A REVIEW OF THE NASSAU COUNTY DEPARTMENT OF SOCIAL SERVICES HOME CARE PROGRAM

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June 2000

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Prepared for:

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Center for Governmental Research Inc (CGR)
Mission Statement

CGR is an independent, nonprofit research and management consulting organization that serves the public interest. By developing comprehensive perspectives on issues facing communities, CGR distinguishes itself as a unique professional resource empowering government, business and nonprofit leaders to make informed decisions. CGR takes the initiative to integrate facts and professional judgment into practical recommendations that lead to significant public policy action and organizational change.

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Summary

The Nassau County Department of Social Services Home Care program includes Personal Care Services (PCS) and the Title XX Social Services Homemaker program. Based on New York State DOH data, the Nassau PCS program spent $97.3 million in calendar year 1998, far above the average for New York State counties whether measured on a per capita basis or per recipient. As a result of a thorough analysis of the programs in Nassau County and other urban counties in the state, CGR identified a variety of recommendations that can lead to reduced costs while still maintaining or even improving quality of care. Some recommendations are policy oriented, and do not necessarily result in direct program savings. Others are likely to result in savings, and where possible, specific savings estimates are presented throughout the report.

Department of Social Services Home Care Program

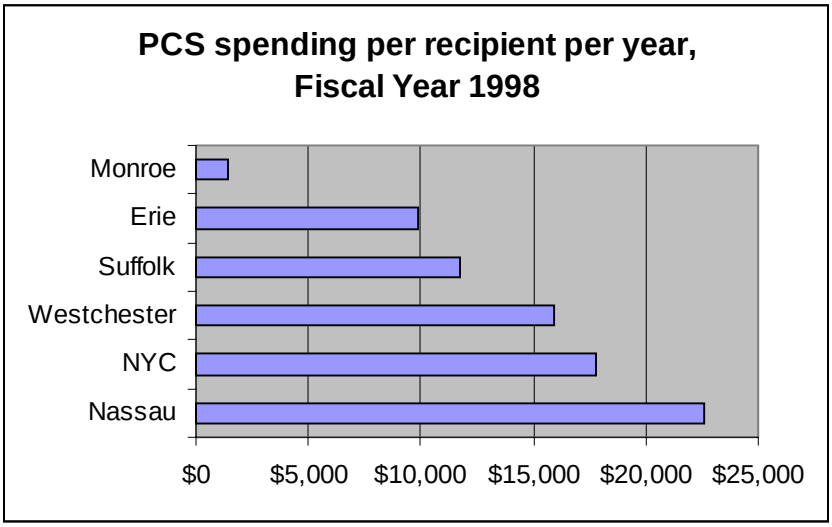
The primary component of the DSS Home Care Program is the Personal Care Services (PCS) program, also called the Personal Care Attendant (PCA) program in Nassau County DSS. This program is intended for persons with impairments who require assistance with activities of daily living (ADLs) to remain safely in their homes. Traditional PCS involves personal care aide visits to a client's home for one-on-one assistance with personal care. The agency providing the aide services is reimbursed on an hourly basis. Other DSS home care programs that utilize PCS aides include the Shared Aide program and the Long-Term Home Health Care (LTHHC) program, and potentially the Limited License program.

In addition to PCA, the DSS Home Care Program also includes the Social Services Block Grant Homemaker Services Program as defined in Title XX of the federal

Social Security Act. The Title XX Homemaker program is used in Nassau County to provide homemaker and housekeeping services to individuals who are not income-eligible for Medicaid.

What are the Problems?

We believe the initiative for this study stems from the substantial cost of the PCA program to the County. Despite the fact that Nassau is a high income county, it nonetheless spends a disproportionate amount of money (compared with comparable counties) on its PCS program, which is only for Medicaid beneficiaries. Some of the



manifestations of the high costs are documented below.

- Medicaid costs to the County account for approximately 13% of the County tax burden.

- Nassau County spends a disproportionate share of Medicaid dollars on PCS (10.9% in 1998) compared to the state as a whole (7.4%).

- Nassau County spends the most of any county (including those in NYC) per PCS recipient per year ($22,588 in 1998).

- Nassau PCS spending accounted for 33.6% of all spending on personal care outside of New York City, even though Nassau County accounts for only 12.8% of the over-65 population outside of New York City.

Medicaid Expenditures, 1998

Service Category	New York State	% of Total Spending	Nassau County	% of Total Spending
Total Spending	**$22,518,301,228**	**100.0%**	**$889,263,137**	**100.0%**
Personal Care (PCS)	$1,676,213,428	7.4%	$97,299,431	10.9%

Source: NYS DOH, MARS Report

What are the Solutions?

CGR identified a number of potential solutions to the high costs of the PCS and other home care programs in Nassau County.

Develop a Long-Term Care Policy and Comprehensive Plan for the County

CGR believes that DSS and the County government need to assess their expectations of both the DSS home care program, as well as other county-wide home care programs. In this time of fiscal instability, public officials should come together to form a County-wide Home Care policy group to develop a County policy and to consider long-term care alternatives proposed in this document to take steps towards reduced costs with improved quality of services. Further, the County legislature should consider its role in the support of DSS, and should consider passage of a local law, such as was done in Erie County, to aid DSS in its dealings with providers and other aspects of the program.

Improve Management Tools for Oversight

Management requires the necessary tools to run an efficient program. The lack of automation in the DSS home care program is a considerable burden. Without the means to track and monitor cases electronically, the job becomes prohibitively time-consuming. We strongly recommend that DSS implement tracking software, which would allow for

data-driven performance indicators, better tracking of patients, better oversight of providers and aides, the ability to monitor the LTHHC program, and a substantial reduction in the time spent on paperwork and other clerical functions. It is difficult to estimate the dollars to be saved from automation, but other counties believe that automation allows them to reduce staff, monitor cases much more efficiently, and identify problems much earlier.

Use Home Care Programs more Efficiently

CGR found that several DSS home care program components--including traditional PCS, LTHHC, Shared Aide, and Limited License--are not used in an optimal manner. Several of our recommendations revolve around the re-organization of these programs. For example, several staffing issues are of concern. It appears that the nurses do not have sufficient clerical support, which results in less than optimal use of nurse time. In the recommendations section we discuss reorganization of the staff that could lead to a more productive and efficient home care program.

Hours allocated to patients in the traditional PCS program are high compared to programs in other counties. *If DSS could reduce the number of hours allocated per patient per week by one hour, savings to the County would be $2,281,500 (County share is $228,150). If DSS could reduce average hours per week to the mid to high-20s, as has been done in Westchester, Suffolk, and Erie Counties, annual savings would approach $45 million, with a County share savings of $4.5 million.*

Full utilization of the LTHHC slots allocated to the Nassau County DSS could realize *gross savings of $3,715,500 annually (County share $371,550).* If Nassau County DSS were to increase the proportion of PCS clients in a Shared Aide site to the proportion in Shared Aide in Erie County (34.6%), *savings would approach $7,128,773 (County savings $712,877).* If the County would approve the use of Limited License Adult Homes, we estimate that *savings could be approximately $374,400 annually (County share $37,440).*

Some counties have implemented a central intake/screening unit for all patients entering the home care system. This unit is able to consistently screen potential clients, and refer them to the most appropriate home care option given their particular needs.

Such a unit provides DSS with more control over the intake process, and simultaneously ensures that clients are receiving the most appropriate level of care.

Use Licensed Provider Agencies More Efficiently

Nassau County DSS has not taken a proactive approach to working with the providers they rely on for personal care aides. CGR believes DSS should establish mechanisms for aide and provider agency oversight, establish standards for provider inclusion in the program, and consider a change in their reimbursement system. While it is important to maintain a positive and productive working relationship between DSS and provider agencies, DSS nonetheless can take steps to make these relationships more efficient and effective. If the average hourly rate paid to agencies for aides were reduced by $.10, the county could save $812,500 annually (County share $81,250). A $.50 per hour reduction would save about four million dollars, with county savings of about $400,000.

Room for Optimism

In the course of this project we found many reasons to be optimistic about the DSS home care program in Nassau County. Clearly a number of dedicated staff persons are employed by DSS, and the citizens of Nassau County can count on receiving high quality care. However, we also found that the program is not run as efficiently as possible, and we found several areas where minor shifts in the program could lead to substantial savings and enhanced quality of service. While some of our recommendations, such as the move towards automation, would require up front expenditures, these expenditures will pay for themselves many times over in the long-run. We encourage DSS and County officials to take recommended action to improve services and reduce costs.

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Acknowledgments

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Staff Team

This project was directed by Kent Gardner, CGR's Director of Economic Analysis. CGR Research Associate Sarah Boyce Fasick is the primary author of the report and conducted much of the investigation and analysis. CGR Senior Research Associate David Bond contributed significantly to the conceptual approach and development of this report.

CGR called on the specialized expertise of consultants James Fatula, Ph.D., Associate Professor at the State University of New York at Brockport; Gabriel T. Russo, CSW, former Monroe County Commissioner of Human Services and former Commissioner of the New York State Department of Social Services; and Claudia Tuckey, Home Care Consultant. Their contributions had significant bearing on our analyses and recommendations.

I. Introduction

A. Background and Context

In 1998, the Nassau County Department of Social Services (DSS) decided to pursue a full review of their home care services program due to increasing costs, changes in the population, and changes in regulatory requirements. For the purpose of this review, home care services include the Medicaid Personal Care Attendant program (PCA), also referred to as Personal Care Services (PCS) in state regulations, and Title XX Social Services Block Grant Homemaker services (SSBG). The goal of the project is to evaluate DSS's internal administration of the home care services program, as well as the manner of delivery of home care services to eligible recipients. CGR (Center for Governmental Research) was engaged to perform this review. As part of the review, CGR gathered relevant County and State data on the home care programs, interviewed stakeholders in the home care services programs, and compared the Nassau programs to those in other counties. This report presents background material, the current state of the home care program, and recommendations for improved efficiency and effectiveness.

B. Purpose and Objectives of Project

The primary purpose of this project is to help DSS develop a comprehensive picture of the strengths and weaknesses of the home care program as it currently functions, and to develop recommendations for improved efficiency. Medicaid is a substantial component of the Nassau County budget and is an area the County has targeted for improved efficiency. The County takes pride in the services it provides for its elderly and disabled residents and is understandably reluctant to reduce the present level of services. It is possible, however, to maintain current services while improving the efficiency of service delivery. CGR conducted a thorough evaluation of current home care service provision in the County, evaluated the provision of home care services in other counties, and developed practical recommendations for improved efficiency in Nassau County.

This report outlines the current state of the DSS home care programs in Nassau County, and presents several recommendations for changes designed to lead to more efficient, better quality provision of home care services to the disabled and elderly. In making recommendations, CGR considered not only the cost and administration of each home care program individually, but also the DSS home care system as a whole. We considered the best use of each of the home care programs, including traditional PCS, Shared Aide, LTHHC, Title XX, and others.

C. Study Approach and Process

Interviews in Nassau County. The first phase of the home care services review involved a series of in-person interviews with various stakeholders in the provision of home care services in the County. In this initial portion of the project CGR gained a comprehensive understanding of various perspectives on home care in the community, learned which program areas were of particular concern or interest, identified common themes and competing interests, and began to identify problem areas that could lead to recommendations for change. CGR held interviews in Nassau County with various personnel at DSS, certified home health care agencies, a provider of the Long-Term Home Health Care (LTHHC) program, County Legislators, and the Expanded In-home Services for the Elderly Program (EISEP). This interview process provided information for comparison purposes, and revealed innovative approaches to the provision of home care services in terms of controlled costs and improved quality of care.

Management Review of Nassau County Home Care Services. CGR interviewed staff at all levels of DSS involved with the following programs: PCA, Title XX, LTHHC, Shared Aide, Consumer-Directed Care, and the Commonwealth program. This series of interviews included program directors, personnel responsible for scheduling, staffing, vendor oversight, case management, and direct service provision.

Data Collection. CGR reviewed any appropriate written materials pertaining to the various home care programs. These materials were part of a comprehensive review of services provided throughout the County. In addition, CGR reviewed numerical data

generated by Nassau DSS and from the NYS DOH, Office of Continuing Care, as well as data from home care programs in other counties.

Survey of Home Care programs in Metropolitan Counties. CGR interviewed DSS staff in-person in several metropolitan counties to review the organization of home care services, differences in service provision, management approaches, and cost control approaches in other counties. CGR identified best practice approaches where possible, and generated many recommendations for Nassau County out of this process.

Interviews with the State Agencies. CGR met in-person with representatives in the relevant program areas at the NYS Department of Health Office of Continuing Care, which oversees the Personal Care Services program and the LTHHC program, and at the Department of Family Assistance (DFA), which oversees Title XX funding. The state perspective was an important addition to county perspectives on issues surrounding home care.

II. Long-term Care in New York State

In its 1996 report, "Securing New York's Future: Reform of the Long-Term Care Financing System," the State Task Force on Long-Term Care Financing expressed its frustration with the lack of long-term care service options in the state and noted that "the current system is the result of the lack of a coordinated long-term care policy" at the state level. It went on to note that "the type and amount of long-term care provided in New York State has relied on the availability of public financing, especially Medicaid." The Task Force concluded that dollars alone, rather than any rational policy, have historically shaped long-term care provision in the state. With perhaps a few exceptions, similar comments can also be made about counties throughout the state. Very few counties have clear goals about the provision of long-term care services for their older and disabled residents.

In most counties, individuals and families make decisions about long-term care options with little or no overall discussion of issues such as the most appropriate level of care, the relative costs of such care, and the options that make most sense for

the individual and family. The net effect is that even those who are conscientious and want to make smart decisions about home care options typically must do so without the guidance of either a statewide or county policy perspective on long-term care. *Without a long-term care policy framework, the decisions that need to be made about the use of various home care services are far too likely to be made on an ad-hoc basis, without adequate consideration for the County's overall needs or the overall needs of the client seeking services*. As a result, some of the problems that exist at the county level in Nassau stem from this lack of a coordinated state long-term care policy framework. Nonetheless, a number of other counties have been successful in articulating and implementing more efficient home care programs.

A. Medicaid Program

With the exception of Title XX in-home services, DSS-funded home care services are funded through the Medicaid program. Medicaid is a jointly funded federal-state program that is administered by the states within federal requirements. Authorized under Title XIX of the Social Security Act, the program covers more than 40 million low-income individuals in the country, one-half of whom are children (U.S. GAO, 1999). The program is also known as the nation's number one financing mechanism for long-term care coverage, including nursing home, home health, and personal care services. While the elderly and disabled make up a small portion of Medicaid beneficiaries nationally (27%), they account for the vast majority of spending (72%) because of their use of acute and long-term care services (Kaiser Family Foundation, 2000).

Medicaid is an entitlement program based on financial need, among other things. That is, it is intended for certain low-income individuals who fall into certain categories (blind or disabled, elderly, children, adults receiving cash assistance). Each state is required to provide core services as mandated by the federal government. The states then may opt to provide additional services; as a result of the optional services, Medicaid functions as 56 different programs. This includes a separate program in each state, plus the District of Columbia, Puerto Rico, and the U.S. territories. Eligibility is based on income and resource levels. The federal government establishes mandatory eligible groups, and the states can include

additional optional groups. The state and federal governments are required to pay for all covered services provided to an eligible individual. Personal care services (PCS) are not mandated by the federal government and are an optional service that NYS chooses to provide.

Medicaid costs increased at double-digit rates nationwide in the late 1980s. A variety of factors drove these costs, including increasing enrollees, increasing prices of medical and long-term care, increased use of covered services, and state decisions about coverage for optional eligibility groups or optional services. Federal Medicaid spending grew at an average annual rate of nearly 20 percent between 1988 and 1993. The growth slowed to three to four percent in 1996 and 1997, and is expected to remain in the single digits. This drop in growth is due in part to federal legislation passed in the 1990s regarding hospital payments and provider-based financing techniques.

Medicaid costs make up a substantial portion of state and county budgets. State costs vary substantially due to variations in eligibility, benefits, and payments to providers from state to state. In 1997, states spent 10% of their general fund dollars on Medicaid, on average (Kaiser Family Foundation, 2000). The federal government pays at least 50 percent of the cost of Medicaid in each state, and up to 83 percent, depending on the state's per capita income. States with lower per capita income receive the higher federal match. The federal match for New York State is 50 percent. In New York State, the state (25%) and counties (25%) split the remaining 50 percent of Medicaid costs for acute care services. However, for long-term care services, the county share is lower (40% state share and 10% county share). Because personal care services are a long-term care component, the county share is 10% for these costs.

B. Personal Care Services in New York State

Provision of Personal Care Services (PCS) is optional for states under Title XIX (Medicaid). The federal statutory authority for the provision of PCS is found in section 1905 (1) (7) of the Social Security Act. Federal regulatory authority is found in the Code of Federal Regulations, Title 42 Public Health Chapter IV, 440.167. New York State statutory authority is found in NYS Social Services law 365-a(2)(e). State regulatory requirements are found in 18 NYCRR 505.14 (NYS DOH Office of Continuing Care, 2000).

