HUMAN SERVICE DEPARTMENT

Audit of Medicaid Personal Care Option Program
January 19, 2004

Report to
the LEGISLATIVE FINANCE COMMITTEE

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DAVID ABBEY
DIRECTOR

January 19, 2004

Ms. Pamela Hyde, Secretary
Human Services Department
Santa Fe, New Mexico 87504

Dear Ms. Hyde:

On behalf of the Legislative Finance Committee (LFC), we are pleased to transmit this report of the Medicaid personal care option (PCO) program. We believe this report addresses the issues the LFC and Human Services Department (HSD) asked us to examine and hope that you will benefit from our efforts.

The audit team, with assistance from HSD's medical assistance division staff, examined documents and analyzed data from the Affiliated Computer Services (ACS) Omnicaid database relating to the PCO program. This report was discussed with HSD staff at an exit conference held January 6, 2004. We also met previously with staff of HSD's Office of the Inspector General to discuss recurring PCO audit procedures.

LFC audit procedures identified 4,972 hospitalizations for PCO recipients during the 18 month period ended December 31, 2002 when PCO services were also billed. Of 121 hospitalizations tested for one provider, 72 (59.5 percent) were overpaid $30, 242, an average of $420 each. There is a possibility that HSD could recoup as much as $1.2 million if the other hospitalizations were reviewed to determine allowability of PCO billings.

Thanks to you and your staff for your cooperation and assistance. This has been a mutually beneficial and successful collaborative effort of our two agencies. If you need any additional information, please do not hesitate to contact Manu Patel or La Vonne Cornett at 986-4550.

Sincerely,

David Abbey
Director

CC: Senator Ben D. Altamirano, Chairman
Luciano "Lucky" Varela, Vice Chairman
DA:llc/lg

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

Pursuant to a request from the Human Services Department (HSD) and the Legislative Finance Committee (LFC), an audit of issues relating to HSD's Medicaid funded personal care option (PCO) program was conducted by LFC performance auditors with assistance from HSD staff. In four years, PCO expenditures grew from an initial estimate of $9 million for FY00 to $155 million for FY03. A June 2003 report of the Personal Care Option Committee warns of 50 to 60 percent growth in the next ten years.

As of December 2002, there were approximately 6,600 Medicaid recipients in the PCO program with approximately 120 provider agencies. Although PCO is Medicaid funded, no portion of expenditures are paid under Salud! managed care. PCO is a fee-for-service program. Medicaid recipients who are 21 years of age or older qualifying for nursing home care are eligible for the PCO program.

The purpose of this audit was to assess operation of the PCO program and identify improvements that could help contain and/or reduce costs. Specific tests were performed to determine that:

- PCO services did not duplicate or overlap with hospitalizations, nursing home or other similar care;
- Persons receiving services were Medicaid eligible and authorized to receive PCO services. Appropriate person(s) such as a licensed physician attested to the need for those services;
- PCO services have been provided in units of service authorized;
- Provider used appropriate assessment tool(s) to determine whether PCO services were needed and to what extent;
- Personal care attendants received the agreed upon hourly rate of pay; and
- Criminal background checks and trainings were conducted for all care attendants.

The program was not evaluated to determine its benefits.

Findings

A significant problem exists with payment for services when PCO recipients are hospitalized. For this report, a major provider of services in Santa Fe and Bernalillo counties was selected for a comprehensive audit. Using this audit as a prototype, it is expected that HSD staff will increase monitoring of PCO providers in the near future. Results of testing identified:

- Payment errors:
    - Unallowable claim reimbursements of $30,242 for periods when personal care attendants (PCA) reported hours as worked while PCO recipients were hospitalized. The $30,242 represents one tenth of one percent (.001) of the total claims for Bernalillo and Santa Fe counties for one provider during the audit period.
    - PCAs were overpaid $2,926 for 166.4 hours of services provided to three of 18 Santa Fe County recipients because monthly services exceeded authorized amounts. This amount is immaterial to the total allowable payments during the 18 month period audited.
- LFC audit procedures merged all PCO claims by date with hospitalization claims for all PCO recipients statewide for the 18 month audit period ended December 31, 2002 which identified 4,972 hospitalizations of PCO recipients. Examination of 121 PCO claims of one provider for Santa Fe and Bernalillo counties indicated that 72 (59.5 percent) were overpaid $30,242 as indicated above. This represents an average overpayment of $420 each ($30,242 divided by 72). There is a possibility that HSD may be able to recoup up to $1.2 million (4,972 X 59.5 percent X $420) in PCO payments.
- HSD cannot detect hospitalizations and deny payments when PCO recipients are hospitalized. Hospitals have 120 days to bill and do not bill as timely as PCO providers.
- Provider's clinical documentation is weak. However, HSD has not standardized requirements. For example, the technical reviewer could not determine who had performed initial assessments and whether they had been done in the home. The reviewer was also unable to determine who had prepared plans of care.
- Full compliance with the following:

- all persons receiving services were Medicaid eligible and authorized to receive PCO services. Plans of care appeared to be followed by the provider.

- all PCO services were paid for at the contracted rate for the service period.

- all PCAs were paid $9.00 or more per hour for PCO services as required by contract.

- criminal background checks were performed for each PCA.

- In 21 out of 39 (54 percent) requests it took the state more than 60 days to complete criminal background checks.

- None of the 42 PCAs for Santa Fe County recipients were found to be receiving PCO services as rumors had alleged. However, nineteen PCAs were either Medicaid eligible or were receiving Medicaid/TANF services which may have fueled the rumors.

Recommendations:

Unless otherwise indicated, recommendations are directed to HSD management.

Improve PCO payment review and approval procedures. Although identified payment errors are immaterial, ensure that they are not happening in other agencies by scrutinizing payment requests more closely to control costs.

Provide a standardized form for agency care attendants to sign acknowledging that qualifying PCO services are home based and that claiming hours worked when the recipient is hospitalized or receiving certain other services outside the home constitutes Medicaid fraud which is a prosecutable offense.

Require provider agencies to have timesheets which require attendants to state positively or negatively whether the recipient was hospitalized during the service period and indicate admission/discharge dates/times if recipient was hospitalized.

Perform match of hospital and PCO claim data for all providers to identify additional recoupments. Merge database of 4,972 hospitalizations with PCO claims for the audit period. Visually review merged database to identify PCO billings which appear to overlap hospitalization periods. Send notification letters to providers requesting billing documentation for each day of the identified hospitalization. Calculate and request recoupment as appropriate.

Increase monitoring of PCO and other community based service programs by using Affiliated Computer Services (ACS) Omnicaid database to match dates of PCO services billed against dates of hospitalization. Automatically mail recoupment requests to provider agencies where there are overlapping service dates.

Require provider agencies to use standard forms for assessment, plans of care, etc. At a minimum, forms should include check off box identifying whether assessment is initial or re-assessment and where assessment was performed. All assessments and plans of care should require signature/title of person preparing them. Assessment could also indicate whether the recipient is capable of self-directing their care. Further consider having all assessments and plans of care prepared by persons external to the service provider.

Coordinate efforts with appropriate state agencies to improve state response time in performing criminal background checks.

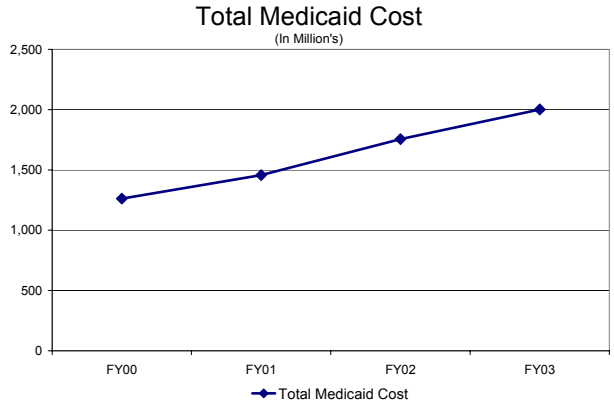
Department Response:

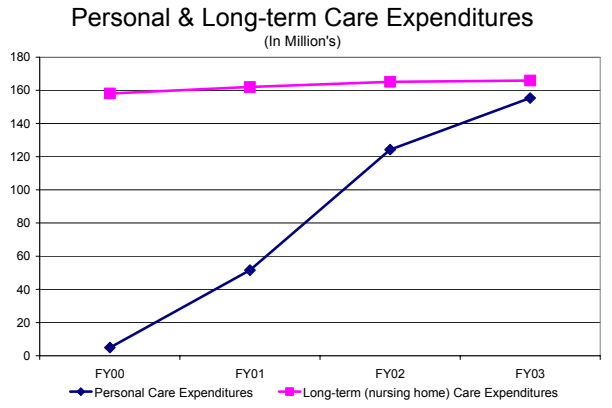
HSD/MAD accepts the recommendations submitted by the Legislative Finance Committee (LFC) and is moving towards implementing some of these recommendations. A major recommendation made by the LFC is to increase the monitoring of Personal Care Option (PCO) agencies by utilizing the Affiliated Computer Services (ACS) Omnicaid database. HSD/MAD has begun looking into ways to improve the monitoring of payments and control costs by using the current OmniCaid system. Other recommendations are in the process of implementation. Prior to this audit HSD/MAD began drafting standardized timesheets, a standardized assessment tool, and developing a process for a third party assessor to conduct all assessments for consumers in the PCO program. HSD/MAD will also seek legislative approval, this legislative session for an attendant registry. With regard to meeting with Department of Labor, Department of Health, and Department of Public Saftey to resolve labor issues and criminal background check turn around time, the division would like to focus more on the structure of the program and will consider this recommendation in future efforts to improve the PCO program.

REVIEW INFORMATION

BACKGROUND

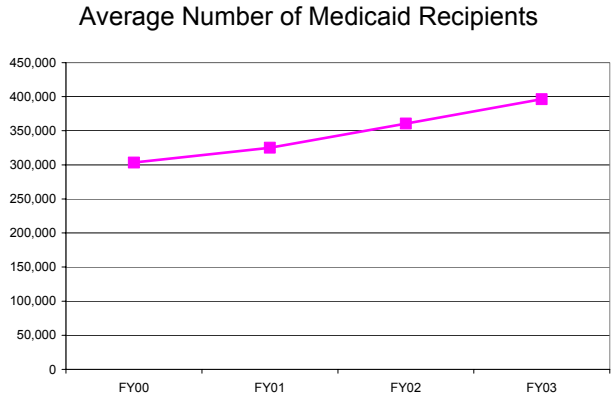
Medicaid is a jointly funded federal-state program that provides medical assistance to certain low-and moderate-income persons. The program began in 1965 with the enactment of Title XX of the Social Security Act. Medicaid is administered by the Human Services Department (HSD). Medicaid expenditures have grown from $1.26 billion in FY00 to $2.0 billion in FY03. Per data compiled by HSD (Exhibit A), there has only been a modest increase in long-term care (nursing home) costs from $158 million (FY00) to $166 million in FY03. However, personal care option (PCO) program expenditures have grown from $5 million (FY00) to $155 million (FY03) for the same period:

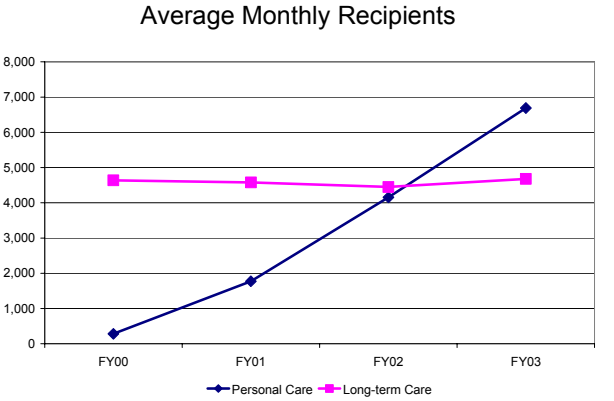




Source: Exhibit A

The number of Medicaid recipients has grown from 303,323 as of FY00 to 396,350 at the end of FY03. However, the number of long-term care (nursing home) residents has remained static at approximately 4,600 over the same period while the number of PCO recipients has grown from 280 in FY00 to 6,688 at the end of FY03:





Source: Exhibit A

In 1999, the New Mexico Legislature passed House Joint Memorial 18 which requires the Health Policy Commission (HPC) to develop a strategic plan for an integrated, publicly funded health-care financing and delivery system. In addition to requiring a managed care Medicaid delivery system, certain community based services are also included. The personal care option program is one of those programs serving 6,688 Medicaid recipients in FY03 at an average monthly cost of $1,935. As indicated in Exhibit A, average monthly nursing home cost was $2,955 in FY03.

