

Legislative Health & Human Services Committee
Disability Subcommittee
October 7, 2011

The Personal Care Option: A Vital Part of New Mexico's Long-Term Services System

(and it's NOT “out of control”!)

The Disability Coalition
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PCO provides assistance with activities of daily living (ADLs). Allows individuals who need nursing home level of care to remain in their own homes and communities.

PCO serves important role in Medicaid long-term services and supports (LTSS) system.

- Meets growing need for LTSS to seniors and younger persons with disabilities
- Helps rebalance long-term services system away from institutional care and toward community-based services

To get PCO, must be at nursing facility (NF) level of care

- Every PCO recipient is eligible to enter NF and have Medicaid pay for it

PCO allows people to get services at home instead of in institution

- cheaper than institutional care
- Improved quality of life – maintain independence, participate in community through work and leisure activities

PCO available without waitlist, unlike waivers

- DD waiver – waitlist >5,200; wait time > 8 years
- D&E (CoLTS-c) waiver – waitlist >16,000; wait time infinite (Pursuant to HSD policy, no allocations from waitlist; slots available only to individuals transitioning out of nursing facilities and back to the community.)

Growing need for home- and community-based LTSS

- Growing number of seniors (by 2030, NM will have fourth highest percentage in country of persons >65)
- More people living with disabilities
- Reduced availability of family supports (fewer children, living farther away, more women in labor force)
- Desire for independence, especially for younger people with disabilities

A little history...

The early days of PCO: design flaws, inadequate oversight

- “Oversight regulations were not built into the original design of the program.” (C. Ingram, MAD director, 2004)
- Pay structure overpaid provider agencies and encouraged costlier agency-directed care rather than consumer direction.
- Incentives for agencies to maximize hours of service for their own benefit rather than basing services on true consumer needs

2003: Jennings Committee

- Included consumers, providers and advocates
- Made recommendations to improve PCO program administration

2004: HSD implemented changes pursuant to Committee's recommendations, to increase oversight and assure quality

- standard assessment form
- independent assessor to determine eligibility and service needs
- credentialing standards for providers,
- standardized timesheets for attendants,
- requiring HSD approval for provider advertising, and
- other regulatory revisions

The result: total PCO spending fell from FY04 to FY05 even as the number of people served rose.

Over the years, HSD has continued to take numerous steps to control PCO costs

Growth since the 2004 program changes has been below the rate of growth in the Medicaid program as a whole (52% increase in PCO compared to 65% for entire program)

1) Changes to payment rates

(Source: HSD, "PCO Services Fact Sheet", 3/1/2011; 1999 information added)

PCO Hourly Provider Rates

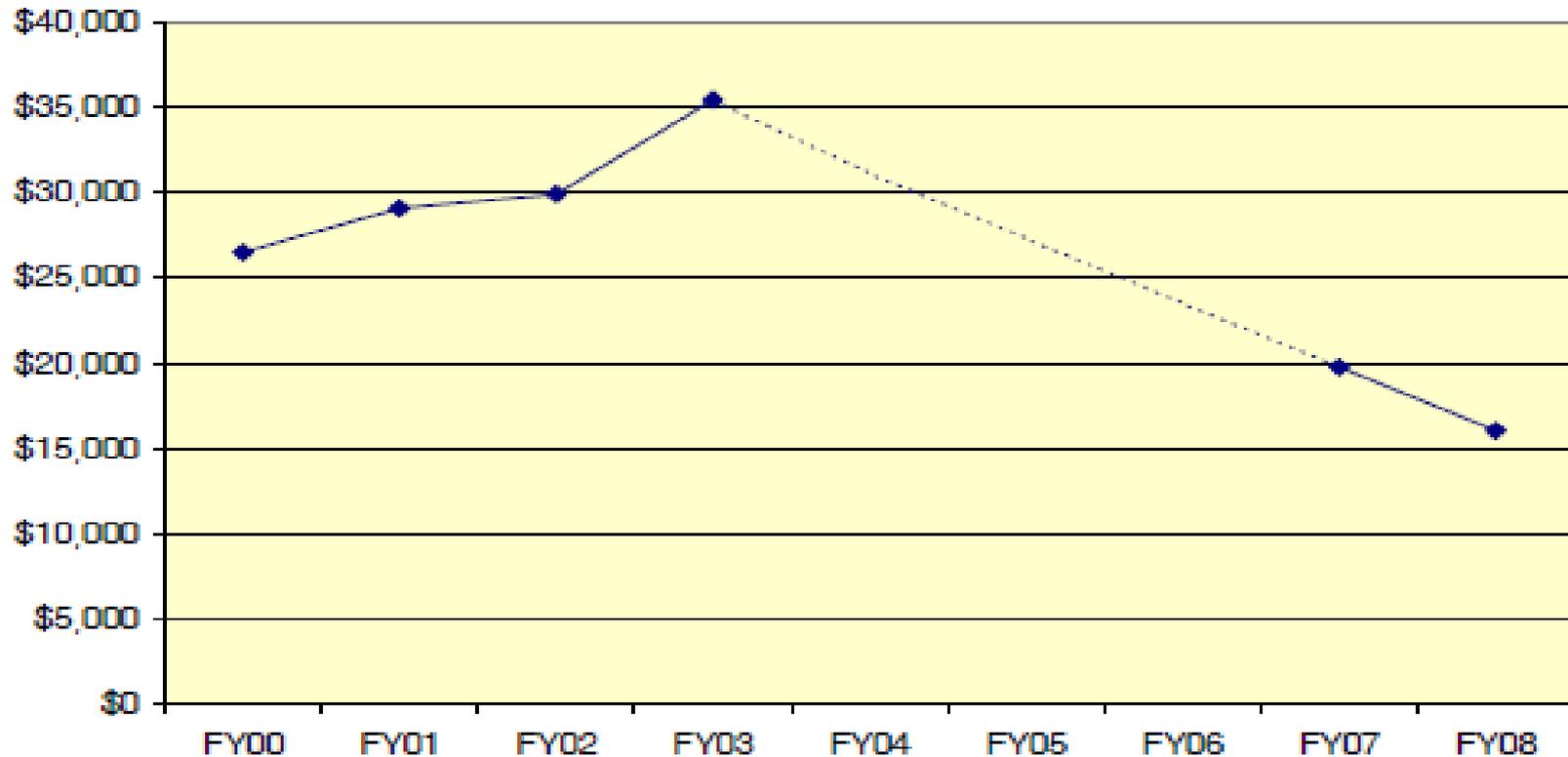
Year	Delegated		Directed	
	Provider Agency	Caregiver	Allowed maximum	Caregiver Rate
1999	\$18	\$9	\$10.20	\$9
2002	\$16	\$9	\$10.80	\$9
2003	\$15	\$8.50	\$11.50	\$8.50
2004	\$13.50 or \$11.50 (Under 100 hrs)	\$8.00	\$11.50	\$8.00
2005	\$13.50 (First 100 hours) \$11.50 (101 hours +)	\$8.00	\$11.50	At least \$8
2006	\$13.16	Set by provider	\$12.63	Set by Recipient
2009 (12/1/09) \$5.5 million annual savings	\$12.88	Set by provider	\$12.35	Set by Recipient

