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Independent Assessment Requirement for Personal Care Services (Health Services -- Medical Assistance -- General)

[LFB 2015-17 Budget Summary: Page 206, #6]

CURRENT LAW

Personal care services are a covered benefit under the state's medical assistance (MA) program. Personal care services are medically-oriented activities related to assisting recipients with activities of daily living necessary to maintain the individual in his or her place of residence in the community. These services are provided under the written orders of a physician and are performed by a personal care worker under the plan and supervision of a registered nurse. The specific covered services are the following: (a) assistance with bathing; (b) assistance with getting in and out of bed; (c) teeth, mouth, denture and hair care; (d) assistance with mobility and ambulation, including use of walker, cane, or crutches; (e) changing the recipient's bed and laundering the bed linens and the recipient's personal clothing; (f) skin care, excluding wound care; (g) care of eyeglasses and hearing aids; (h) assistance with dressing and undressing; (i) toileting, including the use and care of bedpan, urinal, commode, or toilet; (j) light cleaning in essential areas of the home used during personal care service activities; (k) meal preparation, food purchasing, and meal serving; (L) simple transfers, including bed to chair or to wheelchair and the reverse; and (m) accompanying the recipient to obtain medical diagnosis and treatment.

Of the activities of daily living that are reimbursable under MA, some are considered medically-oriented services, while others are considered incidental activities. Incidental activities include changing bed linens and laundering, light cleaning, and food purchasing, meal preparation, and meal serving (items (e), (j), and (k) in the list above). The MA program uses a personal care screening tool to allot a specific amount of time, in 15-minute units, to the medically-oriented activities based on the recipient's functional capabilities and medical condition. For the incidental activities, the screening tool adds an amount of time equal to one-third of the total time allotted for medically-oriented activities.

Personal care services must be included in a care plan developed in accordance with a physician's orders. The care plan is developed by a registered nurse (RN) employed by the personal care agency that provides the services. In developing the care plan, the RN must visit the person's home to assess his or her environment and functional level. The RN must review the care plan at least every 60 days, which involves evaluating the person's condition and discuss with the physician any necessary changes in the care plan.

Home health agencies, independent living centers, Wisconsin tribes and bands, certain county departments, and freestanding personal care agencies can be certified to provide personal care services. These agencies employ personal care workers, who provide the direct services, and employ or contract with registered nurses to prepare care plans and supervise the personal care workers.

GOVERNOR

Require, prior to an MA recipient receiving personal care services on a fee-for-service basis, that an entity that does not oversee, manage, or provide the personal care services conduct an assessment to determine the amount and frequency of services the individual requires.

Reduce MA benefits funding by $8,473,900 (-$3,546,900 GPR and -$4,927,000 FED) in 2015-16 and by $19,214,300 (-$8,073,100 GPR and -$11,141,200) in 2016-17 to reflect the administration's estimates of savings that would result by reducing the number of personal care hours that would be provided to MA recipients as a result of this provision.

Provide $4,061,200 ($2,030,600 GPR and $2,030,600 FED) in 2015-16 and $4,078,600 ($2,039,300 GPR and $2,039,300 FED) in 2016-17 to fund: (a) a contract with an entity to conduct assessments ($2,000,000 GPR and $2,000,000 FED annually); and (b) DHS program administration ($30,000 GPR and $30,000 FED in 2015-16 and $39,300 GPR and $39,300 FED) in 2016-17 and 1.0 position (0.50 GPR position and 0.50 FED position), beginning in 2015-16.

DISCUSSION POINTS

1. Personal care services (PCS) are provided to persons who need assistance with activities of daily living and medically-oriented tasks that can be safely designated to a personal care worker. Services are delivered by a personal care worker in accordance with a care plan prepared by a registered nurse. The plan is developed following a nursing assessment that must include a visit to the recipient's place of residence. The nurse must review the care plan at least every 60 days, which involves evaluating the person's condition and discussing with the recipient's physician any necessary changes.

2. The MA program reimburses the personal care provider $4.02 for each 15-minute unit of service provided. The program does not reimburse separately for the time needed to complete assessments and develop a care plan, worker training, filing documentation, or for other administrative duties. Consequently, these overhead costs, as well as personal care worker wages and benefits, must be covered from the reimbursement paid for the direct services provided by the

personal care worker.

3. Most recipients of personal care services qualify for MA based on disability or age status, although a small number of recipients qualify for other MA eligibility groups, including BadgerCare Plus. Some MA recipients who receive personal care services are enrolled in an MA long-term care program, such as Family Care, IRIS (Include, Respect, I Self-Direct) or one of the "legacy" long-term care waiver programs that operate in a county that has not implemented Family Care. Other MA recipients receive personal care as an acute care service (not long-term care).