Nationally, costs of home health services (including personal care programs) are steadily increasing. In Pennsylvania, Medicaid spending increased 20 percent from 1993 to 1997, however, the state's personal care program increased 164 percent with costs rising from $50 million (FY93) to $132 million (FY97). In just four years in New Mexico, PCO expenditures have grown from $5 million (FY00) to $155 million (FY03). A June 2003 report of the Personal Care Option Committee warns of 50 to 60 percent growth in the next ten years. PCO is a fee-for-service program. Although funded by Medicaid, PCO costs are not covered by managed care (Salud!).

Personal care option program services are available to Medicaid eligible individuals, 21 years of age or older who meet nursing facility level of care criteria. Qualifying persons must require assistance with two or more activities of daily living (ADL). Blue Cross Blue Shield (BCBS) determines qualification on behalf of HSD. Services such as assistance with dressing and bathing allow a person who would otherwise be institutionalized to live in his or her home in the community to achieve the highest possible level of independence and quality of life.

The program allows family members (other than a spouse and children under 18), as well as unrelated persons, to serve as personal care attendants. However, all attendants are required to be cardio-pulmonary resuscitation (CPR) certified, pass a criminal background check, and be certified as tuberculosis free.

AUTHORITY FOR REVIEW

The Legislative Finance Committee (LFC) has the statutory authority under section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies and institutions of New Mexico and all of its political subdivisions, the effects of laws on the proper functioning of these governmental units and the policies and costs of governmental units as related to the laws, and to make recommended changes to the Legislature. In the furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state law. Pursuant to a request from the Human Services Department (HSD) and the Legislative Finance Committee (LFC), an audit of issues relating to HSD's Medicaid funded personal care option (PCO) program was conducted by LFC performance auditors with assistance from HSD staff.

OBJECTIVE AND SCOPE

The audit period included the 18 months from July 1, 2001 through December 31, 2002. The audit was conducted to assess operation of the PCO program and identify improvements which could help contain and/or reduce costs. Specific tests were performed to determine that:

- Persons receiving services were Medicaid eligible and authorized to receive PCO services. Appropriate person(s) such as a licensed physician attested to the need for those services;

- PCO services have been provided in units of service authorized and paid for at the contracted rate for the service period;

- Provider used appropriate assessment tool(s) to determine whether PCO services were needed and to what extent;

- PCO services did not duplicate or overlap with hospitalizations, nursing home or other similar care; and

- Criminal background checks and training were conducted for all personal care attendants.

PROCEDURES

Audit procedures included:

- Review of program requirements;

- With the assistance of HSD staff selecting a major provider of PCO services for a comprehensive audit;

- Obtaining data from Affiliated Computer Services (ACS) database for PCO recipients. Selecting sample of claims in Santa Fe County for testing compliance with program requirements. Also, identify possible overlap of hospital and other claims for Santa Fe and Bernalillo counties for examination.

- Review of program audits of other states;

- Review of provider's contract;

- Review of PCO Committee report dated June 23, 2003;
- Examination of provider case files, payroll and billing records; and
- Examination of other relevant data.

The program was not evaluated for its benefits.

Exit Conference

The contents of this report were discussed with deputy secretary Tom Romero, Carolyn Ingram, Director and staff of the medical assistance division, and staff of the office of the inspector general on January 6, 2004.

Distribution of Report

This report is intended for the information of the Office of the Governor, Human Services Department, Department of Finance and Administration, Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Manu Patel
Deputy Director Performance Audit
Legislative Finance Committee

FINDINGS and RECOMMENDATIONS

FINDINGS

1. Overpayments of $30,242 to a provider were identified for periods when personal care option (PCO) program recipients were hospitalized. This was primarily due to erroneous reporting of services by personal care attendants (PCAs).

Using data obtained from HSD's Affiliated Computer Services (ACS) database, LFC auditors merged and sorted PCO claims by date with other Medicaid services such as hospitalizations, nursing home stays, hospice and similar full care services for Santa Fe and Bernalillo county clients of the provider agency.

One hundred twenty-one (121) hospitalizations overlapping with PCO claim periods for one provider in Santa Fe and Bernalillo counties were examined. Although no PCO payments were found for periods when a recipient was receiving nursing home and other long-term care**,** a significant problem exists with payment for services when PCO recipients are hospitalized.

Overpayments of $30,242 to one provider agency representing one tenth of one percent (.001) of PCO claims for Santa Fe and Bernalillo counties during the audit period (July 1, 2001 through December 31, 2002) were identified for days when PCO recipients were hospitalized. Most family member care attendants did not report hospitalizations as required by the provider's operating policies. Even though most recipients were required to sign timesheets, PCAs often requested payment for hours worked while the recipient was hospitalized as indicated in Table I:

Table 1-Overpayments to Provider During Periods of Hospitalizations

County	Number Hospitalizations Reviewed	Number Billed Services Questioned	Percentage Questioned	Estimated Amount Overpaid	Number of PCO Recipients
Bernalillo	103	56	53.4%	$24,823	87
Santa Fe	18	16	88.9%	$ 5,419	18

Note: PCAs sometimes billed in fractional hours different from fractional basis used by HSD's fiscal agent.
Source: Auditor's fieldwork

In several instances the provider agency did not bill the HSD when the provider was aware of the hospitalizations despite submission of incorrect timesheets by personal care attendants.

However, if the hospitalization was identified subsequent to paying the PCA, no correction was made to subsequent employee paychecks nor was reimbursement to HSD initiated. PCA coordinators indicated having verbally "counseled" care attendants in these instances. Family member care attendants have told PCA coordinators that they are providing many of the same services while their loved one is hospitalized as they provide in the recipient's home and therefore think that they should be paid. Indeed, auditors observed several PCA timesheets which reported the hospitalization but documented that services were nevertheless performed while the

recipient was hospitalized. HSD reports that four out of five attendants are family members which is consistent with our sample.

Some non-family care attendants also requested payment for services during periods of hospitalization. In some cases, the agency failed to notify non-family member care attendants and they reported to work at the recipient's home. In those cases, the agency had a practice of paying the attendant for one hour with the intention of not billing HSD. Nevertheless, HSD was occasionally billed for those single hours. Some non-family care attendants also failed to report a hospitalization and billed for services just as though the recipient were home.

As indicated in Tables II, III and IV slight differences were found between the Albuquerque (Bernalillo county) and Santa Fe offices. In Santa Fe, a higher percentage of family member PCAs are reporting hours worked during hospitalizations than are non-member PCAs. However, in Bernalillo county a higher percentage of non-family PCAs are also requesting payment during periods of hospitalizations.

Table II-Bernalillo County PCAs Not Adjusting Hours

PCA Type	Number hospitali-zations	Instances of PCAs not adjusting hours (Not reporting hospitalization)	Percentage not adjusting hours
Family Member	82	51 (49)	62%
Non-family	21	8 (7)	38%
Total	**103**	**59 (56)**	**57%**

Table III- Santa Fe County PCAs Not Adjusting Hours

PCA Type	Number hospitali-zations	Instances of PCAs not adjusting hours (Not reporting hospitalization)	Percentage not adjusting hours
Family member	15	11 (9)	73%
Non-family	3	1 (2)	33%
Total	**18**	**12 (11)**	**55%**

Table IV-Combined Data

PCA Type	Number hospitali-zations	Instances of PCAs not adjusting hours (Not reporting hospitalization)	Percentage not adjusting hours
Family member	97	62 (58)	64%
	24	9 (9)	37%
Total	**121**	**71 (67)**	**59%**

Sources: Omnicaid Information System

As indicated above, PCAs sometimes report the hospitalization, but do not reduce their hours accordingly.

LFC audit procedures compared all PCO claims by date with hospitalization claims for all personal care recipients statewide for the 18 month period ended December 31, 2002 which identified 4,972 hospitalizations of PCO recipients during the audit period. Further examination of 121 PCO claims of one provider for Santa Fe and Bernalillo counties indicated that 72 (59.5 percent) were overpaid an average of $420 ($30,242 divided by 72 instances) indicating that there is a significant payment problem when PCO recipients are hospitalized. There is a possibility that the department may be able to recoup up to $1.2 million (4,972 X 59.5 percent X $420) in PCO payments.

At an October 2002 training in Albuquerque, a state Department of Labor (DOL) representative directed provider's administrative staff to pay personal care attendants for all hours reported on timesheet unless the provider could prove that the attendant had not worked. If the provider was unaware of a hospitalization, the provider basically could not prove hours were not worked. The provider also indicates being instructed to pay all hours to PCAs as indicated on their timesheets even if those hours exceeded the monthly total authorized by Blue Cross Blue Shield (BCBS). DOL guidance may have contributed to the erroneous payments.

MAD Policy 99-17 for Personal Care Services (section 738.7) clearly states that:

- ✓ Personal care services are furnished in the consumer's place of residence and outside the home only when necessary and when not available through other existing benefits and programs, such as home health.

- ✓ Personal care services are services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, mental health facility, correctional facility, or other institutional settings.

These findings are consistent with audit reports of other states. In 2001 the New York Office of the Comptroller reported that "$1.6 million was paid for services that may not have been provided…or authorized" and recommended improvements in the procedures used to monitor Medicaid payments for New York's personal care services. Previously a 1998 audit reported that three percent of claims reviewed may have been overpaid.

A June 2003 Government Accounting Office report "Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened" concludes that the Centers for Medicare and Medicaid Services (CMS) have not developed detailed state guidance on appropriate quality assurance approaches as part of initial waiver approval and that CMS "does not adequately monitor state waivers".

Recommendations & Department Response:

- Improve procedures to monitor payments and control costs.
    - HSD/MAD will look into was to improve the monitoring of payments and control costs using the current OmniCaid system.

- Perform match of hospital and PCO claim data for all providers to identify additional recoupments. Merge database of 4,972 hospitalizations with PCO claims for the audit period. Visually review merged database to identify PCO billings which appear to overlap hospitalization periods. Send notification letters to providers requesting billing documentation for each day of the identified hospitalization. Calculate and request recoupment as appropriate.

  Continue to perform similar match of claims for all PCO providers subsequent to December 31, 2002 to identify other hospitalizations which appear to overlap PCO payments and initiate steps to recoup as appropriate.

    - HSD/MAD will review and verify data once the information has been forwarded from the LFC to MAD/QAB. Recoupment will be made for overpayment of Medicaid funds where appropriate.