As described in the above regulations, PCS includes some or total assistance with personal hygiene, dressing and feeding, and nutritional and environmental support functions. To qualify for PCS, a client must be Medicaid eligible, have a doctor's order for PCS, be self-directing or have someone available to provide direction, must be medically stable, and the client's health and safety in the home must be able to be assured by provision of services.

Once a client is deemed eligible for PCS services, local social services districts may arrange for the provision of such care through a contracted Long-Term Home Health Care Program (LTHHC), a Certified Home Health Agency (CHHA), or a licensed home care services agency (LHCSA). Most social service districts, including Nassau, contract with LHCSAs for personal care aide services.

At one time, the state DOH had a heavily staffed local district monitoring division that permitted frequent visits to districts. These visits provided an opportunity for the state representatives to identify areas in which the districts were non-compliant with regulations, and help the districts to correct the situation. Due in part to restructuring when the state DSS and DOH merged, the division no longer is staffed to conduct such visits.

III. Nassau County Characteristics

A. Medicaid and Nassau County

Table 1: Total Medicaid Spending, Calendar Years 1997-1998

	1997	1998
New York State	$20,367,049,658	$22,518,301,228
Nassau County	$822,067,003 (4.0%)	$889,263,137 (3.9%)

Source: New York State Department of Health, MARS Reports

In 1998, total Medicaid spending in the state amounted to $22.5 billion, a 10.6 percent increase over 1997 (Table 1). Medicaid spending for Nassau County increaed more slowly than the state's (8.2 percent), and amounted to $889.3 million in 1998. While Nassau County comprised 7.2 percent of the NYS population in 1998, the County's portion of Medicaid spending was lower, at 4.0 percent. While the lower increase in spending from 1997 to 1998 and the lower proportional costs for Medicaid considering the County's population are positive indicators, this discussion must also acknowledge Nassau County's overall wealth. Medicaid is designed for certain low income people, and Nassau is one of the wealthiest counties in the state. Wealthy counties would be expected to spend less on Medicaid dollars than less wealthy counties (Table 2).

Table 2: Median Household Income, Selected Counties, 1995

State Average	$33,805
Nassau	**$58,155**
Westchester	$53,043
Suffolk	$52,080
Monroe	$41,278
Erie	$33,554

Source: U.S. Bureau of Census

Table 3 shows a breakdown of Medicaid expenditures by service for New York State and for Nassau County for 1998, based on state DOH data. Of the $889 million spent by Nassau County on Medicaid services in 1998, the biggest spending category was skilled nursing facilities (SNFs), which represented nearly a third of total Medicaid spending (32.2 percent). This was followed by spending for hospital inpatient costs (17.5 percent), and by spending for personal care (10.9 percent). Compared to the state figures, Nassau spends disproportionately more on SNF costs and on personal care, but spends less on hospital inpatient costs.

State Medicaid spending on personal care services in 1998 amounted to $1.7 billion, an increase of 7.6 percent over 1997 (Table 4). The spending on personal care services comprised 7.4 percent of all Medicaid spending in the state. New York City accounted for $1.4 billion, or 82.7 percent of all spending on personal care in the state. Spending on personal care for the rest of the state declined by $5 million from 1997 to 1998.

Table 3: Medicaid Expenditures, by Service Category, 1998

Service Category	New York State	% of Total Spending	Nassau County	% of Total Spending
Total Spending	**$22,518,301,228**	**100.0%**	**$889,263,137**	**100.0%**
Hospital Inpatient	$5,215,191,128	23.2%	$155,220,151	17.5%
Hospital Outpatient	$1,361,600,611	6.0%	$36,350,670	4.1%
Freestanding Clinic	$1,261,868,686	5.6%	$59,224,367	6.7%
Skilled Nursing Facility (SNF)	$5,048,699,962	22.4%	$286,112,796	32.2%
Child Care Per Diem	$116,722,223	0.5%	$1,232,534	0.1%
ICF DD	$422,647,811	1.9%	$31,085,649	3.5%
Physician Services	$362,457,817	1.6%	$10,963,316	1.2%
Dental	$102,973,600	0.5%	$2,015,552	0.2%
Drugs/Supplies	$1,701,208,422	7.6%	$50,191,255	5.6%
Personal Care (PCS)	$1,676,213,428	7.4%	$97,299,431	10.9%
Home Health	$714,227,208	3.2%	$8,603,059	1.0%
LTHHC	$634,022,530	2.8%	$41,922,665	4.7%
Assisted Living	$28,843,863	0.1%	$80,429	0.0%
Transportation	$221,929,536	1.0%	$11,911,386	1.3%
Lab/Xray	$59,362,023	0.3%	$1,014,667	0.1%
Prepaid Services	$1,969,973,172	8.7%	$42,982,051	4.8%
Other	$1,620,359,208	7.2%	$53,053,159	6.0%

Source: NYS DOH, MARS Report

Table 4: Personal Care Expenditures: 1997-1998

	1997	1998
New York State	$1,557,979,719	$1,676,213,428
New York City	$1,263,224,685	$1,386,440,676
Rest of State	$294,755,034	$289,772,752
Nassau County	$96,916,096	$97,299,431

Source: New York State Department of Health, MARS Reports

Spending on personal care services in Nassau County in 1998 increased 0.4 percent to $97.3 million, and accounted for 10.9 percent of all Medicaid spending in the county. *More importantly, Nassau's spending on personal care services accounted for 33.6 percent of all spending on personal care*

outside of New York City, even though Nassau County accounts for only 12.8 percent of the over 65 population outside of New York City.

Based on Nassau County DSS data, total Medicaid spending in Nassau County has grown over the last decade from $418 million in 1990 to an estimated $916 million in 1999, an increase of 119 percent over nine years (Table 5).[1] Spending on long-term care services—institutional, such as nursing home care, and non-institutional, such as personal care services—accounts for a significant, but declining portion of total Medicaid spending in the county. In 1990, spending on nursing home services (skilled nursing facilities (SNF) and intermediate care facilities (ICF)) amounted to $197 million and accounted for 47.0 percent of total Medicaid spending in the County. This grew to an estimated $322 million in 1999, but shrunk in terms of total Medicaid spending to 35.2 percent. Spending on personal care and home health care grew from $61 million (14.6 percent of total Medicaid spending) in 1990 to $107 million (11.7 percent) in 1999. Based on DSS data, PCA costs account for 90 to 95 percent of the "personal care/home health" spending category.

Table 5: Medicaid Spending in Nassau County, 1990-2000

	Total Medicaid	PCA and Home Health		SNF/ICF	
		(Dollars)	(Percent)	(Dollars)	(Percent)
1990	$418,405,889	$61,035,486	14.6%	$196,600,270	47.0%
1991	$494,332,657	$78,027,160	15.8%	$223,067,673	45.1%
1992	$567,593,665	$90,419,249	15.9%	$240,842,566	42.4%
1993	$648,335,807	$108,237,559	16.7%	$252,759,858	39.0%
1994	$763,481,735	$115,625,030	15.1%	$283,436,793	37.1%
1995	$822,981,201	$119,030,201	14.5%	$292,799,760	35.6%
1996	$819,788,291	$108,267,933	13.2%	$284,401,875	34.7%
1997	$818,426,018	$99,862,709	12.2%	$311,058,933	38.0%
1998	$875,701,695	$100,618,259	11.5%	$321,511,405	36.7%
1999 est.	$915,897,506	$107,302,653	11.7%	$322,407,603	35.2%
2000 est.	$961,692,382	$112,667,786	11.7%	$338,527,983	35.2%

Source: Nassau County Department of Social Services

Another way to compare spending on institutional and non-institutional expenditure is the following. In 1990, Nassau County spent $3.22 in gross Medicaid costs for

[1] Note that some data categories in tables 3 and 5 are the same, but the actual figures differ slightly. Table 3 is based on NYS DOH data while table 5 is based on Nassau DSS data.

SNF/ICF services for every $1.00 it spend on PCA/home health. In contrast, in 2000 Nassau County will spend slightly less at $3.00 on SNF/ICF for every $1.00 it spends on PCA/home health. While Medicaid spending on institutional services has declined as a percentage of total spending, Medicaid spending on institutional services relative to spending on home care services has not changed significantly over time.

Since our charge in this report was to examine Medicaid home care services, we did not explicitly analyze Medicaid nursing home costs and the factors affecting them. Nevertheless, we can make some observations about spending on nursing home services. County Medicaid spending on nursing home costs is affected by a number of factors. Certainly the increasing availability of alternatives to institutional care (the various home care programs including LTHHC, the expansion of adult day care services, enriched housing and other housing options for seniors, and assisted living) has affected the use of institutional care. In addition, the relative supply of nursing home beds in a county, and Medicaid's payment system using Resource Utilization Groups (RUGs), have had a significant impact on nursing home utilization. Finally, per capita income and wealth also significantly affect Medicaid nursing home use in counties. Most individuals who are admitted to nursing homes in New York State enter as "private pay" individuals. If they remain in the nursing home long enough, they "spend down" their assets and their income, and become Medicaid eligible.

Individuals with higher levels of monthly income who become Medicaid eligible due to a nursing home stay contribute higher amounts of their income for the cost of care (as required by the Medicaid program), thus offsetting Medicaid spending to some extent. Counties like Nassau with higher per capita income are more likely to have relatively lower Medicaid nursing home costs as a result.

The Nassau County budget has come under severe criticism recently from the New York State's Office of the State Comptroller. A memo dated March 1999 outlined a deficit of $150 million for the County in 1998. Social Service expenditures were mentioned as one source of expenditures that exceeded expectations in 1998. In addition, the 1999 budget was said to have insufficient appropriations of $30 million for Medicaid MMIS expenditures.

Nassau County is one of four local social service districts that was given a state-determined spending target for the period July 1, 1999 to June 30, 2000. Other districts include NYC, Westchester, and Ulster. In a time of fiscal shortfalls, CGR through this report provides the County with recommendations that will lead to improved efficiencies in the County's Home Care program.

For County budgeting purposes, it is the "County share" of Medicaid spending that is most relevant.[2] Since the County share of long-term care costs is 10 percent, the net County share for the estimated $107 million to be spent on personal care/home health services in 1999 will be $10.7 million. Generally, the "net County share" for Medicaid is included in the County budget, not "total" or "gross" Medicaid spending. Nassau County's share of Medicaid costs ranges from 10 to 25 percent depending on the type of service. We estimate that the net county share of Medicaid spending has grown from $66 million in 1990 to over $164 million in 1999. This "county share" for Medicaid spending comes directly out of county-raised taxes, such as the sales tax and property tax. County sales and property taxes are estimated to be about $1.26 billion in 1999. Based on this tax figure, net Medicaid costs to the County account for about 13 percent of the County tax burden.

B. Demographics of Nassau County

Some have suggested that Medicaid long-term care costs in Nassau County are so high because the county has a disproportionately large elderly population. Data from the U.S. Bureau of the Census indicate that while Nassau's elderly population has been growing more rapidly than many other large metropolitan counties across the state, the proportion of the elderly compared to the total population is still comparatively low. Table 6 shows a comparison of Nassau County to others such as Westchester, Suffolk, Queens, Erie (Buffalo), and Monroe (Rochester).

When evaluating the age of a population, it is useful to examine the percentage of the population that is age 65 and older, as well as the portion of the population that is 85 and older. While those age 65 and older are considered the "elderly," due in

[2] Both Nassau County records and NYS Department of Health (NYS DoH) summary tables from the MMIS payment system were used for the budget analysis, as discussed below and also as discussed later in the cost analysis section.

part to age 65 being a traditional retirement age and the age of eligibility for Social Security and Medicare, it is really those age 85 and older, or the "oldest-old" who are of most interest in terms of disability and health care costs. The oldest-old population is the fastest growing population segment across the United States, as people are living longer both with and without disability.

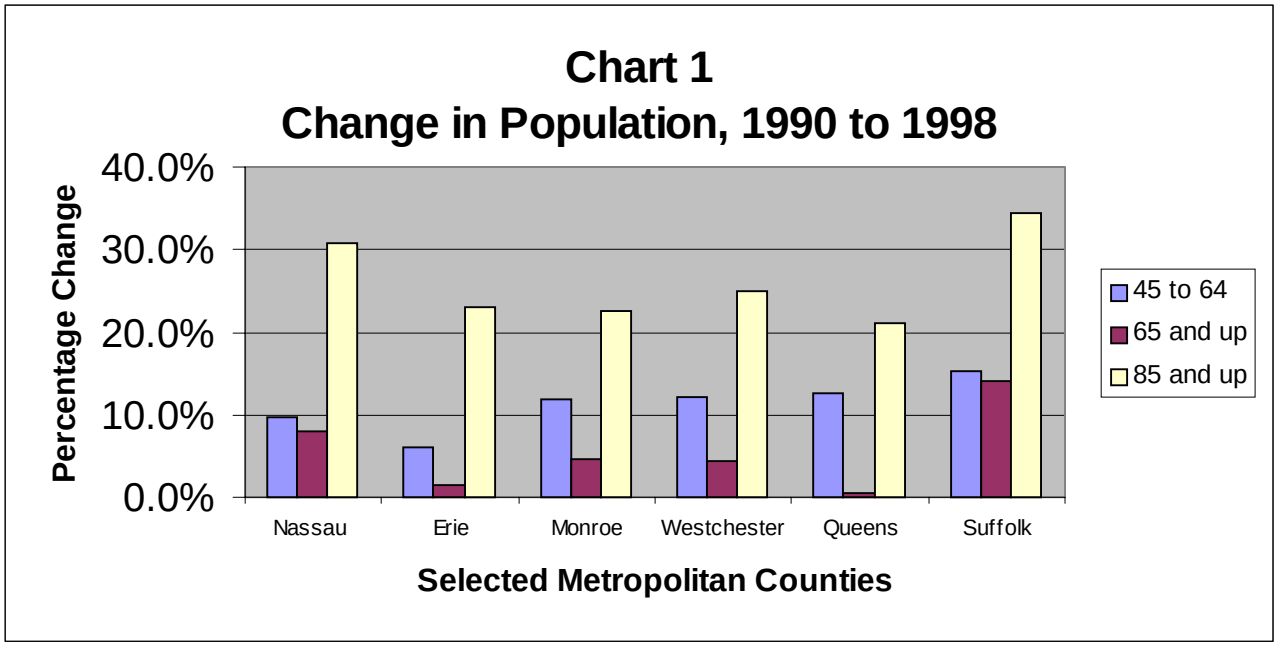
Table 6 shows that among NYS metropolitan counties, the percentage of the population that is age 65 or older in 1998 was 15.1 percent in Nassau County. While this is significantly higher than Suffolk (11.7 percent) and Monroe Counties (13.0 percent), it is comparable to or lower than the percentage in Erie (16.0 percent), Westchester (14.6 percent), and Queens Counties (14.3 percent). To provide a more complete picture of the elderly population in the county, Table 6 presents the percentage of the elderly (ages 65+) who are over age 85. This figure indicates the frailty of the elderly population, and may provide a sense of the level of home care needs in a community in comparison to other counties. Among the elderly population, Nassau County has the lowest percentage of oldest-old among the comparison counties. While the percentage of persons aged 85 or older among the elderly population in Nassau comprises 10.7 percent, this is lower than the percentages in Westchester (13.3 percent), Suffolk (11.7 percent), Queens (12.2 percent), Erie (11.2 percent), and Monroe Counties (13.3 percent).

Table 6: Demographics of Nassau and Other NYS Metropolitan Counties, 1998

	Total Population	Persons Age 65+		Persons Age 85+		Percentage of Those Aged 65+ Who Are 85+
County						
Nassau	1,302,220	197,132	15.10%	21,170	1.60%	10.70%
Westchester	897,920	130,740	14.60%	17,398	1.90%	13.30%
Suffolk	1,371,269	161,045	11.70%	18,798	1.40%	11.70%
Queens	1,998,853	286,282	14.30%	34,890	1.70%	12.20%
Erie	934,471	149,167	16.00%	16,651	1.80%	11.20%
Monroe	716,072	93,221	13.00%	12,375	1.70%	13.30%

Source: U.S. Bureau of the Census, 1999

Chart 1 shows changes in the percentage of various age groups between 1990 and 1998. The elderly population in Nassau has grown more quickly than in the other comparison counties except for Suffolk. The over 85 population in Suffolk has grown more rapidly than in Nassau, and the over 65 population has grown much more quickly in Suffolk compared to the other counties.



In addition to the 65 and older age group, it is also critical for planning purposes to evaluate the growth of the population aged 45 to 64, since they are in the pipeline to become elderly within the next two decades. Chart 1 shows the percentage increase in persons aged 45 to 64 since 1990 among comparison counties. For all counties, the number of persons, as well as the rate of increase in the size of this age cohort is increasing rapidly. While Westchester, Suffolk, and Queens counties are experiencing faster increases in this age group, Nassau saw a 2.2 percent increase in those aged 45-64 between 1997 and 1998. If this rate of increase is maintained, the elderly age groups can be expected to grow dramatically in the next 20 years. Table 7 shows the distribution of those aged 45 to 64 over the last decade among comparison counties.

