

An Overview of
Medicaid Long-Term Care Programs
in New York

**MEDICAID
INSTITUTE**
AT UNITED HOSPITAL FUND

Chapter 3

Personal Care

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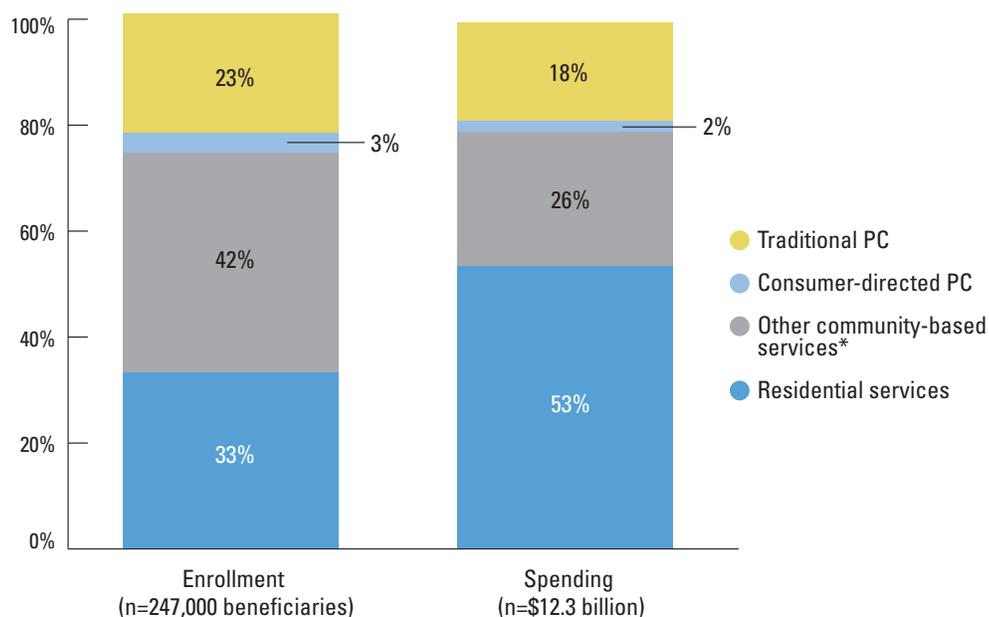
Program Snapshot

In September 2007, there were an estimated 57,000 New Yorkers enrolled in the “traditional” Medicaid personal care (PC) program (called the Home Attendant program in New York City) and an additional 7,000 enrolled in the consumer-directed personal care program.¹ Other community-based Medicaid long-term care programs also provide personal care services, but the personal care program almost exclusively provides hours of personal care and is not typically responsible for other long-term care services, such as care management. This chapter focuses primarily on personal care in New York City, as most enrollment and spending is located there.

Enrollment and Spending

Traditional personal care program beneficiaries represent an estimated one-fourth (23 percent) of long-term care beneficiaries; consumer-directed personal care program beneficiaries account for an additional 3 percent of the total.

Figure 3.1
Percentage of PC Program Enrollment and Spending as a Share of All Medicaid Long-Term Care Programs, FFY 2007



Source: UHF analysis of FFY 2007 CMS-64 and Sept 2007 MARS.

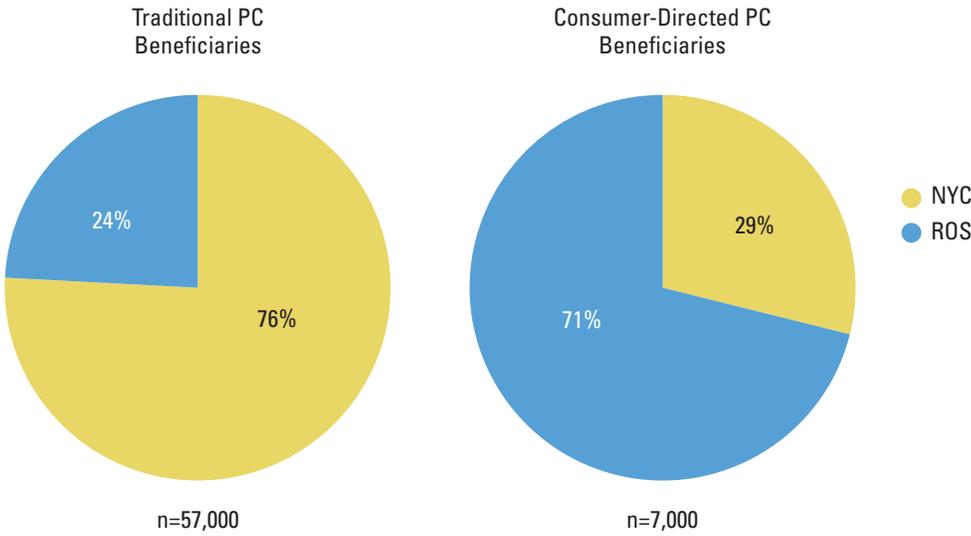
Note:*Other community-based services = CHHA, ADHC, TBI, LTHHCP, MMLTC, and PACE programs.

