs) are actually operational in the state. The other 278 facilities reported by DSS are specialized day programs that serve only persons with developmental disabilities. The discrepancy occurs since the same license is issued for these centers as for day centers that serve frail elders and physically disabled adults. Similar discrepancies occurred with data from Illinois, New Hampshire, and Nebraska where state

agency representatives and state association representatives reported significantly different numbers. Clarifying the numbers involved interviewing the informants to determine why differences were reported and comparing current data to historical documents (e.g., NADSA reports from previous years). In most cases, the definition of adult day services was not consistent among informants and variations related either to more than one agency being involved or to differences in organizational structure and conception between the regulatory agency and practitioners. Thus the numbers of adult day centers reported in Table 1 were derived from a number of sources and clarified to the greatest extent possible.

Figure 1 illustrates the states with the greatest concentration of adult day services. Based on the number of centers specified in Table 1, states were categorized as high, moderately high, moderate, and low numbers of adult day centers in the state. High is defined as more than 100 adult day centers; moderately high is defined as between 50 and 99 centers; moderate is defined as between 25 and 49 centers; and low is defined as fewer than 25 centers. States with the greatest number of adult day centers include California with 181, Texas with 176, New York with 170, Florida with 145, and Pennsylvania with 135. A number of states have a low number of adult day centers in accordance with their known small populations (e.g., Nevada, Utah, North Dakota, Montana, and Wyoming), but states such as Iowa and Nebraska, also known to have smaller, rural populations, have significantly

Figure 1

Concentration of Adult Day Centers in U.S.



more adult day centers than other states with similar population characteristics.

A comparison of how the number of adult day centers relates to demographic characteristics in each state appears in Table 2. The five states with the greatest concentration of adult day centers are also states that have large total populations. Although the percentage of the U.S. population that is 65 or older (12.5 percent) is greater than the percentages in California in Texas (10.5 percent and 10.1 percent respectively), the shear numbers of older persons along with other key indicators in these states suggests the need for adult day and other community-based services.

The percentage of the population age 65 and older is significant since the need for community-based or institutional care increases with age and the majority of the users of adult day services are elderly. Older people are diverse in health and chronic conditions but the growth in the number of older persons with functional difficulties will have a dramatic impact on health care and social services in coming years. Since chronic conditions, as the predominant health problem for older individuals, lead to disabilities and functional impairment, the sharp rise in the number of frail elderly in need of institutional and community-based care will dramatically affect health policy in coming years. Minority status and socioeconomic indicators are also key factors affecting chronic conditions and associated impairments that result in the need for community-based or institutional care.

Table 2

State Profiles: Number of Adult Day Centers and Demographic Characteristics (Raetzman & Jensen, 1991)

State	Number of Adult Day Centers	Total Population in Thousands	Percent Population 65 +	Percent in Rural Areas	Percent Non-White	Percent receiving Social Security	Percent below Poverty
AK	12	550	4.1	58.9	24.5	6.1	11.4
AL	35	4041	12.9	32.6	26.4	17.5	19.2
AR	25	2351	14.9	59.9	17.3	20.0	19.6
AZ	27	3665	13.1	21.0	19.2	16.1	13.7
CA	181	29,776	10.5	4.3	31.0	12.3	13.9
CO	32	3294	10.0	18.5	11.8	12.8	13.7
CT	56	3287	13.6	7.6	13.0	16.0	6.0
DE	8	666	12.1	33.7	19.7	15.7	6.9
FL	145	12,938	18.3	9.2	16.9	20.5	14.4
GA	51	6478	10.1	35.0	29.0	13.6	15.8
HI	15	1108	11.3	24.5	66.6	13.4	11.0
IA	32	2777	15.3	56.0	3.4	18.9	10.4
ID	1	1007	12.0	79.6	5.6	15.6	14.9
IL	95	11,431	12.6	17.3	21.7	15.3	13.7
IN	81	5544	12.6	31.5	9.4	16.5	13.0
KS	15	2478	13.8	46.2	9.9	16.4	10.3
KY	80	3685	12.7	53.5	8.0	17.5	17.3
LA	14	4220	11.1	30.5	32.7	15.4	23.6
MA	100	6016	13.6	9.6	10.2	16.1	10.7
MD	93	4781	10.8	7.2	29.0	12.7	9.9
ME	30	1228	13.3	64.1	1.6	17.5	13.1
MI	96	9295	11.9	19.9	16.6	16.0	14.3
MN	75	4375	12.5	32.3	5.6	15.3	12.0
MO	40	5117	14.0	33.8	12.3	17.9	13.4
MS	10	2573	12.5	69.9	36.5	17.5	25.7

State	Number of Adult Day Centers	Total Population in Thousands	Percent Population 65 +	Percent in Rural Areas	Percent Non-White	Percent receiving Social Security	Percent below Poverty
MT	27	799	13.3	76.1	7.3	17.2	16.3
NC	72	6629	12.1	43.3	24.4	16.2	13.0
ND	8	639	14.3	59.7	5.4	17.6	13.7
NE	39	1578	14.1	51.5	6.2	17.0	10.3
NH	14	1109	11.3	43.9	2.0	14.6	6.3
NJ	100	7730	13.4	n/a	20.7	15.9	9.2
NM	12	1515	10.8	51.6	24.4	14.4	20.9
NV	4	1202	10.6	17.1	15.7	14.0	9.8
NY	170	17,990	13.1	8.9	25.6	15.7	14.3
OH	85	10,847	13.0	21.0	12.2	16.6	11.5
OK	19	3146	13.5	40.6	17.9	16.9	15.6
OR	15	2842	13.8	31.5	7.2	17.5	9.2
PA	135	11,882	15.4	15.2	11.5	18.8	11.0
RI	13	1003	15.0	7.5	0.6	18.0	7.5
SC	39	3487	11.4	39.4	31.0	15.5	16.2
SD	14	696	14.7	70.5	8.4	18.4	13.3
TN	35	4877	12.7	32.3	17.0	16.9	16.9
TX	176	16,987	10.1	18.4	24.8	12.9	15.9
UT	8	1723	8.7	22.5	6.2	11.1	8.2
VA	46	6187	10.7	27.5	22.6	13.5	11.1
VT	16	563	11.8	76.6	0.4	15.6	10.9
WA	53	4867	11.8	18.3	11.5	14.7	8.9
WI	98	4892	13.3	32.6	7.8	17.1	9.3
WV	6	1793	15.0	63.6	3.8	20.6	18.1
WY	8	454	10.4	70.4	5.8	13.7	11.0

Although California ranks forty-fifth in the percentage of persons 65 or older and Texas ranks forty-seventh, California ranks nineteenth and Texas ranks twelfth in the percent of population below poverty (Raetzman & Jensen, 1992). Minority populations in California and Texas are also significant. Thirty-one percent of California's population and 24.8 percent of Texas' population are non-white. Other states with a large number of adult day centers have high percentages of persons 65 and older along with high poverty and/or minority rates. The percentage of the elderly population in New York, for example, is higher than the national average. New York also has a higher percentage of minorities and people living below poverty than the U.S. averages. In Florida, 14.4 percent of the population lives in poverty and 16.9 percent are minorities, but the state ranks first in the percentage of older population (Raetzman & Jensen, 1992). Other states with large numbers of older persons (e.g., Pennsylvania and New Jersey) also have more adult day centers than states that are less populated and/or have a low percentage of persons 65 or older. States with very few adult day centers are typically less populated overall and have fewer older residents. In Arkansas, for example, 14.9 percent of the population is 65 or older (higher than the U.S. average) and the state ranks fifth in poverty. Arkansas' total population, however, is only 2,351,000 compared to California with almost 30 million, New York with nearly 18 million, Texas with about 17 million, and Florida with nearly 13 million.

Funding Sources and Levels of Reimbursement

Data relating to funding sources required extensive clarification for a number of reasons. In several cases, the individual completing the questionnaire represented a state agency that provides regulatory oversight and/or administers adult day care licensing, but does not provide any form of public funding. The response from the California Department of Social Services, for example, indicated "not applicable" on items referring to the number of adult day centers in the state that receive each form of funding. Data submitted by states where more than one agency provides funds (e.g., Florida) also required extensive clarification. In states such as California and Florida, state association leaders verbalized knowledge and understanding of funding types and methods for adult day services. However, in other states, state association leaders and NADSA regional representatives admitted that they have limited understanding of the public funding available to adult day centers or how to access it.

Because of these problems with data collection, extensive cross-checking was required to assure that adequate information was obtained and validity was assured. Combining the survey data with information obtained from interviews and documents provided a greater quantity of information and assisted in clarifying the data. Integrating these various methods to examine each independent variable also produced a greater degree of external validity. Thus, specific information obtained from key informants

not only presented different perspectives, but also provided data that could be cross-checked with the survey and document information. These multiple viewpoints resulted in greater reliability and validity in the interpretations about each variable.

The utilization of a number of funding sources were reported in the surveys and during the telephone interviews. Analysis procedures, including descriptive statistics and frequencies, revealed that the HCBS Waiver is the funding source used most often with 628 centers utilizing the waiver in 24 states. Medicaid as part of the state health plan, Title III of the Older Americans Act, and the Social Services Block Grant are also predominant funding methods. Table 3 summarizes the funding sources for adult day care and indicates the prevalence of each source. Examples of states that use more than two funding sources include Pennsylvania, where Title III funding is predominant, but the Office of Mental Retardation also provides support; Oklahoma, where funding comes primarily from SSBG, but VA and Mental Health funds are also utilized by some centers; and Illinois, where 9 centers receive Medicaid funds as designated in the State Health Plan, 66 centers utilize Medicaid waivers, five centers receive Title III funding, 28 centers are reimbursed for MR/DD participants, and 25 centers have VA contracts. New Jersey also utilizes a variety of funding sources for both its medical and social model facilities. Funding in New Jersey is available through Medicaid as part of the state health plan, Medicaid waiver, Title III, respite care

Table 3

Adult Day Services Funding Sources (N=40)

FUNDING SOURCE	NUMBER OF STATES	TOTAL # OF CENTERS
Medicaid, State Health Plan	11	477
Medicaid Waiver (1915C)	24	628
Title III (OAA)	17	416
SSBG	22	170
Any two sources	8	
Any three sources	7	
Any four sources	8	
Any five or more sources	11	

contracts, reimbursement for developmentally disabled persons, and grants from the state Alzheimer's Association.

Information about the levels of reimbursement was obtained via analysis of documents provided by state agencies and telephone interviews with key informants in select states. Significant disparity was noted in the levels of reimbursement among the various states (see Table 4). A number of states incorporate complex reimbursement methodologies and, due to the variability in their funding practices, are not listed on Table 4. Illinois, for

example, uses a flat rate[2] based on each participant's Determination of Need (DON) assessment score. The Illinois Department on Aging (IDoA) reimburses $22.43 per unit for "regular" adult day care clients and $24.12 per unit for "hard-to-serve" adult day care clients. A unit is defined as a minimum of five hours and only one unit is reimbursed in a 24-hour period. In addition to the client rate, transportation is reimbursed at $2.81 per one-way trip with a maximum of two one-way trips allowed per day[3].

Washington and California are currently developing methodology for reimbursement based on each participant's level of care that will be much more complex than the Illinois system. The Washington and California procedures will utilize an assessment tool derived from the nursing home and home health care Resource Utilization Groups (RUG) systems. These tools will assure a more extensive assessment process than the eligibility form used to determine clients' needs in Illinois.

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[2]Prior to the implementation of a fixed rate in July 1989, the Illinois Department on Aging had a single rate structure which included transportation as a component of the adult day service. Adult day providers with a contract prior to this date were offered the choice of switching to the new fixed rate or retaining the single rate used before July 1989 (which ranged from $23.32 to $26.30).

[3]Transportation reimbursement does not include transportation for outings, trips to physicians' offices, shopping, or other miscellaneous trips.

Table 4

Adult Day Services Funding Level Comparison in Select States
(per diem unless otherwise specified)

Medicaid State Health Plan		
	New Jersey	$46.77 - 52.00
	California	$54.30
	Texas	$22.48
Medicaid Waiver		
	Florida	$4.32 - 10.00 per hour
	Louisiana	$26.00 - 40.24
	Washington	$41.74
SSBG		
	Oklahoma	$25.00
	Florida	$30.00 - 35.00
	Washington	$20.00 - 35.00
Title III		
	California	$3.50 per hour and up
	New Jersey	$34.00 (average)
	Pennsylvania	$70,000 per year (line item) or more

Among the states from which data on funding levels were collected, California reported the highest per diem Medicaid rate at $54.30 while Texas reported the lowest at $22.48. SSBG and Title III per diem rates in states other than Texas were also higher than Texas' state health plan rate among the states polled. Considering the similarities in the population size and demographic characteristics of California and Texas, further exploration is required to determine why and how the number of adult day centers in the two states is almost identical even though funding levels vary significantly. In order to explore the theory that greater availability of public funding

yields a higher number of adult day centers in a state, it is important to understand that the concept refers not only to the level of funding, but also to its accessibility. Funding variables used in cross-tabulation analysis, therefore, are treated equally. Table 5 presents a comparison of the types of funding and the number of different funding sources utilized to the number of adult day centers in each state.