Table 7: Population Aged 45 to 64, Selected Counties, 1990-1998									
	1990	1991	1992	1993	1994	1995	1996	1997	1998
Nassau	294,001	292,289	296,888	299,346	302,056	305,408	309,637	315,539	322,484
Westchester	191,863	190,817	194,531	196,846	199,052	201,917	205,645	210,008	215,156
Suffolk	276,503	275,241	282,242	287,220	291,611	296,235	302,139	309,793	318,617
Queens	399,060	396,904	401,576	406,489	411,678	418,158	427,622	437,764	449,700
Erie	193,729	192,704	195,793	197,249	198,377	199,414	200,899	203,189	205,565
Monroe	131,998	131,771	135,387	137,555	138,890	140,093	142,066	144,744	147,527
Source: U.S. Census Bureau, Population Estimates Program, Population Division, 1999									

Our review of the data indicates that Nassau County does not have a disproportionately older population when compared to surrounding metropolitan counties, nor when compared to upstate metropolitan counties. While the elderly population has been growing at a faster rate in Nassau when compared to other counties (Suffolk excepted), the current proportion of elderly is still comparable to most counties. The aging of the population will continue to present long-term care challenges for all counties in the years to come. Based on Nassau's demographics, the County is spending a disproportionate share of dollars on its PCS program.

IV. DSS Home Care Programs

This section provides a summary of the programs currently administered under the Medicaid home care program, including the type of clients served by each program, and each program's goals. The purpose of the home care program, including both the Personal Care Attendant (PCA or PCS) and the Title XX Social Services Block Grant (SSBG) Homemaker programs, is to provide efficient and effective delivery of home care services to eligible clients. The PCS program encompasses a number of sub-programs, as discussed below.

A. Personal Care Attendant Program

The Medicaid PCA program is intended for persons with impairments who require assistance with activities of daily living (ADLs) so that they may remain safely in their homes. Activities of daily living include bathing, dressing, toileting,

transferring, eating, and walking. The Nassau County DSS is responsible for determining Medicaid eligibility, as well as for determining client eligibility for home care services, authorizing the level of home care services provided to eligible recipients, arranging for the delivery of services from contracted home care providers throughout the county, and monitoring the delivery of services to clients. A physician must initially order such services, and a trained personal care worker must provide services under the guidance of a DSS-approved care plan. A registered professional nurse must supervise the service.

In order to become eligible for DSS PCA services, a client must first obtain a 517 form signed by a physician, which indicates that the client is in need of PCA services. If he or she is not already a Medicaid beneficiary, the client must then go through the eligibility process. The DSS nurse assigned to the geographic area where the client resides then makes a house visit to complete medical and social assessments and other paperwork to help determine the number of hours of aide service the client will need. For the functional assessment that helps to determine the plan of care, prospective clients are asked to demonstrate various tasks to enable the nurse to accurately assess the client's needs. As part of a social assessment, family members are asked directly what their role will be in helping to care for the client. Until recently, a fiscal assessment was completed that required that the client's costs remain below 90% of nursing home costs, or $4,274 per month in 1999. That translated to a maximum of about 70 hours of personal care aide hours per week. However, the fiscal assessment requirement expired and has not been reinstated. Once approval is made for aide service, the client may either select a provider agency, or one will be assigned. Many cases are currently being turned down because the prospective client is in need of safety-monitoring, which is not permitted under PCA, a decision that has been upheld in the courts.

Nassau County serves about 3,000 PCA clients at any point in time. In April 1999, provider agencies served 2,992 clients. Seventy clients, or 2.3 percent, received round-the-clock care. The largest group of clients, 959 persons or 32.1 percent received 70 to 79 hours of care per week. Many of these clients are receiving "live-in" aide care, for which providers are reimbursed 10 hours per day. The second largest group of persons received 20 to 29 hours per week. This group included 586

persons, or 19.6 percent of the total. For the month of April, an average of 48 hours of care per case per week was provided.

Each Nassau County DSS field nurse carries a caseload of about 200 patients simultaneously. The nurses rarely see each client between the time of the initial assessment, and the re-assessment six months later. *According to the NYS DOH Office of Continuing Care, nursing supervision of clients should be done a minimum of every 90 days following the initial assessment visit*. These supervision visits are used to ensure that PCS client needs are met by the provider agency, and that the aide providing care is doing so appropriately. Nassau County DSS nurses indicated that they have little time available to monitor provider agencies or the aides. The provider agencies are required by state law to monitor their own aides.

When clients become unable to be maintained safely in their own homes, DSS advocates for them to be taken off of PCA and moved into a nursing home. When this happens, families often request a fair hearing because the client does not want to move into a nursing home. The DSS perception is that nine out of ten times DSS loses the fair hearing.

B. Shared Aide Program

The Shared Aide approach is mandated by the State for the personal care services program. There are currently 25 Shared Aide sites in Nassau county, serving approximately 250 clients (out of the 3,000 total PCS cases). Most sites are in apartment buildings. The two key differences between Shared Aide and traditional PCA are that under Shared Aide (1) a single aide can cover two or three clients simultaneously throughout a day, and (2) clients are told that they will be helped with certain named tasks during the day, such as bathing, meal preparation, and dressing, rather than being told that they will receive a particular number of aide hours in a day. This approach works very well for clients who need help at various times throughout an eight-hour day, but do not need constant help all day. As a result of the program, services are provided more efficiently because fewer aide hours are needed, and costs are reduced.

The Shared Aide program has tangible and intangible benefits for its clients. The aides used in Shared Aide tend to be highly motivated and proactive. In addition, clients selected for participation in Shared Aide tend to be the higher-functioning clients who prefer to have a bit of privacy during the day. The presence of a lead aide in the Shared Aide site provides an extra layer of client supervision that is generally appreciated by clients. The lead aide is available to fill in if one of the aides calls in sick, or has a problem with a client that needs attention. In addition, the lead aide always makes a final check on all clients before ending his or her shift for the day.

About 20 providers currently participate in the Shared Aide program, as a result of two rounds of RFPs for provider recruitment. Providers seem to like the Shared Aide program because it helps them to establish a territory. If a new PCA client is admitted, and determined to be eligible for Shared Aide, then the provider serving that site automatically picks up the new client. The new client case does not go out to the general provider list. Because the Nassau County DSS nurse in charge of Shared Aide makes regular visits to each Shared Aide site, there appears to be more supervision of providers under the Shared Aide program than under traditional PCA.

There appear to be many more potential Shared Aide sites throughout Nassau County. A third RFP to recruit more providers for this program is under consideration. To identify new sites, DSS sorts current clients by geographic location. When they are able to see a cluster of clients in one area, the area is investigated as a potential new site.

C. Long-Term Home Health Care Program (LTHHC)

Nassau County DSS has approximately 1,000 clients on the LTHHC program, also known as the Lombardi program, or Nursing Home Without Walls. The clients are served by twelve LTHHC provider agencies. Eligibility for LTHHC includes a need for a waivered service such as a Personal Emergency Response System (PERS) or social worker help, and a score of 60 or higher on the DMS-1 form, one of the assessment forms used to determine a client's care needs. Clients are often recruited by provider agencies when a patient is discharged from a hospital or other health care

facility through what is known as “alternate entry.” This entry mechanism allows providers to recruit clients directly into the program without DSS prior approval, as long as the client scores 60 or higher on the DMS-1. Once the patient is admitted to LTHHC, the provider agency nurse and DSS nurse schedule a joint visit to review the care plan and patient eligibility.

Benefits of LTHHC to the client include easy access to a nurse (who visits once each week or every other week), case management of the various services, and spousal impoverishment protection provisions. Spouses of clients in LTHHC are allowed to maintain the same levels of income and assets as the spouses of Medicaid recipients in nursing homes. These protection provisions are not available for clients in the PCA program.

The monthly cap for most clients in LTHHC is $4,136 per month for all Medicaid services, not just for aide services. This figure is based on 75% of the cost of an average monthly nursing home stay. For clients who reside in an adult home, the cap is $2,757 (50% of nursing home stay) because these patients already receive some level of care from the adult home. Providers send a monthly budget to DSS to indicate how they will use services and remain under the cap. However, this information resides with a single person at DSS, and *there are no provisions for monitoring whether a provider stays under the cap. The person in charge of the program has very little recourse with providers who exceed monthly caps besides telling them to bring their costs down. DSS personnel estimate that about 15 percent of cases exceed the monthly cap, but no mechanism exists to estimate the true number.* Under the program the maximum number of aide hours per week is approximately 35, and the aides are reimbursed at a higher rate than under PCA ($18.50 versus an average of approximately $13.50). There are 12 providers of LTHHC in the county, and some are considered to be more careful about keeping costs below the monthly cap than others.

Nassau DSS perceives PCA to be more cost effective than LTHHC, based primarily on the higher rate paid for aide services for LTHHC. On the other hand, LTHHC program recipients are subject to a cap on total Medicaid costs, which is not the case for PCA clients.

D. Limited License Adult Homes

In 1995, Governor Pataki signed the law enabling the Limited License Home Care Services Agency (LLHCSA). The premise of the limited license law is that Adult Home staff could provide many selected "home care services" directly to their patients in a more cost-effective manner than having a separate agency come in to provide the service. This law allows licensed adult home and enriched housing program providers who are under contract with County DSS to receive Medicaid reimbursement for providing selected home care services to Medicaid-eligible persons. Traditionally, patients in adult homes receive home care services from CHHAs, LTHHC programs, and licensed home care agencies. Such services can be costly when, for example, a patient receives two insulin injections per day at a cost of $90 per nurse visit. The premise of the limited license law is that the adult home staff could provide many services in a more cost effective manner.

Nassau County is currently faced with the option of utilizing Adult Homes as vendors of PCA services for eligible residents. The County has not yet made a decision whether or not to participate in such an arrangement. Currently, patients in Adult Homes who require PCA services receive them in the traditional manner, from an external PCA agency aide. DSS sees the limited license program as an opportunity to cut costs if it is managed efficiently, because hourly rates would be lower ($11 per hour for aide service, compared to an average of $13.50 for aide services for licensed agencies). However, that additional management may require additional staff for oversight and other tasks.

A limited license program also raises the concern that there will be a disproportionate increase in the number of patients receiving PCA services due to the "woodwork effect." The woodwork effect is a colloquial term often used to describe the sudden increase in the number of individuals in need of services when a service suddenly becomes reimbursable, or becomes covered at little or no cost to the patient. Adult Homes with limited licenses that become approved PCA vendors will be incented to identify patients in the home who might be eligible for PCA services, who previously were not receiving such services. However, according to state Office of Continuing Care staff, and to information in the Administrative Directive, homes can only provide limited license home care services (and bill Medicaid for them) to

individuals who require "total assistance" with a task, not to those residents who require "some assistance," which the homes are already required to do. This requirement minimizes the potential woodwork effect.

The Ambassador Adult Home in Nassau County has 116 beds and has been approved by the State DOH for a limited license to provide personal and home care services to their patients. Since the County has not contracted with the Adult Home for personal care service provision, such services are currently provided by outside agencies. Between 15 and 25 residents at Ambassador receive personal care services from outside provider agencies, generally between two and four hours a day, seven days a week. The home believes it would be able to prevent costly nursing home admissions by providing more services, such as management of urinary incontinence, through the limited license program.

Two agencies, Star Multi and Aides at Home, provide the majority of the services to clients at Ambassador. The Ambassador's Administrator commented on the problem of frequent no-shows, and the difficulty in supervising outside aides. The Ambassador is reimbursed at $26 a day for SSI eligible residents. If the County were to approve a contract with the Ambassador, the rate for personal care services would be $11 per hour, which is lower than the average rate paid to PCA aide agencies. Care plans and the number of allocated PCA hours would still be approved by DSS.

E. Consumer-Directed Care

The Consumer-Directed Care program permits PCA clients to hire the person of their choice to serve as a personal care aide. The program serves about 143 clients, and is a good option for clients who are capable of managing their own care, but need help with some tasks. There are currently two administrators of the consumer-directed program, the Long Island Center for Independent Living and Concepts of Independence, both of whom reimburse the aides. The clients enjoy this program because they can hire almost anyone to be their aide, including individuals who are not certified to provide aide services. It also works well for clients with language barriers, since they are able to hire someone who speaks their native language. The

aides like the program because they are reimbursed at a higher hourly wage since the administrators are functioning solely as middle-men, rather than as true providers. Therefore, more of the Medicaid reimbursement is passed along to the aide in the form of hourly wages. The assessment process works the same for consumer-directed care as for the traditional PCA aide program. The perception of DSS is that this program is not abused or used incorrectly, and it works well for all involved.

F. Katie Beckett Waiver Program (Care at Home)

The Care at Home program is often referred to as the "Katie Beckett waiver program" referring to the child whose circumstances prompted the enactment of this special waiver program in the early 1980s. Care at Home is a Medicaid Model Waiver program mandated by the NYS Department of Health. Funding is provided at the federal, state and county levels, with a 25% county share. In Nassau County, six case management agencies provide services to children who are physically or developmentally disabled. These agencies provide services only for the Care at Home program, and are required to undergo a state approval process. The goal of Care at Home is to provide financial assistance to families with children living at home who have severe disabilities or medical conditions (NYS DOH website).

Unlike traditional eligibility for Medicaid, there are no eligibility ceilings for income or assets for the Care at Home program. As a result, higher income families who would normally not qualify for Medicaid can qualify for this waivered program, under which they are able to obtain Medicaid coverage for nursing care, case management, and other services for their disabled children. To qualify for services, children must have complex medical care needs, be under 18 years of age, have a developmental disability, be eligible for ICF/DD level care, not be hospitalized, and be ineligible for Medicaid. Approximately 100 children in Nassau County are served by the Care at Home program, with 10 to 15 new cases pending at any time. The majority of eligible children are disabled as a consequence of premature birth. Two levels of reimbursement are available; Level I care is reimbursed at $9,000 per month, and Level II care at $14,500 per month.

G. Commonwealth Program

The Commonwealth program is a pilot project initiated by the State. The program was intended as a first step towards capitation of long-term care. Commonwealth is a partially-capitated program, whereas the more recently legislated Managed Long-Term Care program will be fully capitated. Commonwealth was intended to serve as a first step towards putting incentives into place to manage care under a State-set rate, or cap.

Commonwealth currently serves about 37 clients in Nassau County. A single provider agency is responsible for serving all the clients' needs under the capitated arrangement. The provider agency is responsible for providing all client care needs under a partial capitation fee set by the NYS Department of Health. Patients who need more case management than that provided by PCA are sometimes referred to the Commonwealth Program.

H. Title XX Social Services Block Grant Homemaker Program

Title XX (of the federal Social Security Act) refers to the federal Social Services Block Grant program that provides block grant funds to the States. The program has several goals:

1) Achieve or maintain economic self-support to prevent, reduce, or eliminate dependency;
2) Achieve or maintain self-sufficiency, including reduction or prevention of dependency;
3) Prevent or remedy neglect, abuse, or exploitation of children and adults unable to protect their own interests, or preserve, rehabilitate or reunite families;
4) Prevent or reduce inappropriate institutional care by providing community-based care, home-based care, or other forms of less intensive care; and
5) Secure referral or admission to institutional care when other forms of care are not appropriate, or provide services to individuals in institutions.

(Sec. 2001 of the Social Security Act, 42 U.S.C. 1397)

Funds are allocated to the States, and in New York State, nearly all block grant funds are then re-allocated to the counties. The total federal appropriation for FFY 1998/99 was $1.91 billion, down from $2.38 billion in the previous year. New York State's share was $130.1 million. New York State withholds two percent of this amount for training purposes, and allocates the remaining amount--$127.5 million--to the counties. Nassau County's share in FFY 1998/99 was $5.1 million.

The State and the counties have much flexibility in how they will use these funds, consistent with the intention and goals of the block grant. Each county/local district spells out how it will use this grant funding in its multiyear Consolidated Services Plan, which lays out the county's four year plan for family and children's services, and services to adults, including services provided to those individuals who are eligible to receive a service without regard to financial circumstance.

Title XX reimbursable services to eligible individuals include:

- adoption services;
- day care services for children;
- day services;
- family planning services;
- home management services;
- homemaker services;
- housekeeper/chore services;
- housing improvement services;
- information and referral services;
- adult preventive;
- protective services for adults;
- clinical services;
- other preventive services;
- emergency cash;
- emergency goods and/or shelter;
- residential placement for adults;
- social group services for senior citizens;
- transportation services;
- parent services;

- services to victims of domestic violence; and
- health services.

These categories of service can be either "mandated" for certain groups (e.g., adoption services, foster care preventive services for children) or "optional" (e.g., transportation, social group for seniors). Homemaker and housekeeping/chore services for adults are for the most part optional categories for Title XX funding, as explained below.