4. Personal care services are provided either on a fee-for-service (FFS) basis or as part of the package of benefits offered to MA beneficiaries who are enrolled in a managed care organization (MCO) or health maintenance organization (HMO) plan. IRIS participants, participants in the long-term care legacy waiver programs, and MA recipients who are not enrolled in an HMO for acute care services receive personal care services on a FFS basis. Family Care participants receive personal care services through an MCO and other MA recipients who are enrolled in an HMO receive services through their health plan.

5. IRIS participants who are eligible for personal care services have two options for the delivery of those services. Under the self-direct option, a single statewide agency, under contract with DHS, conducts assessments to determine the amount and type of services needed. Using the results of this assessment, the agency develops a care plan and an associated budget that the recipient uses to employ his or her own personal care workers, which may include family members. Under the other option, a personal care agency conducts assessments to develop a care plan and also employs personal care workers who provide services.

6. The MA program must give prior authorization to any personal care service beyond 50 hours. Prior authorization is a process the program uses to ensure that the services meet criteria for medical necessity and that the care plan is consistent with the recipient's functional limitations. Over 90% of recipients of FFS personal care services use over 50 hours of service and thus require prior authorization. The prior authorization process requires the personal care provider to utilize the Department's personal care screening tool, which includes a series of assessment fields covering activities of daily living, such as bathing, dressing, eating, toileting, and mobility. The recipient's assessed functional needs in these areas are used to determine the amount of time and frequency of personal care services allocated for each task in the care plan.

7. Depending upon circumstances, the prior authorization review may involve a medical review by Department staff to determine whether the care plan is consistent with the physician's orders and the recipient's medical records. In other cases, the prior authorization process involves a clerical review, done by the MA program fiscal agent, to determine if the care plan is consistent with the personal care screening tool. The Department indicates that approximately one-fourth of care plans are subject to a medical review, while the remainder are subject to a clerical review only.

8. MA program expenditures for FFS personal care services have increased markedly in recent years, from $159 million in 2010-11 to $273 million in 2013-14, and increase of 72%. Most of this increase appears to be attributable to an increase in the number of persons receiving FFS personal care services, rather than an increase in the average amount spent per user. From 2011 to

2014, the number of persons receiving FFS personal care services at any one time increased by approximately 60%, from 7,900 to 12,600. [On an annualized basis, approximately 14,000 persons receive personal care services, although some receive services for only a part of the year.]

9. The bill reflects an estimate of a reduction in benefit expenditures associated with modifying the delivery of personal care services provided on a fee-for-services basis under the personal care agency model. Under the bill, the nursing assessment would be done by an entity that is independent of the personal care agency. The expenditure reduction is based on the premise that under the current system, the personal care agency has an interest in including more hours of service in the care plan than what would be medically necessary, since doing so would increase MA revenue (but not the reimbursement rate) for the agency. The administration believes that requiring an independent party to assess the medical necessity for personal care services would eliminate this conflict of interest and reduce the amount of unnecessary personal care services authorized.

10. The proposed change would not affect personal care services provided through a managed care organization or under the IRIS self-direct model, since these services are not subject to the same potential conflict of interest associated with the FFS personal care agency model. That is, for those MA beneficiaries enrolled in a Family Care MCO or an HMO, the health plan receives a capitation payment to provide services for the recipient under terms of a contract with the state, but has no financial interest in providing more services than are necessary. Under the IRIS self-direct model, the care plan is developed by an agency that is independent from the provider of services.

11. The Department cites recent investigations of the Department's Office of Inspector General (OIG) as evidence of the conflict of interest inherent in the current FFS personal care delivery model. In 2014, OIG conducted 87 in-home personal care assessments for persons who were already receiving FFS services and found that in 84% of these cases the screening tool prepared by personal care agencies included services that the OIG believed to be unnecessary based on the recipients' limitations. Although the Department notes that these assessments were selected cases in which there was reason to suspect that the screening tool completed by the provider allocated an inappropriate level of services, the Department believes that these evaluations provided sufficient evidence of an excessive level of services to require independent assessments for all FFS personal care services. In addition to these evaluations, OIG has conducted audits of providers and found that some personal care agencies had not provided proper documentation of services provided, had failed to follow plans of care, and had submitted claims for services that were not documented. In a few cases, OIG found sufficient evidence of fraudulent activity to merit suspension of payments to agencies.