Table 5

Type of Funding by Number of States with High, Moderately High, Moderate, or Low Numbers of Adult Day Centers

	MEDICAID WAIVER	MEDICAID SHP	SSBG	TITLE III
HIGH (100 or more ADCs in the state)	2	3	4	4
MODERATELY HIGH (50-99 ADCs in the state)	8	10	11	7
MODERATE (25-49 ADCs in the state)	8	8	9	8
LOW (< 25 ADCs in the state)	15	16	16	15

As previously mentioned, the HCBS waiver is used by more states than any other funding method, but there is no significant variation in comparisons between the type of a single funding source and the number of adult day centers in a state. In some states, several different funding sources are utilized either because the provider groups have targeted certain types of funding or because agencies make funding available for specific types of

programs or participants. A crosstabulation was performed to determine if a relationship exists between the number of funding sources available in a state and the number of adult day centers operating in the state. Table 6 presents the findings.

Table 6

Number of Funding Sources by Number of States with High, Moderately High, Moderate, or Low Numbers of Adult Day Centers

	TWO SOURCES	THREE SOURCES	FOUR SOURCES	FIVE + SOURCES
HIGH (100 or more ADCs in the state)	1	0	3	2
MODERATELY HIGH (50-99 ADCs in the state)	1	0	2	4
MODERATE (25-49 ADCs in the state)	1	2	1	5
LOW (< 25 ADCs in the state)	5	5	2	0

Although the findings fail to provide evidence of a significant relationship between the number of different sources used and the number of adult day centers in the state, this chart suggests that adult day care development is possibly enhanced by a greater number of different funding options. States that provide five or more different funding sources include California, Iowa, Indiana, Maryland, Maine, North Carolina, Nebraska, New Jersey, South Carolina, Virginia, and Wisconsin. In addition to the predominant funding methods (Medicaid, Title III, and SSBG), several of the states provide

funding that assists people with special needs due, for example, to Alzheimer's Disease, developmental disabilities, or mental health problems. Adult day centers that contract with the Department of Veterans' Affairs are counted as an additional source for states that reported any number of centers with VA contracts. In addition, states like Wisconsin reported a number of funding variations for its adult day centers including the Community Options program, county funds, grants, funds from the MR/DD board, the County Aids program, state general revenue, and Medicaid Waiver.

Medicare funding for adult day services has been proposed in recent years but has not passed through Congress. Both the Senate and the House have introduced bills to extend Medicare, Part B coverage to adult day care. Summaries provided by NADSA describe 1987 and 1989 House and Senate bills that propose a specified number of days of adult day services per calendar year for beneficiaries who are certified eligible for institutionalization. Policy makers concerned about financing for Medicare coverage of adult day services assert that HCFA's adult day care demonstration projects[4] have "repeatedly shown that expanding publicly

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[4]One of the best known demonstrations of consolidated long-term care was launched in 1979 by On Lok Senior Health Services in San Francisco. Since 1983, On Lok has had a Medicare (§222) waiver allowing it to receive fixed monthly per capita payments to provide complete care to nursing home-certified participants.

financed community care dramatically increases aggregate costs rather than reduces costs as is commonly thought" (Adult Day Care--HCFA Testimony, 1988). Proponents of Medicare coverage for adult day services argue that adult day care saves money because it keeps people out of nursing homes longer. However, the Congressional Budget Office conducted a cost estimate of S. 1839, proposed by Senator John Melcher (D., Montana) in 1987 and found that not only would there be no cost savings, but the program cost would grow to $1.8 billion by 1992. Currently, NADSA's social policy committee is developing a proposal for Medicare coverage of adult day services along with plans to introduce the legislation in a way that will appeal to the Republican Congress. However, in the midst of concerns that would have a greater impact (e.g., block granting) NADSA does not consider the Medicare proposal a priority issue.

Regulatory Practices

Regulatory practices for adult day services are as diversified from state to state as funding practices. Unlike regulations for nursing homes and home health care, there have been no federal mandates or government-imposed requirements for adult day services--nor has there been a major federal funding source that has dominated the development of the program. The absence of federal funding and its associated operational requirements has accelerated the grassroots movement, but it has also impeded the growth of adult day services in a policy arena (Lipson, 1994). Funding and

regulatory oversight are fragmented and the lack of federal policy characterizes adult day care as a relatively unknown entity (Lipson, 1994; Henry & Capitman, 1994).

The only national directive for adult day providers has been NADSA's voluntary standards and guidelines, originally published in 1984 and revised in 1990. Unlike most state standards that specify minimal requirements, the NADSA standards and guidelines encourage a high quality of care. The most significant change in the latest NADSA standards has been the generic approach to the needs of adult day care participants. While a few states still adhere to the distinction between social and medical models of adult day care, many adult day care leaders favor the concept of a continuum of care (Lipson, 1994; Canterbury & Missaelides, 1994; NADSA, 1990). The research that was conducted prior to the revision of the standards (Von Behren, 1988) revealed that licensing categories and major funding sources account for only a small percentage of the differences in service packages. The research also found that participant sub-groups were served in most centers, regardless of funding source or licensing category. Two essential common elements were noted in the adult day centers that participated in the study: (1) the participant's needs took precedence over rigid or artificial lines of responsibility among the staff, thus promoting an interdisciplinary function and a holistic team approach; and (2) the centers provided a therapeutic milieu that was intended to improve the participants' quality of

life (Canterbury & Missaelides, 1994).

Because of the absence of uniform national directives, states have considerable freedom in determining how they define and regulate adult day services. Regulatory authority is often fragmented among a variety of state agencies that oversee specific health and social service programs. As a result, a highly variable regulatory environment has developed ranging from comprehensive requirements such as licensure for all adult day services to specific and often limited standards only for the adult day centers that contract for public funding (Lipson, 1994). Generally, however, these standards include service definitions, descriptions of the target population, administrative policies, facility requirements, and health and safety rules. In addition, standards typically address staffing qualifications and requirements, and core services.

The survey conducted by the Intergovernmental Health Policy Project at George Washington University (GWU) in 1993 collected information on state regulations relating to licensure, certification, and any specific funding or program standards for adult day services. The study confirmed that a number of methods are used by states to regulate adult day services: (1) licensure; (2) certification; (3) standards for funding or contracts for specific programs; (3) standards or provisions for adult day care programs located in nursing homes or other facilities; (4) voluntary guidelines; or (5) no standards. Findings from the GWU study (Lipson, 1994) were compared to

findings from this study and, in most cases, served to validate survey results. Since the data for the GWU study were collected in 1993, some of the information collected for this study served to update the Intergovernmental Health Policy Project's findings. Reference to Texas, for example, is more current in my paper since licensure for adult day care in Texas has become mandatory since the GWU study was completed. Table 7 lists the states in which adult day care licensure and/or certification is mandatory.

Table 7

States with Mandatory Adult Day Care Licensure and/or Certification

Arkansas	Minnesota	Oklahoma
Arizona	Missouri	Pennsylvania
California	Montana	Rhode Island
Florida	Nebraska	South Carolina
Hawaii	Nevada	Texas
Kentucky	New Hampshire	Utah
Louisiana	New Jersey	Virginia
Massachusetts	New Mexico	West Virginia
Maryland	North Carolina	

Mandatory licensure refers to the requirement for licensing for all adult day centers in a state that adhere to a specified definition. In some states, separate requirements apply to adult day care and adult day health care. New Jersey, for example, licenses medical model adult day programs but not social model. Certification requirements refer to regulation

associated with contracts for reimbursable services from Medicaid, Title III, or SSBG. Two of the states listed in Table 7, North Carolina and Rhode Island, have comprehensive certification requirements similar to licensure (i.e., certification is required for all adult day centers in the state).

According to the Intergovernmental Health Policy Project report (Lipson, 1994), and to data collected from the surveys and interviews for this study, licensure, certification, or other regulatory mechanisms are available, although not mandatory, in many of the states not listed in Table 7. The standards or guidelines associated with these regulatory processes typically specify requirements for health, safety, staffing, and the facility. Most states' regulations also specify services that are required for licensure and/or certification. Table 8 summarizes select services required or provided by the 24 states that responded to that part of the survey. One notable observation relating to this finding is that the state agencies that responded recognize that many adult day centers provide a number of services that are not mandated. For example, although transportation is not listed as a required service in at least ten states, it is typically provided by the centers in these states. ADL assistance, including bathing and toileting, is also not required in many states but is typically provided by most of the centers. This finding confirms NADSA's belief that most adult day centers exceed minimum standards and provide the range of services dictated by the needs of their participants.

Table 8

Number of States Requiring Select Services by Adult Day Care Centers (N = 24; values for some variables are not listed)

Service	Required by Regulation	Not Required but Typically Provided
Health assessment	15	7
Nursing supervision	17	3
Nursing assessment	12	7
Medication administration	15	8
Assistance with bathing	7	9
Assistance with toileting	15	7
Assistance with other ADLs	16	6
General transportation	13	10
Transportation to medical services	4	10
Group activities	21	3
Individual activities	17	7
Socialization	19	5
Therapeutic recreation	15	8
Exercise	12	12
Nutrition assessment	12	10
Social work services	9	13
Case management / care coordination	12	8
Physical therapy	3	11
Occupational therapy	4	8
Speech therapy	2	7

Child and Adult Care Food Program

Information about the Child and Adult Care Food Program (CACFP) was obtained primarily through documents provided by NADSA. Data from

the survey provided only information about the number of centers in the responding states participating in CACFP and whether participation is mandatory or optional. The documents provided by NADSA included the executive summary of a national study on the adult component of the Child and Adult Care Food Program (CACFP) conducted by Mathematica Health Policy, Inc. The study, sponsored by the Food and Nutrition Service of the U.S. Department of Agriculture, examined the characteristics of adult day centers and adults participating in the CACFP; factors that affect CACFP participation (e.g., program features and state regulations); dietary intakes of adult CACFP participants; and the effect of the growth in the number of eligible centers and adults on the CACFP program. A total of 542 adult day centers participated in the study; half of these participated in CACFP and half did not. In addition, 752 adults attending adult day centers completed the survey. Mathematica also conducted a census of the fifty states and the District of Columbia to obtain the program information for the study (Ponza, et al., 1993).

According to the Mathematica report (Ponza, et al., 1993), 31 percent of the 2,837 adult day centers operating in the U.S. in 1991 participated in the CACFP. The number of participating centers has increased from 213 in 1988 (one year after the program began). In 1990, 728 centers participated. Most CACFP centers are non-profit programs (93 percent) operating under the auspices of a parent organization (78 percent) such as a health or social

service agency. Seventy-two percent of participating centers charge participant fees averaging $30 per day; 67 percent receive funding from Medicaid, and 52 percent receive other state funding. Twenty-five percent receive SSBG funding and 15 percent receive Title III funds.

Mathematica's findings on center and participant characteristics are similar to the findings of the other national studies by Von Behren (1988); Conrad, Hanrahan, and Hughes (1990); and Weissert and his colleagues (1990). For example, the Mathematica study (Ponza, et al., 1993) found that most centers operate five days a week and eight hours a day providing a variety of health and social services to approximately 30 participants per day. Services provided by at least 50 percent of the centers include recreation therapy, exercise, nutritional counseling, assistance with activities of daily living and instrumental activities of daily living, nursing care, individual or group counseling, and transportation. Fifty-four percent of the participants attending CACFP centers are age 60 or older, 62 percent are female, and 57 percent are white. Eighty-four percent of the participants have incomes of less than 130 percent of the U.S. poverty level. Only 20 percent of the respondents reported inability to perform one or more of the activities of daily living independently; 62 percent reported inability to perform one or more instrumental activities of daily living without assistance. The most prevalent chronic health problems reported by the respondents were mental disorders, arthritis, hypertensive disease, heart

conditions, and vision impairments.

Descriptions of Select States

The following descriptive summaries of select states provide a comparative analysis of the diversity that exists in adult day care funding and regulation from state to state.