Homemaker services reimbursable under Title XX include: assessing the need for, arranging for, providing, and evaluating the provision of personal care, home management, and incidental household tasks through the services of a trained homemaker who meets Departmental standards. These services are provided for three groups of people: for children, because of illness, incapacity or absence of a caretaker relative; for individuals, families, caretaker relatives and/or children to achieve adequate household and family management; and for individuals because of illness or incapacity. Homemaker services are a mandated service for SSI eligibles, but optional for others.

Housekeeping/chore services reimbursable under Title XX include: assessing the need for, arranging for, providing in accordance with standards of the Department, and evaluating the provision of light work or household tasks (including such activities as help in shopping, lawn care, simple household repairs and running errands) which families and individuals in their own homes are unable to perform because of illness, incapacity or absence of a caretaker relative, and which do not require the services of a trained homemaker.

Homemaker/housekeeping services are a "mandated" category for adults who are receiving Supplemental Security Income (SSI), and are an "optional" category for Title XX funding for non-SSI eligible adults whose income is less than 200% of the federal poverty level. Medicaid recipients are not eligible for Title XX services. Nassau County has established the income eligibility ceiling at 150% of the federal poverty level for non-SSI adults who are eligible for homemaker/housekeeping services. The maximum monthly income is therefore $1,036 per month. Most of the

adults who receive Title XX homemaker/ housekeeping services in Nassau County are non-SSI, and qualify under the "optional" category.

While under PCA a client must have an available back-up person, under Title XX there is no such requirement. Referrals for Title XX come from a physician, who initiates the process by filling out a form 517, which documents the need for assistance with ADLs. Adult Protective Services reviews the form and makes a determination about the client's eligibility. Re-certification occurs every six months or so. There is no asset test, which means that some clients may have substantial amounts of assets and choose not to spend their money on homemaker services, but to obtain such services through Title XX instead. In some cases clients may have substantial assets, but do not have the capacity to make decisions about money management. There are about 360 Title XX clients currently in Nassau County.

Providers for Title XX are the same as those used for PCA, but are reimbursed at a lower, fixed rate of $10.50 per hour. Services are usually provided two days per week, four hours per day. In some cases, the number of allocated hours can be as high as 20 hours per week. Sleep-in services are rarely provided. The type of service provided is a blend of personal care with "hands off" housekeeping services. In the past, Title XX services included no hands on care and were exclusively light housekeeping and chores. The County has amended this to include "some" assistance with ADLs, but the term "some" has never been defined; as a result, providers are unclear on what their true role is with these clients. Title XX services have no explicit time limit, and generally continue until an individual needs a higher level of care.

V. Certified Home Health Agencies (CHHAs)

Nassau County has ten CHHAs, which provide home health aides to Medicare and Medicaid patients who have a defined skilled medical need. To receive Medicare HHA services, the patient must be homebound; the homebound requirement does not apply under Medicaid. Referrals to the CHHAs come from the community, physician offices, hospitals, and elsewhere. Substantial competition exists in the community among CHHAs for eligible patients. Patients receiving Medicaid PCA services

sometimes develop a skilled need that renders the patient eligible for CHHA services. When this occurs, DSS coordinates with the CHHA so that Medicare reimbursement is maximized before billing Medicaid.

VI. Expanded In-Home Services for the Elderly Program (EISEP)

The Department of Senior Citizen Affairs (SCA) administers EISEP. Unlike the Medicaid PCA program, EISEP is not an entitlement. There is no income ceiling for eligibility, but clients must not be Medicaid-eligible. Several additional eligibility criteria apply. The client must be age 60 or older, must have one or more ADL limitations, or two or more Instrumental Activities of Daily Living (IADL) limitations, and must have an unmet need for assistance with these limitations. The client must not be eligible to receive similar services from other programs (such as Medicaid). Clients must be able to be safely maintained in their homes.

As of July 1999, there were 286 persons receiving in-home EISEP services in Nassau County, and the waiting list had approximately 324 names. Within the last year, the SCA has developed a new method of patient admission, whereby applicants are screened for their level of need. Those with higher levels of need are pulled to the top of the waiting list, while those with lower levels of need remain lower on the list.

Clients pay for services on a sliding scale that ranges from zero to 100% of the cost. The regular rate is $12.40 per hour for aide services, with a slightly higher "hard to serve" rate of $13.20. The SCA negotiates a single rate among all agencies. In the past the SCA worked with multiple rates, but that created a large amount of administrative burden. *While it is difficult to negotiate with providers to set a single rate each year, the program receives calls every month from providers who want to become in-home EISEP providers, knowing that the reimbursement will be a set rate, and that it is lower than the Medicaid rate*. The EISEP program contracts with six providers of in-home services. Providers compete through an RFP process. *Selected providers must guarantee coverage of all cases they accept at a fixed rate.* EISEP providers must also be Medicaid-approved providers.

Sometimes clients reach a point where they need such a high level of care that they can no longer be safely maintained in their own homes. At that time, SCA recommends that the client be taken off the EISEP program. The average number of approved aide hours is 20 hours per week. The maximum number of hours of aide care that EISEP will approve is generally eight hours per day, seven days per week, although weekend hours are very unusual. EISEP does not approve any 24-hour care, nor any night-time care.

The total annual budget for EISEP is $2,478,533. Sixty percent of this amount covers in-home care, while 40 percent covers case management. The County share for EISEP is 25 percent. The average cost of in-home care is $5,199 per client per year.

VII. Problem Areas and Recommendations

A number of issues surfaced in the home care units discussed above that need to be presented in a larger context. Other issues that have only been hinted at deserve focused discussion in the context of the home care services program and the role of the programs in the future. This section presents issues and problem areas along with specific recommendations to address the problems.

A. Program Goals

Program goals exist for the PCS program at the state level, at the county level, and at the DSS agency level. We believe the Nassau County PCS program can improve as a result of more targeted program goals at the County and DSS agency levels.

In addition to DSS, the County Legislature and the County Executive should be involved in the goal-setting process for home care programs. At one time, counties were required to submit an Annual Plan for Home Care to the state DOH, Office of Continuing Care. This is no longer required as a result of the mandate relief

implemented under the Office of Regulatory Affairs. While the Plan may have been burdensome to create, it was likely a useful exercise in coordinating resources. A working group with participants appointed by the Executive and the Legislature could work to address goals related to access, cost, and quality issues as well as other areas. The group could consider some integrated planning and goal-setting for all home care programs in the County including DSS, EISEP, and CHHAs.

Some long-term care programs such as Title XX and EISEP overlap with one another. Other programs, such as PCA, are not used as effectively and efficiently as they could be, as described in more detail in the remainder of the report. The County should develop long-term care policies and a plan for its long-term care system, including both the private and publicly funded components. In particular, the County must determine its goals for each of the home care programs, explore how they interact, and how they can best work together to serve the needs of Nassau County residents.

Recommendation: Form a Countywide Home Care policy group, to develop a long-term care policy and comprehensive plan for the County.

- This group would consist of members appointed by the County Executive and the County Legislature.
- The group would function as an advisory group to the DSS Commissioner.
- The group could seize the opportunity for change to redefine and reshape the delivery of Nassau County's home care programs with the following objectives:
  1. Improve and enhance service to clients;
  2. Improve efficiency and program oversight;
  3. Increase management control; and
  4. Reform contract procedures with providers.
- This group should develop a comprehensive County long-term care policy and plan.
- This group should identify Nassau County's specific goals in terms of the Medicaid home care program.

The DSS home care program managers currently have extensive contact with one another. However, when asked to define the type of patient that best fits into the

PCA program, LTHHC, or Title XX, the responses are somewhat subjective and non-distinct. No formal set of objectives or goals for the various programs as a whole exists. In addition to a countywide Home Care policy group, DSS should have its own internal formal management group that can address common goals and objectives.

Recommendation: Form an internal DSS operations group.

- Ideally this group would include managers from each of the home care programs under the auspices of DSS, including the Director of Medical Administration, the managers of all PCS programs including Shared Aide, LTHHC, and other home care programs such as Care at Home, Consumer-directed care, and the Title XX Homemaker program.
- The group would work to identify best practices within its own programs, and would also work to explicitly define the best use of each program.
- To implement this recommendation would require no added cost.

B. Costs

A primary goal of this review is to find ways to improve efficiency in the provision of home care services by DSS. Improved efficiency involves two vital components: controlled costs, and improved or maintained quality of care. Costs in some programs in Nassau greatly exceed comparable services in other counties. Table 8 illustrates costs for non-institutional long-term care programs in several metropolitan counties in the State of New York.

Table 8: Non-institutional Long-Term Care Expenditures and Recipients, FY 1997 and 1998

		Personal Care		Home Health Care		LTHHC	
		1997	*1998*	1997	*1998*	1997	*1998*
Erie							
	Dollars	$24,118,420	*$23,206,245*	$5,734,825	*$5,735,526*	$14,039,747	*$13,415,143*
	Recipients	2,499	*2,357*	5,025	*5,037*	1,381	*1,269*
	$/Recipient	$9,651	*$9,846*	$1,141	*$1,139*	$10,166	*$10,571*
Monroe							
	Dollars	$505,545	*$428,087*	$30,604,143	*$27,599,524*	$10,954,610	*$12,423,237*
	Recipients	334	*299*	5,382	*5,412*	1,230	*1,274*
	$/Recipient	$1,514	*$1,432*	$5,686	*$5,100*	$8,906	*$9,751*
Nassau							
	Dollars	**$83,458,907**	***$82,286,364***	**$4,676,881**	***$4,588,392***	**$19,818,921**	***$21,340,959***
	Recipients	**3,726**	***3,643***	**2,505**	***2,284***	**1,290**	***1,408***
	$/Recipient	**$22,399**	***$22,588***	**$1,867**	***$2,009***	**$15,364**	***$15,157***
Suffolk							
	Dollars	$24,387,749	*$23,563,343*	$12,958,275	*$12,587,129*	$12,416,593	*$12,889,339*
	Recipients	2,094	*2,010*	3,034	*2,738*	1,031	*1,026*
	$/Recipient	$11,646	*$11,723*	$4,271	*$4,597*	$12,043	*$12,563*
Westchester							
	Dollars	$33,247,674	*$31,695,260*	$4,727,048	*$4,843,410*	$29,497,843	*$31,646,813*
	Recipients	2,068	*1,989*	3,323	*3,344*	1,803	*2,050*
	$/Recipient	$16,077	*$15,935*	$1,423	*$1,448*	$16,360	*$15,437*
NYC							
	Dollars	$1,046,347,928	*$1,149,010,592*	$466,737,459	*$469,520,761*	$221,434,746	*$245,645,894*
	Recipients	63,056	*64,734*	64,874	*64,902*	11,843	*12,721*
	$/Recipient	$16,594	*$17,750*	$7,195	*$7,234*	$18,698	*$19,310*
Erie+Monroe+Suffolk+Westchester							
	Dollars	$82,259,388	*$78,892,935*	$54,024,291	*$50,765,589*	$66,908,793	*$70,374,532*
	Recipients	6,995	*6,655*	16,764	*16,531*	5,445	*5,619*
	$/Recipient	$11,759.74	*$11,854.69*	$3,222.64	*$3,070.93*	$12,288.12	*$12,524.39*

Source: NYS DOH, OnLine SURS Annual File, FFY 97, FFY 98

- Total PCA Costs. At $82.3[3] million in federal fiscal year 1998, Nassau County's total PCA costs are the highest in the state outside of New York City.

[3] This number differs from the figure of $97.3 million given earlier in the report. The difference is due to different data sources, and to different time periods. The $97.3 is for calendar year 1998, while the $82.3 is for Fiscal Year 1998.

- Cost Per PCA Case. Nassau County stands out with the highest expenditures per PCA recipient per year ($22,588). Nassau costs per recipient are higher than those of New York City ($17,750). After Nassau the highest cost per recipient outside of NYC is in Westchester County ($15,935). When PCA expenses are standardized for the number of elderly persons in each county, Nassau County spent $417 per person age 65 and older, much higher than the amount spent in Westchester ($242) or Suffolk ($146), but substantially lower than New York City ($1,224) (Table 9). When all non-institutional long-term care services are included (PCA, Home Health care, LTHHC, Assisted Living), Nassau spent $549 per person age 65 and older, more than any of the other comparison counties including Westchester ($522) and Suffolk ($305).

Table 9: Non-Institutional Long-Term Care Expenditures and Recipients, FY 98

Counties		Personal Care	Home Health Care	LTHHC	Assisted Living	TOTAL
Erie						
	Recipients per 1,000 age 65+	16	34	9	1	58
	$ per person age 65+	$162	$38	$90	$4	$290
Monroe						
	Recipients per 1,000 age 65+	3	58	14	1	75
	$ per person age 65+	$5	$296	$133	$12	$434
Nassau						
	Recipients per 1,000 age 65+	18	12	7	0	37
	$ per person age 65+	$417	$23	$108	$0	$549
Suffolk						
	Recipients per 1,000 age 65+	12	17	6	0	36
	$ per person age 65+	$146	$78	$80	$0	$305
Westchester						
	Recipients per 1,000 age 65+	15	26	16	0	56
	$ per person age 65+	$242	$37	$242	$4	$522
New York City						
	Recipients per 1,000 age 65+	69	69	14	1	$152
	$ per person age 65+	$1,224	$500	$262	$15	$1,986

Source: NYS DOH, OnLine SURS Annual File; U.S. Bureau of Census

On the other hand, Nassau spent relatively lower amounts per capita on nursing home care, compared to other metropolitan counties. In 1998, an average of $1,530 was spent on Medicaid nursing home care per person age 65 and older in Nassau,

compared to $1,319 in Erie County, $1,634 in Monroe, $1,789 in Westchester, and $2,019 in Suffolk.

- Number of Recipients. Nassau appears to make greater use of the PCA program than other metropolitan counties. Comparing the number of PCA recipients per 1,000 persons aged 65 and older shows that Nassau's recipient rate is 18/1,000, compared to 12 for Suffolk, 15 for Westchester, and 16 for Erie County (Table 8). Conversely, when all non-institutional long-term care services are included, Nassau provides services to a lower than average number of recipients, at 37 per 1,000 age 65 and older. This compares similarly to Suffolk at 36, but is low compared to Westchester at 56, or Monroe at 75 per 1,000. While Nassau's use of all non-institutional long-term care is low, the county's use of PCA is very high, leading to higher overall non-institutional costs.

- Total Non-Institutional Costs. Some would argue that high PCA costs should be reflected in lower costs in some other portion of the long-term care arena. In the case of Nassau, that argument does apply. For example, Monroe County appears to rely more heavily on certified home health agency services than Nassau. In 1998, Monroe County provided home health services to 58 recipients out of every 1,000 persons aged 65+, compared to only 12/1,000 in Nassau (Table 9). In addition, of those recipients of home health care in Monroe the intensity is higher ($5,100 per recipient) than in Nassau ($2,009 per recipient) (Table 8). Westchester has more clients per 1,000 elderly in the LTHHC program than Nassau (16 versus seven), and spends slightly more per person on LTHHC ($15,437) than Nassau ($15,157).

  However, when all the long-term care programs are summed for an analysis of total county spending on non-institutional long-term care, Nassau still shows the highest expenditures outside of New York City. The total dollars spent on non-institutional care, when standardized by the total number of persons aged 65 and older in the county is $549 in Nassau, compared to that of $522 in Westchester, $434 in Monroe, and $305 in Suffolk County. New York City spends a staggering $1,986 on non-institutional long-term care expenditures per person over age 65.

Total Medicaid spending on personal care services in Nassau County has been fairly stable at approximately $100 million over the last few years, and has even declined at times (see earlier Table 5). When compared against other counties, however, Nassau appears to have room to control costs. There are effectively three ways to control overall spending on the personal care program while maintaining a high quality of care:

- Control the number of recipients of personal care services;
- Control the per capita intensity of personal care service provision; and/or
- Control the price paid for personal care services.

These three options, and their appropriateness for Nassau County, are discussed below.

1. Control the number of PCA recipients

As discussed earlier, Nassau has relatively more recipients of personal care services per elderly population in comparison to other metropolitan counties. The proportion of elderly receiving PCA services is in part a result of Nassau County's goals, and is in part a result of the defined personal care state regulations. While the regulations define the type of care necessary to warrant PCA services, there is substantial variation across metropolitan counties in the state as to how these regulations are applied. Monroe County avoids using the personal care services program, while Nassau uses it more freely. There is no right or wrong answer to the question of how many persons should receive personal care.

Nassau County officials believe that they cannot reduce the number of individuals for whom they authorize services. They believe that based on the current regulations, the patients they approve for PCS services are appropriate. Nonetheless, we believe the County should embrace all three cost control measures bulleted above.