- Give providers written guidance for independently initiating reimbursements and referrals to the office of inspector general or to the Attorney General's Medicaid fraud investigation division when erroneous PCA billings are discovered.
    - HSD/MAD will include language in the PCO regulations to include guidance on the appropriate way to refer Medicaid fraud and abuse.

- Provide a standardized form for agency care attendants to sign acknowledging that qualifying PCO services are home based and claiming hours worked when the recipient is hospitalized or receiving certain other residential type services constitutes Medicaid fraud which is a prosecutable offense.
    - HSD/MAD will create a standardized form for providers to have PCO attendants sign when they are employed by a PCO agency. The form will be mandated and verification will be conducted during audits.

- Require provider agencies to have timesheets which specifically require attendants to state positively or negatively whether the recipient was hospitalized during the service period and indicate admission/discharge dates and times if recipient was hospitalized.
    - HSD/MAD is currently developing a standardized timesheet that will be mandated under the PCO program. The timesheet will contain language holding the attendant and consumer liable for any false information put on the timesheet. The timesheet

will also include a statement indicating if the consumer was institutionalized in anyway during that particular pay period.

- Provider should require all care attendants, including family member attendants, to enter beginning and ending work hours on timesheet. Also require attendants to enter service units in increments no smaller than quarter hours, the same fractional units which HSD reimburses.
    - HSD/MAD will take quarter hour time recording into consideration during the development of the PCO standardized timesheet.

- Meet with DOL to resolve PCA pay issues. Enter into a memorandum of understanding, then jointly issue written guidance to provider agencies and their staff.
    - HSD/MAD appreciates this recommendation and will take it into consideration.

- Consider not allowing family members to serve as PCAs and/or require provider agencies to terminate PCAs upon discovery of fraudulent billing.
    - HSD/MAD appreciates the recommendation of considering not allowing family members to service as PCAs and will take into consideration. MAD is in the process of seeking legislature approval which will create a state registry of attendants who have been discharged after an incident of abuse, neglect, exploitation or fraud. The agencies will post the name of the employee on the registry making the individual not eligible for hire by another PCO agency.

2. Electronic monitoring of PCO payments is not adequate. HSD could electronically perform significant financial monitoring at minimal additional cost.

Because hospitals have 120 days to bill and do not bill as timely as PCO providers, it is unlikely that HSD will catch and deny provider agencies payments for duplicate services. Only one hospitalization out of 121 reviewed was detected by HSD prior to payment.

Modifications can be made to ACS so that probable overpayments could be electronically identified and recoupment requests automatically generated once hospitals submit their claims. In order to facilitate data matching, all providers will need to bill PCA services by daily hours rather than weekly hours. It would also be helpful if hospitals entered the time of admission and discharge into the ACS database when billing.

BCBS approves an individual care plan with daily working hours specified for personal care attendants for each PCO recipient. Attendants' daily working hours from those care plans also could be entered into the ACS and used for detailed electronic crosschecking of hospitalizations with PCO claims.

Recommendation and Department Response:

- Improve monitoring of PCO and other community based service programs through better utilization of ACS database. Program ACS to match hospitalizations with PCO claims and automatically mail recoupment requests to provider agencies when PCO payments overlap with hospitalizations.
    - HSD/MAD will work with ACS, Inc. to automatically generate a report that identifies clients with overlapping PCO payments during times of hospitalization. It is the division's expectation and hope that it will also be possible to automatically generate recoupment letters to the providers after overlapping billing has been confirmed.

3. Provider's clinical documentation is weak; however, HSD has not standardized requirements.

An examination of clinical documentation by HSD technical staff for 10 Santa Fe County clients indicates that the provider agency needs to improve case file documentation. The examination indicated that:

- provider's assessment form does not provide a place to identify the location (such as the recipient's home) of the assessment for any of the 10 PCO recipients;

- all 10 assessments lacked the signature and title of the preparer because the provider's form contained no space for the preparer's signature;

- assessment tool lacks a place for the recipient's signature;

- one assessment was not dated;

- the provider documented only initial assessments. Re-assessments, performed every one (higher need persons) or two years (lower need persons) thereafter, billed to and paid for by HSD, were not separately documented. Provider relied on the initial assessment document and used the care planning schedule submitted to BCBS for annual updates. The care planning schedule is being used inappropriately as an assessment tool when it is really a billing and PCA scheduling tool. However, it appeared that the plan of care was being followed for all 10 recipients;

- one personal services care plan did not correlate with the medical assessment. However, all 10 plans reflected the services to be provided and provided limited description of client needs. All ten plans were signed and appeared to reflect the appropriate level of care;

- documentation was inadequate to justify that the annual review was completed in two of ten case files. HSD pays $150 (plus gross receipts tax) for each annual review;

- the assessment tool was considered adequate to determine that assistance with two or more activities of daily living (ADL) was needed;

- changes were made to three of ten medical assessment MAD075 forms which the provider indicates the doctors made;

- care hours appeared excessive for one of the 10 PCO recipients. Case file documentation was insufficient to determine if this was the case for the other nine recipients;

- seven of 10 case files indicated that on-site visits to the recipients home were conducted by telephone, rather than performed on-site; and

- care agreements between the provider agency and the PCO recipient lacked a signature in one instance and selection of care type (delegated or self-directed) was missing in two (20%) instances. The provider was only offering delegated care during the audit period.

The PCO program provides services only in the personal residences of qualifying recipients. Therefore, ADL assessments and supervisory visits should also be performed in the recipient's home. However, HSD had not provided specific guidance to provider agencies specifying good practices.

Recommendations and Department Response:

- Require provider agencies to use standard forms for ADL assessments, plans of care, etc. At a minimum, forms should include check off box identifying whether assessment is initial or re-assessment and identifying where assessment was performed.
    - HSD/MAD has developed a standardized assessment tool that will be implemented before July 1, 2004. The PCO program already has standardized Personal Care Service Plan (PCSP), which are currently being revised and will soon have standardized timesheets.

- Require signature and title of persons preparing assessments and plans of care.
    - HSD/MAD has included a signature and title line in the standardized assessment tool. The PCSP will also contain a signature and title line.

- Require that assessments/re-assessments be performed on-site. Follow-up with providers to ensure compliance.
    - HSD/MAD already requires assessments/re-assessments be performed in the consumer's home. This will be verified during audits.

- Develop written guidelines for good practices. Good practice should include having all assessments and plans of care prepared by persons/agencies external to the service provider in order to standardize the assessment process.
    - HSD/MAD has begun working on an assessment process that will be conducted by a 3rd party assessor. The 3rd party assessor will be required to conduct assessments, assign personal care services based on need and referring consumers to other beneficial programs. The 3rd party assessor will also be required to conduct quality assurance audits to ensure consumers are receiving adequate services.

4. The provider agency generally complied with contractual requirements of the PCO program.

A sample of 18 of the provider's recipients in Santa Fe County was selected to test compliance with program requirements. The sample included all Santa Fe County recipients who had received services aggregating $50,000 or more during the audit period (July 1, 2001 and December 31, 2002) and the two smallest amounts of individual claims, as well as other randomly selected recipients. This sample covered 30% of all payments made to the provider for Santa Fe County PCO recipients during the audit period.

All payments for PCO services to those recipients were examined, including supporting documentation such as attendant timesheets and personnel files. Additionally clinical documentation determining eligibility for services was also examined.

Examination of documentation found:

- Overpayments of

    - $2,926 (166.4 hours) for three of 18 recipients because compensated service hours exceeded authorized amounts. The amount is considered immaterial to the total allowable payments. Other than this, PCO services have been provided in monthly units of authorized service.

    - Payments increased a net $263 due to rounding errors caused by an upgrade in the ACS database during the 18 month audit period. ACS programming has since been corrected.

    - Total net overpayment error was less than one percent of claims. Total claims of $724,668 were tested.

- Without exception,
    - all persons receiving services were Medicaid eligible and authorized to receive PCO services.
    - appropriate persons such as a licensed physician attested to the need for those services.
    - all PCO services were paid at the contracted rate for the service period.
    - all PCAs were paid $9.00 or more per hour for PCO services.
    - criminal background checks were performed for each PCA.
    - all PCAs were found to be certified in cardiopulmonary resuscitation.
    - all PCAs were found to have received other training from the provider agency.
    - all PCAs had passed tuberculosis screening and were offered hepatitis shots.
- No PCO recipients received overlapping or duplicative services under Children, Youth and Families Department (CYFD) attendant care programs.
- Although not a program requirement, the provider indicated making surprise visits and telephone calls to PCAs during their regularly scheduled working hours.

Recommendations and Department Response:

- Program ACS to limit monthly payments to the total hours authorized by BCBS.
    - HSD/MAD has issued revised billing instructions mandating weekly billing for PCO services. Utilization review edits have been put in the OmniCaid system to ensure over billing does not occur.
- Require all provider agencies to make surprise visits and telephone calls to ensure that PCAs are on duty during scheduled working hours.
    - HSD/MAD is currently re-writing the PCO regulations changing the requirement for supervised visits.

5. Criminal background checks need to be performed more timely.

The provider agency generally has fingerprints taken on the PCA's first work day which is usually an orientation session. Most attendants are found to have no disqualifying events such as physical assault or armed robbery.

However, it is taking too long for criminal background checks to be performed. During this time attendants work with PCO recipients. One instance was noted where a family selected PCA had a disqualifying factor and was appropriately terminated by the provider agency upon notification from the Department of Health. However, that individual had worked a month before notification which potentially subjected the PCO recipient to physical harm.

Data from the provider's personnel files for 42 personal care attendants were reviewed as to the dates fingerprints were taken and the date of the Department of Health reported findings of the criminal background check to the provider. Data was incomplete for three attendants. In 21 out of 39 (54%) requests, criminal checks took 61 days or longer to complete as indicated in Table V:

Table V-Days to Complete Criminal Background Checks

Number of days from date of hire to certification letter	Number of requests
Under 30	5
31 to 60	13
61 to 90	11
91 to 180	6
181-365	4
Over 365 days	0
Total	**39**

Note: Results of file review.

The state appears to be responsible for many of the delays beginning with the time that one of two state contracted vendors takes the employee's fingerprints. In nine of those instances, the provider also contributed to the delays.

Recommendations and Department Response:

- Meet with Department of Health, state contracted vendors, and other appropriate agencies such as the Department of Public Safety to identify ways to perform the criminal background check more timely.
    - HSD/MAD appreciates this recommendation and will take it into consideration.

- Do not allow care attendants to work until results of the criminal background check have been received.
    - HSD/MAD appreciates this recommendation and will take it into consideration.

6. None of the personal care attendants was found to be receiving PCO services as rumors had alleged.

Forty-two persons were identified as being Santa Fe County personal care attendants for 18 PCO recipients in the sample selected. Their social security numbers were obtained from the agency's personnel files and provided to HSD to identify whether they themselves were PCO/Medicaid recipients. None of the PCAs was a PCO recipient as rumors had alleged.

However, eleven PCAs were receiving Medicaid funded services which may have fueled the rumors. One elderly man caring for his mother was Medicaid eligible because he was fully disabled under Social Security. [Social Security provisions allow some work even when disabled and relies upon an individual's doctor(s) to determine whether an individual is capable of performing certain job duties.] Another PCA also qualified for full Medicaid services. Three others qualified for Medicaid under Temporary Assistance to Needy Families (TANF), one of whom is TANF transitional. Six other PCAs, children of PCO recipients, were identified as qualifying for family planning services (5) or pregnancy benefits (1). Eight other PCAs had previously been Medicaid eligible.

Sufficient data was not available to determine whether any of the attendants are inappropriately employed in their positions.