¹ This program portrait is a chapter of *An Overview of Medicaid Long-Term Care Programs in New York* by Alene Hokenstad and Meghan Shineman of the United Hospital Fund with Roger Auerbach of Auerbach Consulting, Inc. Please note: The spending and enrollment figures in this report are estimates for 10 programs primarily serving frail seniors and adults with disabilities, including nursing homes, Medicaid Assisted Living Program (ALP), traditional personal care, certified home health care, consumer-directed personal care, adult day health care, the Long-Term Home Health Care Program (LTHHCP), the traumatic brain injury waiver program, Medicaid Managed long-term care (MMLTC), and the Program of All-Inclusive Care for the Elderly (PACE). They do not include programs that primarily serve people intellectual disabilities or medically fragile children, such as the Care at Home Program. The personal care data presented here do not include enrollment and spending for beneficiaries who receive personal care services through other community-based long-term care programs, including LTHHCP, MMLTC, or PACE. It was not possible to identify and exclude enrollees in the TBI waiver program, an unknown percentage of whom receive services through the personal care program and are included in this profile's analysis of enrollment and spending. See the Technical Notes of the full report for a discussion of data sources and research methods. For ease of discussion and consistency of terms, the consumer-directed personal assistance program is referred to here as the consumer-directed personal care program.

Medicaid spent an estimated \$2.2 billion in FFY 2007 on the traditional personal care program and an additional \$300 million on the consumer-directed personal care program — 18 percent and 2 percent, respectively, of all Medicaid long-term care spending in programs primarily serving frail seniors and adults with disabilities.

New York City vs. Rest of State: An estimated three-fourths of all traditional personal care program beneficiaries and 29 percent of all consumer-directed personal care program beneficiaries reside in New York City. Beneficiaries in New York City account for an estimated 83 percent of traditional personal care expenditures.

Figure 3.2
Share of Enrollment in the Traditional and Consumer-Directed Personal Care Programs in New York City, September 2007

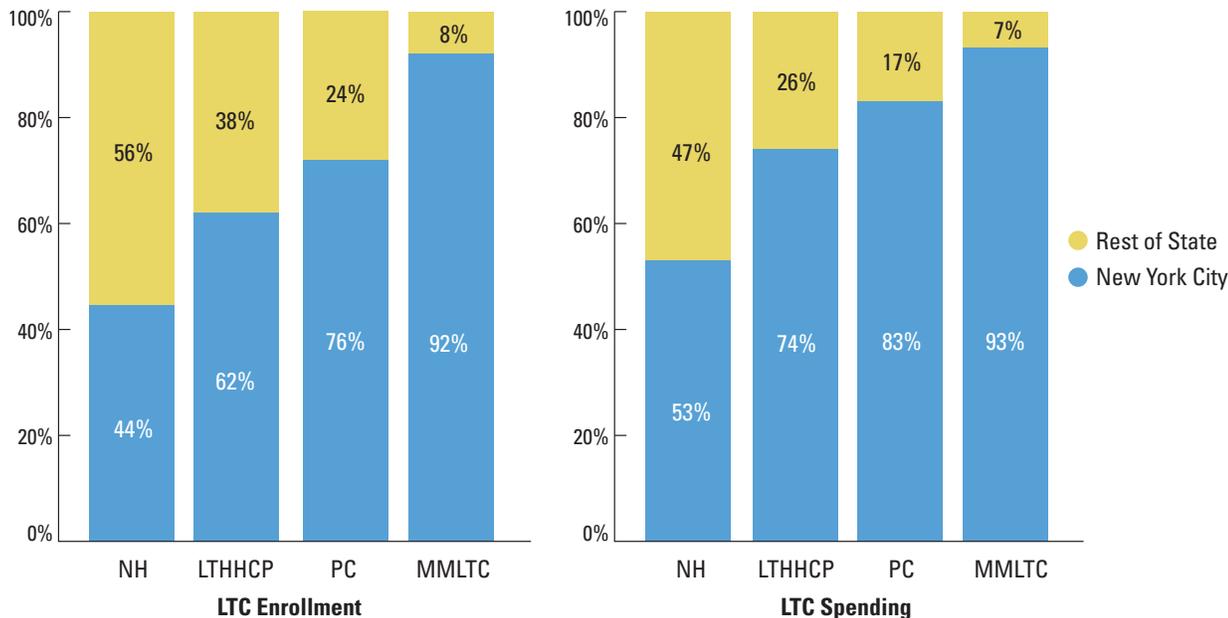


Sources: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008), September 2007 MARS data, and HRA estimate of NYC enrollment.

The regional distribution of enrollment and spending for the traditional personal care program is similar to the pattern for other community-based programs but different from that of nursing homes, which are used more outside New York City.