Controlling the number of PCS recipients can be approached in two ways: by re-evaluating current clients, and by more carefully evaluating incoming clients. Careful evaluation of incoming clients is likely the most feasible approach given the

volume of fair hearings the program has experienced in the past. To evaluate incoming clients in an efficient manner and ensure their appropriateness for PCS among other home care programs, we recommend the Department consider establishing a central screening intake unit, as described in more detail in the CASA section (VII.E.3.) below.

Recommendation: Establish a central screening and intake unit for DSS home care programs.

- Such a unit can ensure that incoming patients are appropriate for the home care program to which they are referred.
- An intake unit gives DSS a more consistent approach in admitting new clients.
- Such a unit has worked in other counties, including Erie, in decreasing the number of clients by targeting services to those most appropriate for PCS-level home care.

2. Control per capita intensity of PCA hours

The number of average hours of PCA care per week per client is extremely high in Nassau County. The following is an example of the dollars that could be saved with very small reductions in the number of hours per week. The reductions in the first example below do not even approach the average number of hours indicated as appropriate in the personal care regulations.

If we assume an average of 3,250 PCA beneficiaries per month, at an average annual number of 2,500 hours (about 48 hours a week) of services used, at an average rate of $13.50 per hour (for an average annual Medicaid cost of $33,750 per person), then:

- A one hour reduction on average per week per PCA recipient (with everything else remaining constant) would produce annual (gross) savings of $2,281,500. The net savings to the county would be 10% of this amount, or $228,150.

Westchester County limits the number of weekly hours to 28 with very few exceptions; their average number of PCS hours per week is likely to be even lower.

- If Nassau were to bring their number of weekly PCS hours on average down to 28, which until recently was the maximum number of hours permitted in the PCS regulations, *annual (gross) savings would be $46 million, with a county share of $4.6 million.* This would cut the cost of the program by nearly one-half, without reducing the number of clients.

Suffolk County DSS has reduced the average number of PCS hours per client per week from 53.5 to 25.5 in the last ten years, and has reduced the cost of the program by 60 percent without a jump in fair hearings. They approached this cost control period in a slow and deliberate manner. They ensured that their nurses were well trained, and that their clientele was well educated on the issues surrounding PCS and home care. They worked closely with families and providers to encourage cooperation and collaborative approaches to the care of the disabled and elderly.

Hours of care have been reduced under the Shared Aide program in Suffolk with no adverse events. Other counties have been successful at reducing hours while maintaining high quality service, and Nassau can be successful too. Even a reduction of one hour two hours per client per week can reap hundreds of thousands of dollars in savings for the County.

Current PCA recipients are likely to ask for a fair hearing if DSS tries to reduce their hours. The best approach is to evaluate how hours are determined for new patients entering the program. DSS staff informed us that the number of hours assigned to each task in the task-based assessment are "generous." While DSS wants to assure that each patient receives the number of hours necessary to perform the needed tasks, there is no reason for DSS to err on the side of being more generous with hours than the client's needs require. We were also told that many aides spend substantial portions of their day watching television or doing other such activities with their clients. Part of this is due to the need to be available for meals and other tasks that occur throughout the day. However, this is also very wasteful. DSS should consider a serious review of the number of hours allocated for each task.

Recommendation: Modify the approach used to determine hours for new clients. Strive to provide care in the most efficient way so that excess hours are not necessary.

- The task-based assessment approach does not go far enough to control the number of hours provided.
- This is a no-cost option for DSS, with substantial savings likely to result.

Performance goals have become more and more popular in both the private and public sectors. Goals and their underlying specific objectives provide organizations with a mechanism to measure and track their performance over time. Erie County DSS has begun to use performance goals for a variety of issues, including the number of PCA hours they provide each month. They monitor average hours per client, and set goals based on the number of hours they believe should be appropriate. The Nassau County DSS has the capability to report the average number of PCA hours per client per month. This information was provided to CGR at the start of the project. Home care program managers could evaluate this information each month to determine whether nurses are increasing the number of hours in any particular time period. Managers could then set goals, or at least try to determine why the numbers are increasing. Any added monitoring of program use would lead to a better understanding of the use of these County resources.

Recommendation: Re-visit the hours currently allocated to current clients.

- Suffolk County took this approach and was successful in reducing hours for current clients with very few fair hearings.
- This approach would require nurse training for approaching clients and families about the potential change, and the reasons for it.
- If approached properly, families and clients are much less likely to oppose a reduction in hours.

Recommendation: Set performance goals to provide a more efficient number of PCA hours for current clients.

- DSS currently has the capability, through the Planning and Research Department and the Financing unit, to provide monthly statistics on average

number of hours, average monthly PCA beneficiaries, average PCA aide rate paid to providers, and other relevant information.

- Home care managers should be able to track their programs more carefully, plan goals and objectives in advance, and use the above data to their advantage in an attempt to identify outliers.

3. Control the price paid for PCA

- Based on the same assumptions as those presented in the previous section, a $0.10 reduction in the average hourly rate paid for PCA services (with everything else remaining constant) would produce annual (gross) savings of $812,500. The net savings to the County would be 10% of this amount. Thus, if the County could reduce the average rate of payment to PCA providers by $.50, gross savings would amount to $4,062,500 with a net county savings of $406,250.

Recommendation: Pursue methods of reducing provider rates.

- This is discussed in more detail below in the section on provider oversight (section VII.D.).

Recommendation: Be careful not to inadvertently give providers incentives to raise their rates.

- If DSS were to publish a list of the rates paid to each provider with the hopes of encouraging the high-cost providers to lower their costs, the reverse could occur instead, and the low-cost providers might increase their costs.

C. More Efficient and Effective use of Programs

As discussed earlier, improved communication between DSS home care managers could lead to more optimal use of the various programs. Better initial placement of clients in the most appropriate program, through a central intake unit or some other mechanism, will lead to more efficient use of the programs, and can also lead to a minimization of fair hearing requests.

1. Shared Aide Program

The Shared Aide program in Nassau County has room for growth. Currently, Shared Aide cases comprise about 250 of its 3,000 PCS clients, or 8.3%. Based on interviews with DSS personnel, there are clusters of clients in the county that are not currently using Shared Aide. Shared Aide benefits all involved parties. Clients are pleased with the quality of care, providers are pleased to be part of an innovative program, and DSS saves costs while maintaining the same or even improved quality of care. DSS might want to consider using Adult Homes as Shared Aide sites. The expansion of the Shared Aide program would likely be acceptable to all involved parties.

In 1989, the Erie County CASA established seven Shared Aide sites serving less than 100 total clients as a pilot program. They started tracking the program in 1995, when they had 811 clients. As of fall 1999, the program had 723 clients (out of a total of 1800 PCS/LTHHC clients), and they had more than 80 sites. Most of the sites are apartment buildings, although some are neighborhoods. The neighborhood sites do not work as well logistically. For example, some of the neighborhood sites were established when there were clients using PCS who lived very close together. Over time some moved away, died, etc. so the clients in those original neighborhoods are no longer living in as close proximity.

The Erie CASA estimates that Shared Aide saves them 40% in costs for participating clients. Nassau currently has about 8.3% of its PCS clients in Shared Aide, compared to 34.6% of Erie clients. If Nassau could increase its proportion of clients in Shared Aide to 34.6% (an increase of 789 clients), and realize a savings of 40% for those additional clients (whose current average cost is $22,399), the total savings to the PCS program would be $7,128,773, or $712,877 annual county share.

Initially the Shared Aide program was designed to combat the aide shortage. It was a success on that front, and on others including cost and quality of care. The Erie CASA identifies new site opportunities from time to time using their computer database to sort patients by zip code and identify clusters. *Erie has moved away from*

billing in one-hour increments, and towards 15 minute increments, which has led to further cost reductions. The CASA has incorporated the Shared Aide approach into its LTHHC program as well. They have one LTHHCP with Shared Aides currently, which saves an estimated 26 percent in costs.

Suffolk County has about 450 of its 1,300 PCS clients in Shared Aide (more than one-third). Suffolk County feels that it has penetrated all apartment buildings, and is now branching out into neighborhoods surrounding the apartment buildings, a process they refer to as geographic clustering. When Suffolk first introduced Shared Aide into the PCS program, they ranked their provider agencies based on a variety of criteria including quality of service, experience, size of PCS caseload, and others. The district then awarded Shared Aide sites to the top providers on the list.

Westchester County has 100 of its 1,600 PCS clients in their seven Shared Aide sites. They plan to expand the program, and are currently in the process of identifying additional sites.

Recommendation: Expand the Shared Aide program, including neighborhood sites.

- A Shared Aide program on the scale of Erie County could save $7,128,773, or $712,877 County share annually.
- Identify new sites as soon as possible and put out RFPs for providers.
- Do not exclude neighborhoods with single-family homes (as opposed to apartment buildings) as possible sites.
- If DSS staff do not have time to identify sites, consider permitting providers to identify sites based on their caseloads.
- Assign a current staff nurse to help the current Director of Shared Aide manage the expansion of Shared Aide.
- This is a no cost recommendation.

Recommendation: Consider a Shared Aide site for LTHHC.

- This should be a reasonably simple recommendation to implement given that the Shared Aide program is already so successful.

- This can follow on the expansion of Shared Aide as described above. The recommendation can be implemented with a shift in staff resources, at no additional cost.

Recommendation: Consider Adult Homes for Shared Aide sites.

- Adult Homes that maintain multiple PCA clients would be a natural site for Shared Aide.
- Again, this is a no cost option with a shift in current DSS staffing resources.

2. LTHHC Program

Nassau County currently has about 1,000 of the 1,501 State-approved LTHHC slots filled. The LTHHC program was initially designed to maintain nursing home-eligible persons in their homes by providing case management and a variety of other in-home services. In a comparison of DMS-1 forms for 50 randomly-selected LTHHC patients, and 100 randomly-selected PCA patients, average DMS scores were higher (more severe) for LTHHC patients than for PCA patients (234 versus 175). In addition, the average number of limitations in activities of daily living (ADLs) was higher for LTHHC patients (4.5) than for PCA patients (4.2). This indicates that to some degree the LTHHC program is being used as intended, for patients who have more severe levels of disability as compared to those in the traditional PCA program.

Nassau County tends to rely on the personal care program for the provision of home care services, and tends to underutilize the LTHHC program. The LTHHC program, if properly used and monitored, is a potential cost-saver for the County. A common complaint about the LTHHC program is that it pays higher rates for aide service than does the personal care program, and therefore it is not cost-effective. The LTHHC program is reimbursed at higher unit rates for aide service, but this higher reimbursement is intended to cover the costs of case management which is not billed separately. In addition, it must be noted that the cap on expenses under LTHHC is a true Medicaid cap for all services (75% of nursing home care costs) provided under Medicaid reimbursement (with proper monitoring in place). The aide hours are not the sole cost to Medicaid. In fact, referring back to Table 8, the Medicaid costs per client in LTHHC are approximately $15,157 compared to average

costs per PCA client of $22,588. *Based on these average figures, if 500 PCS clients with the appropriate needs could be shifted from the PCS program to the LTHHC program, the County could realize a gross savings of $3,715,500, or $371,550 for the County share annually*. In fact, since the patients that would shift from PCA to LTHHC would be the more severely ill patients, the savings would likely be even greater.

Several strong advantages to the LTHHC program, when properly used, include the following:

- It has a budget ceiling, or cap, unlike other home care programs;
- It involves practically all services under that budget ceiling, not just in-home aide service;
- It includes effective nursing involvement, and ongoing case management;
- It allows for flexibility; e.g., can substitute services for hard to serve clients; and
- Married couples who qualify for the program can keep larger amounts of income and assets compared to the amounts allowed for recipients who use personal care and other home care programs (spousal impoverishment protections).

On the other hand, potential disadvantages include the following:

- It is not cost effective when targeted to an inappropriate population; and
- Without effective monitoring by the County, providers can exceed the budget cap.

Recommendation: Fully use and effectively monitor the LTHHC program

- DSS should actively monitor the type of patient entering this program.
- Appropriate patients include those who need ongoing case management and closer nursing involvement, those with complex medical needs, and those who use prescription drugs.

Erie County DSS uses seven providers of LTHHC. Alternate entry, which occurs in Nassau, has not occurred in Erie since they established an Access and Coordination unit. The Access and Coordination unit ensures that a nurse is available to do an assessment at any time, so there is no excuse to allow a provider to admit a

patient to LTHHC without DSS approval. For similar reasons, Suffolk County also permits no alternate entry. The district ensures that sufficient staff are available to handle incoming patients. Suffolk DSS recognizes the benefit to having staff present when a patient is first assessed and first informed about the LTHHC program.

Recommendation: Do not permit alternate entry.

- Providers should not be given the opportunity to admit patients to LTHHC. DSS nurses should always be available to conduct an assessment within 24 hours so that alternate entry is not necessary.
- Nurses currently conduct five to six in-home visits weekly as discussed in the staffing section below. There is no reason why one of the 16 PCA field nurses cannot provide a LTHHC assessment with 24-hour notice to the unit.
- Alternate entry can be avoided completely if a central intake unit is in place and properly managed.
- This is a no cost option if nursing resources are used more efficiently.

In the course of our interviews, we learned that some LTHHC providers exceed monthly caps for LTHHC patients on a regular basis. We also learned that without an information system in place, the DSS nurses are powerless to monitor such non-compliance. While rare instances of budget over-runs are to be expected with this frail population, such over-runs should not occur regularly. Nassau County managers must be provided with the information necessary to flag provider agencies who submit bills that exceed the expense caps, and DSS should be able to collect the overpayments from providers who have exceeded the caps currently and in the past. Improved monitoring of monthly budgets could result in substantial savings. For example, *if 15% of the LTHHC clients (150) go over budget by 10% ($414) six times per year, to recuperate those extra dollars would save $372,600, or $37,260 County share*.

Recommendation: Do not permit providers to exceed their monthly caps.

- This is a difficult recommendation to implement without an information system in place, so up-front costs for such a system would be necessary.
- An end to budget over-runs could save nearly $40,000 annually.

LTHHC, if used properly, will be a money saver. While the reimbursement rates for aide hours are somewhat higher than under PCA, LTHHC clients receive less aide hours per week. Further, the LTHHC patients have more complex care needs and require case management, which is the justification for higher aide reimbursement rates. *It is critical that the County begin to think about the total Medicaid budget, rather than just one component (such as PCA) at a time*. LTHHC is a capitated program. With sufficient management and oversight to avoid monthly overruns, this program can save the County money when the appropriate individuals are using the program. This is another reason why the County must move towards developing an overall long-term care policy and comprehensive plan.

Recommendation: Utilize all 1,501 slots allotted to the County.

- Use of all slots could result in an estimated $3,715,500 in savings, or $371,550 for the County share annually.
- Expansion of LTHHC should NOT occur through alternate entry. DSS should refer appropriate incoming patients to the program. Again, a central intake unit could be of use here.
- This is a no cost recommendation for DSS if nursing resources are used more efficiently.

The LTHHC program is set up such that the local district is fully responsible for ensuring that the providers do not exceed monthly budgets. If a provider consistently exceeds a monthly budget, DSS should be aware of that and should work with the provider to bring the budget into line. It is also the local district's responsibility to ensure that the appropriate types of patients are admitted to the program. DSS nurses should monitor their LTHHC clients regularly to ensure they are adequately cared for in this program. The nurses should develop a good relationship with LTHHC provider agencies so that alternate entry is rare or non-existent.

Recommendation: Ensure that the LTHHC nurses are well-trained, develop good relationships with providers, and carefully monitor their cases.

- The LTHHC program may need increased staffing; this issue is addressed in a separate section (section E below).

- Nurses should have adequate training so that they understand the LTHHC program. Training and other technical assistance is available from the state DOH.
- LTHHC nurses should be encouraged to visit clients frequently, monitor provider agency aides, and review budgets on a regular basis to reduce the need for budget overruns.

3. Limited License

The ultimate effect limited license will have on DSS and on the Medicaid program is unknown. Some perceive the potential change as a more efficient use of Adult Home staff, and see it as a cost saver and as a way to improve continuity of care. Others are concerned that there is potential for abuse if Adult Homes are given more control over the provision of personal care services. Further, whereas the Adult Homes feel that they have no ability to supervise aides from provider agencies, there are concerns that DSS would have difficulty supervising Adult Homes in their provision of personal care.

The state DOH Administrative Directive (AD) regarding limited license home care agencies is written quite clearly. It indicates that the law allows for home care services to be provided in an adult care facility if DSS determines that this is the most cost-effective way to provide needed services. The AD states that the rates for personal care services and for nursing are significantly less than home care provider rates under the fee-for-service rates, and as such should be a cost-saver.

Erie County CASA has six providers interested in becoming limited license facilities. The CASA views the limited license approach as one that could help address the aide shortage problem, but there is a question about whether it will add clients who were previously getting by with their regular adult home services. The limited license approach still requires the same prior approval process for prospective clients, so the same level of control is maintained for the CASA. However, the CASA plans to watch the program carefully to see if the number of clients begins to go up disproportionately.

