WHAT'S THE MATTER WITH FLORIDA?

Public Funding for Long-Term Care

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This article examines the role of the state of Florida as a social service provider and how it informs the long-term care of some of its most vulnerable citizens—Holocaust survivors. It shows how the state's traditionalist political culture favors low public spending and institutional care, resulting in inadequate home- and community-based services. After a review of the services available, the author suggests that stakeholders advocate that Florida follow the lead of other state governments that have entered into public-private partnerships with insurance companies that combine private long-term care insurance with special Medicaid eligibility standards.

Readers of this article will recall the Presidential election of 2000 in which the ambiguous nature of Florida's butterfly ballots gave Pat Buchanan more than 10 percent of the vote in Palm Beach County. Although the subsequent court cases regarding a manual recount put many in a state of disbelief, students of American politics viewed the battle of Florida as just another example of Southern politics first described by V. O. Key in 1949. Simply stated, Florida is a southern state, despite Miami's economic role as the gateway to Latin America and the Caribbean and the ethnic diversity of its southeast counties.

Florida's southernness informs social service delivery to its Holocaust survivors as well. Nearly 10,000 survivors, of whom an estimated one-third live at or near the poverty level ("Financial Institutions Urged," 2005), reside in Florida, giving it the third largest survivor population in the United States after New York and California. But when compared to survivors in those two states, Florida's population has more unmet needs, particularly in the area of long-term care (LTC), specifically programs that allow survivors to remain in their homes and communities.

The stakeholders—mainly survivors, their advocacy organizations, and the local Jewish agencies that serve them—advocate for more home care in supply-demand terms. On the supply side is the unavailability of adequate publicly funded home- and community-based services (HCBS) programs, mostly through Medicaid, the costs of which are shared by the federal and state governments. The supply side also includes privately funded programs that local Jewish agencies administer, mainly through allocations from the Jewish federation system and the Conference on Jewish Material Claims Against Germany (Claims Conference). Claims Conference allocations themselves come from a variety of sources—its own funds, as well as those made available through the Swiss Banks settlement, the International Commission for Holocaust Era Insurance Claims (ICHEIC), and other settlements.

The demand side focuses on unmet needs for in-home services, which are based on population estimates of survivors, their socioeconomic characteristics, and their geographic distribution throughout the state, all of which are subject to debate as various proposals to federal court in the Swiss Banks case attest. This dispute over the enumeration of survivors includes how local Jewish community studies account for part-year residents, as well as recent retirees.

The supply-demand approach seeks parity

The opinions presented in this article are wholly my own and have not been vetted by any organization or its board members.

for Holocaust survivors living in Florida with similar cohorts both in and outside the United States. To achieve this parity, advocates argue that private philanthropy for in-home services should supplement public sector funds. This essentially requires a redistribution of allocations, mostly originating from the Claims Conference. The approach dismisses public spending for home care in Florida as inadequate. However, missing from this argument is an examination of the role of the state and the relationship between Jewish communal organizations and government—either as supplement to or subcontractor of the public social welfare function.

In this article, I examine the role of the state as a social service provider, framing Florida's LTC system within the context of its political culture, which informs the formation and implementation of state public policy. How has the state's capacity and willingness to provide for its most vulnerable citizens resulted in inadequate public spending for HCBS, particularly when the state's population is older than the national average and is getting older? As such, I refer to other HCBS programs to show how Florida's political culture results in inadequate funding, but my intention is not to present a comparison.

In 1984, Daniel Elazar posited a theory of state political culture. He divided states into three types—moralistic, individualistic, and traditionalist—with the caveat that none of the 50 U.S. states was a pure type. Moralistic states are oriented to achieving community-minded goals; they justify their political positions by appeals to the public interest. For example, California relies on public referenda, rather than the state legislature, to pass laws and make policy as a means of appealing to the public interest. There are competitive political parties and high political participation. Sacramento's strong public administration and bureaucracy are evident in relatively high social welfare benefits—provided the beneficiaries are not immigrants—which also reflect liberal and innovative programming (Mead, 2003).