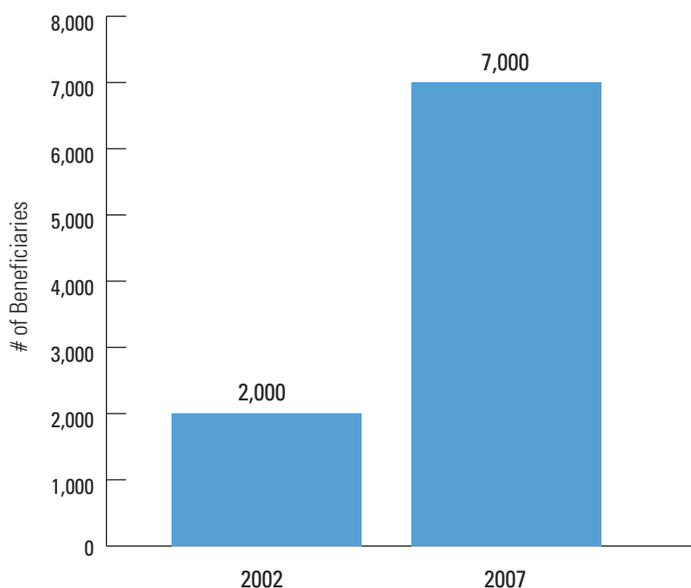
We do not have information on the spending or growth of the consumer-directed personal care program by region. We do know, however, that the program has grown fairly rapidly in the last five years, and that much of the growth has occurred outside New York City.

Figure 3.3
Share of Enrollment and Spending in New York City, by Medicaid LTC Program, FFY 2007



Sources: For nursing homes, LTHHCP, and personal care: UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008). For MMLTC: UHF analysis of September 2007 SDOH managed care enrollment data and SDOH Medicaid Managed Care Operating Report (MCOR) data, 12/31/07, provided by the MLTC/PACE Coalition.

Figure 3.4
Consumer-Directed Personal Care Program Enrollment, 2002 and 2007



Sources: New York State MARS December 2002 and September 2007 data.

Program and Provider Capacity

There are 215 licensed home care services agencies that provide traditional personal care services in New York State, including 62 in New York City.² In New York City, the local department of social services (the Human Resources Administration, or HRA) selects providers through requests for proposals. Agencies in New York City typically cover services for 400 to 2,000 beneficiaries, with an average of 680. Providers in the rest of the state serve an average of 100 beneficiaries.³ Licensed home care services agencies may also have contracts to provide Medicaid-financed direct care services for other long-term care programs and to provide Medicare-financed direct care services for certified home health care agencies. There are 27 fiscal intermediaries for the consumer-directed personal care program in the state, including two in New York City; fiscal intermediaries process payroll and benefits for the personal care assistants hired by consumer-directed personal care program beneficiaries.

Workforce: We do not have accurate information about turnover rates among direct care workers (home attendants and personal care aides). However, workforce analysts believe that the personal care program's home attendant workforce in New York City is relatively stable; average turnover rates are about 10 percent (PHI 2008). This is very low compared to the average national turnover rates of 40 to 50 percent in the home care industry (Seavey et al. 2006). Workforce analysts attribute the stability of the home attendant workforce in New York City to fairly recent labor-management agreements.

Health Status and Demographics

In FFY 2007, 29 percent of all personal care beneficiaries were under 65 years.⁴ In New York City, an estimated 47 percent of personal care beneficiaries are 81 years and older, while 20 percent are under 65 years.⁵ Information about personal care beneficiaries' health status is limited. One of the few available studies, conducted by the United Hospital Fund in 1995, found that half (52 percent) of personal care beneficiaries in New York City were cognitively impaired. Two-thirds (69 percent) had three or more chronic medical conditions. Three quarters (74 percent) were people of color (Hokenstad et al. 1997).

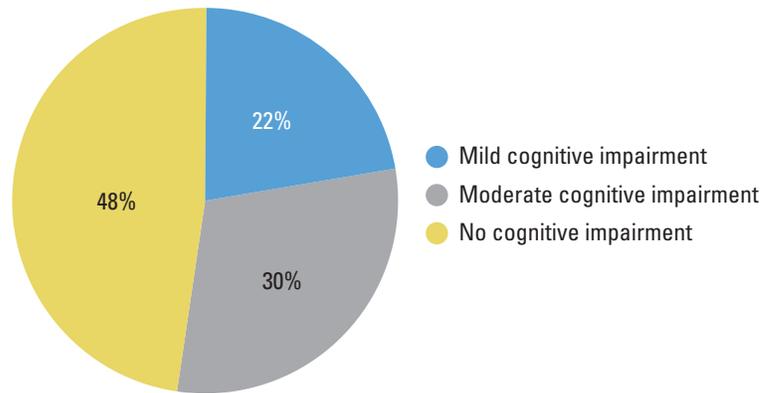
² Based on UHF analysis of January 2008 Medicaid long-term care reimbursement rate computation sheets for personal care (SDOH website) and December 2008 New York City personal care vendor authorized caseload size (estimate from HRA).

³ Average caseload for traditional personal care in NYC reflects authorized caseloads; we were unable to obtain actual enrollment by provider. Full range of provider size elsewhere in the state is not available.

⁴ UHF analysis of Medicaid reference statistics, FFY 2005-2007 (SDOH, Office of Health Insurance Programs, June 2008).

⁵ According to the Home Care Council of New York City.