The hourly rates for personal care services under limited license are approximately $2.50 less than under traditional PCS based on state regulations. With DSS still in control of assessments and weekly hour estimates, patient volume for PCS should remain constant, and the "woodwork effect" should not occur. With no change in volume, every hour of PCS provided under limited license saves $2.50 (County share $0.25). *If each of the six interested Adult Homes were to provide such services to 10 of their residents currently receiving PCS, and if those residents receive the Nassau County average of 48 hours of services per week, limited license could save the county $374,400 annually (County share $37,440).*

Recommendation: Permit the use of Limited License facilities as PCA providers.

- The jury is still out on the long-term ramifications of this program. However, based on input from other metropolitan counties, from state DOH, and from our own judgment, the limited license approach can be a money saver if it is properly managed.
- This is a no cost recommendation for DSS.

4. Title XX Homemaker Program

The Homemaker program in Nassau County lacks definition in terms of the type of services it provides. The services are intended to be preventive, but no clear definition of the prevention goals or overall program goals are available from the DSS office. In addition, the types of services provided are not defined, in terms of hands-on versus hands-off care. The type of service intended should be made clear so that providers have a better understanding of their role.

Recommendation: Define Nassau County's use of the Title XX program.

- Nassau County DSS must decide how it wishes to use the program.
- This would be a good agenda item if an internal DSS management group were formed, and would tie into the long-term care plan.
- This is a no cost option for DSS.

Recommendation: Improve coordination between the PCA and Title XX homemaker programs.

- Improved coordination should ensure appropriate use of service resources, contracting with and monitoring of agencies (since the same agencies are used), and more efficient use of internal staffing in monitoring both programs.

Title XX funding is a fixed annual amount of money allocated to the counties. When that money is expended each year for reimbursable mandated and optional services, the county is then liable for additional service costs: 50% of the costs for certain services such as those provided to protective cases, and for 100% of costs for all other services.

Since the County must provide the services under the mandated categories, it is important for DSS to carefully monitor its spending for Title XX mandated and optional categories so as to maximize the use of the block grants, and to avoid incurring unnecessary County costs. Note that State funding is available to continue reimbursement for certain services expenditures when a county exceeds its federal Title XX allocation. The State's Family and Children's Services Block Grant will provide 100 percent State funding of the non-Federal share, up to the grant ceiling, for preventive services and adoption services.

Recommendation: Adult protective cases receiving Title XX services must be identified as protective cases.

- In the event that the County expends its Title XX allocation, DSS will need to claim protective cases as such in order to qualify for the 50% state share.

Recommendation: Evaluate whether homemaker/housekeeping services for adults are the most effective use of the Department's resources, particularly if (after review) the County is picking up 100% of the cost of this service.

- Homemaker/housekeeping services for adults are for the most part an optional service.
- If DSS chooses to continue to offer these services, the Department could consider lowering the income eligibility for services.

D. Providers

Nassau County has not taken a proactive approach to working with the providers they rely on for personal care aides. It is important to maintain a positive and productive working relationship between DSS and provider agencies. Nonetheless, DSS can take steps to make these relationships more efficient and effective.

1. Provider Oversight

The Shared Aide program has substantial provider oversight as a result of the frequent site visits made by the DSS nurse who manages the program. Oversight of providers is important and necessary to ensure that Medicaid dollars are spent properly. Outside of Shared Aide, however, very little provider oversight occurs. Providers are expected to monitor their own aides, but there are no guidelines for this monitoring process. Many DSS personnel indicated that they would like to have the time and resources to conduct more extensive provider oversight and to be able to check on aides more consistently. Further, DSS works with 63 providers on a regular basis, which undoubtedly generates a substantial amount of administrative work.

In addition to an interest in more extensive provider oversight, there may also be justification to reduce the number of providers. Westchester County, for example, has 43 PCS providers, down from 50 in 1996. Westchester has not allowed any new providers to enter the market since 1996. Even with mergers, and with some providers going out of business, the county still feels that the 43 providers is too many, and they do not plan to open their vendor list in the foreseeable future.

Another county with a similar focus on reducing providers is Erie County. Erie County DSS currently contracts with 18 PCS providers. DSS policy is to freeze the addition of new provider contracts until DSS becomes unable to cover cases with the current providers. Further, the Erie County DSS does not contract with every licensed provider who is interested in participating. A comprehensive local law is in place that prohibits adding providers unless the providers meet stringent criteria (see Appendix B). For example, providers must have a proven track record, and must go

through a strict screening process. A DSS unit reviews providers annually. Providers are assigned patients on a rotating basis, similar to the procedure utilized in Nassau.

In Suffolk County, the PCS program was closed to new providers for nine years, starting in August 1990. In October 1999, the district sent out a Request for Qualifications and selected seven additional agencies, of which five will ultimately be added, bringing the total number of providers up to 24. The district believes that a high number of providers leads to several problems. First, it is administratively difficult to juggle a large number of providers. Second, with a high number of providers cases are spread very thin across agencies. With PCS caseloads comprising a small part of their business, agencies are less likely to be responsive to DSS. *If there are fewer providers with higher caseloads per provider, those providers will be more reliant on DSS as a portion of their business, and are likely to be more accommodating in meeting DSS needs and requirements.*

Another possible area to explore is the contracting process between DSS and PCA providers. Several contracting changes can be implemented to help DSS gain more control and oversight of their providers. Selective contracting can be based on the development of catchment areas, price negotiations, state reviews of providers, guarantees of service, and other factors. Catchment areas are geographically designated areas that one or more providers are dedicated to serving. The county could be broken into a number of catchment areas, and might assign a limited number of providers to each area. Price negotiations would involve a rate set by DSS that would be dictated to provider agencies. Providers would then have the option of providing PCA services if they wish to abide by the designated rate.

There is no reason why a county DSS would be unable to limit the number of providers with which it does business. The requirement of patient choice can be met with a list of two service providers. In fact, PCS clients in New York City currently have the choice of just two providers. Several years ago the Human Resources Administration (HRA) divided the city into catchment areas for PCS provision, and each provider was assigned to a particular area. There is enough overlap in the catchment areas so that clients always have a choice of two providers. It may be reasonable for DSS to consider reducing the number of licensed agencies with whom they contract, using a set of guidelines such as those used in Erie County.

The County DSS must substantially improve its monitoring of provider performance. Providers have had free reign in Nassau County for many years. There are no limits placed on adding providers to the DSS list. DSS cannot currently determine whether aides are showing up to provide services. There is no information to indicate whether some providers provide better services than others. There are steps DSS can take to move towards improved provider oversight.

Recommendation: Establish mechanisms for aide oversight.

- Nassau County DSS currently has limited ability to monitor aides, to determine whether they show up, or whether they are present for the number of hours for which their agency is reimbursed.
- DSS should ensure that it is not paying for aides that do not provide services.
- With a shift in nursing resources, this recommendation could be implemented with no additional costs.
- Improved aide oversight would be simplified by the addition of an information system that would provide summary information for each client and each provider and would allow analysis from month to month. While this would require additional initial spending, long-run savings could be substantial. The addition of an information system is discussed below in section E.

Recommendation: Establish standards for provider inclusion.

- Erie County has a clear list of requirements for any provider who wishes to be involved in providing services to Medicaid PCS patients. This serves as a mechanism to both limit the number of providers, and to encourage that only the highest quality and most efficient providers are involved.
- This can be developed internally by DSS at no cost, or by the legislature.

Recommendation: Pursue a reduction in the number of provider agencies.

- The reduction can be based on the standards as described above.
- In fiscal year 1999, Nassau County made payments to 63 licensed agencies. This number could be reduced substantially for administrative ease.
- Reduction in the number of agencies can lead to improved management, improved ability to hold agencies accountable, and is likely to lead to reduced costs.

Recommendation: Collect outcome and cost data by provider.

- This recommendation requires an information system to be done effectively.
- DSS knowledge of quality and cost information could provide the agency with leverage when negotiating with provider agencies. If agencies are aware that DSS has such information, they could begin to compete on cost and quality.
- We would not recommend publishing cost data, in particular, because it could lead the lower cost providers to increase their costs.

Recommendation: Consider a brief review of the DOH Statements of Deficiency.

- The NYS DOH reviews home care providers periodically. These Statements of Deficiency are available from DOH (see Table 10).
- The reviews are paper reviews, and as such do not evaluate quality from a consumer perspective. However, they can identify deficiencies with some providers that DSS should be aware of.
- Until DSS institutes an information system that will permit better monitoring of quality, the Statements of Deficiency might be worth regular review.
- This is a no-cost option for DSS.

Table 10: Incidents of Statements of Deficiency, Among Nassau County Licensed Home Care Agencies

Agencies	II. Amendment of License	III. Patient Rights	IV. Patient Service Procedures	VI. Medical Orders	VII. Clinical Supervision	IX. Governing Authority	X. Plan of of Care	XI. Personnel	XII. Contracts	Total Areas
1	X	X	X	X	X	X	X	X	X	9
2		X		X	X	X	X	X	X	7
3	X	X		X	X	X	X	X		7
4		X		X	X	X	X	X	X	7
5		X		X	X	X	X	X	X	7
6	X			X	X	X	X	X	X	7
7		X	X	X	X	X	X	X		7
8		X		X	X	X	X	X		6
9		X			X	X	X	X	X	6
10		X		X	X	X	X	X		6
11		X			X	X	X	X		5
12			X		X	X	X	X		5
13		X	X		X	X				4
14		X			X	X		X		4
15		X		X	X				X	4
16			X		X	X	X			4
17					X	X	X			3
18		X	X		X					3
19						X	X	X		3
20				X	X		X			3
21						X				1
22										0

Source: NYS DOH Office of Health Systems Management

Note: The above information includes Deficiency Statements for the largest agencies, covering about 75% of PCS cases. The time period covered is 1995-1998

2. Provider Rate-Setting

Nassau County PCA and the other home care programs made payments for personal care aide services to 63 licensed agencies in fiscal year 1998-1999. In April of 1999, three vendors served one client each, and six vendors served over 100 clients each. The remaining 2,992 PCA cases were distributed at varying levels among the remaining provider agencies. The 63 providers each were assigned up to seven different rates approved by New York State to cover seven categories of home visits

including personal care, hard-to-serve, live-in, shared aide, and nursing supervision visits. The challenge is substantial to Nassau County staff in tracking all the programs, contacting providers to assign clients, monitoring providers, and keeping up with new rates each year.

The State Health Department establishes Medicaid payment rates for each provider of personal care services statewide. All providers of PCA must file an audited cost report to the State, using Health Department forms, by September of each year. The County is not involved in these reports, which must be filed electronically as of 1999. The September cost report details costs from the previous calendar year, in order to determine rates for the following calendar year. For example, reports submitted in September 2000 contain cost data from 1999, which will be used to set rates for the year 2001. Different providers of the same service are paid significantly different sums as a result. Hourly rates in Nassau County for Personal Care Assistant Level II, for example, range from $11.12 to $15.91, simply because the providers have a different cost basis. The high cost provider has no incentive to reduce costs unless administrative costs exceed the 28% cap or the direct cost per hour exceeds the regional cap.

Outside of New York City, which is treated separately, there are two rate-setting regions: downstate metro area (Nassau, Suffolk, Westchester, and Rockland Counties), and the rest of the state. Using a methodology established by the enabling legislation, State Health Department staff review total spending by several categories of direct care and training cost per service hour, add “pass-through” costs that have no ceiling (rents, depreciation), add administrative costs per service hour (limited to no more than 28% of direct costs), a fixed profit (determined by reference to treasury bill interest rates) and a complex trend factor to account for the two-year delay. A regional ceiling on direct care and training components also exists. Since the early 1990s, the state has been generous with direct care ceilings (at 115 percent), with the expectation that the extra dollars would be passed along to aides in their hourly wages. However, according to a State representative, the supposed wage increases have not occurred.

State regulations permit counties to seek an exemption from the State’s rate setting methodology for PCA. Because the rates are cost-based, there is generally a

great degree of variation across provider agencies. Counties that receive a waiver from the cost-based rates may generate a "uniform" rate that applies to all providers with whom the county has a contract. The local districts may take the State-calculated rates, take a weighted average, discount it, and establish a uniform rate. *This uniform rate is intended to result in payments that in the aggregate will be less than what would be paid using provider-specific payment rates*.

The State must approve the exemptions from the State-approved cost-based methodology. Counties interested in the exemption must prepare a proposal to the State, and indicate how the exemption would save money. The exemption application is completed and submitted annually. The exemption application requires a letter to the State Health Department, with a spreadsheet indicating how the proposed uniform rate was calculated (reflecting, for example, a 3% to 5% discount against the weighted average rate for all providers, using all providers and the published rates), and letters of support from providers. Since "Level II" personal care services account for about 90% of all personal care spending, it is customary to apply for the exemption for "Level II" rates only. But there is no reason why other Medicaid rates for personal care services, including rates for shared aide services, could not be set on a uniform basis. The NYS Department of Budget approves all PCA rates for all providers, and the new approved rate is then entered into the MMIS payment system.

Table 11 shows the Medicaid rates approved by the State Health Department for the Level II Personal care services for calendar year 1999 in Nassau County. The table also shows the calculation of a uniform, discounted rate for Level II services, and the difference in reimbursement to agencies per week, if the County were to apply a 10% discount to the uniform rate. Note that only 37 provider agencies are included in this table. Information for either the rates, or for the number of cases served in April 1999 was missing for the remaining contracted providers. Under the 1999 rates, and using actual cases per provider in April 1999, along with average hours per case per week (actual hours were not available), we estimate that one week of Level II service reimbursement in April 1999 was approximately $1.37 million dollars (gross). If the County were to take a weighted uniform rate ($13.50) and discount that rate by 10%, the reimbursement for a week in April would have been approximately $1.23 million, *for a savings of $136,875 weekly, or $7.1 million annually*. Since these are gross estimates, it is important to point out that the county

share (10%) savings would be approximately $711,750 annually. Further, since information was only available for 37 of the 63 licensed agencies, this estimate is likely to be quite conservative.

Suffolk, Erie, Westchester, Greene, Chemung, Niagara, and Chautauqua counties have obtained exemptions from the State in the past. The principal

Table 11: 1999 Level II Personal care Rates, and Application of Discounted Uniform Rate

Provider Agency	*1999 level II rate*	*Number of April, 1999 Cases*	*Average Hours/Case/ Week*	*Reimbursement Per Week*	*Uniform Rate*	*Change in Rate*	*Reimbursement With 10% Discount*
1	$15.54	47	48	$35,058	$13.50	($2.04)	$27,410.40
2	$15.15	25	48	$18,180	$13.50	($1.65)	$14,580.00
3	$14.90	51	48	$36,475	$13.50	($1.40)	$29,743.20
4	$14.85	38	48	$27,086	$13.50	($1.35)	$22,161.60
5	$14.66	24	48	$16,888	$13.50	($1.16)	$13,996.80
6	$14.45	45	48	$31,212	$13.50	($0.95)	$26,244.00
7	$14.43	32	48	$22,164	$13.50	($0.93)	$18,662.40
8	$14.24	48	48	$32,809	$13.50	($0.74)	$27,993.60
9	$14.18	150	48	$102,096	$13.50	($0.68)	$87,480.00
10	$14.09	56	48	$37,874	$13.50	($0.59)	$32,659.20
11	$14.08	80	48	$54,067	$13.50	($0.58)	$46,656.00
13	$14.03	124	48	$83,507	$13.50	($0.53)	$72,316.80
14	$13.97	37	48	$24,811	$13.50	($0.47)	$21,578.40
15	$13.68	5	48	$3,283	$13.50	($0.18)	$2,916.00
16	$13.66	72	48	$47,209	$13.50	($0.16)	$41,990.40
17	$13.52	63	48	$40,884	$13.50	($0.02)	$36,741.60
18	$13.45	192	48	$123,955	$13.50	$0.05	$111,974.40
19	$13.45	87	48	$56,167	$13.50	$0.05	$50,738.40
20	$13.39	76	48	$48,847	$13.50	$0.11	$44,323.20
21	$13.31	8	48	$5,111	$13.50	$0.19	$4,665.60
22	$13.27	26	48	$16,561	$13.50	$0.23	$15,163.20
23	$13.26	76	48	$48,372	$13.50	$0.24	$44,323.20
24	$13.23	116	48	$73,665	$13.50	$0.27	$67,651.20
25	$13.19	98	48	$62,046	$13.50	$0.31	$57,153.60
26	$13.13	78	48	$49,159	$13.50	$0.37	$45,489.60
27	$13.06	24	48	$15,045	$13.50	$0.44	$13,996.80
28	$12.95	11	48	$6,838	$13.50	$0.55	$6,415.20
29	$12.92	54	48	$33,489	$13.50	$0.58	$31,492.80
30	$12.71	69	48	$42,096	$13.50	$0.79	$40,240.80
31	$12.54	57	48	$34,309	$13.50	$0.96	$33,242.40
33	$12.38	60	48	$35,654	$13.50	$1.12	$34,992.00
34	$12.21	53	48	$31,062	$13.50	$1.29	$30,909.60
35	$11.85	55	48	$31,284	$13.50	$1.65	$32,076.00
36	$11.85	37	48	$21,046	$13.50	$1.65	$21,578.40
37	$11.12	38	48	$20,283	$13.50	$2.38	$22,161.60
TOTALS				$1,368,593			$1,231,718

Note: Average Hours per Case per Week was 48. Provider-specific averages were not available.

advantage to the county is the reduced Medicaid costs for personal care services. Counties that have used this method eventually discontinue it once their personal care service costs are under control. While Suffolk is still using the uniform rate approach, in 1997 Westchester decided to go back to a cost-based rate set by the State after three years of using a uniform rate. Westchester found that the delay in state approval of Westchester's uniform rate each year was prohibitively lengthy, and the rate did not save the County enough money to be worth the wait. The main disadvantage to this approach is the groundwork needed, including obtaining letters of support from providers, to implement it.