California

In California, three different levels of adult day care exist due to reimbursement policies and licensing categories that have emerged since the 1970s. Adult Day Care (ADC), administered by the Department of Social Services (DSS), developed as a licensing category in 1973 that applies to any program providing non-medical care and supervision to adults on less than a 24-hour basis. The majority of the programs operating as ADCs in California serve persons with developmental disabilities (Canterbury & Missaelides, 1994). Many ADCs serving seniors receive Title III funding as either a fee for service or line item allocation. Rates are determined by each Area Agency on Aging and therefore vary. Some ADCs also receive varied levels of funding from regional centers serving the developmentally disabled population. In 1977, California became one of the first states to make Adult Day Health Care (ADHC) a Medicaid benefit. ADHC is administered by the California Department of Aging (CDA) and the Department of Health

Services and is reimbursed $54.30 per day[5]. "Assessment days" for new clients are reimbursed at a higher rate[6]. In 1984, the California Association for Adult Day Services (CAADS) recognized that state regulations for adult day care did not adequately meet the needs of chronically disabled older adults and did not adequately reflect the national adult day care standards (National Council on the Aging, 1984). Consequently, legislation was introduced which established Adult Day Support Centers (ADSCs) as a third licensure category. Since 1992, guidelines have been available for operation of ADCs or ADSCs under an ADHC license (Canterbury & Missaelides, 1994). In addition to the three distinct licensing categories, ADC, ADHC, and ADSC, a program was established in 1984 to provide grants to ADCs or ADHCs providing specialized care for individuals with Alzheimer's or related dementia. As a result, Alzheimer's Day Care Resource Centers (ADCRCs) were created. Currently, thirty-six variously licensed adult day programs are grant recipients as ADCRCs (Canterbury & Missaelides, 1994). The ADCRC grant awards $60,000 annually[7].

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[5]Rate effective August 1, 1994.

[6]"Assessment days" refer to the first day(s) of attendance for a new participant. These days are reimbursed at a higher rate since a greater concentration of staff time is required to perform comprehensive evaluations of the participants health and social needs and to develop the individual's service plan.

[7]Due to an allocation discrepancy, eight of the thirty-six programs actually receive $59,375 each.

As a result of these various regulatory practices, adult day care is monitored by several state agencies with no central oversight (Canterbury & Missaelides, 1994). The Rural Adult Day Health Care Act of 1990 made it possible to operate multiple levels of care under the ADHC license but did not resolve the discrepancies that exist among the various sets of regulations. Programs, for example, that have an ADHC license and receive funding from the ADCRC grant, must comply with two distinct regulatory/funding requirements. Based on the recognition that the similarities among service provisions specified by the various licensure categories far outweigh the differences, efforts are underway to revise adult day care policy in California and a proposal is being developed for funding to be based on levels of care (Canterbury & Missaelides, 1994). CAADS has completed the first phase of research for the proposal by developing and testing the assessment tool that will be used with adult day participants. The next phase of development toward the levels of care reimbursement system will involve a pilot project to collect assessment, cost, and utilization data.

Florida

Three separate state agencies are involved with adult day care in Florida. The Aging and Adult Services Division of the Department of Health and Rehabilitative Services (HRS) provides Medicaid waiver funding for adult day care participants between the ages of 18 and 59 and for adults of all ages with developmental disabilities or HIV disease. HRS reimbursement

is provided for quarter hour units and ranges between $4.32 and $10.00 per hour with a maximum daily allocation of eight hours. Reimbursement for adults older than 59 is administered by the Department of Elderly Affairs (DEA) at the state level and filtered to the Area Agencies on Aging for rate determinations and contract negotiations. In addition to Medicaid, the state's general revenue, administered by both the HRS and the DEA, funds adult day care at a rate of $30 to $35 per day. Although the HRS and the DEA both have rule-making authority, they do not handle licensing. Licensing for adult day care in the state is administered by the Department of Professional Regulations' Agency for Health Care Administration and applies to all adult day centers in the state. Licensing is provided for two types of adult day services: adult day care (ADC) and adult day health care (ADHC). Licensing requirements for both ADC and ADHC include provisions for therapeutic recreation, assistance with activities of daily living, nutritional services, and written service records. Staffing in both ADC and ADHC centers must include a program director and at least one direct service staff member for every 6 participants.

New Jersey

In addition to the HCBS funding available to Adult Medical Day Care, a variety of other funding options are available to both social and medical adult day care providers in New Jersey. Social model programs, which are not licensed but must comply with certification requirements, are reimbursed

through Title III funds. The level of reimbursement varies by county but averages $34 per day. Adult Medical Day Care utilizes Medicaid dollars available through both the state plan and the HCBS waiver[8]. The HCBS waiver also provides reimbursement for a limited number of social adult day care slots. Medicaid reimbursement, administered through the Department of Health, is based on organizational affiliation with free-standing adult day care programs receiving $46.77 per day and hospital-based programs receiving $52 per day. Other funding options include respite contract reimbursement, available to both health and social programs, and contract reimbursement for the care of persons with developmental disabilities through the Department of Youth and Family Services (DYFS). In addition, non-profit centers may apply for an Alzheimer's grant that funds a limited number of slots in both medical and social settings.

North Carolina

Information about adult day services in North Carolina is found in the report of findings from a survey conducted by the Center for Aging Research and Educational Services at the University of North Carolina, Chapel Hill (Compton & Thomas, 1994). The survey was conducted in 1993 for the North Carolina Adult Day Care Association Survey and the North Carolina Division of Social Services. The survey was mailed to all 72 adult day and

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[8]The HCBS waiver also provides reimbursement for a limited number of social adult day care slots.

adult day health centers operating in the state in August 1993; 39 of the centers responded. The questionnaire primarily addressed fiscal and operational aspects about the centers such as information about the center's history, affiliation, location, capacity, and enrollment; characteristics of the staff; characteristics of the clientele; services offered; and funding.

The reported findings of the NCADCA survey reveal that the characteristics of adult day centers and participants in North Carolina are similar to those reported in national studies (e.g., Von Behren, 1988; Conrad, Hanrahan, and Hughes, 1990; Weissert et al., 1990). Information about regulatory and funding practices in the NCADCA report is limited to a brief discussion about services offered, services required (e.g., meals and transportation) under certification standards, and funding sources. Public funding for adult day services in North Carolina is provided by the Medicaid Community Alternatives Program (a nursing facility alternative Medicaid waiver), block grants, and Title III.

Oklahoma

One center in Oklahoma is currently serving as a demonstration site for the HCBS waiver in that state. However, since the 1970s, Social Services Block Grant (SSBG) reimbursement has been the predominant funding source for adult day care in Oklahoma. Until 1984 when the rate was

supplemented with state general revenue dollars[9], adult day care was reimbursed at the same level as child day care. Currently, contracted adult day care centers are reimbursed $25 per day. Nineteen licensed adult day care centers are located in Oklahoma but funding is available to only ten of these centers to contract for SSBG. The others utilize a variety of revenue sources including V.A. contracts, allocation agreements with local mental health units, Title III funding, United Way, local contributions, and private fees.

Pennsylvania

In contrast to states that predominantly utilize Medicaid funding for adult day care, either as part of the state health plan or as a waiver, Pennsylvania applies no Medicaid funding to its 135 adult day care centers. Instead, all 51 of the state's Area Agencies on Aging (AAAs) provide Title III funds at various levels. Licensing of adult day care in Pennsylvania is administered by two agencies: the Department on Aging and the Department of Public Welfare, Office of Mental Retardation. Because of the funding requirement by the Department on Aging to serve individuals 60 and older, centers that provide care for younger adults with physical or developmental disabilities as well as for older persons must be licensed by both agencies. Approximately 60 of the adult day care centers in

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[9]Less than three percent of the state's general revenue is allocated to aging services.

Pennsylvania have dual licensing. Participant fees range between $25 and $50 per day. Reimbursement from Title III or the Office of Mental Retardation varies significantly from program to program as determined by the individual AAAs or state agency. According to the Pennsylvania Adult Day Care Association (PADCA), funding ranges from $70,000 paid annually by the AAA to an adult day care center in one county to covering the total budget for all three adult day care centers in another county. Transportation is not included in the reimbursement in Pennsylvania since revenue from the state's lottery is allocated to provide 85 percent of the transportation costs for elderly or disabled persons.

Washington

Funding sources available to the 35 certified adult day care centers operating in the state of Washington include Medicaid (HCBS waiver), Title III discretionary funds, SSBG, and respite contract reimbursement. All programs are administered through the Department of Social and Health Services' Aging and Adult Services Administration with contract authority designated to the Area Agencies on Aging for allocation of Title III funds. Medicaid reimburses $41.74 per diem for existing programs[10]. Only certified adult day health centers are eligible to apply for funding through the AAAs.

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[10]Recent legislation resulted in transportation costs ($5 of the per diem rate) being excluded from the reimbursement for all new programs. New programs, therefore, are reimbursed $36.74 per day.

Rates are determined on an individual contract basis and range between $35 and $50 per day. SSBG reimbursement ranges between $20 and $35 per day based on individual contracts with no funding available for new programs. The respite contract is supported through the state's general fund and negotiated with each center. Participant eligibility is determined based on assessment of need and income. Sliding scale reimbursement for respite services ranges between $12 and $46 per day.

Summary and Discussion

The organizational structure of adult day centers from state to state has certain characteristics in common. Each state utilizes highly specialized bureaucracies to oversee funding and regulatory practices for adult day care as one of many health and social services administered by the agency. Adult day care is a fledgling program in the sense that the U.S. has taken a slow start in the development of community-based programs and adult day services is among the newest of these programs. There is no current initiative to develop national policy and there is little hope--especially in the present political, budget-cutting climate--that adult day care will gain significant strength in the near future at either the state or federal level. The National Adult Day Services Association is in the process of developing its third edition of standards and guidelines, but earlier editions received little attention by state agencies. Federal funding guidelines are even less likely as Congress leans more toward a block grant system in which states

are allowed full autonomy in determining their service and funding priorities.

The picture is not completely bleak, however. Adult day services have grown in number and recognition in spite of the level of attention paid by the state agencies that monitor them. Because of the lack of consistency between states, the actual number of centers is difficult, if not impossible, to determine. But an estimated 3000 to 3300 centers are currently operational, compared to only about one-third that number fifteen years ago. A number of factors have contributed to the growth including a larger number of individuals in need of community-based services and greater public awareness about the benefits of adult day care. Bureaucratic forces have also impacted growth. Although state agencies are constantly striving to balance their limited budgets with consumer and provider demands for services, their directors and staff have recognized a growing interest in adult day care as a cost-effective method of providing quality care for frail elders and physically disabled adults in a community setting. Such interest is manifested by the development of policy to provide reimbursement, expansion of existing funding programs to include adult day services, additional funding options to assist participants with special needs, and a higher level of professional standards. This bureaucratic eye for rationality and efficiency will, to a large degree, continue to influence the growth and development of adult day services. The concerns in coming years are

twofold: (1) whether the rate of growth will be adequate to meet local needs and (2) whether program quality will be maintained.

CHAPTER V

ADULT DAY SERVICES IN TEXAS

Texas is second to California in the number of adult day centers in the nation with 176. California has 181 centers and, whereas their growth has been accompanied by funding and regulatory legislation intended to assure quality and appropriate reimbursement, the rapid growth and large number of adult day centers in Texas has resulted from a different force. The organizational structure of adult day care in California is manifested by a strong, well-structured membership association and state agencies that respond to the association's lead in the progressive development of standards and reimbursement methodology. In Texas, on the other hand, the state association has a weak and informal organizational structure and the state agency maintains a status quo approach to adult day care as a small component of its community care system.

The rapid growth of adult day care in Texas is a phenomenon that has not appeared in any other state. The high number of centers is due exclusively to the development of for-profit, multi-facility corporations and proprietary organizations opening more than half of the centers in the state in the Lower Rio Grande Valley region of South Texas. The adult day centers

in this region serve large numbers of predominantly low-income, elderly Hispanics; thus, centers are reimbursed at the Medicaid rate of $22.48 per day for almost all of the participants. Although the Adult Day Care Association of Texas (ADCAT) reports that the daily cost of operation in Texas is about $30 per day, and adult day services providers in other parts of the state must depend on subsidies to break-even, centers in the Valley are reportedly earning large profits as a result of their large volumes and shared expenses.

As seen in the previous chapter, the organization and structure of adult day care varies considerably from state to state. The growth and characteristics of adult day centers in any state relate to the availability and accessibility of public funds, the level of interest on the part of the state agencies that monitor adult day care, the influence on these agencies by the state associations, and the level of interest and demand by consumers. In states where Medicaid waivers are encouraged or adult day care is included as part of the state's health plan, the development of adult day centers is greater than in states that provide limited funding.

Descriptions of the structure of adult day care in other states, and the function of state associations and state agencies, promotes a better understanding of adult day care in Texas. Based on these comparisons, this chapter presents the characteristics of adult day care in Texas including the number of centers and funding and regulatory practices. In order to fully

understand the development of adult day care in Texas, a historical overview is also provided along with a description of the structure and function of ADCAT, TDHS, and other state agencies that relate to adult day care in Texas.

Findings and Discussion

Historical Background

Adult day care in Texas began on the community level with centers opening in Austin, El Paso, Houston, and Amarillo in the mid-1970s. Lutheran Social Services opened the first adult day center in the state in 1975 as a social service program for minority elders. In its early days, the center, known today as Elderhaven Adult Day Care Center, was located in the basement of a predominantly black Catholic church. It coordinated with the local health department for nursing services, the Area Agency on Aging, and the Meals on Wheels program for nutrition services. The Austin center began as a Community Action Program pilot project and, along with the other adult day centers in Texas at the time, was funded exclusively by Title XX between 1975 and 1980. When Title XX funds began to diminish around 1980, the Texas Department of Human Services made Title XIX available to adult day health care in Texas. Centers that were operational at the time submitted applications to become certified as Medicaid providers; the Lutheran Social Services adult day center in El Paso was the first to be granted a Medicaid contract in 1981.