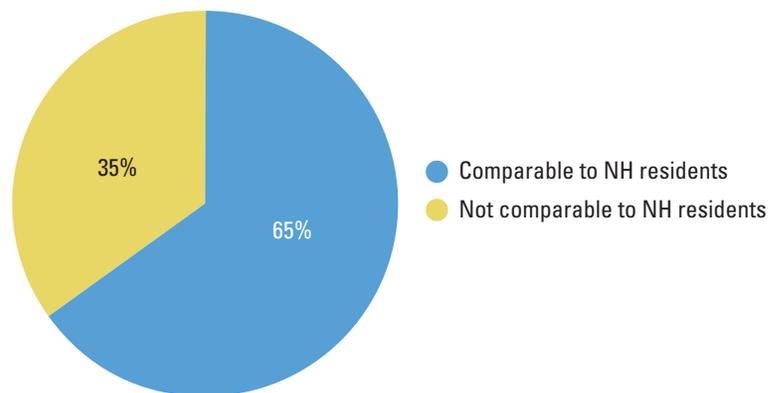
Figure 3.5
Traditional Personal Care Program Beneficiaries with Cognitive Impairment in New York City, 1995



Source: Hokenstad et al. 1997.
Note: Figure includes beneficiaries receiving home attendant services only.

Health Status in Relationship to Nursing Home Beneficiaries: We do not have much information about how the needs of beneficiaries enrolled in one program compare to those of beneficiaries in another. While the previously mentioned study, based on 1995 data, found that the nursing home resident population on the whole was sicker and frailer, two-thirds of New York City’s personal care beneficiaries had comparable levels of need on key indicators, such as functional and cognitive status, as indicated by resource utilization group (RUG) scores.⁶

Figure 3.6
Traditional Personal Care Program Beneficiaries with Nursing Home Level of Care Needs in New York City, 1995

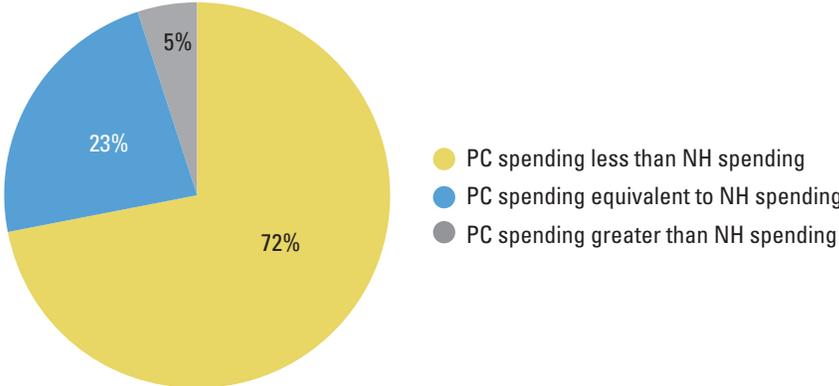


Source: Hokenstad et al. 1997.
Note: Figure includes beneficiaries receiving home attendant services only.

⁶ Resource utilization groups (RUGs) are categories within a need-based classification system developed by the New York State Department of Health that is the basis for case-mix adjusting nursing home reimbursement rates. There are 16 RUGs, sorted into the following categories: rehabilitation (RA, RB), special care (SA, SB), clinically complex (CA, CB, CC, CD), severe behavior problems (BA, BB, BC), and reduced physical functioning (PA, PB, PC, PD, PE). Definition of need includes RUGs for clinically complex conditions, severe behavioral problems, or reduced physical functioning, as indicated by cognitive impairment or an ADL score of 5 or more on a 10-point scale.

The study also compared spending on direct care services in both settings. It found that, on average, Medicaid spending was less for the 72 percent of personal care program beneficiaries in the lowest RUG reimbursement groups and roughly equivalent for the 23 percent of beneficiaries in the next highest RUG reimbursement groups. Average Medicaid spending for personal care services for the 5 percent of personal care program beneficiaries in the highest RUG reimbursements groups was higher than nursing home spending (Hokenstad et al. 2002).

Figure 3.7
Medicaid Spending on Direct Care Services in New York City: Traditional Personal Care Program Compared to Nursing Homes, 1997



Source: Hokenstad et al. 1997.
Note: Figure includes beneficiaries receiving home attendant services only.

We do not know all of the ways in which New York City’s personal care population has changed since these data were collected. There is broad consensus that, like the nursing home population, the personal care program beneficiary population has grown sicker and frailer in the intervening years (Dennison 2008).

Rules, Regulations, and Administrative Structure

The personal care program provides a number of different levels and types of services. In this report, traditional personal care includes housekeeping, home attendant, and shared aide. While consumer-directed personal care is technically an option within the personal care program, we refer to it separately because of its policy significance. The principal difference is that in the traditional personal care program, the direct care worker is hired and supervised by a licensed home care services agency; in the consumer-directed program, the beneficiary (or a designated family member or guardian) hires and supervises the direct care worker.

Federal Coverage Requirements

The personal care program is an optional state plan service. The federal government gives states the option to cover some services in their Medicaid program. New York, like 33 other states, has opted to cover personal care services.⁷ Once a state opts to cover a service, it must make it available to all beneficiaries who meet medical and financial eligibility requirements.

Covered Services

The personal care program provides assistance with both activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include basic personal care needs, and IADLs are activities associated with independent living; (see inset box). The assistance is generally provided in blocks of hours per day. Housekeeping is limited to help with IADLs. The state limits the number of hours of housekeeping services to 12 hours per week.