New York exemplifies Elazar's individualistic state. Like California, it has a well-developed state government and bureaucracy and relatively high social welfare benefits. However, Albany serves more specific interests. New York's political parties are strong, but the parties comprise coalitions of groups seeking advantages from government. These coalitions appear to appeal to the public interest, but their strengths lie in their ability to remain partisan in nature. As a consequence, significant decisions regarding services, such as the availability of HCBS, tend to be delegated to the counties.

Florida has a traditionalistic political culture. Its state government limits its functions largely to the preservation of traditional values, including the racial caste system that characterized the segregated South. State political parties have no mass attraction—either in appealing to the public interest or in forming special interest coalitions; the state bureaucracy is underdeveloped and distrusted, and policymaking is casual and personalized, resulting in low social welfare benefits. Current state policy shows very little commitment to LTC in any setting that is not institutional. Clearly with Florida's traditionalist political culture, its political actors have no interest in appealing to any particular constituency, including the elderly.

In the case of LTC, Florida adheres to tradition—institutional care—despite mounting evidence against it. Several studies have shown that older people in general and Holocaust survivors, in particular, resist leaving their homes and communities no matter how much assistance they need in day-to-day tasks. Entering a nursing home or similar facility is accompanied by adaptation difficulties (Thomas, 2005). Long corridors disable frail people, forcing them into wheelchairs. Massive dining rooms, with fixed mealtimes, are impersonal and intimidating and promote anxiety. There is limited access to outdoor space. Double rooms and shared

bathrooms limit privacy. For Holocaust survivors, these changes in living arrangements and coping with nursing home personnel in positions of authority can trigger memories of wartime experiences in concentration camps or in hiding (Letzter-Pouw & Werner, 2004).

One alternative to institutional care is home health care, which has dramatically changed the lives of persons 65 years of age and older over the past 20 years. Extensive gerontological research has shown that providers know how to deliver noninstitutional services in an efficient and responsive manner to even the most seriously impaired persons. Between 1985 and 1995, the proportion of elderly who stayed overnight in a nursing home fell by more than 8 percent (Polivka & Oakley, 2000), with the decline in institutionalization rates most striking for older adults who were at least 85 years old (Moon, 1996). In the period between 1992 and 1996 alone, the rate of home-based care usage among the elderly increased 78 percent (from 295 patients per 10,000 population to 526 per 10,000 population; Gibson, Gregory, & Pandya, 2003).

In addition to having a political culture that differs from New York and California—the two other states with significant survivor populations—Florida has an older population (see Table 1). Florida's elderly (age 65+) comprise 19 percent of the state's population, compared to 13.3 percent in New York, 10.6 percent in California, and 12.8 percent in the entire United States (Weiner & Stevenson, 1998). My own analysis of 2000 U.S. Census data compares the elderly population in the areas within these states where survivors reside. Older adults comprise 13.3 and 23.2 percent of the populations of Miami-Dade and Palm Beach County, respectively. In the New York metropolitan area, the elderly are 11.9 percent of the total population, and in Los Angeles and San Francisco, they represent 9.7 percent and 13.1 percent of the total, respectively. As a proportion of all Medicaid beneficiaries, the ranks of elderly are similar in New York and Florida (12.3% and 12.2%, respectively) but are a smaller proportion of the population in California (9.8%).

Florida's elderly also differ in the popular perception of them—that they did not "age in place" and moved to the state after they retired—which has three implications for the architects of social policy in Tallahassee.

First is the lack of adult children who live nearby and would provide informal care. The current patchwork system of long-term home care presupposes much unpaid, informal care provided by other family members. If the perception is that migration patterns of retirees result in the unavailability of other family members to provide informal care, policymakers may prefer institutional care.

Second is the assumption that Florida's elderly are wealthier than older adults in the rest of the country, even though the financial profile of Florida's elderly is strikingly similar to the national profile (Polivka & Oakley, 2000). Moreover, even if there is a crit-

Table 1. Demographic characteristics and potential demand for LTC services in California, Florida, and New York

	Total Elderly Population	Elderly as Percent of Total Population	Elderly Medicaid Beneficiaries (1000)	Elderly Beneficiaries As Percent of Total Beneficiaries
United States	34,100,000	12.8%	3,889	11.1%
California	3,486,000	10.6	486	9.8
Florida	2,743,000	19.0	211	12.2
New York	2,419,000	13.3	371	12.3

Source: Wiener & Stevenson (1998).

ical mass of affluent retirees in need of LTC, questions remain as to the lack of public-private partnerships that combine private LTC insurance with publicly funded programs (see discussion below).