Recommendations and Department Response:

- Establish an on-going process to obtain social security numbers and names for PCAs of all agencies. Continue to perform similar search and investigation to ensure that Medicaid and TANF eligibility do not preclude individuals from being personal care attendants.
    - HSD/MAD will meet with ISD Director Katie Falls to discuss a process to share PCA information and Medicaid and TANF recipients.

7. In general, LFC auditors support the recommendations of the Personal Care Option Committee dated June 23, 2003. However, we are hesitant to support a one-time payment to encourage recipients to select the self-directed model of care.

A copy of findings and recommendations of the Personal Care Option Committee dated June 23, 2003 is presented as Exhibit B. LFC auditors support the following recommendations of that committee:

- Establish an assessment process separate from provider agencies. Conduct independent assessment and utilization review. Standardize assessment tool.
- Revise medical assessment form to capture more functional information relating to medical condition(s) of PCO recipient.
- Provide additional staff to HSD to effectively manage and monitor the PCO program.

- Establish credentialing standards for providers.
- Standardize PCA time sheets.
- Conduct on-going quality of care audits.
- Create a state registry of attendants.
- Reduce incentives to advertise for PCO clients.
- Require HSD approval of provider agency advertisements.

However, LFC auditors are concerned about the recommendation to offer a one-time $500 payment to encourage PCO recipients to move to the self-directed model of care. Interviews of PCO recipients (Exhibit C) suggest that many PCO recipients would be unable to direct their own care due to poor health and/or dementia. As indicated in finding number one, 80 percent of PCAs are family members who would then be directing themselves.

As indicated in Exhibit C, five of 16 (31 percent) reported being alone at night and relying upon the provider's emergency assistance phone number. Some PCO recipients appeared to be extremely debilitated.

Recommendations and Department Response:

- Exercise caution in offering payments to encourage PCO recipients to move to the self-directed model of care. Use independent assessment/assessors to identify those who are suited to self-directed care.
    - HSD/MAD has elected not to accept this recommendation by the PCO committee.

- Also, use assessment to determine if the personal care option program provides the appropriate level of care and medically necessary services given the condition of the recipient.
    - HSD/MAD appreciates this recommendation and will take it into consideration.

EXHIBITS

Human Services Department
Comparison Personal Care Option Program to Long-Term Care
Fiscal Years 2000 through 2003

Fiscal year ended		FY03	FY02	FY01	FY00
Monthly Average Number PCO Recipients*		6,688	4,153	1,773	280
Monthly Average Number Long-term Care Recipients		4,678	4,449	4,577	4,636
Personal Care Expenditures* for 12 months ended June 30	$	155,331,662	124,239,123	51,603,042	4,950,224
Average monthly cost per PCO recipient	$	1,935	2,493	2,425	2,210
Long-term (nursing home) Care Expenditures** for 12 months Ended June 30	$	165,887,936 ***	165,127,264	161,994,073	158,049,748
Average monthly cost per nursing home recipient	$	2,955 ***	3,093	2,949	2,841
Total Medicaid Cost	$	2,001,600,000	1,755,578,000	1,456,394,607	1,262,292,352
Total Average Monthly Cost Per Medicaid Recipient		421	406	373	347
Average Number of Medicaid Recipients for Fiscal Year		396,350	360,592	325,169	303,323

Data Source: Human Services Department

* PCO program figures for recipients and expenditures are for ongoing personal care services only. These amounts exclude ancillary program services such as assessments, criminal background checks, consumer-directed attendant training, consumer-directed administrative fees, etc. Also excludes non-PCO Medicaid benefits (primary and acute care, pharmacy, etc.) rendered while the participant was in PCO.

** Nursing Facility expenditures reported here are for institutional care. Excludes non-NF Medicaid benefits, rendered while the participant was under the NF program care, if services were claimed and paid separately from the NF institutional care claims.

*** FY2003 NF expenditures and members per month figures were derived from HMGR543 report, payments through October 2003, for category of service codes 33 and 35.

New Mexico

Personal Care Option Program

Review and Recommendations
June 23, 2003

To:

Pamela Hyde, Secretary
Human Services Department

Carolyn Ingram, Director
Medical Assistance Division

Submitted By:

Personal Care Option Committee
Patty Jennings, Chair

Executive Summary

Continue with the Current Eligibility Criteria

Recommendation: The committee recommends that no changes be made in eligibility, although eligibility criteria should be more clearly defined. No one currently on the PCO Program should be removed; however, some people's hours of care may change as a result of other recommended regulation changes.

Clarify the Criteria for Eligibility for a Nursing Facility or PCO

Recommendation: Immediately define and/or clarify who is eligible by revising and standardizing the language in every record including assessments, regulations, rules, publications, utilization review criteria, and the like. Those conducting assessments must understand what the actual criteria are in order to reduce confusion and frustration, as well as prevent false advertising.

Future Goal: Change Nursing "Facility" Label to Nursing "Services"

Recommendation: During this administration, rename the "Nursing Facility" level of care in New Mexico to reflect a more appropriate standard. The requirements to qualify can remain the same, but the name is demeaning and insinuates helplessness. If "Facility" was changed to "Services", it would not imply that an individual is qualifying to be cared for in a facility, but that he/she is qualifying for a higher more appropriate level of care.

Future Goal: Waive Income Level on a Case-by-Case Basis

Recommendation: Determine how many people in the PCO Program are on WDI. In addition, determine how many people are in nursing homes that are just above the PCO income guidelines. **If feasible**, implement regulations that allow an income "waiver" for persons **already on the PCO Program** to "buy-in" to the program should they become ineligible due to a change in their income. Or, if feasible, create a transitional option for the person to move seamlessly into either the D & E or DD Waiver Programs. Either option would prevent nursing home placement.

If feasible, allow an income "waiver" for persons **already placed in nursing homes** who wish to re-enter the community. Allow the income level of persons to be adjusted or spent down for medical or living costs associated with their disability so they may qualify

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for the PCO Program if the D & E or DD Waiver Programs won't or can't meet their needs.

Establish an Independent Assessment Process

Recommendation: Establish regional independent assessment teams, removing the responsibility of conducting assessments from providers, by using the money (almost $1M) paid to providers for assessments. Utilize the Request for Proposals (RFP) process to select contractors to serve as assessment teams, or bring the assessment function "in-house" utilizing qualified state employees. The assessment team members would be responsible for determining eligibility, calculating unmet needs, identify natural and other community supports, determining the number of hours to be provided, and helping the consumer choose whether he/she will enter a Consumer Delegated or Consumer Directed model. Consumers will then have results from an objective evaluation from the team that will allow them to go to the provider of their choice, statewide. This will stop the practice of consumers going from one agency to another, being assessed each time at an additional cost to the state.

Combine Assessment, Quality Assurance and UR Functions

Recommendation: Independent assessment teams will conduct quality assurance and utilization review functions provided there is no financial conflict. An RN is on the team to approve each of the care plans. An independent assessment and quality assurance team located regionally could respond immediately to a request for assistance. This team could conduct program audits of sample consumers from every agency and seek input on quality from other representatives close to consumers. The process should not take longer than it does presently under the current system.

Standardize Assessment Tools

Recommendation: Provide criteria to standardize the assessments so that all persons are being evaluated using the same objective measures.

Certify Assessors

Recommendation: Standardize and provide requisite training for all assessors to include a normative test to determine each assessor's competency in the role as a member of the program and how to properly conduct a comprehensive assessment. Certifications should be issued upon satisfactory completion of the test.

Revise Medical Assessment Form

Recommendation: Revise the Medical Assessment Form to capture more functional information and how it relates to medical conditions of the individual being reviewed.

Assessment Team Trains and Assists in Selection of Model Design

Recommendation: The assessment team shall be responsible for informing the consumer, perhaps through a video developed by one of the model programs in New Mexico, of the differences between the two models. The consumers will exercise their rights and make non-biased decisions as to which model would suit them. The consumer shall be given a list of all providers in the area to select from. Once the assessment team, along with the individual makes a choice, the consumer will not be able to change to another model without going back to the team to present why the chosen model is not working to meet their needs.

Train Providers on Available Consumer Directed Model Services

Recommendation: Require that all providers receive training so that they fully understand the Consumer Directed model. New Mexico has providers that are nationally recognized experts and they should be sharing their experiences with other providers so that more consumers can benefit from this model.

Hire Five to Six Additional Staff for the PCO Program

Recommendation: Immediately hire at least five or six staff to assist in overseeing the PCO Program. Otherwise, quality, program changes, training and credentialing providers, oversight, regulation changes and anything other than crisis intervention will not be possible.

Credential and Certify Providers

Recommendation: Develop credentialing standards that all providers must adhere to in order to become certified and remain or become providers. The state should develop the application, review and credentialing process for all current and future providers to be effective date: July 1, 2004.

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Assign a Resource Coordinator to Each Region

Recommendation: Work with CILs, the State Agency on Aging, senior centers and any other local resources to identify who can serve as local resource coordinators in each region. The assessment team should identify appropriate local resources during the assessment and include this information on the recommendation for services to be given to providers upon initialization of PCO services. There could be more than one resource coordinator in each region. For example, a senior center may be coordinator for an elderly person, while an ILC may serve as one for an individual with a disability.

Examine the Need to Require All Providers to Offer Both Models

Recommendation: Assess the need and practicality of requiring all PCO Program providers to offer both the Consumer Delegated and Consumer Directed models to.

Standardize Time Sheets and other Accountability Documents

Recommendation: Standardize and provide forms that may be audited making them simple, clear and concise.

Conduct On-Going Quality of Care Audits

Recommendation: The PCO unit does not have the resources or manpower to go into the field and audit a provider or attendant when necessary. Use at least one of the staff regionally to review quality of care. This staff could also review all incident reports from agencies to determine if any providers need assistance in preventing incidents, or sanctioning agencies if the quality of care is not adequate. A provider should also be sanctioned for any insufficiencies in quality of care. Once certified, DHI could assist regional staff in these types of audits.

Assign an Authorized Representative for Some Consumers

Recommendation: Develop a system to authorize representatives to oversee quality of care. Colorado has a system in place that could be used as a model in New Mexico.

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Maximize Funding and Services from Centers for Independent Living by Moving Them to the Human Services Department

Recommendation: Propose or support legislation that will move the funding for CILs from the Department of Education, Division of Vocational Rehabilitation to the Human Services Department. This would generate at least a 50 – 50 federal match.

Seek More GAP Funding

Recommendation: Request that GCCH seeks legislation and support their attempts in the legislature. This would allow more people to remain in the community without being placed in nursing facilities waiting for modifications to occur.

Seek Legislation to Create a State Registry of Attendants

Recommendation: Seek legislation that creates a state registry of attendants who have failed to provide proper care where agencies can post employees who have been discharged after incidents of abuse, neglect or exploitation. This is not allowable without legislative authority, but it has been repeatedly brought up as an issue that needs to be addressed.

Reduce Incentives to Advertise for New Clients

Recommendation: By having intake conducted by an independent assessment team who will assess consumers, recommend program placement (Consumer Directed or Delegated) and allocate hours, the provider can't guarantee that its advertising will pay off since it will be competing against all others providing the service.

Approve All Advertising and Publicity Campaigns

Recommendation: Create guidelines for providers who wish to advertise or do community outreach. Require that all ads be approved in writing by the state to avoid any misleading ads as found on the next page.

Reimburse at a Limited Capitated Hourly Rate

Recommendation: Reimburse providers at a limited capitated hourly rate. The state would pay an hourly rate up to 100 or 120 hours. Thereafter, the state would pay an $11.00 hourly rate to cover the cost of the caregiver. This cap would not reduce the

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hours of service an individual could receive. It would limit the hourly reimbursement to a defined number of hours and allow unlimited hourly reimbursements to match the number of hours of care.