Activities of Daily Living and Instrumental Activities of Daily Living (ADLs and IADLs)

ADLs:

Feeding
Toileting
Bathing
Transferring/Mobility
Dressing/Grooming

IADLs:

Household Chores
Meal Preparation/Shopping
Escort/Errands

Service Utilization

Most beneficiaries in the traditional personal care program in New York City receive 20 or more hours of care per week. Almost a quarter of these beneficiaries receive 84 hours or more of personal care each week. (We do not know the breakdown of hours for beneficiaries in the personal care programs in the rest of the state.)

Table 3.1
Traditional Personal Care Program Beneficiaries in New York City, by Service Hours per Week, December 2007

	0–19 hours	20–48 hours	49–83 hours	84 hours	168 hours*
Beneficiaries	4,200	16,700	11,700	9,000	1,200
Percentage of Total Beneficiaries	10%	39%	27%	21%	3%

Source: UHF analysis of data provided by the Home Care Council of New York City. Home attendant hours only.

Note: * Includes 27 clients who received between 85 and 167 hours of care; all the rest in this column received around-the-clock care (i.e., 168 hours per week).

⁷ Data from the Kaiser Family Foundation Medicaid Benefits Online Database, October 2006. Available at <http://www.kff.org/medicaid/benefits/service.jsp?yr=3&cat=1&nt=on&sv=28&so=0&tg=0&gr=off>. Accessed January 6, 2009.

Eligibility — Medical and Financial

Applicants must meet both medical and financial eligibility requirements. Unlike the restrictions on nursing home care that prohibit enrollment of individuals with a primary diagnosis of either a severe and persistent mental illness or intellectual disability, such as mental retardation or developmental disability, there are no excluded populations for personal care.⁸

Medical and Functional Eligibility: Medical eligibility is based on the level of functional disability. Unlike nursing home care and most community-based long-term care programs, personal care programs do not require applicants to demonstrate the need for nursing home level of care. Applicants must be capable of self-directing services, or have a designated representative to direct care on their behalf, and they must be able to remain safely in their home or community. Eligibility is determined primarily on the basis of a state-approved assessment (M27R in New York City), completed by a nurse for the local department of social services.⁹ Unlike medical eligibility determinations in most other long-term care programs, the M27R does not yield a numerical score that corresponds to a level of need. Instead, it includes an algorithm (task-based assessment) that calculates the number of minutes of personal care assistance required per day. The local department of social services is responsible for administering the nursing assessment twice a year and whenever a beneficiary's needs change (e.g., following a hospitalization). New York City's HRA has a waiver that allows it to review the semiannual assessment, which is administered by the program provider's nurse.

Financial Eligibility: On behalf of the State Department of Health (SDOH), county governments determine financial eligibility for personal care, using general Medicaid eligibility criteria (income no greater than \$8,700 annually and savings no greater than \$13,050) and the additional "home equity limit" that applies only to financial eligibility for long-term care (primary residence valued at no more than \$750,000).¹⁰ County caseworkers may assist beneficiaries in gathering the documentation required to prove financial eligibility and with required annual recertifications. See Chapter 1.

⁸ For more information on Medicaid long-term care program eligibility, see Bogart 2007.

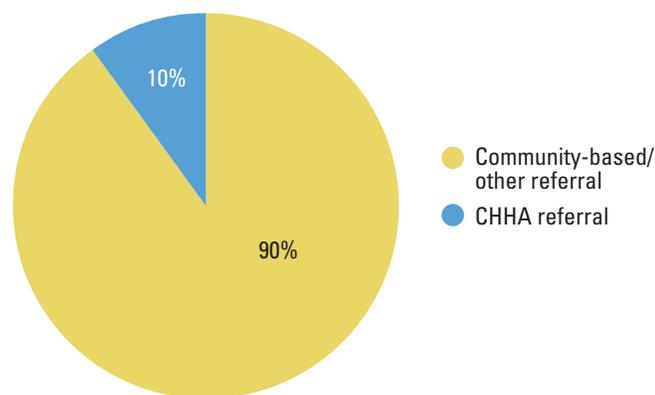
⁹ If the applicant is transitioning from certified home health care agency (CHHA) services in New York City, a CHHA nurse (in lieu of the local department of social service's nurse) may complete the nursing assessment.

¹⁰ Individuals whose income is higher than the rules allow may still qualify through the spend-down ("Medically Needy") program, which allows applicants with "excess income" (the amount above \$725 per month in 2007) attributable to medical expenses to "spend down" to the financial resource limit in order to qualify for Medicaid.

Access

An estimated 90 percent of admissions to the personal care program in New York City come directly from the community — from physicians and from community-based social service providers. This includes an unknown number who have been disenrolled from other community-based long-term care programs, such as the Long-Term Home Health Care Program (LTHHCP) or Medicaid managed long-term care (MMLTC). The remaining 10 percent come primarily from certified home health agencies (CHHAs), a process commonly referred to as “conversion.”¹¹ A small number come directly from hospitals through the expedited hospital discharge program (commonly called the “Bridge” program).¹² There is no reliable source of information about discharges from the program.