Finally, there is the relationship between the perception of an older population who did not age in place and Florida's fixed limits on state spending and revenues that are entrenched in state law and the state constitution (Mead, 2003). A higher proportion of elderly means a lower proportion of working-aged adults to provide public revenue. Moreover, Tallahassee, Florida's capital, may view retirees from other states in much the same way that the U.S. Congress viewed immigrants when it passed the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, which together restricted the social rights of immigrants.[1] Similarly, Florida's traditionalist political culture would dictate a weak social safety net for a population (retirees) who never contributed their fair share in state taxes when they were in the labor force.

However, these three assumptions regarding the demography of Florida's elderly only partially explain the state's LTC policy. If policy were made entirely from a fiscal perspective, it would favor in-home care. In 2002, the annual cost of home care was estimated to be $23,000 compared to $56,000 in a nursing home (*A Shopper's Guide*, 2003). Although all states (with the possible exception of Oregon) are heavily weighted toward institutional care, Florida relies on it more than any other state.

In 1995, 96 percent of Florida's Medicaid expenses for all LTC went to nursing homes with the remainder going to HCBS (Tilly & Weiner, 2001). Centers for Medicaid & Medicare Services (CMS) data for 2000 found that less than 7 percent of Florida's Medicaid LTC funding went to HCBS for the elderly, ranking it the 40th among states, compared to 18 percent nationally (Nawrocki & Gregory, 2000). At the same time, allocations for Florida's Medicaid nursing home programs increased by over 100 percent (Polivka & Oakley, 2000).

CMS data also showed that Florida ranks at the bottom on various per capita measures for LTC. In its per capita Medicaid spending of HCBS for the age 65+ population, it was 48th out of 50 states ($146). New York at first place spent $1,710, and California spent $156, placing it right above Florida at 47.[2] However, California provides in-home services for the elderly on similar levels to New York (see discussion below).

Throughout the 1990s, per capita spending for all elder long-term programs in Florida (institutional and HCBS, federally matched and general revenue) was $60.20 per person age 65+ compared to a national average of $247.35 (Nawrocki & Gregory, 2000). At the same time, however, Florida's HCBS expenditures per HCBS elderly beneficiary exceed that of New York and California, which both provide more extensive services, including personal care. In 1999, the Florida average was $4,734, compared to $3,013 in California and $1,208 in New York (Appendix I in *Long-Term Care,* 2002).

It is important to note, however, that per capita HCBS spending data are not always helpful for comparative purposes. For example, New York alone accounted for almost 20 percent of all national Medicaid spending on LTC and over 40 percent of all home care expenditures for the elderly, but has only 10

[1]Although the intention here is to use both federal laws as an example of how ideology informs the creation and execution of public policy, it should be noted that both statutes have extremely serious ramifications for the well-being of Holocaust survivors in the United States, particularly recent immigrants from the Soviet Union and its successor states.

[2]The second ranked state is Alaska at $1,221 per person aged 65 or older. However, Alaska uses state funds for "Pioneer" nursing homes that are licensed as assisted living facilities because they do not meet Medicaid's nursing home requirements. See Reinhard & Fahey (2003).

percent of the nation's share of elderly Medicaid beneficiaries (Wiener & Stevenson, 1998). New York also spends the most on nursing homes so that the 34 percent allocated for HCBS is less impressive than the percentages found in other states. Oregon (62%), Vermont (54%), and Kansas (42%) all spend proportionally more on HCBS than New York (Reinhard & Fahey, 2003).

Generally, New York's costs are disproportionately high to the population served. In 1995, Medicaid LTC expenditures per elderly New York resident were $2,444, more than twice the national average of $967 (Wiener & Stevenson, 1998). The New York State Governor's Task Force found that in federal fiscal year 2001, the elderly represented only 11 percent of the state's Medicaid eligible population, but accounted for almost 30 percent of all Medicaid expenditures. Translated into actual numbers, this meant that $7.9 billion was spent on almost 386,000 seniors in FFY 2001. In contrast, in the same year, California's Medicaid program spent $4.2 billion (47% less than New York) on almost 627,000 seniors (62% more eligible; *Report of the Senate Medicaid Reform Task Force*, 2003).