TDHS implemented the adult day care option, known as the Day Activity and Health Services (DAHS) program, as a covered service under the state's health plan. Before the advent of the DAHS program, Title XX funding for adult day centers was designated for day activity programs. Even though many of the early programs offered at least a limited amount of nursing services (e.g., the Austin program utilized a local health department nurse for screening and assessment) the health requirement was not added until the state added DAHS to the state's health plan and the program's name was changed. By 1982, the program was characterized by the addition of nursing and medical care to the existing social services and daily activities and the program's funding had shifted from Title XX to Title XIX, even though most programs were combining both funding sources (G. Dewey, personal communication, January 19, 1983).

Since its inception, specified services in DAHS have included nursing and personal care; physical rehabilitation; nutrition; transportation; and social, educational, and recreational activities. To be eligible for DAHS, participants must meet financial eligibility criteria[1], have a medical diagnosis and physician's orders, have a functional disability, and require assistance in one or more personal care tasks. Adult day centers that wish to

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[1]The individual must already receive SSI or Aid for Families with Dependent Children (AFDC) benefits or meet Medicaid or SSBG income guidelines and resource limits.

participate in the DAHS program must be licensed[2] and apply for certification through the Texas Department of Human Services' Community Care Division.

Links with Other State Agencies

Unlike states such as Pennsylvania and Florida, where the state departments on aging provide direct regulatory and/or funding oversight for adult day services, the Texas Department on Aging (TDoA) has had little involvement in adult day care. Some of the Area Agencies on Aging in Texas have provided minimal support. The Concho Valley AAA, for example, has provided equipment grants to Adult Day Care of San Angelo and the Lutheran Social Services centers in El Paso have received surplus funds from the Rio Grande AAA for a number of years. Since the Older Americans Act was originally intended for planning and advocacy rather than for direct service delivery[3], TDoA and most of the state's AAAs have not provided significant direct support for adult day care. In 1991, the Texas Legislature created the Health and Human Services Commission (HHSC) to address a number of problems in the delivery of services to Texas citizens. The

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[2]Until 1994, licensure for adult day centers and other community care or institutional facilities was handled by the Texas Department of Health.

[3]This trend began to change in 1985 when the Options for Independent Living initiative was developed. The Options program provides a package of supportive services (e.g., home-delivered meals and homemaker services), coordinated by a case manager, to help elderly persons remain at home regardless of limited self-care abilities.

commission was directed to create a six-year strategic plan, a consolidated budget, model local service delivery systems, and to recommend to the Legislature how the state's twelve health and human service agencies[4] and their functions could be combined (R. C. Ladd, personal communication, April 18, 1992). An initial recommendation of the HHSC was for the commission to act as a coordinating body for the twelve agencies and to have certain authority (e.g., rule review, interagency dispute resolution, and the ability to request budget execution for transfer of funds from one agency to another). As part of this broad recommendation, the commission urged TDHS and TDoA "to continue to work together to create an integrated service system for people who are aging" (Ladd, 1993, p. 7). In response to the recommendation, TDoA recognized an opportunity for interagency cooperation when the mandatory licensure bill for adult day services was passed in 1993. Because of the concern on the part of TDoA[5] and certain AAAs that part-time respite

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[4]The 12 agencies are the Texas Department of Human Services (TDHS), the Texas Department of Health (TDH), the Texas Department of Mental Health and Mental Retardation (TxMHMR), the Texas Department on Aging (TDoA), the Texas Commission for the Blind and Visually Impaired (TCB), the Texas Commission for the Deaf and Hearing Impaired (TCDHI) the Texas Rehabilitation Commission (TRC), the Texas Commission on Alcohol and Drug Abuse (TCADA), the Texas Department of Protective and Regulatory Services (DPRS), the Interagency Council on Early Childhood Intervention Services (ECI), the Texas Juvenile Probation Commission (TJPC), and the Texas Youth Commission (TYC).

[5]TDoA had submitted a grant proposal to the Health Resources and Services Administration (HRSA) for the development of ten Alzheimer's respite care programs across the state.

programs they sponsored might have to comply with the new adult day care licensing requirement, TDoA hosted a forum to discuss the interpretation and impact of the new law. A workgroup was created that included representatives of the relevant state agencies (i.e., TDHS, TDH, TDoA and HHSC), area agencies on aging, Alzheimer's associations, ADCAT, and NADSA. The purpose of the workgroup was to define key terms specified in the new legislation in an attempt to assure that the new law would not affect the proposed respite programs (D. Loflin, personal communication, July 14, 1993). The group recognized that part-time respite programs are a necessary option for caregivers of persons with dementia and other chronic disabilities, but pointed out that the licensing requirement could impede their existence due to the cost involved with staffing and other licensing requirements. As a result of the workgroup's efforts, definitions for key terms were added to the licensure rules and the regulatory agencies interpreted the new law to apply only to "those facilities providing health care, no matter what other services are included" (D. Loflin, personal communication, August 9, 1993).

Another example of interagency collaboration in Texas was the Medicaid waiver workgroup directed by the boards of TDHS and TxMHMR in 1991. The purpose of this workgroup was to study the feasibility of expanding and enhancing the availability of and accessibility to community-based services in Texas using the Medicaid waiver provisions. Members included representatives from all the major provider associations and

disability and advocacy organizations. At the time of the group's activities, there were three Medicaid 1915(c) waiver programs for persons with mental retardation and/or related conditions and one waiver program for children eligible for nursing facility care. The process for developing the nursing facility waiver program for adults had just begun (TDHS & TxMHMR, 1992).

Due to lack of funds, the Nursing Facility Waiver (NFW) was not implemented in Texas until 1994. For program clarification, the name of the waiver was changed to the Community-Based Alternatives (CBA) program. The CBA, which became statewide on September 1, 1995, provides home and community-based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing facilities (i.e., the participant's service plan cannot exceed 95 percent of the individual's actual Texas Index for Level of Effort payment rate). Services covered by the waiver include medical supplies, adaptive aids, assisted living/residential care, emergency response, minor home modifications, occupational therapy, physical therapy, speech pathology, nursing services, personal assistance services, and respite care (TDHS, 1995a). There is no reference in the report to adult day services, either as a separate program or as a program that can be utilized to provide specific services covered under the CBA (e.g., nursing services, personal assistance, and respite care).

In its report to the boards of TDHS and TxMHMR, the Interagency Workgroup cited serious deficiencies in the Medicaid state plan:

> In Texas, the pressure to utilize waiver services to meet the obvious shortcomings in the availability of Medicaid state plan services has been great. Traditional Medicaid services in Texas are severely limited in amount, duration and scope by definition in the state plan and by the availability of funding. The workgroup strongly believes that waiver services are only a component of a comprehensive community service delivery system. Waiver services cannot be relied upon exclusively to meet the needs of all persons with disabilities in Texas. (TDHS & TxMHMR, 1992, p. 10)

Accordingly, the group recommended that the state plan be expanded and that more Texans have access to supports in the community. Specifically, the group proposed that the state plan be expanded to include up to 50 hours per week of personal care services, all medically necessary prescription drugs[6], durable medical equipment and supplies, targeted case management for persons whose disabilities were incurred after age 22, preventive services, and rehabilitative services.

None of these collaborative efforts have resulted in tangible outcomes for adult day care. Due to budget cuts and their already limited involvement in adult day care, TDoA has made no attempt at repeated interagency cooperation with TDHS. Although mental health and/or mental retardation

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[6]The Vendor Drug Program remains limited to three prescriptions per month.

funding is available to adult day care in other states, discussion relating specifically to this issue in Texas has not taken place. Workgroup collaborations between TDHS and TxMHMR, for example, were directed at expanding the availability of and accessibility to community-based services in Texas using the Medicaid waiver provisions. Adult day care was not listed as an option in these discussions. Although the CBA can be used for participants in adult day care, few referrals are being made and providers are discouraged in its use by long waiting periods for eligibility determinations. Thus, state government has not volunteered alternative funding methods for adult day care and the state association has not taken the lead in pursuing possible options.

The Adult Day Care Association of Texas

During the first five years that adult day centers operated in Texas, adult day care providers were included in the membership of the Community Based Services Association in Texas, an organization that encompassed all aspects of community-based care and services. Members included representatives of such organizations as battered women's groups, homeless shelters, and other organizations whose primary objective was to influence local funding providers. By the early 1980s, however, adult day providers recognized the need to develop their own association and began conducting regular state-wide meetings. In 1983, providers of adult day care throughout Texas met in Austin and formed the Adult Day Care Association of Texas

(ADCAT). ADCAT was chartered as a Texas Corporation October 6, 1983. The original purpose of the association was to "give Texas adult day care providers the opportunity to participate in both the state and national legislative processes, as well as the ability to help develop standards and guidelines for quality adult day health care programs for the elderly and disabled of Texas" (D. Loflin, personal communication, March 2, 1983). According to its by-laws, ADCAT also proposes to promote the concept of adult day care as a viable community based option for adults who require day care as an alternative for remaining independent; to offer a forum for the exchange of information; and to act as a planning, researching and training body for adult day services.

ADCAT's activities in its early years included statewide meetings two to three times a year (a formidable task considering Texas' geographical expanse and the adult day centers' small operating budgets) and a newsletter to its members. In 1983, there were fourteen adult day centers operating across the state in El Paso, Austin, Dallas, Houston, San Antonio, Beaumont, Amarillo, Abilene, and Port Arthur (G. Dewey, personal communication, January 19, 1983). The association's members consist of directors and other staff members of operating adult day centers, individuals representing agencies or organizations associated with adult day care, or anyone interested in adult day services. Officers of the association are elected from the membership; committee members volunteer or are appointed to serve on

ADCAT working committees (i.e., membership, legislative, and finance). In 1992, due to the increase in the number of adult day centers in Texas and the corresponding growth in the membership of the association, ADCAT added its first paid staff position--a part-time (0.25 FTE) executive director. Out of the 176 adult day centers currently licensed in Texas, approximately 100 of them are members of ADCAT.

Because of Texas' geographical expanse, ADCAT has recently reorganized its structure into regions based on location. Each regional group appoints a representative to attend state meetings and participate in decision-making activities that affect the entire organization. Since the regions are not equally represented in terms of the number of adult day centers (i.e., 60 percent of the state's adult day centers are located in the Rio Grande Valley region), ADCAT revised its by-laws to protect against monopoly vote. Membership rules now state that representatives from multi-facility organizations have one vote. The association's dues structure was modified accordingly: multi-facility groups pay the regular membership dues ($200) for the primary membership and additional centers pay at the associate membership level ($75 each). Associate members cannot vote according to ADCAT by-laws.

Number of Adult Day Centers in Texas

Texas is a close second to California in the number of adult day centers in the state. According to figures verified by state agency and state

association leaders, the number of licensed adult day centers in Texas, according to the most recently published directory (TDHS, 1995c) is 176. California leads the nation with 181 centers. The growth in the number of adult day centers since 1975 is displayed in Table 9. During the first ten years that adult day programs were available in Texas, growth was negligible with the number of centers increasing by only twenty between 1975 and 1985. Between 1990 and 1992, however, the number doubled and then doubled again by 1995. Increases in the reimbursement rate in 1989 and 1990 were key occurrences that possibly contributed to the sudden growth beginning in 1990. Significant disparity exists, however, in the location of Texas' adult day centers. These disparities (detailed later in this chapter) include geographical variations and inconsistencies in availability

Table 9

Increase in the Number of Adult Day Centers between 1975 and 1996 in Texas and the U.S.

Year	TEXAS	U.S.
1996	176	>3300
1995	160	>3300
1994	130	>3300
1993	117	>3000
1989	39	2100
1984	20	1200
1975	1	15

and accessibility. Most of the state's adult day centers are located in far south Texas, while centers located in the rest of the state are often either geographically or economically inaccessible to potential users.

Funding Sources and Levels of Reimbursement

As previously mentioned, Texas includes adult day care as part of the state health plan. The Day Activities and Health Services (DAHS) program is administered by the Texas Department of Human Services and is available to any licensed adult day care program that meets certification criteria. Medicaid reimbursement for licensed/certified centers is a flat rate of $11.24 per unit[7] ($22.48 per day) for eligible participants. Although considerably lower than the reimbursement provided by other states and the reported national average cost per day of $29 to $31 (Von Behren, 1986; Weissert et al., 1990), this amount is calculated based on providers' annual cost reports. In addition to Medicaid reimbursement, many adult day care centers in Texas have contracts with TDHS for SSBG funding. SSBG contracts typically reimburse a percentage of the Medicaid rate for eligible participants (e.g., 70 to 90 percent of the Medicaid rate or $15.74 to $20.23 per day). Adult day centers that contract with TDHS for Medicaid and/or SSBG, therefore, must utilize other funding sources to subsidize the difference

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[7]A unit is defined as a half-day which is at least 3 hours of service but less than six hours within a twenty-four hour period. A full day consists of six or more hours.

between the daily cost per participant and the reimbursement rate.