Figure 3.8
Percentage of Traditional Personal Care Program Referrals in New York City, by Source, 2007



Source: New York City Human Resources Administration, Home Care Services Program.

Beneficiaries learn about personal care from their physicians, hospital discharge planners, community-based service program providers, or word of mouth (e.g., from other beneficiaries or family members). There is no publicly reported information about the quality of personal care programs to either promote application or help beneficiaries select a provider. An unknown percentage of applicants receive help navigating the application process from community-based aging and social services organizations.

Individuals apply to receive personal care through their local department of social services. A physician must first complete a medical form (the MIIQ in New York City) attesting that the applicant requires help with ADLs or IADLs. (The same form must be resubmitted annually.) Unlike physician’s orders for CHHA services, the MIIQ is a recommendation for

¹¹ Personal communication, Marie Brady, HRA.

¹² The Bridge program is a state program established to facilitate faster discharge of hospital patients receiving an “alternate level of care” after an acute medical event. It places individual discharged from the hospital into certified home health care agencies, provides faster processing of applications for personal care, and allows more hours of care than the personal care system usually does.

services, not a medical order; it attests that the applicant has a medical need for the services. After a telephone screening, a county nurse visits the applicant in his or her home and administers the previously mentioned assessment. A county caseworker then conducts a second in-home visit to administer another state-mandated screening called a social assessment (the M11S in New York City). The purpose of the social assessment is to review the home environment. The county is responsible for administering the social assessment annually.

In New York City, a medical review team is responsible for reviewing the three completed documents (M11Q, M11S, and M27R) and developing a service plan. The team comprises a nurse and social worker. All service plans recommending around-the-clock care or multiple shifts of personal care services must be approved by the local professional director, a physician. In the rest of the state, the county nurse and county caseworker who conduct the nursing and social assessments confer and develop the initial service plan.

Once the applicant has been approved for care and authorized to receive a stipulated amount of personal care, the case is assigned to a licensed home care services agency (commonly referred to as a service vendor), whose nurse may conduct another needs assessment (also usually the M27R in New York City).¹³ Unlike other community-based long-term care programs, such as MMLTC and the LTHHCP, the personal care program does not include care management services. Provider agencies are responsible for managing the service plan, but not for other care coordination. Provider nurses are required to make four home visits a year to supervise the direct care worker (home attendant or housekeeper); on two of those visits (semi-annually) they re-administer the nursing assessment. County caseworkers are responsible for resolving problems with the service plan and may assist beneficiaries in obtaining information needed to reconfirm medical and financial eligibility. Caseworkers in New York City have an average caseload of 190 beneficiaries.¹⁴ In the consumer-directed program, the beneficiary or a family member acts as his or her own care coordinator.

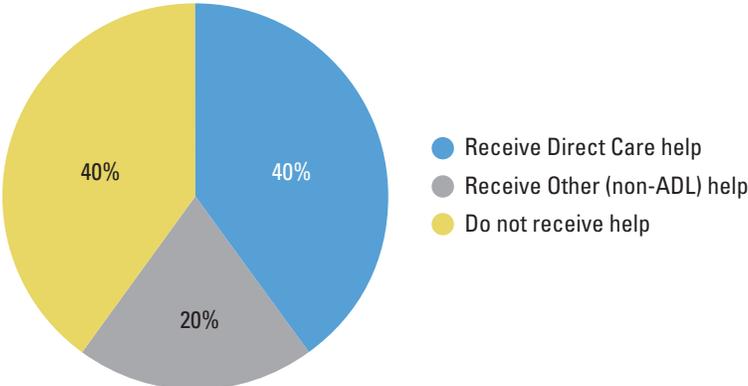
Family Involvement: There is no specific guidance about how the availability of family care should affect a beneficiary's eligibility or the hours of service authorized. Anecdotal evidence suggests that the availability of family care is an "unofficial" consideration in determining eligibility and hours of service, and that such subjectivity may affect regional variation in access and utilization.

¹³ There is more than one service vendor per zip code. Beneficiaries have the choice to switch vendors, and also to request a change in direct care worker assignment.

¹⁴ Data from Human Resources Administration.

An estimated 40 percent of traditional personal care program beneficiaries in New York City receive hands-on help with ADLs and IADLs from family members. An additional 20 percent receive other kinds of help from their families (Hokenstad et al. 1998). The extent of a personal care program beneficiary’s needs does not appear to change the likelihood of receiving help from families, nor does it seem to have a significant impact on the number of hours of help they provide.