These state data are limited in other ways as well because they do not reflect public spending for state-funded long-term home care programs that provide for older adults who do not meet Medicaid financial eligibility requirements.

On paper, Florida's publicly supported HCBS programs for the elderly look extensive. The state Medicaid program provides for in-home care and there are nine elder-related HCBS Medicaid waivers. There are also two general-revenue home care programs: Community Care for the Elderly and Home Care for the Elderly (Table 2; *Florida*

Table 2. Florida State HCBS Summary

% of U.S. Jewish Nazi victim population	8%
% of population aged 65 and over	18.5% state: 13.3% Greater Miami area 23.2% Palm Beach County
Elderly Medicaid beneficiaries as % of state total	12.2%
% of Medicaid beneficiaries served by HCBS waivers for the elderly	15.5%
Average expenditure per HCBS elderly beneficiary (1999)	$4,734
Coverage limitations for Medicaid in-home services	Nursing or home health: 4 visits/day up to 60/year Other therapies (personal care services, private duty nursing services and occupational therapy services) not covered; only specific medical equipment and supplies covered
Number of people served and waiting list	In 1997, there were 4,476 elderly in HCBS waiver programs, with 11,000 people on waiting lists
State-funded program	Community Care for the Elderly served 37,000 persons in 1999. No data on number served under Home Care for the Elderly

Sources: Conference on Jewish Material Claims Against Germany, individual compensation program data; 2000 US Census of Population; Wiener & Stevenson, Table 1, 1998; *Medicaid Home and Community-Based Waivers*, 2003 (GAO-03-576), Appendix IV; Kaiser Commission on Medicaid and the Uninsured/National Conference of State Legislatures, *Medicaid Benefits on-line survey;* Polivka & Oakley, 2000.

Medicaid Long Term Care System, n.d.).

As Table 2 shows, nursing or home health care in Florida is limited to only 60 visits per year. State Medicaid or Medicaid waiver programs cover no other therapies, such as personal care, private duty nursing, or occupational therapy services. In contrast, New York provides round-the-clock care, if needed, and California provides upward of 283 hours per month of in-home, personal care. Moreover, there were more than twice as many people on the waiting list for Florida's Medicaid waiver programs (11,000) than were actually served (4,476) in 1997.

In a telephone interview and subsequent e-mail correspondence, Bob Maryanski, the Acting Bureau Chief for Medicaid Services in Florida, presented the state in somewhat more generous terms. For example, when asked about the maximum hours per week an elderly HCBS program participant can receive, he remarked that the state measuring unit is a "visit," not an hour, and that home care providers are "not on the clock." He corroborated the U.S. General Accounting Office's data shown in Table 2 that each HCBS program participant can receive up to four visits per day from a registered nurse, licensed practical nurse, and home health aide (Maryanski, personal communication, 2003). He did not mention, however, that what seemed like a system that might deliver 20 hours of home care per week (4 visits per day X 5 days) was actually capitated at 60 visits per year. In fact, Florida may be one of the few states whose benefits for long-term home care under Medicaid are dwarfed by short-term home care under Medicare, which is limited to 100 days following a hospitalization of three days and includes personal care services.

In addition to its statutory limits on spending and revenue collection, Florida, like other states, has had budget problems. Maryanski mentioned that Florida planned to meet budget shortfalls by "limiting rate increases as well as simplifying, consolidating, and possibly capitating long-term care services." Florida has also reduced its Medicaid eligibility limits for the aged and disabled from 90 percent of the poverty line to 88 percent, ending coverage for about 3,400 people (Ku & Nimalendran, 2003).

The two state-funded home care programs, Community Care for the Elderly and Home Care for the Elderly, are much smaller than any of the Medicaid programs. In 1999, Community Care for the Elderly served 37,000 older adults. Although its 1990-1999 per capita expenditures for Floridians age 75 and over were considerably higher than for either HCBS waiver program ($35.34 vs. $17.22 and $12.86, respectively), it has a waiting list of 8,000-11,000 (Polivka & Oakley, 2000).