Conduct a Cost Study to Consider Reduced Hourly Reimbursement for the Delegated Model

Recommendation: A formal cost study should be conducted to determine what the actual costs are. Reduce the reimbursement for the Consumer Delegated model to $15.00 per hour. Estimated cost cut to provider: 6%. Estimated savings to program: $8.M. Estimated cost savings to state: $2.M.

Provide Assistance in Transferring into Consumer Directed

Recommendation: Offer a one time fee of $500.00 to the provider for each consumer they transition from the Consumer Delegated model to the Consumer Directed model. Whether the move is motivated by the provider, consumer or by the assessment team recommendation, it is understood that there is a cost in doing so. This fee will be recovered within months from the savings generated by providing the less expensive Consumer Directed model.

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Introduction

In response to rapidly escalating costs in the Medicaid Personal Care Option Program, herein referred to as the PCO Program, the Human Services Department (HSD) assembled a team of consumers, providers and advocates to examine every aspect of the program and: 1) form a variety of options and solutions to reduce costs; and, 2) recommend changes to the current regulations under the PCO Program. The purpose of this document is to report the findings of the Personal Care Option committee to the Administration of the PCO Program

The PCO program was implemented on September 1, 1999. The goal of the PCO program is to improve the quality of life for the elderly and individuals with a qualifying disability and prevent them from having to enter a nursing facility. The PCO Program allows consumers to achieve their highest level of independence possible. As of December 2002, 6,614 consumers were accessing services through the PCO Program.

The PCO Program is a critical piece of the service delivery system in New Mexico. The program saves the state hundreds of millions of dollars by providing in-home assistance to those who meet the level-of-care criteria for nursing facilities. New Mexico is seen nationally as a leader in serving the elderly and people with disabilities in the PCO Program, and was the first state to demonstrate that the Consumer Directed model would work.

The original cost projection for the PCO Program was $10M by the year 2004. However, the program is expected to reach $150M this year. For this reason, the former administration proposed regulations changes that instituted a cap on the number of hours each consumer could receive. This made it impossible for some people to remain independent, and the current administration did not adopt the proposed regulation. Instead, the administration is exploring other options for controlling growth and costs.

The PCO committee was selected because of their expertise and area of knowledge. The following people participated on the committee:

Crystal Mata, PCO Program Manager
Sandra Cole, RN, Quality Assurance Bureau
Patty Jennings, Chair

Mike Allen, Advocate	Byron Bartley, Provider
Sherry Watson, Provider	Peter Cubra, Advocate, Attorney
Carla Fernandez, Provider	Joie Glenn, Provider Rep.
Jim Jackson, Advocate	Susan Lewis, Consumer, Provider
Jim Parker, Consumer	Lynne Anker-Unnever, SAoA

The committee did a comprehensive analysis of current practices. They conducted an investigation into regional and national best practices and did a continual review of the work product in order to establish the contents of this document. There were over 100 public comments either by phone, email or mail. Consumers who listed phone numbers were contacted with follow up questions or reassurance that the administration did not intend to discontinue the PCO Program.

The committee members consider the PCO Program an absolutely necessity in cost effectively and appropriately assisting New Mexicans who are elderly or have qualifying disabilities. While the committee is proposing the following recommendations with the intentions of curbing costs and controlling growth, it should be noted that the program is clearly expected to continue to grow until there is a stabilization or reduction in the number of people who are elderly or have a disability. That is not anticipated to occur anytime during this administration. In fact, the number of people who will need the PCO Program or who will otherwise qualify for a nursing facility will steadily increase in the coming years. Assuming we have already met the needs of all existing qualified individuals, there would still be an anticipated 50 – 60% growth over the next 10 years.

Justifying the PCO Program expenditures will only be possible if the state can document savings. It is critical for the long term survival of the program that the state develops and

implements a method of calculating savings. This must be verifiable. Audits should indicate how much money would be spent serving the PCO participants if it did not exist. This might be accomplished by indicating on the assessment forms what services the individual consumers would enter should the PCO Program no longer be available.

The blue headings in this document indicate the recommendations the committee feels would benefit the state. They can be implemented individually or simultaneously. The red headings indicate actions that are recommended in the near future. They might have a long term effect on the program, or assist other complimentary programs such as the GAP program or CIL funding. These other programs greatly assist in the implementation of the PCO Program.

The final piece to this document is a consumer comment section. It was made public that the chair would accept and acknowledge public comments in this report. There was substantial discussion between the chair and the public via telephone, email and mail. This section allows their voices to be heard and even though the committee considered each of their recommendations, they did not receive enough support from the committee as a whole to be registered as a recommendation.

Considerations for Future Review

This document is not all inclusive of the committee recommendations and concerns. There were a number of issues the committee wishes to see the administration address in the near future. Most pertain to quality, but some deal with the cost of the PCO Program.

The true expenditures and reduction in expenditures for the PCO Program should be more clearly illustrated in order to define its significance. The PCO Program has reduced waiting lists and nursing home admissions. A financial accounting for this program should take into account the savings from the reduced usage of higher cost services. The alternative placement to the PCO Program might be noted on the assessment form and tracked by HSD.

The current administration should undertake a formal study of the validity of PCO rates over the long term, examining at the same time the rates of other programs such as the D & E and DD Waiver Programs. There must be an accurate identification and projection of how demographic indicators will impact this program in the next 10 years. This information could be presented to the Legislature so they could prepare for expected growth rates each year.

The current administration might look further into establishing a flexible formula for using hours that could perhaps be measured annually, not monthly. The approach could be similar to "cash and counseling." Additionally, the PCO Program could be better promoted to persons who are seeking a nursing home placement.

Quality issues were not specifically addressed in this report unless they directly resulted in cost savings. However, the committee wanted to see the administration improve the availability of substitute decision makers for participants who are incapacitated. All consumers should be offered an opportunity to enact a durable power of attorney.

Assessments should thoroughly evaluate each consumer's capacity to give and withhold informed consent regarding at least:

1. medical;
2. financial decisions; and
3. establish informal decision-making supports ("friend-advocate" or legal representative.

Another important aspect in a quality system is a flexible service design that has an established mechanism for changing assessments and care plans when a consumer's needs change during the year.

It is also a recommendation of the committee that the name of the Consumer Delegated model be changed to the Consumer Assisted model. This title might help remind people that this program, including both the Consumer Directed and Consumer Delegated models, is considered to be a self determination model. The consumer is being assisted to some degree in either model. Some need more assistance with managing their attendants and care plans than others, but each consumer has a say in his/her services. It is also clear that the Consumer Directed model is successfully serving some of the same populations as the Consumer Delegated model and that many more people could receive their care in the Consumer Directed model.

Eligibility

CURRENT SITUATION: The PCO Program is available to residents of New Mexico who are:

- 21 years of age or older,
- On full Medicaid coverage generally through Supplemental Security Income (SSI) (except for waiver or nursing facility categories), and
- Meet the level-of-care criteria required for nursing facilities.

The goal of the PCO Program is to improve the quality of life for people with disabilities and the elderly, and **prevent** them from having to enter a nursing facility.

The PCO Program provides a range of services to consumers who are unable to perform some or all activities of daily living or instrumental activities of daily living because of functional limitations.

PRINCIPLE: The state should provide services for qualified individuals with functional limitations in order to promote independence and prevent placement in a nursing facility.

Issues and Recommendations

Continue with the Current Eligibility Criteria

Recommendation: The committee recommends that no changes be made in eligibility, although eligibility criteria should be more clearly defined. No one currently on the PCO Program should be removed; however, some people's hours of care may change as a result of other recommended regulation changes.

Clarify the Criteria for Eligibility for a Nursing Facility or PCO

Issue: The criterion which determines eligibility for nursing facilities, and therefore, the PCO Program is unclear. Providers are advertising the program as being available to

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those who require assistance with more than one activity of daily living such as dressing, bathing, or meal preparation. The eligibility criterion for a nursing facility is actually much more stringent than that. Lawyers have called arguing that their clients meet the level of care for PCO, but the state utilization review contractor determines that they do not meet the level of care for a nursing facility.

Recommendation: Immediately define and/or clarify who is eligible by revising and standardizing the language in every record including assessments, regulations, rules, publications, utilization review criteria, and the like. Those conducting assessments must understand what the actual criteria are in order to reduce confusion and frustration, as well as prevent false advertising.

Future Goal: Change Nursing "Facility" Label to Nursing "Services"

Issue: Requiring people to qualify for "nursing facility" level of care for this and other programs is inconsistent with today's society. The movement toward self determination, consumer driven services and community care should make it impossible to "qualify" for a "nursing facility" unless that is a person's residential preference. The fact that the state places people, particularly young people, in facilities simply because we have no better way of accommodating their disability is archaic. Many people who are in the PCO Program, would never consider going to a nursing facility, and would only be forced to accept such a placement because there is absolutely nothing appropriate in the community where they reside.

Recommendation: During this administration, rename the "Nursing Facility" level of care in New Mexico to reflect a more appropriate standard. The requirements to qualify can remain the same, but the name is demeaning and insinuates helplessness. If "Facility" was changed to "Services", it would not imply that an individual is qualifying to be cared for in a facility, but that he/she is qualifying for a higher more appropriate level of care.

Future Goal: Waive Income Level on a Case-by-Case Basis

Issue: The qualifying income level for the PCO Program is lower than the Medicaid income level for eligibility into a nursing home. A person qualifying for the PCO Program under the Working Disabled Individual (WDI) category might choose to retire or quit working due to their disability. This would cause them to lose WDI and go onto SSDI benefits which might place them at an income level too high for the PCO Program. Not allowing this person to remain on the PCO Program would result in a more costly, restrictive and undesirable placement in a nursing home.

Recommendation: Determine how many people in the PCO Program are on WDI. In addition, determine how many people are in nursing homes that are just above the PCO

income guidelines. **If feasible**, implement regulations that allow an income "waiver" for persons **already on the PCO Program** to "buy-in" to the program should they become ineligible due to a change in their income. Or, if feasible, create a transitional option for the person to move seamlessly into either the D & E or DD Waiver Programs. Either option would prevent nursing home placement.

If feasible, allow an income "waiver" for persons **already placed in nursing homes** who wish to re-enter the community. Allow the income level of persons to be adjusted or spent down for medical or living costs associated with their disability so they may qualify for the PCO Program if the D & E or DD Waiver Programs won't or can't meet their needs.

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Assessments

CURRENT SITUATION: The assessment process is the most critical component for controlling consistency, cost, fraud and abuse in the PCO Program. Currently, the providers conduct the assessments which determine eligibility, program model placement, either Consumer Directed or Consumer Delegated, and hours of care to be provided for consumers. A few provider agencies are also reported to be determining the level of care.

There is limited consistency among assessments since each provider is responsible for developing and utilizing their own assessment tool. These metrics are not reviewed or approved at the state level. While the utilization review contractor approves hours, it has limited and sometimes unclear criteria to evaluate eligibility, and only the information made available by the provider agencies upon which to base their decisions. Providers are often uncertain as to why and how the utilization review contractor makes its determinations. While some agencies have fewer rejections, others have many. This maybe partly due to the inexperience of some provider agencies its assessors, or to the unclear criteria provided to the utilization review contractor.