Figure 3.9
Percentage of Traditional Personal Care Program Beneficiaries Receiving Family Help in New York City, 1995

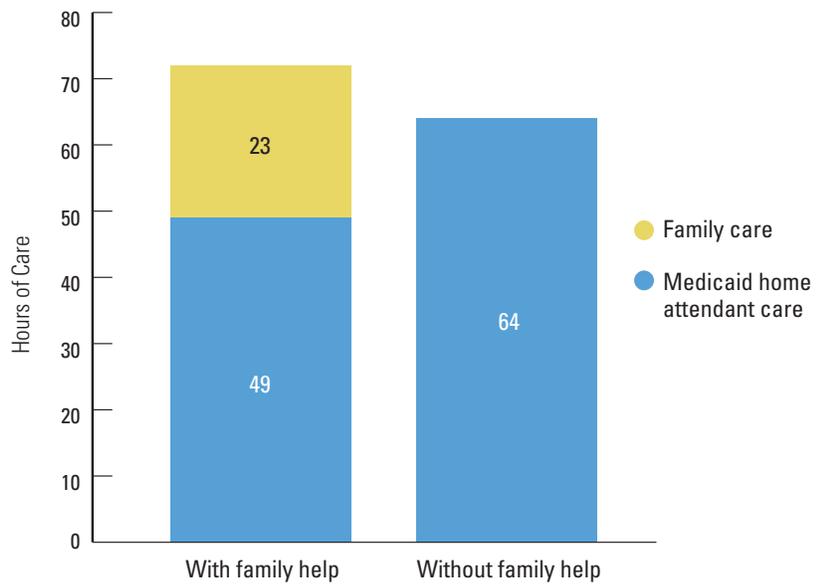


Source: Hokenstad et al. 1998.
Note: Figure includes beneficiaries receiving home attendant services only.

Personal care program beneficiaries who have the most extensive needs — and who have family available to help — receive, on average, 72 hours of direct care per week: 23 hours of family care plus 49 hours of Medicaid-financed care (Hokenstad et al. 2002).¹⁵ Those without family help receive, on average, eight fewer hours of total care per week. For beneficiaries with extensive needs, family care appears to supplement — and possibly substitute for — paid help (Hokenstad et al. 1998).

¹⁵ “Extensive needs” is a grouping that represents the 40 percent of personal care beneficiaries with an ADL score of 5 or more based on a 10-point scale; 4 or more and a clinically complex condition; or 3 or more and a severe behavioral problem. Data for the beneficiaries who scored in the two lowest RUGs (PA and PB) are not included.

Figure 3.10
Median Weekly Hours of Direct Care Services and Family Help for Beneficiaries with Extensive Needs in New York City, 1995



Source: Hokenstad et al. 2002.
 Note: Figure includes beneficiaries receiving home attendant services only.

Payment

The Medicaid program pays agency providers directly for each hour of service provided. The administrative component of the rate in New York City is approximately 9 to 11 percent. Average provider rates are \$16 per hour in New York City and \$21 per hour in the rest of the state. Differences in payment rates may be attributable to economies of scale that allow for efficiency in overhead expenditures, including training costs.

Table 3.2
Average Hourly Medicaid Provider Payment Rates for Traditional Personal Care, by Region, 2007

Region	Average Hourly Rate
New York City	\$16
Rest of State	\$21
Capital	\$21
Central	\$21
Long Island	\$21
New Rochelle	\$22
Western/Buffalo	\$20
Western/Rochester	\$21
New York State (Average)	\$20

Source: Based on estimate from HRA and UHF analysis of 2007 Medicaid reimbursement rate computation sheets for personal care program, available at http://www.health.state.ny.us/facilities/long_term_care/reimbursement.
 Note: Estimated weighted averages based on total patient hours of service, 2006.

In New York City, HRA actively monitors providers' finances, reviewing all provider expenditures at the line-item level. HRA conducts programmatic and financial audits three times a year, and arranges an annual independent audit of its personal care contracts.

Quality Monitoring

County governments monitor the quality of personal care programs on behalf of the state Department of Health. In New York City, HRA tracks and rates 34 service performance measures. Numerical scores are shared with individual providers as part of their "Vendor Stat" report, but are not publicly available. Poor performance results in the development of a corrective action plan. Lack of progress in making corrections may result in suspension of admission privileges (i.e., no additional client referrals). There are no specific rewards for achieving good clinical outcomes.

Policy Implications

New York's traditional and consumer-directed personal care programs play a fundamental role in meeting the long-term care needs of approximately 64,000 people each month. Much of this population suffers from multiple chronic illnesses that cause, contribute to, and interact with functional and cognitive disabilities; care for this group can be intensive and costly. In FFY 2007, Medicaid spending on this population's long-term care services was roughly \$2.5 billion. Although other long-term care service delivery models have emerged and grown over time, the traditional personal care program remains the flagship of New York City's community-based long-term care system. It provides a safety net for beneficiaries unable to enroll in other programs for a variety of reasons, such as resource intensity. This section of the report discusses current and future challenges of the personal care program, and identifies critical issues for further research and discussions about how the state might improve the delivery of Medicaid long-term care services in New York State.

Coordinated Care

The large number of traditional personal care program beneficiaries with nursing home level of care needs, an estimated two-thirds of personal care beneficiaries in New York City, is troubling. The personal care program provides neither care management nor coordinated access to the broader array of services available through program alternatives, such as the Long-Term Home Health Care Program or Medicaid managed long-term care. A reform strategy for New York State should consider explicit criteria about who should receive care management, a routine process for identifying such beneficiaries, and guidance on whether care management should be mandatory for them. It should determine whether care

management should remain available only through designated programs or be provided as a discrete service through the Medicaid state plan. Finally, since many long-term care beneficiaries have multiple chronic conditions, it will be important to more fully integrate long-term care with the delivery of medical, mental health, and social services.