Similarly, in Erie County rates are again cost-based. However, at one time the county negotiated a discounted rate when they were under the state-mandated targets (as a number of counties were several years ago). In Chautauqua County, the CASA set a maximum rate that it was willing to reimburse providers. If providers wanted to participate in Medicaid PCS, and the state-generated cost-based rate was higher than the maximum, the providers were then forced to go back to the state to request a lower rate.

Suffolk County's first uniform rate initiative (in 1991) involved directing care hours at low cost providers, offering the high cost providers the opportunity to unilaterally lower rates in order to continue to get business. In 1994, Suffolk received approval for a uniform county rate. While the average PCA Level II reimbursement for all Suffolk County providers was $12.80, the county received approval to pay a uniform rate of $12.50 to all providers (a 2.3% reduction). In 1995, the County applied for approval of a uniform rate of $13.00, $0.43 less than the average rate calculated by NYS DSS for its providers. During the six years that Suffolk has used the uniform rate, the savings has generally been between $.30 and $.75 per hour of aide time. *However, Suffolk is very concerned about the aide shortage, and would consider moving away from the discounted rate if that move could be part of a comprehensive approach to increase aide wages.*

In moving to a uniform rate system, Nassau County could divide the county into multiple service areas, and then reduce the number of providers by limiting the number of contracts issued in each area. In setting these limits the County could require that the providers guarantee service and accept all the patients referred for

service. A monetary penalty could be charged if the agency failed to provide the service. In order to attract and motivate bidders to an RFP that contained such additional conditions, higher rates could be negotiated for specific levels of care and for service areas identified as difficult to serve because of their physical location and lack of public transportation, and /or higher rates if the extra dollars went to aides wages and there were a mechanism to monitor this..

Recommendation: Consider a move to a uniform rate payment system.

- Inefficient providers should not be guaranteed a higher level of compensation than more efficient providers. While some argue that differences in cost reflect a different case mix, different rates are already set for "hard to serve" clients.
- In the absence of a state act to move towards uniform rates, Nassau County can certainly move forward with a request to establish uniform rates at the county level, as has been done in Suffolk and other counties.
- This will require staff time, but more efficient use of nursing resources should free up the necessary labor to develop a justification of the need for the uniform rate for submission to the state DOH.

The uniform rate and reduced number of providers could have the following positive effects on the PCA and other home care programs:

- Reduce the number of providers with whom the County works;
- Guarantee service to clients;
- Give DSS control over the rate-setting process;
- Give DSS better control over program growth;
- Expand program oversight and accountability as a result of reduced providers;
- Eliminate rate variations by using uniform rates; and
- Encourage expansion of Shared Aide through the use of service areas.

Providers will not withdraw from participation in DSS home care programs if restrictions are placed on them. Westchester, Suffolk, Erie, and Monroe Counties have all introduced a uniform rate and required guaranteed service with no negative repercussions from the providers. The level of funds expended in Nassau for home

care and long-term care programs will continue to attract providers who will compete to provide these services.

E. Need for Improved Management Oversight

Nassau County's expenditures for PCA are viewed by some as a measure of the County's commitment to providing quality services to elderly residents. However, in government, as in business, the sheer level of expenditures is not an indicator of success. Success is determined by outcomes, and the ability of the program managers to measure the quality, access, and cost of a program. Nassau County program managers need to know how the nurses supervised by DSS are in turn supervising their assigned cases, the size of effective caseload management, and the total program and per case expenditures. The managers also need to verify that aides are providing the prescribed services in a quality manner, that services are provided in accordance with physician's orders, and that each client's plan of service is in compliance with New York State regulations. The managers should also determine whether clients are satisfied with the service they receive, and whether the level of care is appropriate to a client's physical and social needs.

In addition, the managers should determine whether the PCA program is coordinated effectively with other programs such as Medicare, Title XX Social Services Block Grant Homemaker program, EISEP, and the LTHHC program to ensure county residents and elected officials that effective use is being made of federal, state, and county funds.

The following are a series of areas in which DSS management could undertake options to provide themselves with an improved capacity for oversight of the PCA program and other home care programs.

1. Automation of Processes

CGR observed remarkably little use of information technology to automate processes in DSS. This appears to be a problem County-wide, but was blatantly apparent at DSS. Without automation nurses spend an inordinate amount of time on clerical tasks, such as determining when re-assessments are due. Nurses are also unable to easily track how a patient progresses over time. When comparing an initial assessment to a re-assessment, the nurses lay the paper documents out side by side on a table to look for changes.

Monthly budgets submitted to DSS from LTHHC providers are centrally entered into a DSS mainframe database. However, the database is very limited in its capabilities, and when providers go over budget there are no red flags to alert DSS personnel. Nurses are unable to monitor the number of patients receiving services under the various LTHHC budgets. The providers perform their own data management of clients with no DSS oversight. Some DSS nurses indicated that they tried to monitor the various PCA programs at home on their own computers because of the lack of computers at work. Six nurses reportedly pay for their own beepers so that they can be reached while doing assessments in client homes.

Nassau County should consider the use of a software program that would provide program managers with the tools to manage program services and productivity. Quality, access, and cost are three important components of the provision of health care, and it is impossible to consider one without the others. Therefore any information on service quality should be considered along with data and information on access and cost.

Counties in New York State have addressed the issue of information and client tracking in a variety of ways. A number of counties use the expenditure data available from the New York State MMIS system, and the State MARS reports. Monroe County is one that uses state data for analysis of payments and services provided. Others, like the Erie County CASA use a case management program to aggregate program and case expenditure information.

Several counties--including Onondaga, Broome, and Monroe--are in various stages of implementing a continuum of care case management system known as the "Q System." The software provides case managers with a capacity to share information, coordinate services, and access client and provider data. The cost of the Q System is currently $24,000, which includes costs to train DSS personnel. The Q System can be licensed to provider agencies so that providers and DSS can all access the same information. The Q System can be used to search for a provider on-line when a new case is admitted, to enter and monitor information from the assessment process, and to readily track financial information on each client. Other case management software packages exist, but the counties in New York State that have evaluated the various packages have found the Q System to be the software of choice.

Recommendation: Begin to train staff in general computer literacy.

- If an automation system is implemented and the staff does not have general computer literacy, it will not be productive.
- Internal DSS staff with computer capabilities can conduct such basic training at no additional cost.

Recommendation: Consider implementing tracking software such as the Q System.

- A system such as the Q System would provide Nassau managers and staff with an increased capacity for oversight of client care.
- The system would also help staff to review each provider agency's service delivery capacity and competency.
- This is a costly recommendation to implement up front ($24,000), but the return on investment would be substantial given the additional control it would provide to the management.

Recommendation: Develop data-driven performance indicators.

- Erie County has had substantial success in understanding better where their PCA resources are being used through their use of data-driven performance indicators (e.g., target number of visits per nurse per day, target number of hours per client per month on average).

2. Staffing Issues

In any review of a program with a large administrative component, staffing issues must be carefully addressed. In the case of the Nassau DSS home care program, a number of staffing concerns exist that affect staff performance. Areas we target for recommendations include nursing and clerical staffing configurations, the need for more management support, caseload issues, the approaches to staffing used in comparison counties, and the chronic aide shortage.

a. Nursing staff

The PCA program includes 20 field nurses, plus a single nurse supervisor, two assistant supervisors, and two office coordinators. Sixteen of the field nurses provide visits for patients in the traditional PCA program, including Shared Aide, while the remaining four are assigned to the LTHHC program. The two assistant supervisors provide primarily administrative support to the supervisor, and do not provide substantial supervisory support. The supervisory nurse therefore effectively supervises a total of 22 nurses, plus the two office coordinators.

Nurses in the PCA unit are not used in the most efficient manner. In particular, if DSS were to incorporate some of the recommendations in this report such as implementing provider monitoring, permitting Limited License, expanding LTHHC, or establishing some type of central intake unit, these nurses could be used to perform the additional oversight responsibilities that will result, but only if they are properly trained and managed.

Recommendation: Promote two nurses to assistant supervisor and grant them supervisory authority.

- An alternative is to grant the current assistant supervisors supervisory authority, and train them to use it.
- The current supervisor is overloaded with supervisory duties. It is impossible for her to properly supervise the activities of 20 staff nurses plus additional office-based nurses.
- The assistant supervisors can also take on responsibility for increased provider agency oversight.

- The additional supervisory capacity should focus on setting accountability standards for the nurses. This could involve specific case management expectations among others.

The 16 nurses in PCA as well as the four nurses assigned to LTHHC are employed directly by the Nassau County Medical Center, and work for DSS under a contractual arrangement. This arrangement hampers DSS's ability to manage its nursing staff. The Medical Center selects the nurses it would like to send to DSS, rather than permitting DSS the opportunity to interview and select the nurses it prefers. Further, if DSS finds that a nurse is not performing up to expectations, the agency has very little recourse for disciplinary action under the current contract language. In order to fire a nurse, DSS is expected to make a very strong case to return the nurse to the Medical Center.

Recommendation: DSS should gain the authority to hire its own nurses for its home care programs.

- DSS should evaluate the level of control it has over its nursing staff.
- The current contractual arrangement for nurses inhibits DSS's ability to manage these staff.
- DSS should consider the pros and cons of the current arrangement, and whether new contract language could be helpful. Westchester County DSS utilizes nurses under contract through the county DOH, and finds it to be a very beneficial arrangement. A copy of the contract with its detailed conditions can be found in Appendix A.

b. Clerical Staff

In many of our interviews with nursing and other staff in the PCA unit, we heard that there is a serious lack of clerks to handle the many administrative tasks to be done. As a result, nurses are performing many lower level tasks that should be done by clerical staff. This leads to nurses who are short on time when it comes to assessments and care plans, tasks that must be done solely by nurses. In addition, DSS is paying nurses to do clerical-level work, which results in unnecessary costs. The current staffing situation of one full-time PCA clerk, two part-time clerks, and six

temporary staff is too low. The temporary staff experience high turnover rates and do not reduce the burden of paperwork on the nurses or on the permanent clerk staff. We suggest increasing the number of full-time permanent clerks to three for the PCA program, including the LTHHC component.

Recommendation: Add two full-time clerks to the PCA unit.

- Adding two Clerk I employees increases expenses by $35,764, according to the Nassau County budget.
- An alternative might be to assign two nurses to complete extra paperwork, to permit the remaining nurses to spend more time in the field on case management activities. With their additional clinical expertise, such nurses could complete the paperwork quickly and effectively.

Recommendation: Use the nurses more effectively by shifting clerical duties to clerks.

- Once clerical duties are shifted either to clerks or to nurses assigned clerical tasks, remaining nurses will be free to monitor providers and aides more effectively, and to provide more case management to clients.

Clerk support is crucial in a PCA and LTHHC unit. A tremendous number of forms must be filled out, verified, filed, etc. While some paperwork must be completed by nursing staff, much of it can be completed by clerical staff. The most efficient use of clerks would be to provide them with cross-training so that they can function in either portion of the PCA and LTHHC unit as needed on a week by week basis. Similarly, cross-training the nurses for use in all PCS-related programs including LTHHC would make them more efficient, especially when some staff experience prolonged absences.

Recommendation: Cross train all nursing and clerical personnel.

- The training costs would be nominal.
- This would provide more flexibility in the use of nursing and clerical staff.

c. Caseload

Caseload for nurses assigned to LTHHC tends to be lower than caseloads for nurses assigned to traditional PCS. LTHHC patients generally are visited quarterly as opposed to semi-annually as in traditional PCS, and LTHHC patients may require extra visits due to changes in their medical condition, hospitalizations, or other complications. However, with relatively low nursing staff, some of the LTHHC re-certifications are reportedly done as paper reviews only, rather than as in-home reviews. The lack of clerks makes the caseload level difficult to maintain, because the nurses must complete much of the paperwork themselves. A more efficient arrangement would be to shift one PCS nurse to LTHHC and to commit 2 FTE clerks to LTHHC, rather than the 2 part-time clerks that are currently providing staff support. Further, if the LTHHC caseload were increased to the full 1,501 slots allowed by the state, as we recommend in this report, an additional nurse would be necessary, for a total of 6 nurses, and an additional clerk FTE would be needed for a total of three clerk FTEs.

Recommendation: Shift a nurse from PCA to the LTHHC unit. Commit an additional clerk to the LTHHC unit.

- Nurses in the LTHHC unit are overloaded with cases. They could more effectively monitor their caseload if they had a more manageable number of cases.
- The shift in nursing resources is a no-cost option.
- The addition of one full-time clerk will require additional cost.

d. Other Counties' Experiences

Other counties approach the staffing of their personal care and LTHHC programs differently than Nassau. Westchester County has nine full time nurses who are all cross-trained to provide support for PCS, LTHHC, or any other type of assessment. In addition Westchester has 1.5 nursing supervisors, and 18 social workers (caseworkers). Nurses and social workers team up to conduct the various assessments necessary for personal care services. While the nurses conduct the nursing assessment and are employed by the County Department of Health, the social

assessment is completed by caseworkers employed by DSS. The DOH nurses are supervised by DOH, not by DSS. The two assessments result in a Plan of Care for the client. The nurses are trained to be available to complete any type of assessment needed in order to meet the need for all nursing assessments in an orderly manner. These nine nurses in Westchester cover 1,600 PCS cases and 1,246 LTHHC cases. With the support of social workers to conduct some of the assessment paperwork, the nurses are able to take on much higher caseloads than in Nassau.

Recommendation: Consider the use of Social Work staff.

- Other counties use social work staff to offset some of the nursing workload.
- This approach provides more involved case management from a social rather than medical perspective, and allows the nurses to take on a heavier caseload.

Monroe County does not use the Personal Care program extensively, but does use the LTHHC program heavily. Monroe County DSS employs a total of 12 staff members, including six nurses, 1.5 FTE clerks, three social workers, and a program manager. The six nurses manage approximately 1,500 LTHHC clients, as well as 500 additional clients under PCS, and Title XX. An important distinction in Monroe is the use of automation. *The automation of the assessment process and ability to track clients leads to much more efficient use of nurses' time*. For example, instead of re-writing all the assessment forms at the time of re-assessment, the nurses are able to enter just the information that has changed. They are able to identify changes in the patient's needs and quickly determine if a different service mix is necessary. The use of automation, and sufficient clerk and social worker support renders the nurses capable of handling higher caseloads in Monroe than in Nassau.

Recommendation: Implement an information system for improved efficiency.

- As discussed in the previous section, automation of the PCS program would lead to greater efficiency in a variety of ways.

Monroe and Westchester Counties both have much higher caseloads per nurse compared to Nassau, while Erie and Suffolk nurse caseloads are much lower. Erie and Suffolk both take an assertive approach towards managing their provider agencies, and towards case management. While their caseloads per nurse are substantially lower than the other comparison counties, this is likely intentional. With

lower caseloads, the nurses in these two counties are able to spend more time on case management functions, overseeing personal care aides and their agencies, and ensuring that the clients receive appropriate, quality care. Monroe and Westchester likely have much higher caseloads per nurse because they also have social workers on staff who are able to provide more case management and are able to complete some components of the paperwork, which relieves the nurses and enables nurses to take on more cases.

Counties can and do approach staffing structures for PCS in a variety of ways. The approach used depends on the agency's goals, and on other staffing configurations such as the presence of social workers or other staff to conduct provider oversight or case management. Again, the need for a county long-term care plan becomes apparent.

e. Aide shortage

Many interviewed parties expressed concerns about the lack of qualified health care aides. The dearth of aides available to provide services to recipients of personal care is problematic nationwide. This problem has been well documented in New York State and at the county level. Several licensed agencies in Nassau indicated a lack of aides, and have developed various incentive programs to encourage applicants. Some examples of incentives include monetary bonuses for time worked, referral bonuses, retirement plans, additional pay for enhancing skills, discount coupons for other services (tax services, car services), vacation bonuses, child care, health care, and direct deposit.