While New Mexico is noted for having some state-of-the-art services, particularly in the Consumer Directed model, there are major reasons why the program is growing other than need. While need is the primary reason for growth in the program, the committee agrees that there are structural flaws in the design of the PCO Program that are resulting in the overuse of the most expensive Consumer Delegated model, misuse and abuse. The following are considered to be the primary reasons for the abuse in the way assessments are managed:

- Providers conduct assessments,
- Assessors are not trained,
- There is no standardized assessment tool,
- Providers assist consumer in determining program model,
- Providers recommend hours, and
- Providers receive $5.00 an hour for every hour in the Consumer Delegated model.

For these reasons 97% of consumers are enrolled in the more expensive Consumer Delegated model. Almost 80% of the caretakers under both models are family members.

Another flaw is that the assessments often do not account for natural supports. For example, the state is reimbursing for house keeping when there is a spouse in the home who could be providing the housekeeping. The state should not pay to replace services already being provided unless the service will no longer be provided in the near future. This is overuse or misuse of the program. The PCO Program costs could additionally be reduced if consumers choose to access senior center services for delivered lunches.

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Instead, attendants are preparing and serving meals. This is common practice according to senior centers even though they have discussed this with providers.

The assessment and assessment process is a key to controlling costs and limiting growth that may lead to misuse of funds. New Mexico must remove the financial incentive for providers to maximize hours in the Consumer Delegated model.

PRINCIPLES

No assessor (individual, company or organization) shall experience financial gain or bear a financial interest based upon the number of hours of service determined to be needed according to the assessment process.

No assessor (individual, company or organization) shall experience financial gain or bear a financial interest based upon the level of care determination according to the medical assessment form.

Issues and Recommendations

Establish an Independent Assessment Process

Issue: The PCO Program has a built-in financial incentive toward the Consumer Delegated model. It is financially advantageous for providers to supply as many hours of care as possible to each consumer and justify them to the utilization review contractor through the assessment process. This does not imply that this is common practice with every provider in the state; however, a cost efficient model would reduce or eliminate this abuse.

Recommendation: Establish regional independent assessment teams, removing the responsibility of conducting assessments from providers, by using the money (almost $1M) paid to providers for assessments. Utilize the Request for Proposals (RFP) process to select contractors to serve as assessment teams, or bring the assessment function "in-house" utilizing qualified state employees. The assessment team members would be responsible for determining eligibility, calculating unmet needs, identify natural and other community supports, determining the number of hours to be provided, and helping the consumer choose whether he/she will enter a Consumer Delegated or Consumer Directed model. Consumers will then have results from an objective evaluation from the team that will allow them to go to the provider of their choice, statewide. This will stop the

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practice of consumers going from one agency to another, being assessed each time at an additional cost to the state.

The assessment teams would include a Registered Nurse (RN) who would oversee the process along with others with expertise on available local services. Each member of the team would be assigned appropriate tasks to conduct the assessments. Staff from local Senior Centers could assist in each case by identifying natural or other outside supports for elderly consumers. Centers for independent living (CIL) staff could conduct interviews with consumers who are not elderly, but have a qualified disability. Their involvement in the assessment process allows New Mexico to be recognized nationally in the area of providing an excellent Consumer Directed model. The provider agencies might make home visits, perhaps with an ombudsman who could deliver information and answer questions regarding a consumer's rights and responsibilities. The team could be modeled after the Preschool and Infant Evaluation (PIE) project in New Mexico, which was nationally recognized by the former Surgeon General C. Everett Koop, MD, as being a model assessment and evaluation process for the country.

Consumers would not be required to be seen by each individual team member. Rather each team member could offer their expertise to the assessment of applying consumers. Senior centers may potentially alleviate the need for PCO services altogether since they offer a number of hours of day time activities, lunch and transportation. They also deliver lunches to those who are home bound.

Each community has a variety of resources, and by utilizing all the resources in the assessment process and care model, people will receive a broader array of services. An independent assessment team will do a better job of determining unmet needs and how to best meet these needs implementing all available resources.

While this model will take some time to design and implement, it is seen as the most positive change to this program.

Combine Assessment, Quality Assurance and UR Functions

Issue: The assessment, quality assurance and utilization review functions are each performed separately and without coordination. The current utilization review contractor and the assessors have different criteria which make it difficult for providers to understand why some care plans are approved and some are not. Because each function is performed separately, the process is fragmented, consistency is lacking and quality is difficult to assess.

Recommendation: Independent assessment teams will conduct quality assurance and utilization review functions provided there is no financial conflict. An RN is on the team to approve each of the care plans. An independent assessment and quality assurance team located regionally could respond immediately to a request for assistance. This team could conduct program audits of sample consumers from every agency and seek input on

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quality from other representatives close to consumers. The process should not take longer than it does presently under the current system.

The RN could use the criteria now being used by the utilization contractor to determine eligibility and approve hours. The RN could sign off on every care plan in his/her region that meets the specific criteria. If there is a question or a challenge, a second level of review could occur by a person at a centralized state level.

Standardize Assessment Tools

Issue: Each provider is currently responsible for developing an assessment tool to use in their program. There are no qualifications for those developing these tools, which results in inconsistent assessments.

Recommendation: Provide criteria to standardize the assessments so that all persons are being evaluated using the same objective measures.

Certify Assessors

Issue: There is no requirement that assessors be qualified through either experience or training. While some assessors are well trained or have significant knowledge due to personal experience, others have little or no qualifications, training or experience. In addition, assessors have varying perceptions as to the purpose and mission of the program.

Recommendation: Standardize and provide requisite training for all assessors to include a normative test to determine each assessor's competency in the role as a member of the program and how to properly conduct a comprehensive assessment. Certifications should be issued upon satisfactory completion of the test.

Revise Medical Assessment Form

Issue: The current medical assessment form does not capture functional abilities and/or needs. When an assessor interviews a consumer, he/she is often unclear as to what is affecting the individual's ability to perform Activities of Daily Living or Instrumental Activities of Daily Living. The form must capture enough information to inform the assessor.

Recommendation: Revise the Medical Assessment Form to capture more functional information and how it relates to medical conditions of the individual being reviewed.

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Program Design

CURRENT SITUATION: The PCO Program is vital in serving eligible citizens of the state who are elderly and/or people with disabilities who meet the level of care required to enter a nursing facility. The PCO Program offers consumers choice, dignity, flexibility, control, support, empowerment, personal responsibility and personal freedom. It offers the state of New Mexico tremendous cost savings since other programs that serve these consumers cost as much as three times more than the PCO Program. The PCO Program also provides nearly $10M in gross receipts and tax revenues for the state.

Additionally, the PCO Program has provided thousands of new jobs statewide, lowering unemployment and transitioning people from welfare to work by offering a livable wage. The PCO Program has prevented institutionalization and fostered community re-integration. The program has enabled many young vital people with a great deal to offer society and remain in their communities. New Mexico must continue this program in order to prevent people with spinal cord injuries, chronically ill elders and others from being placed in nursing homes because they have no other options to make it in the community. It allows adults to live as adults, providing the assistance they need to remain in their own homes. It also provides relief to families trying to care for their loved ones who are elderly or who have disabilities.

The philosophy of the PCO Program has clearly been to prevent people from entering nursing facilities. However, some providers and consumers may be using the program in a different manner. Some advertising insinuates that this program is designed to be a financial aid program to pay $9.00 per hour to a friend or family member who is already helping their relative with their needs. Therefore, the focus of this type of advertising is on paying people who already provide care for free, rather than preventing those who are at risk of losing their independence from having to enter a nursing facility. We must clarify that this is not a "welfare" program, but a program to prevent nursing facility placement.

There are two models of service offered under the PCO Program: Consumer Directed and Consumer Delegated.

The Consumer Directed model puts the consumer in charge of supervising the delivery of services. The consumer advertises if necessary, interviews and selects his/her attendants, supervises the attendant in providing services, and fires the attendant if necessary. The consumer provides or arranges for the attendant's training, and should review and approve the attendant's time sheet and submission for payment. Consumers are largely responsible for quality assurance in the model. PCO provider agencies may provide training or support and assistance to consumers in carrying out the consumer's duties in the model, but this is not required. The Consumer Directed model is very successful in the areas where the PCO providers are committed to providing opportunities consistent with their service philosophy.

In the Consumer Delegated model, the consumer "delegates" supervisory responsibility to the PCO provider agency. The provider is responsible for advertising and recruiting prospective attendants, interview and hiring practices, assigning them to consumers, training and supervision, and disciplining them as needed. This model is responsible for providing 24 hour emergency telephone access. Attendants under the Consumer Delegated model must have TB testing and hepatitis B immunizations (this is optional under the Consumer Directed model). The provider is responsible for quality assurance, which it is expected to achieve through close oversight and unannounced monthly visits.

In both models, the PCO agency provides fiscal services, such as computing withholding taxes and processing salary checks to attendants based on approved time sheets. The PCO providers are required to pay attendants $9.00 per hour in both models, and provide liability and workers compensation insurance, attendant training and annual assessments. The training under the Consumer Delegated model is more extensive and explicit as required in standards for the Consumer Delegated model.

At this time only about 3% of the PCO consumers are enrolled in the Consumer Directed model. There are four providers in the state that offer **only** the Consumer Directed model. An estimated 40-50 providers offer both models, although some have no one enrolled in the Consumer Directed model, and 70 – 80 offer the Consumer Delegated model only. This is primarily due to three factors: (1) the confusion over how services can be provided, (2) the financial incentive of a higher hourly rate paid to providers of the Consumer Delegated model, (3) and the fear of liability in providing the Consumer Directed model. Eighty percent of all attendants in both models are family members of the consumers. Ninety eight percent of all attendants work in Consumer Delegated models.

Some strengths of the Consumer Directed model are:

- New Mexico has some Consumer Directed providers that serve as national models.
- The consumer is the employer.
- The consumer determines the areas in which the caregiver needs training.
- The consumer has more control over his/her life.
- This model is the less expensive model.
- The provider can assist as needed.
- The consumers learn a new role and how to be a responsible employer.

Some weaknesses of the Consumer Directed model are:

- Providers view the Consumer Directed model as a liability problem even with the passage of SB 823.
- There is not enough support given to those consumers who are just beginning the program.
- There is no required oversight or unannounced visits to monitor quality.

Some strengths of the Consumer Delegated model are:

- There is more assistance for consumers who need it.
- Attendants are required to pass competencies.
- The consumer does not have to advertise, train, hire or supervise.
- The agency is the employer.
- There is more required oversight and unannounced monthly visits.
- There are more built in controls.
- Caregivers receive more training in broader areas than the Consumer Directed model.

Some weaknesses of the Consumer Delegated model are:

- The model is more expensive.
- The more hours the consumer receives the more money the provider makes.
- Monthly visits are difficult to implement.
- The model allows for more opportunities for fraud, abuse and misuse.

Strengths in both models are:

- Families can serve as caregivers.
- PCO offers consumers more freedom than nursing facilities.
- PCO offers consumers choice.
- All providers are required to submit incident reports.

Weaknesses in both models are:

- Families can serve as caregivers.
- Quality of care is a concern.
- Providers are not licensed or credentialed which places liability for quality on the state.
- The current design of both allows for significant fraud and abuse.
- There is no system to prevent consumers from going from provider to provider.
- PCO is being advertised and, at times, run as a family hiring service.
- Agencies have no way of tracking employees who have failed to provide proper care.
- Due to inadequate staffing at the state level, there is limited ability to provide proper oversight for this rapidly growing program.

PRINCIPLES

The state should insure that there is enough information for the consumer to make an informed choice free of bias. There should be no barriers to providing services under either the Consumer Directed or the Consumer Delegated models.

Oversight and quality assurance should be provided in both models.