Reimbursement rates are determined by TDHS by excluding unallowable costs and then by combining reported costs in six cost areas: (1) salaries and benefits; (2) transportation; (3) food and food service; (4) building, equipment, and capital costs; (5) utilities; and (6) direct programmatic expenses (e.g., medical and activity supplies). To be allowable, costs must be necessary and reasonable for the administration of the program, authorized, and consistent with policies, regulations, and procedures that apply to the DAHS program (TDHS, 1995b). Unallowable costs are expenses which are not directly or indirectly related to the provision of DAHS services. Examples include advertising, allowances for bad debts, depreciation expenses other than those based on straight-line depreciation; entertainment expenses, donated items and services, and fund-raising or promotional expenses.

The low reimbursement rate has been an area of concern by adult day services providers and ADCAT for a number of years. In 1989, TDHS raised the rate for the first time since December 1984 from $9.70 per unit to $10.40 per unit (G. Dewey, personal communication, January 12, 1989). The rate was increased again in 1990 to $11.16 per unit. Each year since 1989, audits of the annual TDHS/DAHS cost reports have revealed that the reported cost of service is actually less than the reimbursement rate. Data from the 1990 cost reports, for example, resulted in a cost calculation of $10.49 per unit

($20.98 per day)[8], less than the $11.16 per unit ($22.32 per day) reimbursement rate at that time. TDHS audits of the 44 facilities that submitted cost reports in 1990 revealed that the weighted median cost per cost area was $6.350/unit for salaries and wages; $1.065/unit for transportation; $0.492/unit for food and food service; $1.298/unit for building and equipment; $0.392/unit for utilities; and $0.891/unit for program expenses. In an attempt to avoid lowering the rate, TDHS adjusted the data base by applying inflation factors, increasing the minimum wage in accordance with April 1991 federal law, and calculating higher salary costs for nursing staff. In addition, TDHS revised the occupancy rate formula (i.e., transportation, building, utility, and administration expenses were adjusted to reflect per diem costs at the average rate of occupancy for providers)[9]. Even with these adjustments, reported cost remained less than the reimbursement rate, but rather than reducing the rate, the TDHS board voted to maintain the current rate as recommended by its Community Care Division.

A number of actions have been initiated by the Adult Day Care

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[8]Reimbursement rates are determined and approved annually based on cost reports from the previous year (i.e., the reimbursement rate of $11.16 was determined based on FY 1990 cost reports. It was effective April 1, 1991 and expired March 31, 1992).

[9]In 1991, the average occupancy rate for adult day centers in Texas was 57.03 percent.

Association of Texas (ADCAT) and/or the Texas Department of Human Services as attempts to maintain or increase the reimbursement rate. In 1991, the TDHS Board and Interprogram Workgroup formed the Community Care Services Committee to develop specific plans and policies that would expand and enhance existing TDHS community-based services for persons with disabilities. The committee identified five major areas that significantly impact consumers of existing TDHS services in community settings: access to services, outcome monitoring, personal attendant services, residential services, and day health services. Subcommittees were created to develop recommendations for each of these areas. In its report to the Board, the subcommittee for day health services stated that "program standards and reimbursement methodology do not encourage DAHS facilities to provide higher levels of care for individuals in DAHS facilities, including care for individuals with dementia" (TDHS, 1992, p. 20). Accordingly, the subcommittee presented the following recommendation:

> Develop a multi-tiered reimbursement methodology for different levels of need patterned after the ICF/MR/RC model which considers the basic reimbursement rate based on client needs. The current unit rate to day health facilities is based on a range of low to high need clients. TDHS should develop a unit rate for core services provided by DAHS facilities and have different levels of "add-ons" for clients needing additional care. (TDHS, 1992, p. 20)

Soon after this recommendation was made, leadership in both the Community Care Division at TDHS and ADCAT changed. No additional discussions have occurred, according to current TDHS Community Care and ADCAT staff, regarding multi-tiered rates.

In 1994, ADCAT retained the services of an independent accounting firm to conduct an analysis of cost reports and reimbursement methodology. ADCAT viewed proposed rule changes to existing methodology as an attempt to suppress rates. In its report to TDHS (S. Kitchen, personal communication, July 26, 1994), ADCAT listed the following objections to the existing reimbursement methodology:

1. Reference to the use of "Generally Accepted Accounting Principles" in preparation of the report when these principles are not, in fact, the basis for the report.
2. The elimination of in-kind donations from the rate-setting calculation.
3. The use of the lowest inflation factor.
4. The classification of legitimate business expenses as unallowable.
5. The occupancy adjustment.
6. The classification of vehicles costing more than $30,000 as "luxury autos."
7. The reduction of cost by grants.

8. The requirement that adult day centers must provide services for ten hours per day when the reimbursement rate is specified for a maximum of six hours.
9. The departure from an accrual method of accounting (i.e., the cost report does not show accrued wages for unpaid compensation).

In accordance with these objections, ADCAT recommended that the methodology rules be revised in their entirety. They also submitted the following specific recommendations to TDHS:

1. Allow providers to assist in the development of reimbursement methodology.
2. Assure that cost reports are prepared based on Generally Accepted Accounting Principles.
3. Allow the inclusion of in-kind donations in the rate-setting calculation. (The value of such donations should be supported by appraisals).
4. Use the average of several inflation factors.
5. Allow the inclusion of legitimate business expenses (e.g., franchise taxes, board of directors fees, audit fees, advertising, bad debt expense, salvage value, owner's draw) in the rate-setting calculation. Use Generally Accepted Accounting Principles to determine these costs.

6. Eliminate the occupancy adjustment. TDHS should base reimbursement on the actual cost of doing business, not on adjusted costs.
7. Exclude accessible vans and buses from the "luxury auto" rule.
8. Reflect all costs on the cost report prior to any reductions.
9. Reimburse providers for the full amount of time services were provided for each participant.
10. Disclose all costs that are associated with producing revenue.
11. Eliminate the 60 day deadline for accrued salaries.

Since TDHS claims that reimbursement methodology is in accordance with federal Medicaid guidelines, none of these recommendations appear in the latest version of the DAHS manual.

Regulatory Practices

Adult day centers in Texas are licensed and certified by the Texas Department of Human Services (TDHS). Licensure is mandatory for anyone operating an adult day center for four or more persons; thus all 176 centers are licensed. Certification is required if the center chooses to contract with TDHS for Medicaid reimbursement for eligible participants. Of the 176 licensed centers, 160 are also certified. Regulations for adult day care in Texas are available for both licensing and certification. Licensing is administered by the Licensing Division of TDHS who develops and publishes *Licensing Standards for Adult Day Care Facilities.* This document contains

licensing application procedures as well as general and facility requirements; standards for programming, safety, and sanitation; and enforcement procedures. As previously discussed, licensing has been mandatory in Texas since January 1, 1994 for any person operating an adult day care facility[10]. Prior to this date, licensure was mandatory only if the adult day center chose to contract with TDHS to provide Medicaid services; voluntary licensure was available to adult day centers that provided services on a private-pay basis.

Regulation relating to certification as a DAHS facility is administered by the Community Care Division of TDHS. Criteria for certification are found in the *Day Activity and Health Services Provider Manual.* The manual contains rules and procedures pertaining to general requirements for participation in the DAHS program, required services, excluded services, and methods of payment. The manual also contains forms, reports, reimbursement methodology, a billing guide, requirements for advance directives, and guidelines for HIV/AIDS and related conditions in the workplace. The standards specified in the DAHS provider manual are

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[10]The mandatory licensure bill (H.B. No. 1345, 1993) defined "adult day-care facility" as "a facility that provides services under an adult day-care program on a daily or regular basis but not overnight to four or more elderly or handicapped persons who are not related by blood, marriage, or adoption to the owner of the facility." "Adult day-care program" is defined as "a structured, comprehensive program that is designed to meet the needs of adults with functional impairments through an individual plan of care by providing health, social, and related support services in a protective setting" (Adult Day-Care Facilities Licensing Act, 1993).

intended to assure appropriate care and treatment and to protect the health, safety, and welfare of participants in adult day care facilities. Generally, the contractual agreement between TDHS and a DAHS facility states that TDHS will reimburse the facility, using the methodology it has specified, for the care of eligible recipients as long as the facility is licensed and meets DAHS program standards.

In 1995, the architectural section of the Texas Department of Human Services was eliminated due to budget cuts. Prior to this time, programs contemplating new buildings, additions, or conversions were required to submit preliminary plans for review by TDHS architects prior to the preparation of working drawings. Once preliminary plans were approved, the program was required to submit final plans prior to beginning construction. The purpose of these reviews was to assure that usage of all spaces, sizes of areas and rooms, types and locations of fixed equipment, and pertinent conditions (e.g., grades and structures) complied with state standards relating to safety and sanitation (Texas Department of Human Services, 1994). This process assured adult day center sponsors and developers that the general utility of the facility was appropriate and that the program conformed to minimum licensing standards and Life Safety Code requirements before construction was begun. Since the elimination of

the architectural section in July 1995, adult day care developers[11] have been forced to proceed with construction without prior review or approval. Thus the possibility exists that the initial survey of a newly constructed or remodeled facility might result in nonapproval, thereby requiring unanticipated and costly modifications before licensure can be obtained.

Child and Adult Care Food Program

Of the 38 states that responded to the survey item, Texas and Mississippi are the only two states reporting that participation in the Child and Adult Care Food Program (CACFP) is mandatory for all certified adult day centers. Adult day centers in other states participate voluntarily. The Older Americans Act was amended in 1987 to include adult day centers in the Child Care Food Program, but participation by Texas adult day centers was not available until the administrative structure was established and the Food Services Program was created in the Texas Department of Human Services in April 1989[12]. In 1990, the Texas Department of Human Services implemented a rule change mandating participation by all certified adult day centers in the CACFP effective January 1, 1991[13]. The reason for the rule

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[11]The problem also exists for any other type of program or facility in Texas that requires licensure.

[12]Benefits were retroactive to October 1987.

[13]Prior to this date, participation in CACFP was on a voluntary basis for eligible adult day centers in Texas.

change was to maximize the use of federal funds with an estimated savings of $178,930 to TDHS projected in FY 1992, increasing to a projected $430,524 by FY 1995 (R. Lindsey, personal communication to chairman and members of the Texas Board of Human Services, July 2, 1990). The revised policy was implemented simply by presenting recommendations to the Adult Day Care Association of Texas, the TDHS Medical Advisory Board, the Aged and Disabled Advisory Board, and the Texas Board of Human Services; publishing the proposed rule in the Texas Register; and resubmitting the adopted rule. This procedure has not been successful in other states, especially those that fear problems with Medicaid. California adult day centers, for example, must certify that CACFP funds supplement their nutrition services in order to prevent the accusation of duplicate funding.

Program Disparity in Texas

The relatively low level of reimbursement in Texas has resulted in significant inconsistencies in the availability of adult day care programs across the state. The majority of the state's licensed/certified centers are located in the Rio Grande Valley of South Texas while the other licensed/certified adult day centers are scattered throughout other parts of the state. The Adult Day Care Association of Texas (ADCAT) believes that the abundance of adult day care centers in South Texas is due in part to the demographic characteristics of the area, where the level of professionalization and associated costs are presumed to be both lower and in

short supply. In the Dallas/Fort Worth metroplex area, on the other hand, where professional staff (e.g., nurses and social workers) are more procurable and demand higher wages, the number of adult day care centers is limited.

In comparison to the remainder of Texas--and to other states--South Texas differs in the growth rate of new adult day centers and their characteristics. Only eight new centers have opened in Dallas and Tarrant counties since 1993. Three of these are church-affiliated, three are for-profit corporations, one is associated with the Cerebral Palsy organization, and one is a non-profit corporation. In addition to these eight, a 1993 study of adult day care in Dallas, Tarrant, and Denton counties[14] revealed a number of new adult day programs located in nursing homes. Although the utilization of these programs was extremely low (i.e., less than 5 participants per day), a greater number of new adult day care programs in the Dallas/Fort Worth area have appeared in nursing homes since 1993 than as traditional licensed adult day facilities[15] (Weaver, April 1994). The three licensed adult day centers in Dallas and Tarrant counties that are not Medicaid-certified, and the nursing home-based programs, charge private fees ranging between $30

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[14]The study was a telephone survey of adult day care programs in the three counties conducted in 1993 by the Texas Institute for Research and Education on Aging at the University of North Texas Health Science Center.

