ASPE RESEARCH NOTES
INFORMATION FOR DECISION MAKERS

FOCUS ON: *Long-Term Care* *Issued November 1993*

THE MEDICAID PERSONAL CARE SERVICES OPTION
PART I: CROSS-STATE VARIATIONS AND TRENDS OVER TIME

Medicaid's "Personal Care Services" (PCS) optional benefit has long been the single largest source of Federal funding for noninstitutional personal assistance services to the functionally impaired. This remains true even though, in recent years, expenditures under optional Home and Community-Based Care (HCBC) waivers and the required Home Health benefit have grown much more rapidly. The "Frail Elderly" benefit added to Medicaid in 1990 remains a very minor source of funding. (See Table). The term "personal assistance services", as used here, refers to help from a paid attendant in performing basic Activities of Daily Living (ADLs), such as bathing, dressing, transferring, toileting, and feeding, as well as Instrumental Activities of Daily Living (IADLs), such as housekeeping, cooking, shopping, and laundry.

Medicaid Expenditures for Noninstitutional Long-Term Care Services: 1987 and 1992

	1987	1992	ACRG* 1987-92
Personal Care	1,178,031	2,349,443	14.8%
HCBC Waivers	451,061	2,152,786	36.7%
Home Health	439,655	1,258,595	23.4%
Frail Elderly	0	31,628	NA

SOURCE: Health Care Financing Administration.

* Annual Compound Rate of Growth.

Although the PCS option has existed in Medicaid since the early days of the program, relatively few States elected to provide this coverage prior to the 1980s. In FY 1979, only ten States provided PCS. As of FY 1992, 29 Medicaid programs included PCS.

Federal law and regulations impose few constraints on States' use of the Medicaid PCS benefit. The only requirements specific to this benefit are that personal care services be prescribed by a physician, supervised by a registered nurse, and provided by a qualified individual who may not be a member of the recipient's family.

Data Sources

Historically, little information has been available about why and how States have chosen to use the Medicaid PCS optional benefit. In 1989, the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services contracted with the World Institute on Disability (WID) to provide data on the similarities and differences across State Medicaid PCS programs. The data were drawn from two national surveys, designed and carried out by WID, that collected basic descriptive information on all personal assistance services programs, including both Medicaid and non-Medicaid funded programs, in operation during 1984 and 1988. The survey methodology involved a combination of questionnaires mailed to and telephone interviews with State program officials. In addition, six in-depth case studies of selected State Medicaid PCS programs (MD, MA, MI, MT, OR, and TX) were conducted via site visits between October 1990 and February 1991.

Characteristics of State PCS Programs

Program Size: Over the years, NY's program has consistently dominated national PCS expenditures; indeed, NY accounted for fully 70% of all PCS spending in FY 1992. But the WID study, using an alternative measure of program size--participation rates per 1,000 Medicaid aged/disabled recipients--found that a number of other States had extensive PCS programs relative to their eligible populations. In 1988, States with the highest participation rates per 1,000 were: NY (125), WV (129), MI (132), OK (159), AR (169), MO (177), and SD (215). Conversely, ME, MA, NH, and OR had the smallest PC option programs, with participation rates ranging from four to eight per 1,000 Medicaid aged/disabled recipients.

Program Scope: As of 1988, most programs (79%) reported serving disabled persons of all ages; the remainder restricted PCS to adults age 18 or older. Some programs that served all ages in principle were found, in practice, to emphasize particular age groups (e.g., young adults in MA, elderly in TX, foster care children in OR). Almost three quarters of PCS programs reported serving persons with all types of disabilities. The others excluded persons with mental and/or cognitive impairments.

In 1988, all PCS programs offered help with feeding, bathing, dressing, ambulation, transfers, oral hygiene, grooming, and skin maintenance. Most programs also offered a range of household services, including meal

preparation and clean-up, light cleaning, laundry and shopping. Typically--but not universally--access to household services was contingent on need for and receipt of "hands-on" personal care. Availability of paramedical help was much more variable: in 1988, 58% of programs provided assistance with medications, 38% with respiration, 29% with catheter care, and 21% with injections.

Most States set time or financial limits on the amount of personal assistance services that individual clients could receive. Between 1984 and 1988, the number of programs with weekly service limits of 20 or fewer hours decreased (from 33 to 24%) and the number of programs with service limits above 40 hours per week increased (from 22 to 36%). In 1988, two-thirds (64%) of programs with dollar limits set them in the range of $500-1,000 per month.

State Interpretation of Federal Requirements: The six in-depth case studies revealed considerable variation in States interpretation of Federal requirements. Five of the six States operationalized "nurse supervision" by means of periodic R.N. home visits. But the frequency of such visits varied from every two months in MD, MT, and TX, to every six months for adults and every three for children in foster care in OR, to one per year in MA. MI conducted only an annual record review by a State-employed R.N. The standards for a "qualified provider" also varied widely. OR required 120 hours of up-front certified nursing assistant training for agency employed providers, whereas MT required only eight hours of initial classroom training, plus eight hours of annual in-service and on-the-job training by a homecare agency R.N. At the other end of the spectrum, MA and MI permitted recipients to recruit and train their own independent providers.

OR and MI interpreted the prohibition on use of family members as paid providers very narrowly--to exclude only "legally responsible" relatives, i.e., spouses and parents of minor children. In contrast, MD and MT took very restrictive approaches. MD excluded from employment almost all commonly recognized degrees of kinship--siblings, in-laws, step-parents, children and step-children, cousins, aunts and uncles, nieces and nephews--except grandparents and grandchildren. MT prohibited the employment of grandparents or grandchildren, but not cousins, aunts and uncles, or nieces and nephews.

Summary

The past decade or so has seen considerable growth in the number of Medicaid programs electing to cover personal care services--from only ten in FY 1979 to 29 in FY 1992. Substantial inter-State variation exists in Medicaid PCS coverage. In 1988, participation rates per 1,000 aged/disabled Medicaid recipients ranged from a low of four (NH) to a high of 215 (SD). Federal law and regulations place few limitations on States' discretionary authority. Not by accident, States that interpret Federal requirements more liberally are ones that have consciously sought to develop "consumer-directed" models of service delivery, a subject that will be addressed in an upcoming **ASPE Research Notes** entitled The Medicaid Personal Care Option, Part II: Consumer-Directed Models of Care [http://aspe.hhs.gov/daltcp/reports/rn09.htm].

References

Health Care Financing Administration, Office of State Agency Financing Management. Medicaid Expenditure Data.

*Litvak, Simi and Jae Kennedy. September 1, 1991. Policy Issues and Questions Affecting the Medicaid Personal Care Services Optional Benefit. World Institute on Disability: Oakland, CA. Contract # HHS-100-89-0025. [http://aspe.hhs.gov/daltcp/reports/optnales.htm]

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