Barriers to Accessing Program Alternatives

There are many reasons why beneficiaries might enroll in personal care instead of other programs. They may simply be unaware of the alternatives, which are not routinely discussed as part of the enrollment process, or they may be able to access personal care services faster than other programs. Beneficiaries may be counseled not to enroll in other programs (such as 1915(c) waiver programs or managed long-term care plans) that do not provide as much legal protection as the personal care program does. [See Chapter 1.] Finally, beneficiaries may not be able to enroll in alternatives because of the way some programs are financed and regulated. For example, the hard cap on individual spending in the LTHHCP means that individuals in New York City who require more than 36 hours of direct care services are frequently unable to enroll. (As a point of reference, an estimated 60 percent of personal care program beneficiaries in New York City receive 36 or more hours of direct care services per week.) Similarly, because payment rates for MMLTC plans are not risk-adjusted, they may have strong financial incentives or insufficient resources to enroll beneficiaries with the most extensive needs.

There is consensus that a reform agenda for New York should include a strategy for providing beneficiaries more timely information and guidance about their choice of program and provider at points of entry and transition. However, there is disagreement about how best to accomplish this: by consolidating access to all long-term care services through one designated local entity, or by building capacity into pathways that already exist, such as hospitals and CHHAs. New York City's HRA is also a common pathway into community-based long-term care, so its role in providing timely information should be carefully considered.

Consistent Service Determinations

In New York City, 24 percent of personal care program beneficiaries receive 12 to 24 hours of direct care per day, a level of service rarely found elsewhere in the state. In all likelihood, people outside New York City who require around-the-clock care, but do not have family members available to provide it, receive care in nursing homes. Differences in the way local districts interpret state policies (such as health and safety regulations and level of need

determinations) contribute to these stark regional differences, which are likely exacerbated by workforce shortages in some parts of the state. A reform strategy should explore opportunities to achieve more consistent implementation of policies and regulations, including more specific guidelines about the roles and expectations of family caregivers.

The use of a different assessment tool in each of the state's long-term care programs may be another factor in the variation among programs. The Department of Health is in the process of developing a much-needed uniform assessment and data set. Such a tool is a fundamental building block for system reform. It has the potential to help meet a number of desirable policy objectives, including providing a standardized basis for determining what resources are required to address a beneficiary's needs, and supporting a more robust evaluation of quality outcomes across programs and settings. Because several previous efforts to standardize an assessment tool have been unsuccessful, its accomplishment will depend on making this effort a high priority and garnering sufficient resources and stakeholder cooperation.

Family Care

Although family members of frail elderly Medicaid beneficiaries have no legal obligation to provide personal care, their contributions appear to provide a substantial supplement to service hours provided by traditional Medicaid personal care. Family participation is not an explicit eligibility criterion for receiving long-term care, but it is often a common consideration that influences both eligibility determinations and service allocation decisions. In some localities, beneficiaries with extensive needs who do not have family care available may be denied eligibility for personal care on the grounds that they do not meet health and safety requirements. In the current system, caregivers have no formal rights to information or services to support them in their caregiver role (Levine et al. 2006). The effect of reform proposals on their participation and well-being should be carefully considered. A reform agenda should more clearly define the role that availability of family care should play in determining program eligibility and hours of service. It should also explore policies and program strategies that would help support and sustain family caregivers' contributions.

Direct Care Workforce

As in other programs, direct care services account for a substantial share of long-term care service utilization and spending in the personal care program. In formulating a reform strategy for long-term care in New York, it will be important to examine cost-effective ways to provide worker training and evaluate worker competency. For instance, regional

consolidation of training programs for direct care workers in all of the state's long-term care programs could save costs and also be a catalyst for better education. Separately, a successful training curriculum must prepare workers to manage the situations they encounter effectively. For example, more than one-half of personal care beneficiaries have some degree of cognitive impairment, so training should provide a strong foundation in how to address the specific needs of this population.

The Role of Consumer-Directed Care

Outside of New York City, where the recruitment and retention of direct care workers has been more difficult, the small consumer-directed personal care program has grown fairly rapidly in the last five years.¹⁶ This growth is likely related to the severe workforce shortages in some parts of the state. A reform agenda should determine the role that consumer-directed care should play in a future service delivery system, including the extent to which beneficiaries may identify and hire their own workers. Future plans must also decide whether to continue to provide the option through a single program (consumer-directed personal care), or to incorporate it more broadly into other programs.

Administrative Payments

Data limitations make it difficult to compare the cost-efficiency of the various program alternatives. A commonly cited financial advantage of providing direct care through the personal care program is that it has the lowest administrative overhead of any of the state's long-term care programs (an estimated 9 to 11 percent). However, this low administrative payment may limit organizational growth and make it difficult to keep pace with advances in evidence-based practices, improve quality, and provide clinical specialization. More research is needed to evaluate the cost-effectiveness of various service delivery alternatives and the relationship between payment arrangements and quality outcomes.

¹⁶ We do not have complete information on program enrollment growth by region. The available information about regional distribution is from HRA.

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