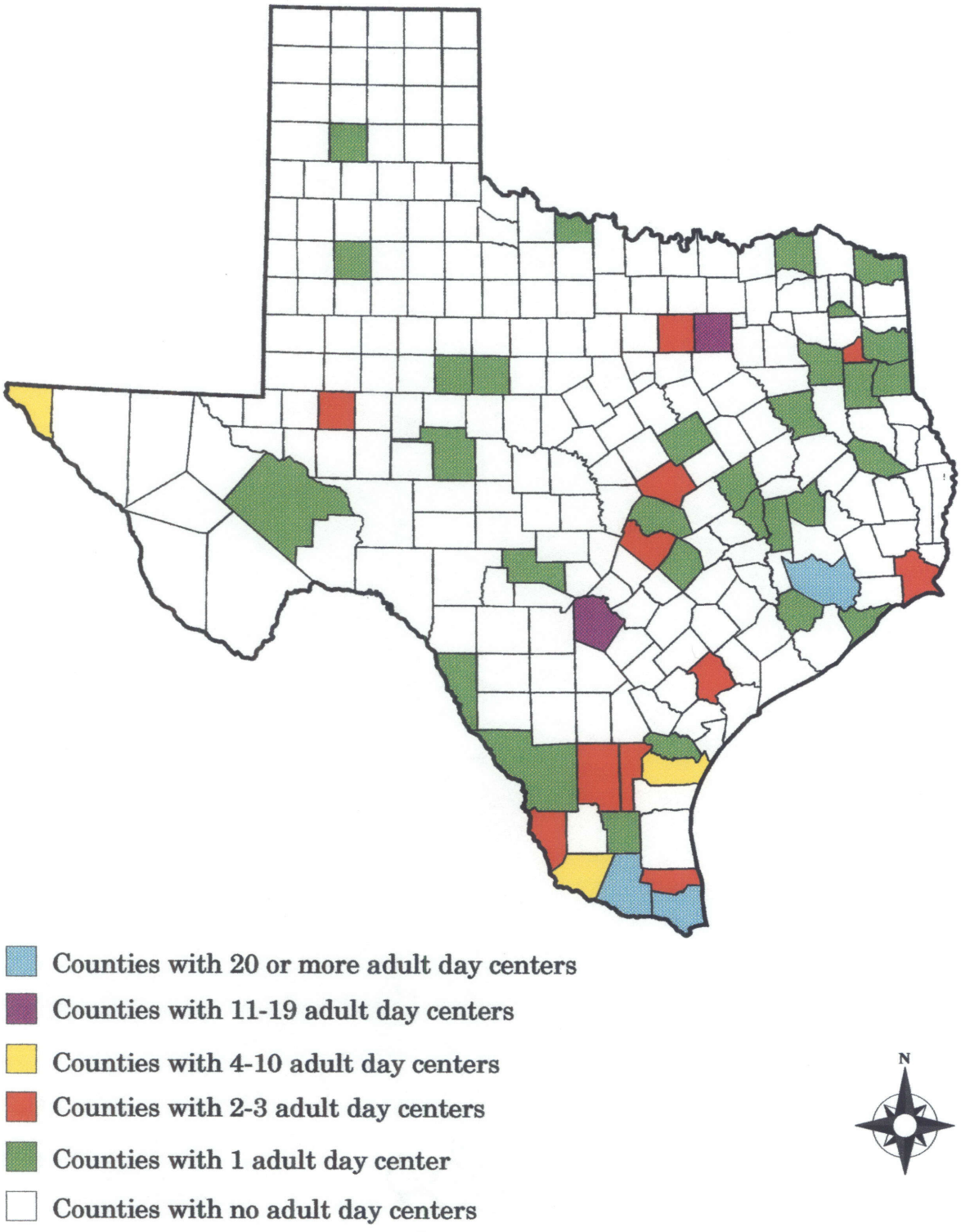
[15]Nursing home based adult day programs are not required to carry a separate adult day care license since they operate under the auspices of the nursing home license.

and $45 per day (Weaver, April 1994). Thus, adult day care is largely inaccessible in the Metroplex to individuals who are unable to pay and to individuals who are not in geographical proximity to an adult day center.

In contrast to the situation in the Dallas-Fort Worth area, more than 60 percent of the state's licensed/certified adult day centers are located in South Texas where the population is predominantly Mexican American and low-income (see Figure 2).

Figure 2

Concentration of Adult Day Centers in Texas



Of the 176 centers currently licensed in Texas, almost half are located in Long-Term Care Region 11 (LTCR-11)[16]. Table 10 illustrates how LTCR-11 compares to the other ten Health and Human Services regions in Texas.

Table 10

Number of Adult Day Centers and Total Licensing Capacity by Long Term Care Region* in Texas

Region	Number of Centers	Total Licensing Capacity
1-Amarillo	2	240
2-Abilene	3	115
3-Arlington	15	1063
4-Tyler	10	494
5-Beaumont	3	157
6-Houston	25	1427
7-Temple	10	447
8-San Antonio	15	1069
9-Abilene (West)	4	187
10-El Paso	6	371
11-Corpus Christi	81	6036

*Designated by the Texas Health and Human Services Commission

Most of the users of adult day care in LTCR-11 are Mexican American elders who are eligible for Medicaid benefits. The Adult Day Care Association of Texas (ADCAT) reports that adult day care programs in South Texas have provided access to medical care and health promotion services that were otherwise not accessible to the centers' participants. Both ADCAT and TDHS admit that these and other adult day care providers utilize a

[16]Counties in LTCR-11 include Brooks, Cameron, Duval, Hidalgo, Jim Wells, Nueces, San Patricio, Starr, Webb, Willacy, and Zapata.

variety of methods to contain costs including shared staff, limited services, and in-kind contributions of staffing and services. Few facilities employ full-time registered nurses and social workers, if available, are typically shared by a number of adult day care centers that are group affiliated. Services associated with activities of daily living for participants who require assistance with bathing, grooming, eating, toileting, and transferring are limited due to the extra staff time required to provide such services. The more time-intensive services such as bathing are almost never routinely offered.

The adult day centers that have developed in South Texas are primarily entrepreneurial, for-profit franchises; multi-facility ownership is common (see Table 11). Many of these centers tend to be much larger (as evidenced by their licensing capacity[17]) than centers elsewhere in the state. The two counties in LTCR-11 with the greatest number of adult day centers are Cameron and Hidalgo. Cameron County includes the cities of Brownsville, Harlingen, San Benito, Santa Rosa, Los Fresnos, and La Feria. There are 24 adult day centers in Cameron County. More than 76 percent of the county's total population of 278,687 are Hispanic and 39.7 percent are

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[17]Licensing capacity is determined by the amount of square footage allocated for participant activities, (i.e., excluding the food service area, rest rooms, bath areas, office areas, corridors, stairways, storage areas, and outdoor space) as specified in §98.43 of the *Licensing Standards for Adult Day Care Facilities* (TDHS, 1995).

Table 11

Corporations and Proprietorships for Adult Day Centers in LTCR-11

Owner	# ADCs
TLC Adult Day Care Centers, Inc.	14
Sunglo Fellowship Centers, Inc.	9
Texas Valley Health Services, Inc.	7
Rural Economic Assistance League, Inc.	5
Modesto Rodriguez, Jr.	3
El Wero, Inc.	3
*Others	40

*Proprietors or corporations with 1 or 2 adult day centers each.

below the poverty level. Hidalgo County has 34 adult day centers located in the towns and cities of Weslaco, Edinburgh, Alamo, Donna, Mercedes, McAllen, LaVilla, Elsa, Pharr, Mission, Penitas, LaJoya, and Hidalgo. More than 77 percent of the county's 420,955 residents are Hispanic and 41.9 percent live below the poverty level. These numbers differ significantly from all other parts of Texas. In Tarrant County, for example, there are only three adult day centers to serve a population of 1,220,119. One of the centers is located in the city of Arlington whose population of 259,678 is close to that of Cameron County. The total licensure capacity for the 24 adult day centers in Cameron County is 1900, while the one center in Arlington is licensed for only 25. In Fort Worth (population 443,102), where the other two adult day

centers in Tarrant County are located, the licensure capacity for one center is 25 and for the other is 90. The larger center serves Medicaid clients while the smaller one serves only participants who pay the $45 per day out-of-pocket fee. Table 12 provides population characteristics for all counties in Texas that have adult day centers along with the number of centers operating in each county and the combined total licensure capacity for these centers.

Table 12

Profile of Texas Counties where Adult Day Centers are Located

COUNTY	TOTAL POPULATION (1992)	% HISPANIC	% BELOW POVERTY	% 65 +	# ADCs	TOTAL CAPACITY OF ADCs
Anderson	47,929	7.8	18.4	12.7	1	27
Angelina	72,014	7.6	17.9	13.0	1	45
Bastrop	39,530	17.1	15.2	12.4	1	30
Bell	190,576	12.6	19.9	8.8	2	90
Bexar	1,233,096	47.5	17.1	9.9	11	863
Bowie	82,285	1.6	17.1	14.4	1	20
Brazos	125,159	12.9	26.7	6.7	1	50
Brooks	8,187	89.7	36.8	13.1	1	59
Cameron	278,687	76.3	39.7	10.6	24	1900
Camp	10,139	5.1	22.5	17.8	1	31
Dallas	1,913,395	16.1	13.5	8.2	12	923
Duval	12,721	88.4	39.0	13.1	3	193
El Paso	628,472	65.4	26.8	8.2	6	371
Fort Bend	255,788	17.0	8.9	4.9	1	90
Galveston	228,084	13.3	15.5	10.5	1	31
Gregg	107,945	3.6	16.8	13.3	2	150
Grimes	19,381	13.6	24.5	13.7	1	30
Harris	2,971,755	21.4	15.7	7.0	22	1271
Harrison	57,149	2.3	28.5	13.5	1	60
Hidalgo	420,955	77.7	41.9	10.0	34	2680
Jefferson	243,257	5.1	19.5	14.0	2	112
Jim Wells	38,259	70.9	30.3	11.7	3	113
Kerr	37,276	16.5	15.0	24.7	1	48
Lamar	44,821	1.2	20.1	17.4	1	40
Lubbock	224,622	22.5	19.0	9.9	1	80
Maverick	40,647	83.7	50.4	8.5	1	59
McLennan	191,500	12.0	20.6	13.5	1	100

COUNTY	TOTAL POPULATION (1992)	% HISPANIC	% BELOW POVERTY	% 65 +	# ADCs	TOTAL CAPACITY OF ADCs
Midland	111,439	20.1	14.5	8.9	2	60
Nolan	16,136	26.2	21.3	16.5	1	20
Nueces	300,815	50.2	20.8	10.1	4	247
Panola	22,000	2.5	20.7	15.8	1	21
Pecos	14,316	57.8	29.6	9.9	1	59
Randall	91,878	6.5	8.9	9.9	1	160
Robertson	15,211	11.5	28.4	18.4	1	28
Rusk	43,658	3.7	20.0	17.2	1	55
San Patricio	60,600	48.8	25.3	10.4	1	59
Smith	154,461	5.9	16.5	13.8	1	90
Starr	44,953	87.9	60.0	7.1	5	324
Tarrant	1,220,119	11.2	11.0	8.3	3	140
Taylor	120,557	14.1	15.4	12.0	1	50
Tom Green	99,110	25.5	17.3	12.7	1	68
Travis	613,159	19.6	16.0	7.3	2	89
Victoria	77,042	32.7	17.6	10.9	2	99
Walker	52.663	10.4	22.2	8.8	1	35
Webb	148,465	84.3	38.2	7.9	1	59
Wichita	120,386	8.6	15.9	12.7	1	45
Willacy	18,278	81.4	44.2	11.2	3	284
Williamson	153,106	12.9	10.1	7.6	1	30
Zapata	9,831	76.3	41.0	14.9	2	118

Implications relating to these findings are considerable. In the midst of budget constraints and proposed policy changes relating to reimbursement for all types of community-based care, TDHS is reluctant to recommend rule revisions for adult day care. Rate increases cannot be justified since provider

cost reports, skewed by lower operating costs in South Texas, indicate that the reimbursement rate is already higher than the daily cost. A higher level of reimbursement would result in even greater disparity, and a higher profit margin, among adult day providers in the lower Rio Grande Valley vs. other parts of the state. The dilemma for TDHS involves the daily reimbursement for approximately 6000 clients in LTCR-11 alone, compared to other regions whose potential for Medicaid reimbursement ranges from 115 to 1427 clients based on licensure capacity[18].

Because of the static response by TDHS and the limited professionalization of the state association, the scope and quality of adult day care in Texas is prohibited. The expansion of adult day services to provide higher levels of care is impeded since the cost of providing the services required by participants who need such care is more expensive and is not covered by the current level of reimbursement. Thus, the projected increases in the number of older Texans needing adult day care and other community-based services are not being addressed by the current system.

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[18]The licensure capacity in these centers does not necessarily refer to the number of participants for which TDHS reimburses since some participants pay privately for adult day services and since the average occupancy of adult day centers in Texas is less than 60 percent.

CHAPTER VI

CONCLUSION

Summary of Study

Adult day services are the fastest growing component of community-based long term care (Partners in Caregiving, 1995). An estimated 3300 adult day centers are currently operating in the U.S. and, as the elderly population increases, more are needed (Reifler, 1995). In their brief history, adult day centers have not only grown in number, but have also evolved professionally. However, significant disparity exists from state to state in the availability of adult day care, and funding and regulatory practices. The purpose of this study has been to explore the organizational environment of adult day care in an attempt to better understand its current state of development.