The state must develop and implement a system for addressing fraud and abuse.

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The state should ensure that there is enough information for the consumer to make an informed choice, and that there are no built in biases toward either model.

Issues and Recommendations

TO ADDRESS THE DISPROPORTIONATE SHARE OF CONSUMERS IN THE CONSUMER DELEGATED MODEL:

Assessment Team Trains and Assists in Selection of Model Design

Issue: Consumers currently access the program through the providers. The majority of providers only offer the Consumer Delegated model and many, if not most of the providers do not understand the extent of services receivable under the Consumer Directed model. Because of this, consumers are not always receiving accurate information and are overwhelmingly choosing the Consumer Delegated model for lack of a comprehensive understanding. This has resulted in the majority (97%) of consumers selecting the Consumer Delegated model.

Recommendation: The assessment team shall be responsible for informing the consumer, perhaps through a video developed by one of the model programs in New Mexico, of the differences between the two models. The consumers will exercise their rights and make non-biased decisions as to which model would suit them. The consumer shall be given a list of all providers in the area to select from. Once the assessment team, along with the individual makes a choice, the consumer will not be able to change to another model without going back to the team to present why the chosen model is not working to meet their needs.

Train Providers on Available Consumer Directed Model Services

Issue: It is obvious through discussions that there is a tremendous misunderstanding regarding the quality, liability and value of the Consumer Directed model. Provider organizations are unclear about what services they are allowed to provide and what extent they are allowed to assist the consumer in managing their care.

Recommendation: Require that all providers receive training so that they fully understand the Consumer Directed model. New Mexico has providers that are nationally recognized experts and they should be sharing their experiences with other providers so that more consumers can benefit from this model.

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TO ADDRESS QUALITY:

Hire Five to Six Additional Staff for the PCO Program

Issue: The Human Services Department has only 2 or 3 people assigned to the PCO unit which serves over 6000 consumers and oversees 120 providers. Quality oversight is impossible. The program needs immediate overhauling and there is not enough staff to manage a program of this size. **Providers and caregivers often know this and are aware there is little danger of being caught in a situation of fraud or abuse.**

Recommendation: Immediately hire at least five or six staff to assist in overseeing the PCO Program. Otherwise, quality, program changes, training and credentialing providers, oversight, regulation changes and anything other than crisis intervention will not be possible.

Credential and Certify Providers

Issue: Providers are not required to have anything other than a business license to begin serving consumers under the PCO Program. This has allowed the program to develop quickly, offering consumers' choice around the state. However, now that there are a number of providers solidly in place, it is time to consider qualifications. There are those who would already be considered qualified such as home health agencies and CILs; however, there are others who have no qualifications to indicate they can provide quality services. In failing to require any proof that a business can provide quality services, the state may bear a huge financial risk for any poor or unsafe services that may be provided.

Recommendation: Develop credentialing standards that all providers must adhere to in order to become certified and remain or become providers. The state should develop the application, review and credentialing process for all current and future providers to be effective date: July 1, 2004.

It is recommended that a committee be organized immediately to develop the qualifications for the credentialing and certification of PCO providers.

Assign a Resource Coordinator to Each Region

Issue: There are many issues consumers deal with that their caregivers may not know how to address. There are agencies ready to assist seniors and people with disabilities statewide; however, people need to know who they are and how to find assistance in their area.

Recommendation: Work with CILs, the State Agency on Aging, senior centers and any other local resources to identify who can serve as local resource coordinators in each region. The assessment team should identify appropriate local resources during the

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assessment and include this information on the recommendation for services to be given to providers upon initialization of PCO services. There could be more than one resource coordinator in each region. For example, a senior center may be coordinator for an elderly person, while an ILC may serve as one for an individual with a disability.

Examine the Need to Require All Providers to Offer Both Models

Issue: There may not be enough providers in each community to provide services under the Consumer Directed model since most only offer Consumer Delegated services. Many providers state that they offer both, but is it common that they will have only one or two people enrolled in the Consumer Directed model, with remaining consumers enrolled in the Consumer Delegated model.

Recommendation: Assess the need and practicality of requiring all PCO Program providers to offer both the Consumer Delegated and Consumer Directed models to.

TO ADDRESS FRAUD AND ABUSE:

Standardize Time Sheets and other Accountability Documents

Issue: There are as many time sheets as there are providers. Consumers under the Consumer Directed model can create their own time sheets. This makes auditing extremely difficult and cumbersome.

Recommendation: Standardize and provide forms that may be audited making them simple, clear and concise.

Conduct On-Going Quality of Care Audits

Issue: Currently, audits are being conducted to examine financial accountability, fraud or abuse of the program. However, field audits of the home environment are not possible due to the lack of local or state staff.

Recommendation: The PCO unit does not have the resources or manpower to go into the field and audit a provider or attendant when necessary. Use at least one of the staff regionally to review quality of care. This staff could also review all incident reports from agencies to determine if any providers need assistance in preventing incidents, or sanctioning agencies if the quality of care is not adequate. A provider should also be sanctioned for any insufficiencies in quality of care. Once certified, DHI could assist regional staff in these types of audits.

Assign an Authorized Representative for Some Consumers

Issue: Some consumers lack the capacity to understand the measures of a quality program, or, in some cases, are unable to address poor quality for one reason or another.

Recommendation: Develop a system to authorize representatives to oversee quality of care. Colorado has a system in place that could be used as a model in New Mexico.

Maximize Funding and Services from Centers for Independent Living by Moving Them to the Human Services Department

Issue: Centers for independent living can be a tremendous resource, and the funding for them can be matched with federal dollars if they are moved to the Human Services Department. They could assist the PCO Program in quality assurance and resource coordination.

Recommendation: Propose or support legislation that will move the funding for CILs from the Department of Education, Division of Vocational Rehabilitation to the Human Services Department. This would generate at least a 50 – 50 federal match.

Seek More GAP Funding

Issue: GAP funding provided through the Governor's Committee for the Concerns of the Handicapped (GCCH) is limited. Approximately $1.5M is needed to adequately assist people moving out of nursing homes or modifying their existing homes due to recent disabling conditions.

Recommendation: Request that GCCH seeks legislation and support their attempts in the legislature. This would allow more people to remain in the community without being placed in nursing facilities waiting for modifications to occur.

Seek Legislation to Create a State Registry of Attendants

Issue: Providers have no way of knowing if they are hiring a person that has been fired for providing dangerous, neglectful, fraudulent service in a previous position.

Recommendation: Seek legislation that creates a state registry of attendants who have failed to provide proper care where agencies can post employees who have been discharged after incidents of abuse, neglect or exploitation. This is not allowable without legislative authority, but it has been repeatedly brought up as an issue that needs to be addressed.

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Advertising

CURRENT SITUATION: One of the main reasons for the rapid growth in the PCO program is advertising. Newspaper, radio and television commercials are filled with ads. Some are honest ads from providers telling the audience that they provide PCO services and are a licensed home health agency. Others state something entirely different and are leading the program in a direction the state cannot afford. Examples of these ads are on the next page. These ads are encouraging people who care for their low income elderly or people with disabilities family member or friend to sign them up so they can receive $9.00 per hour for doing what they are currently doing for free. This is using the PCO Program as family income support rather than a method to **prevent** people from entering a nursing home. It also enables provider to collect $5.00 an hour for each hour worked by these family members. ($16.00 per hour less $11.00 for attendant.)

The PCO Program has become so well known that providers are signing up daily. In fact, any average individual could figure out how to go get a business license, sign up as a PCO provider and hire a relative to take care of someone's mother for $16.00 per hour. They can also hire another relative to care for the person's uncle and aunt. Since all the aunts and uncles are aging just like the mom, they could all get help, at the same time boosting the overall family income. While this may seem far fetched, it is very possible. While most programs do not operate this way, there are those that do.

Reduce Incentives to Advertise for New Clients

Issue: Providers advertise for new clients because the providers are the intake mechanism for the program. They conduct the assessment and justify hours. They are then paid once they have utilization and review approval.

Recommendation: By having intake conducted by an independent assessment team who will assess consumers, recommend program placement (Consumer Directed or Delegated) and allocate hours, the provider can't guarantee that its advertising will pay off since it will be competing against all others providing the service.

Approve All Advertising and Publicity Campaigns

Issue: Too many inappropriate advertisements are causing the program to reach people who would probably not otherwise enter the program, causing the program to expand more rapidly than the state can handle.

Recommendation: Create guidelines for providers who wish to advertise or do community outreach. Require that all ads be approved in writing by the state to avoid any misleading ads as found on the next page.

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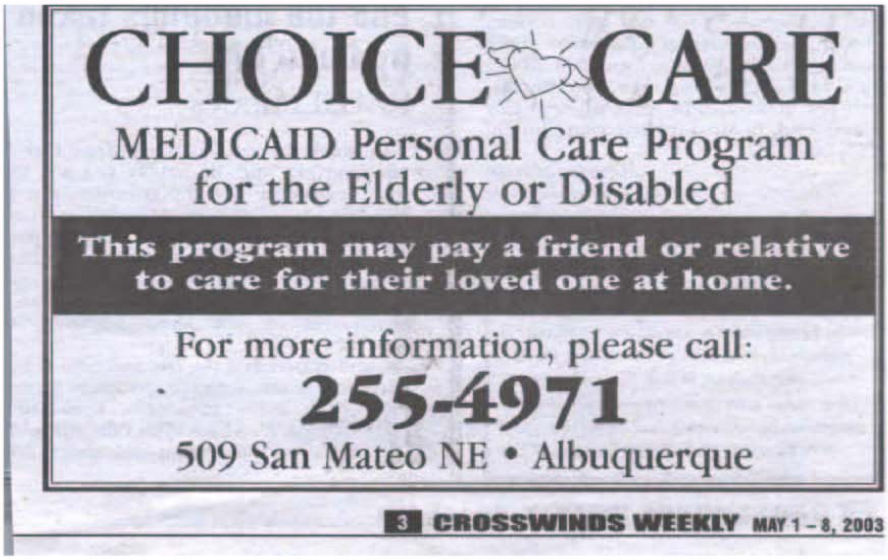

CHOICE CARE

MEDICAID Personal Care Program for the Elderly or Disabled

This program may pay a friend or relative to care for their loved one at home.

For more information, please call:

255-4971

509 San Mateo NE • Albuquerque

3 CROSSWINDS WEEKLY MAY 1 – 8, 2003

Consumer Direct Services

ARE YOU?

- Over 21 years old?
- Eligible for full Medicaid?
- Able to manage medical decisions?

DO YOU?

- Require assistance with more than one activity of daily living such as dressing, bathing, or meal planning?
- Desire or already receive such assistance from a relative or friend?

IF SO, your friend or family member may be eligible for payment through Medicaid at $9.00 per hour. For further information, please contact Consumer Direct Services in Albuquerque at: **344-8182 or toll free 866-344-2371**

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Employees and Employee Benefits

CURRENT SITUATION: In both the Consumer Directed and the Consumer Delegated models, the attendants are paid $9.00 per hour. After expenses, providers are paying $11.00 per hour after the providers' share of taxes, liability and worker's compensation insurances. The committee would have been remiss had it ignored the fact that attendants are paid such a high wage, higher than any other similar program. The committee recognizes that this causes hardships for providers who must justify why an unskilled employee is making more than a skilled employee. We acknowledge that $9.00 an hour is an excellent in many areas of the state and that many people would accept and perform the job at $7.00 per hour.