2) Reductions in hours of service

- 2002 – average 140 hours/month
- 2009 – average 26-27 hours/week (about 115 hours/month)
- Further reductions pursuant to administrative changes imposed by HSD since 2009
- Latest regulatory changes will reduce hours of service by 30-40%.

3) Reduction in average cost per person

PCO - Average annual cost per person



Sources: FY00-03: LFC 1/2004 audit of PCO program, monthly cost multiplied by 12 to derive annual cost; FY07: ALTSD memo dated 1/8/2009; FY08: ALTSD/HSD memo dated 2/5/10. **No data available for FY 04-06.**

Average cost in FY 08 (before CoLTS) \$16,000 – less than half the \$35,000+ average cost at FY 03 peak

Rate of growth in number of people receiving PCO services has leveled off.

- Very rapid growth in early years, reflecting unmet need.
- More moderate rate of growth in subsequent years

Significant uptick in FY09

- CLTS rollout – MCOs, at state's direction, identified unmet need
- administrative change: services moved from D&E waiver to PCO (without increasing # of people served)

Small *decrease* FY09 to FY10 (most recent number available – HSD, PCO Services Fact Sheet, 3/1/2011)

So...

- Payment rates have been reduced
- Average number of hours of service has gone down
- Average cost per person has fallen

That's not a program that's "out of control".

PCO and The Americans with Disabilities Act

- Significant reductions to PCO may run afoul of the ADA and the Supreme Court's *Olmstead* decision.
- ADA Title II – “integration mandate” – goal: provide individuals with disabilities opportunities to live their lives like individuals without disabilities

US Department of Justice, Statement on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and *Olmstead v. L.C.*, June 2011:

- State's obligations under the ADA are independent of Medicaid rules.
- ADA and *Olmstead* protections apply to people at risk of institutionalization, not just those already in institutions.
- Risk of institutionalization need not be imminent to implicate the ADA and *Olmstead* protections.
 - Example: sufficient to show that failure to provide or reduction in community services is likely to cause a decline in the person's health, safety or welfare that could lead to institutionalization.

LFC audit recommendations to cap number of hours available, limit number of people served by PCO, or provide community-based services only to those at imminent risk of entering facilities appear to violate *ADA/Olmstead*.

LFC report also recommended increased reliance on “natural supports”, and HSD has pursued this in recent regulatory changes.

It's appropriate to look at natural supports when they're readily available and willing.

- But families are already bearing the brunt of providing long-term services, both paid and unpaid. They also bear the accompanying physical, emotional and financial stress.
- Forcing family members into role of LTSS provider invites abuse and neglect for the recipient.
- Reliance on family to provide care can undermine the individual's independence.