12. The fiscal effect of the independent personal care assessment proposal consists of a decrease in MA benefit expenditures, an increase in MA administration funding to contract with a third party to conduct assessments and prepare care plans, and an increase to fund a position in DHS to administer the assessment program. The following table summarizes the funding changes.

Fiscal Changes for Independent Assessment of Personal Care Services

	2015-16	2016-17
MA Benefits Funding		
GPR	-$3,546,900	-$8,073,100
FED	-4,927,000	-11,141,200
Total	-$8,473,900	-$19,214,300
Program Administration		
State Operations -- GPR	$30,600	$39,300
State Operations -- FED	30,600	39,300
Contracted Services -- GPR	2,000,000	2,000,000
Contracted Services -- FED	2,000,000	2,000,000
Total Administration	$4,061,200	$4,078,600
Net Change		
GPR	-$1,516,300	-$6,033,800
FED	-2,896,400	-9,101,900
All Funds Net Change	-$4,412,700	-$15,135,700

13. The following sections of the paper provide a discussion of the following: (a) the administration's assumptions underlying reductions in personal care service expenditures as the result of the independent assessment proposal; (b) the proposed funding increase for contracting with a third party to conduct assessments; and (c) general policy considerations associated with the proposal, including impacts on recipients of personal care services and personal care service agencies.

Personal Care Services Expenditure Reductions

14. As with many budget estimates, the administration made certain assumptions regarding the impact of the proposal that cannot be tested in advance of implementation. For this reason, there is some degree of uncertainty in the administration's estimate of personal care expenditure reductions. The following points discuss some of these questions.

15. The reduction in MA benefit expenditures reflects the administration's assumption that personal care services would be reduced by 5% as a result of requiring an independent agency to complete the personal screening tool and develop a care plan. The PCS expenditure baseline used to calculate the 5% benefit cost reduction is $339.0 million in 2015-16 and $384.3 million in 2016-17, amounts that were reflected in the Department's MA program cost-to-continue budget request submitted in September of 2014. However, based on updated expenditure trends, the bill's cost-to-continue decision item reflects lower estimated PCS expenditures -- $309.4 million in 2015-16 and $339.7 million in 2016-17. Though this downward adjustment was made to the cost-to-continue item, the fiscal estimate for the independent assessment proposal was not updated to reflect a lower baseline.

Furthermore, based on more recent expenditure trends, FFS personal care expenditures are now projected to be lower in the biennium than assumed under the bill. The MA cost-to-continue reestimate prepared by this office projects personal care expenditures at $292.3 million in 2015-16 and $316.5 million in 2016-17. Consequently, to the extent that the administration's 5% savings assumption is accurate, the bill may overstate the potential benefit expenditure reduction associated with the independent assessment requirement. To achieve the savings reflected in the bill, the proposed change to the personal care delivery model would have to produce savings of approximately 6%, rather than 5%, if the new personal care expenditure estimate is used as a baseline.

16. The estimated savings associated with an independent personal care estimate could be updated downward by calculating the 5% reduction using a revised personal care expenditure baseline. However, the administration's 5% savings assumption itself is a budget assumption that should be characterized as an approximation. Although the administration believes that the budget proposal would result in some reduction in benefit expenditures, it is difficult to quantify the amount using available evidence. As noted above, the Department's Office of Inspector General found many cases in which an independent assessment of personal care services would have resulted in a less extensive care plan. However, these assessments represent a small sample of all FFS personal care recipients (87 out of 14,000) and were targeted to cases where OIG had reason to believe excessive care was being provided. Consequently, the data gathered from OIG's investigation cannot be used to develop an estimate of expenditure reductions that is applicable to the entire sample of FFS PCS care plans.

17. It should also be noted that some of the fraudulent activity that OIG has uncovered through its investigations of PCS agencies and care plans would not be prevented through the use of an independent assessment alone. An agency that bills for services that are not provided, fails to follow a care plan, or that fails to properly document services would not be prevented from continuing to do so if the assessment is completed by an independent agency. Any savings resulting from the proposal would occur due to the difference in the screening tool completed by an independent agency and those completed by the agency that provides the services.