Two other aspects of Florida's HCBS programs illustrate the state's traditionalist political culture: the implementation of consumer-directed HCBS and the lack of public-private partnerships for LTC insurance. In the consumer-directed HCBS model, Medicaid personal care beneficiaries of all ages have the opportunity to receive cash rather than service benefits (Tilly & Weiner, 2001). Although such a program exists in Florida, it has no impact on elderly beneficiaries owing to the lack of Medicaid in-home personal care services. In this case, the appearance of innovation may have been borne out of the need of the state to bypass home health agencies altogether, particularly when workers in the tourist/hospitality sector earn similar wages to home health workers for less demanding work.

Similarly, Florida has made no inroads in offering LTC insurance policies through public-private partnerships. In 1988, the Robert Wood Johnson Foundation began funding the Partnership for Long-Term Care, a public-private alliance between state governments and insurance companies to combine private LTC insurance with special Medicaid eligibility standards. These partnerships enable individuals who purchase LTC insurance to use state assistance programs (National Conference of State Legislatures, 2004). Four states—California, Con-

necticut, Indiana, and New York—are part of this demonstration project.

Costs for home care (and adjuvant health care) in the United States are also considerably higher than they are in other developed countries, partly because of the structure of the LTC system itself. The means-testing of public LTC benefits makes free-riding an attractive option for elderly even in relatively high income strata through "spending down." At the same time, however, it makes care for those purchasing it privately even more expensive. The dependency on means-tested public programs for LTC also dilutes the market for private LTC insurance, making individual policies more expensive.

Such programs as the Partnership for Long-Term Care create a pool for group LTC insurance. If Florida initiated a public-private partnership for LTC insurance, it would not only increase the revenue stream for publicly funded LTC but would also lower its costs. Holocaust survivors who qualify for means-tested programs would still benefit. The revenue from LTC insurance premiums might increase home care services and eliminate waiting lists. Moreover, it would decrease the costs of supplemental in-home services that local Jewish agencies purchase with communal funds.

By 2010, Florida's frail elderly population age 85 and over is expected to nearly double (Polivka & Oakley, 2000), and by 2020, older adults are expected to comprise 25 percent of the state's population. These demographic projections should make Florida an innovator in LTC for the elderly. Instead, it has slipped far behind several other states in the pursuit of a balanced system of care. Since 1990, it has become more—rather than less—dependent on nursing homes for the delivery of LTC and has not considered such measures as expansion of its HCBS programs, consumer-directed care for the elderly, or public-private partnerships for LTC insurance, all of which are cost efficient, consumer preferred, innovative, and in pace with the need for services.

The problem with Florida's LTC system is structural, begging the question of how much (or how little) an infusion of funds would repair the system. Although there are financial problems, mostly having to do with inadequate public funding for in-home services, the unwillingness of the state to provide for its most vulnerable citizens and its propping up an LTC system biased toward institutional care override the fiscal concerns. In such a traditionalist political culture, preservation of an older system such as nursing home care takes precedence over any other system that may be preferable.

What does all this mean in terms of getting more in-home care for Florida's Holocaust survivors? Here we return to the actions of stakeholders. In the public sphere, the focus has been primarily on the courts and ICHEIC, asking for a redivision of the Nazi compensation pie, rather than on the state legislature.

Even if redivision of the Nazi compensation pie is one goal, why is advocacy to redivide the Medicaid pie so lacking? Reformation of Florida's LTC system requires no extra funding, just reallocation of existing funds into HCBS. Working with the State Insurance Commissioner, who has been responsive to other survivor concerns, to introduce an LTC insurance partnership might be a first step.

Stakeholders have the opportunity to form a grand coalition with such organizations as AARP, advocates for the disabled, and, yes, advocates for institutional reform, such as the Green Houses nursing home movement emerging in the South Of course, this also means abandoning the notion that Florida's survivor population is more worthy than any other constituency in need of publicly funded LTC. Such a coalition would benefit both the supply side (e.g., the state's coffers through LTC insurance as well as the Jewish communal agencies by lowering their LTC costs) and the demand side (survivors plus other elderly and disabled). In an era where it is highly unlikely that any federal or state administration is going to introduce any sort of

legislation to rival either the New Deal or the Great Society, it is something to consider.

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