Reviewing all of these facts, the committee firmly recommends not changing the pay scale for these workers. This wage should be the standard for other programs, such as the D and E Waiver and the DD Waiver. While not the intent, this wage has allowed many people to transition from welfare to work. The PCO Program provides thousands of decent paying jobs in communities where there are often no other jobs available. This wage prevents high turnover rates and provides consumers with consistent care.

Another issue that affects quality, consistency and cost is that some providers are paying their attendants more than $9.00 per hour and often offers "sign-on" bonuses for attendants who will switch from one provider to their business. This increases turnover and consistency for consumers and training costs for providers who then have to train a replacement employee. If possible the state should not allow sign on bonuses or switch over bonuses to either consumers or caregivers.

Another concern is that family members who serve as attendants may not always be providing quality care. It can be difficult for consumers to report that their family member is not doing a good job. Some states do not allow family members to serve as caregivers unless a hardship exists; however, family members are considered an asset in some states, including New Mexico. Many consumers can best be served by family members who thoroughly understand the consumers' needs and are dedicated to their family member/consumer.

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Funding Issues

CURRENT SITUATION: The PCO Program serves well over 6000 people who might otherwise be served in much more expensive settings. The program is projected to need $150M of state and federal funding this fiscal year. It is expected to surpass expenditures for the DD Waiver program after only three years in operation. The DD Waiver has taken over 13 years to grow as much as the PCO Program grew in 3years. One difference is that the PCO Program is an optional service under Medicaid, making it an entitlement for those who are eligible for the services.

For comparison, however, if these people were all served in the DD Waiver or a nursing home, the cost would be well over $300M, or $414M for an ICF-MR facility. While the committee does not have exact numbers, it is understood that the PCO Program has reduced waiting lists and prevented people from entering more expensive programs or institutions. The PCO Program clearly saves the state millions of dollars.

It should be noted that the PCO Program cut its reimbursement last year from $18.00 per hour for the Consumer Delegated model to $16.00 per hour. This has not deterred new businesses from entering the market to provide this program, but it did mean an 11% cut in Consumer Delegated program budgets.

The committee examined a number of different options for controlling costs. The number one recommendation is to remove the assessment process from the providers, and combine it with utilization review functions. Beyond that, the following was also given thorough consideration, however, did not receive the committee's recommendation.

Flat Fee: The state could impose a flat fee for the Consumer Delegated model similar to that of the Consumer Directed model. However, using various techniques, the committee could not determine that there was any financial benefit to a flat fee, other than removing the incentive for providers to boost hours. The committee was concerned that with a flat fee, providers could determine their highest profit margin and recommend hours at that level. Worse yet, they might only accept individuals whose range of hours of service needed met the peak income level. If the department chooses this option, it must be carefully implemented and only after a thorough cost study. The committee also felt that if a flat fee was set high enough to cover individuals with high needs it could result in an increased cost to the state, since a number of agencies provide an average of only 90 hours per person. A flat fee would result in additional income for those providers.

The biggest barrier to a true flat fee, however, was the potential impact it would have on consumers with needs higher than the fee would cover. Providers can deny services for difficult consumers and it is anticipated that high cost consumers might be unable to locate a provider who would accept them as a client. This alone was enough to rule out this option as a recommendation from this committee.

The following options were recommended by the committee:

Reimburse at a Limited Capitated Hourly Rate

Issue: The current reimbursement method of paying hourly wages assumes that the cost of providing oversight management never stops. Yet, the oversight does not necessarily increase because of hours. The training and supervisory visits do not increase simultaneously, although coordination may. The committee agreed that the average number of hours per consumer should be between 100 and 120 per month. The average today is over 140.

Recommendation: Reimburse providers at a limited capitated hourly rate. The state would pay an hourly rate up to 100 or 120 hours. Thereafter, the state would pay an $11.00 hourly rate to cover the cost of the caregiver. This cap would not reduce the hours of service an individual could receive. It would limit the hourly reimbursement to a defined number of hours and allow unlimited hourly reimbursements to match the number of hours of care.

Current Funding (6500 is a sample number.)

6500 people X 140 hrs = 910,000hrs X $16./hr = $14.56M X 12mo = $174.72M

Proposed Funding at a 120 Hour Base

6500 people X 120 hrs = 780,000hrs X $16./hr = $12.48M X 12mo = $149.76M
6500 people X 20 hrs = 130,000hrs X $11./hr = $ 1.43M X 12mo = $ 17.16M
Annual Total $166.92M

$7.8M Cost Savings over current funding. State saving = $1.95M

Proposed Funding at a 100 Hour Base

6500 people X 100 hrs = 650,000hrs X $16./hr = $10.4M X 12mo = $124.8M
6500 people X 40 hrs = 260,000hrs X $11./hr = $2.86M X 12mo = $ 34.32M
Annual Total $159.12M

$15.6M Cost Savings over current funding. State savings = $3.9M

*Today, the average number of hours per person is a little over 140. The committee would anticipate a decline in the number of hours of services allotted per person for some consumers under the new funding mechanism. No reasonable estimation can be made on cost savings due to annual reassessments.

*This model does not increase cost for the consumers who generate less than the 120 or 100 hours.

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Conduct a Cost Study to Consider Reduced Hourly Reimbursement for the Delegated Model

Issue: After conducting a very informal cost study, the committee felt that a $15.00 per hour rate to providers offering the Consumer Delegated model could be tolerated. This was not without concern, however. Licensed home health providers might experience the biggest hit from this since they generally provide more highly qualified and trained employees, and have more built-in quality assurance and oversight.

Recommendation: A formal cost study should be conducted to determine what the actual costs are. Reduce the reimbursement for the Consumer Delegated model to $15.00 per hour. Estimated cost cut to provider: 6%. Estimated savings to program: $8.M. Estimated cost savings to state: $2.M.

Provide Assistance in Transferring into Consumer Directed

Issue: It is difficult to transition consumers from the Consumer Delegated model to the Consumer Directed model. It often requires more time initially to assist them in developing the skills to train and supervise their employee(s). Since 80% of consumers are served by family members, the turnover is manageable, and many consumers do not need to constantly train new caregivers.

Recommendation: Offer a one time fee of $500.00 to the provider for each consumer they transition from the Consumer Delegated model to the Consumer Directed model. Whether the move is motivated by the provider, consumer or by the assessment team recommendation, it is understood that there is a cost in doing so. This fee will be recovered within months from the savings generated by providing the less expensive Consumer Directed model.

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Public Comments

Provider Comments and Concerns:

Oppose the $15.00 per hour reimbursement for the Consumer Delegated model.
Providers expressed the concern that they could not stay in business with another $1.00 cut in the hourly rate paid for Consumer Delegated services. Budgets were submitted which, for the most part, mirrored those discussed by the committee. The primary differences in the budgets were workers comprehensive insurance. Those costs seem to be higher than what the committee gathered.

It was also noted that the cost over what is paid to the attendants is same provider/attendant ratio as in the D & E Waiver. The D & E Waiver reimburses $14.00 and the attendants are paid $7.00. The PCO Program reimburses $16.00 and pays attendants $9.00. They are not allowed to reduce the attendant hourly wage. The D & E Waiver does not fix the hourly wage for attendants working in that program.

Lower the hourly wage paid to attendants.
Providers who responded reported that the high hourly wage paid to attendant is very difficult to administer is other programs are being run from the provider as well. For example, it is difficult to hire D & E Waiver skilled staff or Certified Nurses Assistants for $7.00 an hour when an unskilled PCO attendant makes $9.00 per hour. Additionally, the high hourly rate carries over to people purchasing attendant care services privately. They are forced to pay $9.00 per hour in order to find attendants and compete with the PCO Program.

Rural providers stated that the $9.00 per hour is not justified in their communities. They feel they could provide the same services, providing the same quality for $7.00 or $8.00 per hour. Some stated that they could not loose any employees if the wage was cut since they have limited job opportunities in their communities.

Oppose serving people under the Consumer Directed model.
Providers spoke against serving people in the Consumer Directed model. All of those who did, however, were serving only 1 or 2 consumers under that model with the remainder being in the Consumer Delegated model. Their primary objection to the Consumer Directed model was the fear of a lack of quality and oversight. They feel that few of their consumers had the capacity to manage their attendants in any way. They believe that monthly visits are necessary in order to verify that quality services are being provided and that those visits should be conducted in both models.

Consumer Comments and Concerns:

Do not cut hours.
Consumers feared that another cut in their hours would prevent them from remaining independent. Families with adult children with severe disabilities were shaken when they learned the PCO Program might experience cuts. They could not imagine being able to serve their son/daughter at home without help. They knew the alternative placements where their children would have to reside and were shaken at the thought of having to place their child anywhere but home.

Do not cut pay for attendants.
The consumers who were most concerned about the hourly wage of their attendants were ones who were not being served by family members. Not one attendant called asking that his/her wages not be cut, however, consumers feared loosing their attendants if their wages were cut. Most stated that their attendants were worth much more than $9.00 per hour because of the dramatic difference it made in the life of their loved one and the family as a whole.

Paperwork can be overwhelming.
Some consumers felt the paperwork required from their provider was too cumbersome. They were required to have their attendants call in when arriving and departing work. They had to justify each hour received each day, even though their adult child needed total care. They wanted to see a reduction in the requirements on the Consumer Directed model. However, each provider requires different paperwork and it could not be verified that all providers require such extensive documentation.

Allow banking of hours.
Consumers wanted more flexibility in the program as far as when hours could be used. They wanted to be able to change hours daily or weekly depending on the need of the consumer. They were requesting a model similar to the "Cash and Counseling" model of service.

Allow family members to serve as attendants.
Consumers expressed concern that family members might not be allowed to serve their loved one as an attendant. Some people quit their full time job to assist their loved one part time. Others had loved ones who were so difficult to manage that no one but their parents could bath, dress or feed them. They had experienced the disruption and severe reaction their child has when others came in to provide care. They felt that allowing family members to serve as attendants was one of the strongest aspects of the program.

PCO Recipient Interviews

LFC auditors interviewed 16 of 18 Santa Fe County PCO recipients and/or family member care attendants. (One former recipient could not be located and one was deceased.) An HSD staff person was present as an observer. A standardized questionnaire was developed and used to facilitate the interview process.

Due to time limitations, some interviews were conducted by telephone. Generally persons residing within Santa Fe City limits were visited in their homes; residents outside city boundaries were interviewed by telephone. When available, care attendants were also interviewed; most caretakers available for interview were family members. Several recipients had dementia and were unable to respond to our questions in which case interviews with family members were used.

The following information was obtained from the interviews:

- PCO recipients generally appeared as though they would qualify for nursing home care. In fact, many persons appeared more debilitated than case file documentation suggested in terms of the severity of the impairment to their activities of daily life (ADLs).

- Five of 16 (31%) PCO recipients are alone at night and rely upon the provider agency's emergency assistance number.

- Four of 16 (20%) interviewees, felt that the recipient needed more service hours than those authorized. They commented that HSD had "arbitrarily reduced hours", some with minimal notice.

- One person with environmental illness/sensitivity reported needing more flexibility in the hours assigned to her PCA. Some days she needed more hours than others depending on how she felt.

- One PCA recommended that provider agencies be required to have fringe benefits such as health insurance.

- Many PCAs, including family members, rely on PCO payments as their primary source of income and do not hold other jobs. However, one PCA reported having to obtain a second job when PCO hours were reduced.

- All PCAs understand that they were not entitled to wages during periods of hospitalization.

- Six PCAs felt that the provider agency had excellent training which gave them confidence to perform their jobs. One person would like training specific to her mother's illnesses.

All of the recipient/PCA recommendations would increase the cost of the program. Auditors have not evaluated the merit of such recommendations.