18. Although FFS personal care expenditures have risen rapidly in recent years, expenditures in 2014-15 are currently projected to be approximately the same as in 2013-14, if not slightly lower. Between the time the Department's budget request was prepared (August of 2014) and the Department's most recent quarterly report of MA program expenditures in March of 2015, the estimate of 2014-15 FFS personal care expenditures has been revised downward by $39.5 million. By comparison, the Department's estimate of personal care expenditure reduction associated with using a third-party entity to conduct assessments in 2016-17 is less than half of that amount ($19.2 million). The recent leveling off of personal care expenditures raises the question of whether the Department's oversight and audit activity already has had the effect of limiting the kind of abuses that the proposal is intended to have. The Department believes that additional attention to personal care service providers by OIG has had an impact in limiting abuses. It is possible, therefore, that if the more stringent review of the delivery of personal care services has resulted in a reduction in the scope of care plans, then having a third party prepare the plans may not change their scope as much as anticipated.

19. Although there is some degree of uncertainty in the administration's estimate of FFS personal care expenditures, the amount by which the bill reduces MA benefit funding is small in relation to all MA benefit funding. The biennial reduction of $27.7 million (all funds) is 0.1% of total MA benefit funding under the bill. Even minor shifts in MA enrollment, utilization, or costs, relative to the bill's estimates, can shift total expenditures up or down by well more than the total estimated savings associated with the use of an independent agency for personal care assessments. Regardless of whether or not the Committee decides to approve funding for the administration of third-party assessment contracts (discussed below), the benefit reduction could be approved as proposed [Alternative A1] or funding could be restored [Alternative A2]. In the event that the Committee does not approve funding for the assessment contract, but approves of a reduction in benefits funding, the Department would be required to continue using OIG audits or other means to achieve the reductions.

Administrative Costs of Independent Assessment

20. The bill would provide $4,000,000 ($2,000,000 GPR and $2,000,000 FED) annually to contract with an agency to conduct the assessments and prepare the care plans. The Department assumes that the agency would conduct 20,000 assessments annually at cost of $200 each. Although there are approximately 14,000 persons receiving FFS personal care services on an annual basis, the Department estimates that 20,000 assessments would be conducted, when accounting for assessments needed following a change in medical condition. The $200 estimate is based on the per capita rate paid by state of North Carolina for a similar assessment program. In addition to the contract funding, the bill would provide 1.0 position in DHS to administer the contract.

21. The Department indicates that the details and specifications for the personal care assessment contract have not yet been determined and would be developed during the procurement and contract negotiations process. Issues to be defined in the Department's request for proposal include the method for determining the payment, contract performance measures, appeal procedures, and the training and qualifications for the personnel conducting the assessments. The Department indicates that independent assessments would be implemented gradually once the state enters into the contract, although the schedule of these assessments has also not yet been determined.

22. The Department indicates that the contract would likely begin at the beginning of calendar year 2016, although assessments under the contract would not begin until mid-2016, allowing for start-up activities, including hiring and training of personnel, to occur.

23. As noted above, the bill uses a 5% benefit reduction assumption for the proposal, but also assumes that only one-half of the savings would be realized in the first year, allowing for a six-month implementation timeline. However, the bill would provide for two full years of funding for the assessment contract. The Department indicates that the full year of funding in the first year would allow for the contractor's start-up expenses.

24. Although the Department anticipates that the contractor would have start-up costs prior to beginning assessments, the Department has not yet quantified these costs. However, given the delay in the start of the contract period until around January of 2016, and the fact that assessments

would not begin until mid-2016, a reduction in the amount provided for the contract in 2015-16 may be justified. The bill could be amended to reduce the amount provided for contract costs by $2,000,000 (-$1,000,000 GPR and -$1,000,000 FED), which would provide one-half of the annualized estimated contract cost in 2015-16, but still provide funding for start-up costs during the time period before assessments begin [Alternative B2a].

25. Since there are considerable uncertainties regarding many of the details of the contract, including the cost, the Committee may consider requiring additional legislative oversight. In addition to, or instead of, the alternative discussed in the previous point, the Committee could place the funding allocated for contract costs in the Committee's appropriation and require the Department to submit a request under s. 13.10 prior to the implementation of the contract to receive an appropriation supplement for the amounts needed in 2015-16 and 2016-17. In making the request, the Department could be required to report on several aspects of the contract, including the overall cost, the method by which the contract was procured, the method of determining the contractor payment, the training and qualifications requirements of personnel conducting assessments, the estimated number of assessments to be conducted, performance measures built into the terms of the contract, if any, and the procedure used for beneficiary appeals, if any [Alternative B2b].

26. The personal care agencies that currently provide services for MA recipients are not reimbursed for the time needed to conduct assessments and develop care plans. The agency's overhead costs, including costs associated with assessments, must be covered through the reimbursement for the direct service hours provided. Consequently, the decision to pay a third-party agency for conducting assessments and developing care plans would represent an additional cost to the program. In the event that the Committee does not approve of funding for contract expenses [Alternative B3], the Department would have to fund these expenses from base resources for administrative costs, or, more likely, would take other approaches, such as OIG oversight, to monitoring FFS personal care expenses.