While the problem certainly exists in Nassau, the problem is not unique. Based on data from the New York State Department of Labor, the projected annual openings for personal home care aides on Long Island (Nassau and Suffolk) between 1996 and 2006 will increase by 17.7 percent. This compares to an increase of 18.8 percent in the Capital District (Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Warren, and Washington Counties) and to a statewide increase of 18.1 percent. The Home Care Association of New York State (HCA) has found that it takes provider agencies two to three months to fill aide positions.

Recommendation: Compile a list of incentives for the provider agencies to use in recruiting and retaining aides. Identify new incentives during visits to CASA meetings in Albany.

- This is another example of the potential usefulness of the CASA meetings.
- This is a no cost option that could be of use to the provider agencies, and ultimately to DSS in terms of more reliable aides.

3. Third-Party Administrator (CASA)

As this report has shown, a variety of in-home and community-based services and programs exist for functionally impaired and chronically ill individuals throughout the county, including personal care, LTHHCP, CHHA, Title XX homemaker/ housekeeping services, and EISEP. These programs typically operate fairly independently of each other, without regard to access, use, and monitoring, even though the County has a stake in the cost and effectiveness of these programs.

An innovative and effective response to this lack of coordination has been the Community Alternative Systems Agencies (CASAs). CASAs function as a Third-Party Administrator (TPA) of home care services for DSS and other agencies. CASAs were established in New York State as demonstration programs in the early 1980s in response to the New York State Systems Development Project. That Project called for the development of local level agencies to improve the management and control of long term care services, and particularly Medicaid services. A Request for Proposals (RFP) was issued by the State Department of Social Services, and nine CASA programs were established. The counties included Bronx, Broome, Chautauqua, Chemung, Erie, Jefferson, Rockland, Suffolk, and Warren counties. While Suffolk was one of the initial setups, the county decided not to pursue the approach and subsequently withdrew from the program in 1985.

CASAs were intended to be "designed as an intervention to shift the balance of the long term care system from institutional services to less costly community based alternatives. Within that framework, CASAs are charged with meeting specific objectives:

- Reducing the demand for institutional services through effective control at the point of entry, and the use of community-based services;
- Meeting the growing demand for long term care services by selective expansion of non-institutional community-based alternatives, keeping total systems costs lower than they would have been without the intervention;
- Recognizing and supplementing the informal support system in order to effectively contain expenditures and enhance the quality of care; and
- Developing mechanisms to effectively identify populations in need and to target services to those populations on a priority basis." (NYS DSS, 1983).

Five general functions characterize CASAs:

1. Pre-admission assessment;
2. Determinations of medical eligibility for specific levels and types of care;
3. Case management services;
4. Minimum elements of data collection; and
5. Local system development.

Other CASA functions can include:

- Single entry point for long term care;
- Hospital discharge planning;
- Expedite Medicaid eligibility;
- Gatekeeping;
- Client advocacy; and
- Represent the prudent buyer.

The original CASAs were expected to target certain subgroups, in particular, hospitalized patients for whom alternate care placement has been unduly delayed, and hospitalized patients who have recently been designated for long term care services. Today, CASAs focus on coordinating the provision of care for the personal care and LTHHC programs.

Nassau should explore the use of a Third Party Administrator (TPA) CASA to conduct PCA functions for DSS. Most CASAs are self-contained within the county government, and are run through the County Health Department. Alternatively, the Erie County CASA is an example that is run through DSS.

Evidence is strong that CASAs have been successful in controlling their long term care costs, while assuring access to appropriate services, and a number of counties have continued to use the CASA model, or various components of it. But while CASAs have many appealing features, there are a number of challenges in putting together a CASA.

The groundwork for the Erie County CASA was laid in 1980, when Coordinated Care, a not-for-profit organization, was established with the purpose of becoming a single entry point in Erie County for all LTC services, public or private. The mission of Coordinated Care was to ensure that people were placed in a setting that fit their needs. In 1983, Coordinated Care entered a contract partnership with DSS to become a single entry point for Medicaid as a partnership, called CASA (Community Alternative Systems Agency). As of 1999, the single entry point function is now primarily for Medicaid services, although they do refer people to EISEP or other programs occasionally. The name CASA simply refers to the partnership structure itself; CASA is not a separate entity. The Erie County CASA is unique because of the partnership between the county and the not-for-profit Coordinated Care.

The total Erie County CASA budget is approximately $2 million. Coordinated Care is responsible for the nursing assessments for PCS and LTHHC, and DSS has a contract with Erie County Health Department for nursing supervision. The Health Department orients the PCS aides, and conducts periodic visits. In 1989, prior approval for nursing home placement also started coming through the CASA, although there is a separate nursing home division within DSS.

Patients enter the Erie County CASA through an intake unit (Access & Coordination), which involves a computerized pre-screening process to determine eligibility. The pre-screen consists primarily of ADL questions, and generates an overall picture of the patient's needs. If the screen indicates that the patient is eligible for PCS, a doctor's order is obtained. If the patient seems to want/need nursing home care rather than in-home care, he or she is referred to the nursing home unit. If the patient can demonstrate complex care needs, or a need for a waivered service, and for regular nurse visits (not just aide visits), then the patient may be referred to the

LTHHC program. If a person needs LTHHC, their care is coordinated through the Access and Coordination Team.

Once a patient is determined to need personal care only, the patient is referred from the Access and Coordination Team to one of the six in-home (PCS) teams, which each cover a defined geographic area of the county. Each of the 6 PCS teams has a nursing coordinator (Coordinated Care employee).

The intake unit (Access and Coordination) was described as the key to efficiency in this CASA. The overarching objective of this unit is to place incoming clients in the program that is most medically appropriate for them. The unit saves the nurses a substantial amount of time by obtaining the doctor's orders and doing other administrative work that nurses should not spend their time on. This team was added because the CASA found that they were not being consistent in putting people in the right programs.

The Erie County CASA provides an average of 27 to 32 aide hours per client per week. The PCS caseload and the average hours per case have dropped over the years as a result of more focused management.

There are several benefits to a CASA approach as it exists in Erie County. First, the CASA is able to provide a Research and Development department because of the partnership with Coordinated Care. The R&D department conducts extensive monitoring of utilization and costs in the PCS programs, including traditional PCS, Shared Aide, and LTHHC. The team generates monthly reports that indicate whether utilization has increased or decreased, and by how much. The team also tracks the number of aide hours in total and on average each month. This helps the CASA to identify problem areas, outliers, etc., and helps them to set goals and objectives. The bottom line is that they are able to evaluate their programs and understand trends immediately. In addition, the R&D team is able to apply for and win grants to further the CASA's effectiveness and capabilities.

On the other hand, there are drawbacks to the CASA partnership. It takes a lot of work and attention to keep it running the way it does. The model is expensive and

requires a long term commitment. The two entities are constantly trying to define themselves as individual entities, and as a partnership simultaneously.

DSS management has asked the CASA to develop performance standards and measures. The CASA has set overall goals, but is working on developing specific, measurable objectives. Performance measures began to be implemented November 1, 1999. An example of a performance measure would include a goal to reduce costs, and the specific objective of reducing hours by one hour per person per week. Individual staff members will be required to maintain objectives. If they cannot, they will have to work up a corrective action plan. The CASA recognizes that it has to be prepared for the changing demographics, and hopes that objectives and performance measures will help it to do this. They have an internal work team identify "best practices"—who is doing a particular task well internally, then they train others based on the best practice. Ultimately, they revise the procedures to reflect the best practice.

Recommendation: Consider the benefits of a CASA model for Third Party Administration.

- We recommend that the County consider some of the approaches the Erie County CASA has used to control costs and provide care to the elderly and disabled in a planned, quality manner.
- If DSS management cannot implement some of the recommendations in this report to make the home care program more efficient and effective, a CASA could be a rational approach.

A major consideration, not surprisingly, are the initial, and potentially ongoing, administrative costs in establishing an effective CASA. In a sense, these costs are an investment in the program, intended to pay off over time in terms of the effectiveness and savings generated by the program. A variety of programmatic issues must be resolved for any new CASA: What functions will it be responsible for? Which populations will be addressed (Medicaid-only? Private pay?) Which services will come under its purview (all Medicaid community based services? Other county-sponsored services? Nursing home services?) Will a single comprehensive assessment instrument be used for all programs and all clients? We would suggest

that the CASA be designed to be as comprehensive as possible, to serve the needs of all citizens who need home care in the County of Nassau.

It takes strong political will to see the CASA effort through to fruition. It can be fraught with political problems. Providers, and advocacy groups, often object to this centralization of function and authority. In addition, conflicts may arise within county government regarding the CASA. Should the CASA be "located" within or outside DSS? To whom should the CASA report? Should a non-profit entity be used in conjunction with DSS? Should the EISEP program come under the purview of the CASA?

At a minimum, the single intake unit function of the CASA should be implemented in Nassau County. This could be the first step towards a CASA model. Even if a CASA is not implemented in Nassau, the central intake/screening unit should be implemented immediately.

Recommendation: Implement a central intake and screening unit.

- Such a system can contain long-term care costs.
- A central unit improves the delivery and quality of long-term care services to individuals and families.
- Provides "one-stop shopping" for individuals seeking home care services.
- Helps the County develop a coherent approach to home care.

We also recommend that the Nassau DSS regularly attend the "CASA Association" meetings in Albany which are not restricted to CASA counties. These meetings provide a regular opportunity to keep up to date with developments at the State level, to network, and to discuss "best practices" that other counties are engaged in.

The CASA Association meets in Albany at the NYS DOH OCC office once every other month. Representatives from all county PCS programs are invited to attend, and most counties send representatives on a regular basis. In most cases, the Director of Medical Services, or equivalent, is the staff member who attends such meetings. The meetings include presentations on issues of interest to all PCS programs, provide an opportunity for counties to share innovative and best practice

ideas and information, and provide an opportunity for county representatives to meet with state staff. According to the state DOH OCC, representatives from both Westchester and Suffolk attend regularly. It may be possible to carpool with Suffolk staff for such meetings. The CASA meetings are also scheduled to coincide with New York Public Welfare Association (NYPWA) meetings as much as possible, to make the trip more efficient.

Recommendation: Attend the CASA Association meeting in Albany for information sharing purposes.

- Consider car-pooling with Suffolk to save costs.

4. Assessment

In Nassau County, PCA assessments are conducted at admission, and every six months thereafter. Nurses conduct both initial assessments and re-assessments. The assessment tools include a DMS-1 form, a task-oriented plan of care, a DOH home assessment abstract, a social assessment, and a statement of understanding. The DMS-1, task plan of care, and home assessment include some duplication. DSS nurses indicated that this duplication results in less efficient use of their time. Many sections of the forms can be legally filled out by clerical staff, but because of clerical staffing shortages, they are completed by nursing staff. The task-oriented plan of care is used to calculate hours. Hours are assigned to each task, and the total hours are summed to arrive at the weekly hours a client will receive. DSS staff indicated that they feel the number of hours they assign to each task is generous. The number of hours assigned to each task is based in part on the nurses' professional judgment.

During a period of rapid growth statewide in the Medicaid PCS program in the 1980s, no explicit or suggested limits for aide hours were in place. During the 1990s, the regulations included a guideline that suggested a maximum limit of 28 hours per client per week. However, clients could receive more than 28 hours per week if they met certain criteria, which were quite broad. A lawsuit that originated in NYC in the late 1990s resulted in removal of the 28 hour per week limit from the regulations. As of today, there are no state guidelines on the number of hours to be awarded per week.

In Westchester County a nurse and social worker team up to conduct initial assessments and re-assessments. Westchester County staff believes that the team approach results in a better care plan. A set number of hours are allocated for each ADL limitation, and deviations from this figure are strongly discouraged.

Attempts to formalize a more structured state-wide approach to assessment have not been successful. At one time, NYS DOH OCC attempted to create a uniform functional assessment tool called HARI (Home Assessment Resource Instrument). As various advocate groups and other interested parties commented on the tool, it became less and less useful, and eventually the effort was "litigated away." Currently no statewide assessment tool exists.

Until July 1999, counties were required to apply a fiscal assessment to all prospective PCS clients. Counties were able to use this as a negotiating tool. If a client's PCS costs were high enough such that nursing home care would be a more cost-effective option, the district could ask the family to provide more care hours, and in most cases the families complied with such a request. However, the fiscal assessment requirement expired in the summer of 1999, and has not been reinstated.

Recommendation: Consider development of a single assessment tool.

- Three of the assessment tools--the DMS-1, the task-oriented care plan, and the home assessment--are somewhat duplicative, and could be re-examined for potential improvements.

Recommendation: Provide precisely the number of hours the care plan indicates are necessary, and no more.

- We were told by multiple sources that under PCS (outside of Shared Aide), a large portion of an aide's time is spent watching television, providing companionship, or doing other things that are not specific to the tasks assigned for the client. If the number of hours assigned per task are generous, perhaps this slack time could be reduced through a more judicious allocation of aide hours by DSS.

5. Legal Issues

The PCA program is designed to provide basic nutrition, hygiene, and housekeeping, including help with ADLs and IADLs. It is also intended for individuals who are "self-directed," meaning they can make their own decisions. However, services may be provided to individuals who are not self-directed if there exists a person (family/friend) who is willing to pitch in and help when necessary. In the last several years there has been an increase in the number of clients who are not self-directed because of advanced age or dementia (mostly Alzheimer's).

Historically, safety monitoring was never intended for clients in the PCA program except as an adjunct to assistance with ADLs. For example, while walking a client to the bathroom an aide provides assistance and some supervision in the completion of the task. However, safety monitoring was never meant to be an actual "task" that could be used as justification for allocated PCA hours.

When the PCA program first started, municipalities were unsure how to handle elderly patients (in particular, those who were not self-directed). In some PCA client cases, DSS would refer to supervision or safety monitoring as the type of help a client needed. Those word choices set the stage for the problems DSS faces in the courts today. In the last three to five years, counties have tried to be much more precise in their administration of the program. Today, if you do not qualify for the program, you simply do not get any services. While in the past DSS would sometimes initiate services with the understanding that a client truly belongs in a more protective and appropriate environment, that is no longer the case.

The Rodriguez case has brought the issue of supervision/safety monitoring to the forefront. The argument was made to the District Court that safety monitoring should be provided to guarantee a client's safety in his or her home, and that safety monitoring should be designated as a specific task. In August of 1998, the District Court Judge agreed that safety monitoring should be included as a specific PCA task. The case then went to the State Court of Appeals, and the District Court decision was reversed in April 1999. As of October 6th, 1999, the U.S. Second Circuit District Court of Appeals reversed the lower Court's injunction decision in Rodriguez vs. DeBuono. The Appeals Court determined that the personal care program is not

defined to include safety monitoring as a specific task. Since the lower court's decision had been stayed since April 1999, there is no immediate impact on existing or future personal care assessments. Given the already high costs of personal care in Nassau County, this is a very fortunate outcome.

F. Legislative Tasks and Responsibilities

It is difficult for DSS to enforce regulations that are constantly subject to legal challenge. The DSS needs support from the County Legislature to be able to focus on the tasks at hand without constant challenges from clients and providers. Erie County has taken firm steps towards defining the relationship between DSS and its contracted home health care providers. The Erie Legislature passed a local law in 1998 that provides substantial support to DSS by imposing specific requirements on providers of home health care services who wish to contract with the county.

Recommendation: Develop a Local law to address provider issues.

- The existence of a local law has been immeasurably helpful to the Erie County DSS in terms of provider control.
- This option is of no cost to DSS.
- An example from Erie County is attached as Appendix B.

The local law passed by Erie County also continues the existence of a Home Health Care Advisory Board that includes the commissioner of social services, the Erie County commissioner of health, the Erie County commissioner of senior services, the chairman of the health committee of the Erie County legislature, the president of the Erie county consortium of home care agencies, three persons appointed by the County executive, and three persons appointed by the chairman of the Erie County legislature. The participants aid in the development of Erie County rules and regulations regarding home health service delivery, and make recommendations with respect to Erie County's implementation of the home health review process. The Board also serves as a forum for surfacing home health issues throughout the county. The President of Coordinated Care serves as the chair of the Board.

Recommendation: Explore the County's commitment to the PCA program. Explore home care and other long-term care alternatives to PCA.

- This recommendation is for the Legislature, and is more philosophical in nature.
- The Legislature likely needs to consider this question for many if not all of the county-funded programs in the wake of the budget crisis.
- This is related to the earlier recommendation that the County develop a long-term care policy.

VIII. Conclusion

During the course of this project CGR has experienced many dedicated and caring DSS staff who administer the DSS home care program in the face of many substantial barriers. In addition, CGR spoke with many quality private providers who are eager to work with the County and State to improve the quality of home care service provided to Nassau County's needy. The County Legislature consists of many new members, eager to bring the County into fiscal balance while providing quality care to the elderly and disabled. The CGR project team has enjoyed the cooperation of all involved parties, and hopes that the report recommendations help Nassau County to provide essential care to the disabled and elderly in a caring, quality, and efficient manner.

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