Although a lack of funding and limited staff made it impossible to conduct intensive and comprehensive research of all fifty states, this study began with an exploration of the availability of adult day services, and funding and regulatory practices in various states. The study was intended to portray the organizational structure of adult day services in different states by exploring variations in the types, methods, and levels of funding

and regulation, and describing how these variables influence the availability of adult day care. Such structure is grounded in traditional theories about bureaucracy (Weber, 1921/1968) and in more contemporary theories about the characteristics of regulatory organizations (Blau & Schoenhen, 1971; Noll, 1985). These theories describe regulatory organizations as goal-directed agencies that attempt to increase efficiency, job specialization, and worker productivity and to limit the capacity for individuals to receive communication or control subordinates (Blau & Schoenhen, 1971; Noll, 1985). Thus, the organizational structure of adult day services is comprised of state funding and/or regulatory agencies on the one side and provider groups (i.e., NADSA and state adult day care associations) on the other. The funding and regulatory agencies are state government bureaucracies, such as the state's health and human services agency or the department on aging, that administer various forms of public funding and/or regulation. In many states, more than one such agency is involved. State associations are often informally organized membership groups that attempt to influence funding or regulatory agencies.

Data were collected from all state agencies that are involved in funding or regulation of adult day services. Data collection involved the use of a semi-structured questionnaire, telephone interviews, and review of documentation provided by various agencies and provider associations. The portion of the study that dealt with an overview of adult day services in the

U.S. was guided by the assumption that greater accessibility to public funding promotes the growth and development of adult day services in a state. Both quantitative and qualitative methods were used to analyze the data. Quantitative analysis included descriptive statistics and crosstabulations. Independent variables related to funding and regulation; the dependent variable was the number of adult day centers in a state. Integrating qualitative methods with these procedures provided greater density and better understanding of the information obtained.

Following this general examination of adult day services organization across the nation, adult day care in Texas was critically examined in order to provide a more in-depth portrayal of how organizational structure affects a program's growth and development. Texas' adult day services are organized within a framework of regulation and/or funding by a state agency with minimal influence by a providers' association. The Texas Department of Human Services (TDHS) administers funding and regulation and the Adult Day Care Association of Texas (ADCAT) functions as a membership group for providers. The purpose of this part of the study was to explore the degree to which TDHS, other priorities within the human services spectrum, and ADCAT promote or impede the development of adult day care in Texas. The status of adult day care as a component of the community care system was explored within a historical context and in conjunction with the position it holds in relationship to other programs in the agency's bureaucratic

structure.

Summary of Findings

Adult day programs first emerged in the early 1970s as community-based service models and were created to evaluate alternatives to nursing home care. The evolutionary changes that adult day care has experienced in the past twenty years include a higher degree of professionalization, a service package that is adaptive to participants' changing needs, and a level of growth that has produced greater public awareness. The organizational environment, of which adult day care is a part, has also evolved. The National Adult Day Services Association has gained 1300 members since its inception in 1979 and has influenced practitioners and policy makers alike. State adult day services associations have emerged and influenced legislation that has promoted program growth even in some smaller states. In response to practitioners' pleas and consumers' demands, state agencies have created and enhanced funding opportunities and implemented regulatory control.

Adult day care has developed as one of many components of the human services field in the U.S. The structure of human services is grounded in a theoretical framework of bureaucracy and the relationship between government and society, characterized as representing modern efforts to achieve basic ethical approaches to human needs through efficient and rational means. The structure of adult day services, specifically, is the result of overarching influences by state government agencies that provide

funding and regulatory oversight and, to a lesser extent, by advocacy of provider groups. The impact of these forces has resulted in an organizational structure of adult day care that embodies both the typical voluntary, nonprofit organizations that are heavily dependent on public funding, and a large number of proprietary, profit-making service organizations.

This exploratory study of adult day services across the nation, with emphasis on Texas, demonstrates how the field has evolved, particularly since the early 1960s, as an organized governmental and voluntary effort to provide a variety of services to persons with limited income and/or dependency needs. Early demonstration projects of adult day health models in the 1960s peaked an interest in the development of the program that has resulted today in centers providing a range of therapeutic health and social services at a cost much lower than home health or nursing home care. Since 1984, practitioners have largely abandoned previous attempts to distinguish between health and social models, recognizing that services are dictated by the needs of the programs' participants. Advocates reject the idea of separate models even in states that specify separate health and social services in licensing or funding regulations.

The study confirmed a high level of disparity in the involvement of state agencies and the resulting availability of adult day centers from state to state. Some states (e.g., California, Texas, Pennsylvania, New York, New Jersey, Massachusetts, and Florida) have a large number of centers, whereas

others (e.g., West Virginia, Oregon, Louisiana, Mississippi, and others) seem to have too few to meet the needs of their older populations. Although no relationship was shown between the number and type of funding sources used and the number of adult day centers in a state, adult day care development is clearly enhanced by greater accessibility to funding sources. Regulatory practices also vary from state to state. Since there are no federal mandates for regulation or funding, regulatory oversight is fragmented or non-existent in some states. As a result, public awareness and utilization of adult day services is limited in many areas. States have considerable autonomy in defining, funding, and regulating adult day services and, often, more than one agency is involved. The standards and guidelines associated with these processes specify requirements for sanitation, safety, staffing, and the physical structure. Most regulations also specify required services. In spite of the low level of regulation provided by state agencies, however, adult day centers have grown in number.

In order to determine the influence of bureaucratic control on the development of adult day care, the organizational structure of adult day services in Texas was examined. Although only one agency is involved with the funding and regulation of adult day care in Texas, and Medicaid funding is easily accessible as part of the state health plan, a high level of disparity exists within the state in the availability and characteristics of adult day centers. The state's 176 centers are unevenly dispersed with more than 60

percent of them located in the Rio Grande Valley region of South Texas. In other parts of the state, adult day centers are either non-existent or in short supply. The significant growth in the number of adult day centers located in South Texas, where the population is predominantly Mexican American and living in poverty, is a phenomenon that has not occurred anywhere else in the nation. Three major characteristics of these centers are considered extraordinary: (1) they are serving predominantly Mexican American participants who presumably have depended on informal support systems for their care needs; (2) they are typically larger and more abundant per capita than adult day centers in other parts of the state; and (3) they cost less to operate.

These and other findings of the study provide clues to how the organizational structure of adult day care in Texas has influenced growth and development. The reimbursement rate for Texas' adult day participants is among the lowest in the country at only $22.48 per diem. Adult day care providers in South Texas are reportedly earning profits at this rate by serving large numbers of Medicaid-eligible participants in a geographical region where the costs of operation are lower than elsewhere in the state. Thus, with approximately three-fourths of the Valley's population qualifying for Medicaid, multi-facility owners demonstrate how costs can be contained while providing health care and social services to a vulnerable population. This contrasts with adult day centers in the rest of the state having to rely on

private support since the $22.48 per day reimbursement does not cover the cost of operation.

Need for Further Research

A significant body of literature exists that provides general descriptions of adult day services, participant characteristics, and center characteristics. In addition to physical descriptions, the literature--and the opinions expressed by the informants interviewed for this study--portrays a desire on the part of adult day care providers to maintain the quality and affordability of the program. The method most commonly expressed by advocates who wish to enhance the further growth and development of adult day care is to increase and improve the type and level of public funding allocated to eligible centers. In doing so, providers believe the quality of life for people requiring health and support services will be enhanced and institutionalization will be postponed or prevented, at a cost much lower than nursing home care. Policy-makers, on the other hand, believe that increased funding accessibility for adult day care will actually result in greater overall cost since more people will be using the program. Without research to support the views of either side, state agencies continue to practice the traditional bureaucratic ideas described by Max Weber and to seek the most efficient means for carrying out government policy.

Research is imperative to further explore these issues and to provide reimbursement and program specialists, and providers, with the information

they need to initiate planning, additional research, and policy changes. In order to begin the process of designing a revised community services system--that includes adult day care as one of its key components--more research is needed to answer the following questions:

- What is the average daily cost of operating adult day centers in each state?
- How are operating costs contained?
- Do costs vary by geographical regions within each state and why?
- Do service provisions and the level of quality of the services rendered vary based on the extent to which adult day programs depend on Medicaid reimbursement as their primary source of revenue?
- Do differences exist in the level of professionalization (i.e., staff positions and services) of adult day programs in each state?

On a national scale, additional research and program evaluation is needed to measure participant and center outcomes relating to quality of life--for the participant and family caregivers--and to program effectiveness. Quality of life measurements, pertaining to the participant, should include health status, functional assessment, and life satisfaction; measurements pertaining to family issues should address the degree of support and caregiver stress. Measurements of program effectiveness should include center characteristics,

program quality, and service utilization in addition to macro-level research that compares the cost of adult day services to other types of community and institutional care (e.g., assisted living and nursing home care).

In Texas, research and demonstration projects should be conducted on the availability and feasibility of alternative and/or supplemental funding options and methods including:

- revised DAHS rate-setting methodology that includes level of care or add-on reimbursement based on service needs and provisions;
- collaborative funding through TxMHMR for adult day care programs that serve persons with developmental disabilities;
- other sources that are appropriate for adult day care (e.g., mental health funds, Alzheimer's grants, and local funding);
- development of workplace programs that provide or promote adult day services.

More research is needed to determine whether types of services vary extensively among adult day care programs across Texas and in various states. In consideration of the need to assist adult day services providers in diversifying their revenue sources and in order to meet the current and future demands for services to a growing number of individuals whose chronic care needs are increasing, alternate funding sources and methods must be reviewed and developed.

Implications

The aging of the population is yielding more people in need of health care and social services due to a greater number of people living longer and to the chronic conditions and functional limitations that occur in advanced age. In addition to the many unavoidable challenges associated with the aging process, older Americans are victims of inequity in the current U.S. health care system. Medicare does not cover most community-based services, including adult day services, and Medicaid is available only to individuals whose income and assets are below a designated level. Inequities also persist in specific Medicare and Medicaid policies, including early hospital discharge practices and Medicaid Waiver programs that devalue and underestimate care and nurturing provided by the family unit.

A significant concern in current health policy relates to the elderly being thrust back into the community following hospitalization sicker and poorer than they were previously (Estes & Swan, 1993). This problem has emerged because of early hospital discharge practices resulting from the Prospective Payment System (PPS) for Medicare reimbursement implemented in 1984. As a result, the burden of acute and sub-acute care of older individuals has shifted to ambulatory care and community-based settings. The gap between the level of care required and the availability of services to provide such care continues to widen. Expenditures by federal and state governments associated with these services have created a fiscal

crisis.

The effects of PPS remain far more insidious than were ever anticipated (Estes & Swan, 1993). Combined with the increasingly competitive nature of the health care market, PPS has resulted in a transformation of the site and duration of medical care. The number of multifacility organizations and for-profit providers has increased dramatically while non-profit, independent providers have been forced to tighten eligibility criteria and charge fees or copayments. As a result, the community-based care system is burdened with an increasing demand for services and an increase in the number of sicker elderly requiring care. In the case of adult day care, particularly in states like Texas where reimbursement for services is already significantly lower than the daily costs for participants requiring even minimal care, little incentive is offered to providers to increase the level of services to meet these higher care needs. The need to coordinate appropriate post-acute care paradoxically impacts community care providers who are pressured to provide a higher level of care with limited--and often inadequate--support from public funding.

The increased need for adult day care to be available in every community and to offer a wider array of services (including personal care, transportation, and nursing care that includes sub-acute care provisions) produces a climate in which enhanced private and public funding for the program is necessary. Even though disparity in public funding and

regulation will likely continue, states that have made strong showings in the growth and policy development of adult day services will continue to set the standard for other states. The interest and willingness on the part of provider groups, state agency representatives, and researchers to assist in the continued development of adult day services can result in an improved system that serves as a model for other states. Therefore, documenting the findings of this study, with an emphasis on Texas, is pertinent to policy-makers seeking alternative funding and regulatory practices at the state and federal level.

Texas can serve as one of these models with some carefully planned policy and programming modifications. Because of the high volumes and low operational costs in adult day centers located in South Texas' Long Term Care Region 11 (LTCR-11), TDHS cost reports averaged for all certified adult day centers in the state indicate a daily operating cost of less than $22. Adult day services providers in all other regions of Texas report that daily costs actually range from $27 to $37 per day[1] and published studies show costs to range from $31 to $52 per day (Von Behren 1986; Weissert, Wan, Livieratos, & Katz, 1980). TDHS is forced to reimburse providers outside of LTCR-11 at a rate that is less than actual cost. With the extensive growth in

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[1]Preliminary data collected from a convenience sample of adult day care centers in Texas during a recent telephone survey conducted by the Texas Institute for Research and Education on Aging.

adult day centers in LTCR-11, the current $22.48 rate has produced a tremendous impact on Texas' Medicaid budget. The 34 adult day centers in Hidalgo county are reimbursed at this rate for more than 2000 participants per day; whereas, in the city of Fort Worth, with close to the same population, there is only one certified adult day center that is reimbursed for fewer than 90 participants per day. Discrepancies such as these raise a number of questions pertaining to participant characteristics, program quality, and center characteristics. They also cause policy-makers to question whether programs such as adult day care actually produce the preferred outcomes (e.g., health promotion, cost-effectiveness, and reduced nursing home admissions). In addition, as part of their efficiency determinations, policy planners compare the costs and outcomes of adult day services to other programs such as in-home services and assisted living. Answers to these questions--along with appropriate programming modifications--are imperative if adult day care providers wish to position themselves for inclusion as managed care systems develop.