Considerations Related to Impacts on Recipients of Personal Care Services

27. Representatives of disability advocacy groups have raised several concerns regarding the proposal to use a third-party agency to conduct personal care assessments. Some of these issues are discussed in the following points.

28. *Process Time*. Advocates are concerned that involving a third-party agency for conducting assessments and developing care plans will increase the amount of time elapsed between when personal care services are ordered by a physician and the time when services are first provided. During this time, the recipient may be required to continue performing activities of daily living that are difficult or unsafe, given the individual's functional limitations.

29. *Preparation of a Care Plan by a Party that does not Oversee Service Delivery.* Depending upon the scope of the contract, the third-party agency may prepare the care plan, in addition to completing the assessment. Under this model, the nurse who supervises the work of the personal care worker would have had no role in developing the care plan. In some circumstances, the RN may feel that the plan is insufficient or inappropriate for the recipient's needs. Unlike under the current delivery model, the care plan could not be adjusted without the involvement of the

contracted assessment agency.

30. *Inappropriate Reductions in Service*. Advocates for people with disabilities are concerned that the use of a third-party contractor would result in an unrealistically low allocation of hours for personal care tasks needed to provide the recipient with a safe living situation. They make the argument that the recent increase in personal care expenditures does not, by in large, represent fraud or inappropriate use of services, but rather reflects the increased utilization of resources necessary to provide the elderly and disabled the opportunity to remain in their homes, rather than in a skilled nursing facility. From this perspective, restrictions on the scope of personal care services may result in some MA recipients making the decision that they cannot continue to live at home, resulting, in turn, in higher MA expenditures for institutional care.

31. *Viability of Personal Care Agencies*. Because of low rates of pay in the personal care services industry, personal care agencies report that the rate of employee turnover is high. A reduction in the scope of personal care plans would potentially result in workers providing services to a larger number of clients per day. Although MA reimburses for time spent traveling between clients (within certain limits), the personal care travel expenses, such as vehicle, fuel, or transit costs, are not reimbursed. Consequently, an increase in the number of clients served per day would increase the worker's travel costs, potentially exacerbating the worker turnover problem.

ALTERNATIVES

A. MA Benefits Funding

1. Approve the Governor's recommendation to reduce MA benefits funding by $8,473,900 (-$3,546,900 GPR and -$4,927,000 FED) in 2015-16 and $19,214,300 (-$8,073,100 GPR and -$11,141,200 FED) in 2016-17 to reflect an estimated reduction in fee-for-service personal care expenditures associated with requiring a personal care services plan of care to be prepared by an entity that is independent of the agency that provides the personal care services.

2. Delete provision.

ALT A2	Change to Bill
GPR	$11,620,000
FED	16,068,200
Total	$27,688,200

B. Program Administration

1. Approve the Governor's recommendation to provide $4,061,200 ($2,030,600 GPR and $2,030,600 FED) in 2015-16 and $4,078,600 ($2,039,300 GPR and $2,039,300 FED) in 2016-17 and 1.0 position (0.5 GPR and 0.5 FED), beginning in 2015-16, for the purposes of contracting with an entity to conduct assessments and prepare care plans for personal care services delivered on a fee for service basis.

2. Modify the Governor's recommendation by adopting one or both of the following:

a. Reduce funding by $1,000,000 GPR and $1,000,000 FED in 2015-16 to reflect a delayed starting date for the third-party personal care assessment contract.

ALT B2	Change to Bill
GPR	- $1,000,000
FED	- 1,000,000
Total	- $2,000,000

b. Transfer the funding provided for third-party contract costs to the Committee's appropriation. Require the Department to submit a request under s. 13.10 of the statutes prior to start of the contract period that includes the following: (a) a request for an appropriation supplement of the amount needed to pay the state's obligation under the contract in 2015-16 and 2016-17; (b) a report providing information regarding the contract, the method by which the contract was procured, the method of determining the contractor payment, the training and qualifications requirements of personnel conducting assessments, the estimated number of assessments to be conducted, performance measures built into the terms of the contract, if any, and the procedure used for beneficiary appeals, if any.

3. Delete provision.

ALT B3	Change to Bill	
	Funding	Positions
GPR	- $4,069,900	- 1.00
FED	- 4,069,900	- 1.00
Total	- $8,139,800	- 2.00

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