A new set of issues in policy and programming with respect to day services for disabled and chronically ill adults has arisen in recent years and the future of adult day care is uncertain (Henry & Capitman, 1994). Without a federal mandate, it is impossible to determine how many states will include adult day services in personal care benefits provided by a reformed long-term care system in which states are awarded block grants and autonomy in

determining services and expenditures. The availability of appropriate community-based care for the growing older population depends on comprehensive research and planning. To facilitate the development of adult day services in a managed care system, providers, researchers, and policy makers must work together to develop and test models that assure quality and cost-effectiveness.

As the elderly population continues its rapid growth, current public policy becomes more concerned with future trends in chronic health care services and levels of federal expenditures. By the year 2040, it is estimated that 67.3 million United States citizens (22% of the total population) will be 65 years old or older (Manton & Soldo, 1985). Assuming that the rates of old-age mortality decline only gradually, 13.3 million of these individuals (4% of the total population) will be in the 85 and over age group (Manton & Soldo, 1985). The expanding numbers of this so-called "oldest-old" group will produce higher rates of disability and poverty and will have a major impact on health and social service systems over the next few decades. If current morbidity and service use rates remain constant, the number of the very old functionally dependent in the community will increase fivefold by 2040 (Soldo & Manton, 1985).

Future patterns of community long-term care services will be shaped not only by increases in the number of individuals with functional disabilities, but also by the availability of informal care providers and

changes in federal and state reimbursement policies. The elderly population is increasing while the size of the American family is decreasing (Koff, 1988), resulting in less family-based support and increasing reliance on outside services for elderly people. In addition, paying for services is becoming increasingly problematic for elderly persons who are forced by public policy to spend themselves into poverty. Currently, middle-class citizens faced with immense bills for long-term care must "spend down" their assets to gain eligibility for Medicaid. Existing Medicaid coverage for home and community-based care is restricted by recent cost containment initiatives, thus increasing reliance upon expensive hospital and nursing home care (Koff, 1988). These trends must be addressed in order to ensure that older people have access to appropriate care and the demand for adult day care, as a necessary component within the long-term care continuum, is fulfilled.

Recommendations

Major policy changes are needed in the organization, delivery, and financing of health and social services to assure appropriate and affordable care for the elderly and/or physically disabled adults in the U.S. Possible solutions include shifting community care toward informalization and reducing federal responsibility in an attempt to place the burden of care within the community. Philanthropy will need to play an important role and providers will need to consider a variety of methods for diversifying their revenue sources.

The most significant public policy revision currently being proposed is to convert to a block grant system. Congress continues to debate whether states should receive block grants and greater autonomy in determining how they will address health and social problems. Block grants reflect the political perspective that states and communities are best able to determine the care and needs of their populations. The major goals of a block grant system are to "improve fiscal and program efficiency, reduce federal costs, and give states primary autonomy in the use of their funds" (Cox, 1995, p. 15). Proponents of the block grant programs insist that minimizing--or eliminating--federal requirements will give states greater flexibility to target funding to individuals and communities with the greatest need (Cox, 1995). Critics of the federal system site major failures in Medicare and Medicaid as reasons to support autonomy at the state level. In addition to skyrocketing costs and the enormous federal budget deficit, many analysts fear that Medicare is headed for bankruptcy (Tanner, 1995). Medicaid now consumes approximately 6 percent of the federal budget and is growing at a rate of 10 to 11 percent per year. As spending increases, nearly every state is forced to reduce payments and reimburse providers at rates well below actual costs (Tanner, 1995).

Block grant opponents suggest that there is greater controversy and less broad support than policy leaders acknowledge for a system that allows states the flexibility to adapt the program to their own needs and to apply

market principles to make it more efficient (Ornstein, 1995). Concerns relate primarily to the fiscal pressures states will experience if they are asked to bear the additional costs beyond the federal increment. The proposed 4 percent increases in the Medicaid block grant will be sufficient to cover anticipated demographic changes, but after two years, nothing is budgeted for inflation, despite the fact that health care costs have been rising around 6 percent per year (Peterson, 1995). Making the program equitable from state to state is another major concern. Differences among states in demographic characteristics, health costs, and welfare eligibility criteria will result in considerable difficulty assuring a fair and just system (Peterson, 1995).

The major objective of publicly-funded community-based programs is to control or reduce government expense for institutional care. In meeting this objective, programs rely heavily on means-testing and on informal support, usually by family members. Means testing, in effect, reduces the number of program participants by limiting eligibility to only those below a certain income level. Thus, choices are constricted and families' capacity to provide adequate care is limited. Community care provisions that attempt to control costs by limiting eligibility and rationing benefits raise the threshold of access to services to a level that requires many elders and their caregivers to choose between no support and total support (England, Keigher, Miller, and Linsk, 1991). Family choices are further hampered since the care of dependent family members remains largely the responsibility of women

(Stoller, 1983; Day, 1985; England et al., 1991) who, already disadvantaged by limited opportunities in the work place and lower wages, find that services to assist them in caring for an older relative are fragmented and difficult to obtain.

A number of demographic and social changes will profoundly affect informal care in the next century. Greater participation by women in the labor force and an increase in the dependency ratio will mean that more dependent elderly will require assistance and fewer family members will be available to provide the needed care. The Prospective Payment System places additional strain on families who are forced to provide sub-acute care for frail and more dependent older relatives. The challenge for policy makers will be to develop policies that address these family support and community care issues. Revised policies must be gender neutral and must offer a variety of choices. Personal and family decision-making should not be limited by the lack of availability or accessibility to needed services.

In light of proposed health reforms and unless a national consensus is achieved, public funding and regulation for adult day services will continue to vary significantly from state to state. A new framework for licensing and reimbursement of adult day services is needed that is based on the following assumptions:

- Needs of people with chronic conditions change over time, often unpredictably. Progress or decline is neither incremental nor

step-wise. As needs change, so should the mix of services and intensity of treatment or care.

- Preventive services and maintenance of functional ability should be recognized and valued as highly as restorative services.
- The system should be consumer-oriented and encourage development of high quality programs. (Canterbury & Missaelides, 1994)

This framework defines the ideal type of community-based services system for frail elders and disabled adults--a system that accommodates changing needs and prevents or postpones institutionalization while adhering to consumers' choices. But the policy revisions that come with this improved system require extensive development and evaluation to assure quality, cost-effectiveness, and economic feasibility.

In Texas, plans should begin immediately to develop and diversify public and private funding for adult day services. Planning and implementation of the funding alternatives previously mentioned (i.e., revising the current Medicaid methodology to a level-of-care or add-on reimbursement system; and funding through TxMHMR, Alzheimer's Associations, local government, and private enterprises) should begin as soon as possible. In addition, the utilization of the Community Based Alternative (CBA) waiver program for persons eligible for services in a nursing facility

should be expanded and streamlined. Although the CBA program has been available throughout the state since August 1995, long waiting periods for eligibility determinations impede its use. Adult day care providers should join other advocates in improving accessibility. One suggestion under current consideration is to allow private providers to bid on client eligibility determinations for the CBA. These and other options should be evaluated and tested in Texas as possible methods of demonstrating collaboration, improved care, and cost-effectiveness. The process of reviewing these options should begin with the creation of a work group whose members are purposively selected due to their expertise and/or involvement with key organizations. Members of the workgroup should include representatives of TDHS, ADCAT, TxMHMR, the Texas Alzheimer's Council, the Texas Institute for Research and Education on Aging at the University of North Texas, state legislators, members of the Texas Health and Human Services Commission Long-Term Care Task Force and other key individuals with an interest in developing the community-based care system in Texas.

APPENDIX A

QUESTIONNAIRE

ADULT DAY CARE SURVEY OF STATE AGENCIES

SECTION I
LICENSING AND CERTIFICATION

1.a. Is licensing of adult day/ adult day health programs mandatory in your state?

Yes ___ No ___

b. If not mandatory, is it available?

Yes ___ No ___

c. If licensing is mandatory or available, specify type:_____

2.a. Specify the number of adult day care facilities in each category:

[1]Licensed (not certified)	___	___
[2]Certified (not licensed)	___	___
Licensed & certified	___	___
Neither licensed nor certified	___	___

b. Are these numbers estimated or actual?

___ Estimated ___ Actual

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[1]**Licensed** -- condition of operation specifying criteria intended to protect the public.

[2]**Certified** -- condition for eligibility to receive government funding.

Please indicate the name, address, and contact person for the **state agency that is responsible for licensing of adult day care** programs in your state:

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

Please indicate the name, address, and contact person for the **state agency that is responsible for Title XIX certification of adult day care** programs in your state:

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

Please indicate the name, address, and contact person for the **state agency that is responsible for quality assurance of adult day care programs** in your state.

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

Please indicate the name, address, and contact person for **each state agency that is responsible for funding to adult day care** centers in your state:

Title XIX (Medicaid)

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

Title III

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

Other Public Funding (Specify)_____

State Agency:_____

Address:_____

_____

City, State, Zip:_____

Contact Person:_____

Title:_____

Telephone:_____

SECTION II
COST REPORTING AND STATE REIMBURSEMENT

1. Specify the number of adult day /adult day health facilities funded and/or regulated by your agency that utilize the following funding sources. (Indicate the estimated number of facilities in each category only if the actual number is not known.)

		Estimated	Actual
a.	Total number of adult day care facilities that receive state or federal funding:	___	___
b.	Medicaid Title XIX (as part of state health plan)	___	___
c.	Medicaid Home and Community-Based Services Waiver (1915-C Waiver)	___	___
d.	Title XX of Social Services Block Grant (SSBG)	___	___
e.	Title III of Older Americans Act	___	___
f.	Mental Health	___	___
g.	Mental Retardation/Developmental Disability	___	___
h.	Veterans' Affairs	___	___
i.	Other (specify)_____	___	___
j.	Private pay only (no state or federal funding)	___	___

SECTION III
PROGRAM REQUIREMENTS

1.a. Does your agency have medical eligibility requirements for adult day care participants?

Yes ___ No ___

b. If yes, please provide a general description:

_____

_____

2. Which of the following services are provided by adult day care programs under the auspices of your agency?

	Required by Your Agency	Not Required But Typically Provided
Health assessment	___	___
Nursing supervision	___	___
Nursing assessment	___	___
Medication administration	___	___
Assistance with bathing	___	___
Assistance with toileting	___	___
Assistance with other activities of daily living	___	___
General transportation	___	___
Medical transportation	___	___
Group activities	___	___
Individual activities	___	___
Socialization	___	___
Therapeutic recreation	___	___
Exercise	___	___
Nutrition assessment	___	___
Social work services	___	___
Case management/ care coordination	___	___
Physical therapy	___	___
Occupational therapy	___	___
Speech therapy	___	___

3. Is participation by adult day care facilities in the Child and Adult Day Care Food Program (CACFP) required by any of the funding sources in your state?

   Yes ___ No ___

4. How many adult day care programs in your state participate in the CACFP?

   Estimated # _____ Actual # _____

REPORT COMPLETED BY:

NAME:_____

TITLE:_____

AGENCY:_____

APPENDIX B

KEY INFORMANTS

Contact Persons in State Agencies that Monitor Adult Day Services

Alabama
Alice McLeod
Office of Social Service Contracts
Department of Human Resources
50 Ripley Street, 2nd Floor
Montgomery, AL 36130
(205) 242-1650

Alaska
Barbara Knapp,
Health Programs Administrator
Commission on Aging
Box 110209
Juneau, AK 99811-0209
(907) 465-4798

Arizona
Jan Karlin, Program Manager
Department of Health Services
1647 E. Morten Ave.
Phoenix, AZ 85020
(602) 255-1177

Arkansas
Herb Sanderson, Director
Department of Human Services
Division of Aging & Adult Services
P.O. Box 1437
Little Rock, AR 72203-1437
(501)682-2441

California
Licensing (ADC/ADSC):
West Irvin, Associate Analyst
Department of Social Services
Community Care
Licensing Division
744 P Street, MS-19-50
Sacramento, CA 95814
(916) 327-2459

ADHC:
Charlene Welty, Chief
Adult Day Health Care Branch
Department of Aging
1600 K St.
Sacramento, CA 95826
(916) 323-6525

ADCRC:
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