Licensing Personal Care Assistance Services - A Report to the 2013 Minnesota Legislature

Office of Inspector General
Licensing Division
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Minnesota Department of **Human Services**

Legislative Report

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I. Executive Summary

Personal care assistance (PCA) is a service administered by the Minnesota Department of Human Services (the Department). It is covered through Medicaid for people who meet eligibility requirements. In state fiscal year 2012, the state paid approximately $580 million for this service. Personal care assistants (PCAs) provide services and support to help people who need assistance in activities of daily living (ADL), health-related procedures and tasks, observation and redirection of behaviors, and instrumental activities of daily living (IADL) for adults and children. Staff who provide PCA services are not required to meet any specific educational or licensure requirements. These staff work for provider agencies that must meet certain training and staffing requirements under the PCA program; however, these agencies are not required to be licensed by the Department.

The desire for increased individual control by people using this service, flexible budgeting and minimal oversight of services is sometimes in conflict with the desire to have safeguards in place to protect individuals and ensure proper use of public funds. For example, increased training and regulatory requirements are often viewed as potential barriers to ensuring an adequate supply of workers.

Medicaid funded PCA programs have been the subject of several audits and evaluations both in Minnesota and nationally over the past decade. State and federal audits of the PCA program consistently find issues relating to improper billing and claims submission, inadequate documentation, and insufficient program controls to analyze claims, verify services and maintain fiscal integrity.

The question of whether to require licensure of PCA agency providers has been considered several times over the past 20 years, with varying recommendations made. Licensure for PCA agency providers was first proposed back in 1991, and again in 1997, but the high cost of implementing such reform was a barrier to implementing this regulatory oversight. Licensure was again raised in 2009 by reports from both the state Office of the Legislative Auditor and the Minnesota Department of Health, but cost was again cited as a significant barrier. Instead, the Department's existing provider enrollment requirements were cited in both reports as a framework for enhancing training, supervision and program oversight.

Against this backdrop, the 2009 and 2010 Minnesota Legislature enacted comprehensive reform of PCA services to help people most in need of the service get it in a cost-effective, quality-conscious manner. Changes were made to improve consumer protection and assure consumer health and safety through increased accountability and strengthened provider standards and training requirements for Individual PCAs.

Despite those changes, the 2012 Legislature directed the commissioner of human services to "study the feasibility of licensing personal care attendant services and issue a report to the legislature no later than January 15, 2013, that includes recommendations and proposed

legislation for licensure and oversight of these services." (2012 Laws of Minnesota, Chapter 247, Art. 4 Sec. 49) This signals ongoing concerns about provider qualifications, individual well-being and program integrity. Developing a licensure requirement for PCA providers also recognizes the potential for enhanced oversight that now exists under the Department's Office of Inspector General (OIG). That reorganization removed fraud investigations of providers and recipients from the program policy areas and consolidated them in one Division under the Department's OIG, alongside the Licensing Division, which licenses, monitors and investigates maltreatment in human services programs.

Requiring providers to apply for a license, pay a fee, and show compliance with enrollment policies and quality assurance standards in advance of commencing operations, is the function of licensing. Licensing provides a regulatory infrastructure that is more comprehensive than enrolling as a Medicaid provider. Evaluating applications and provider readiness for engaging in the delivery of personal care services, engaging in periodic (scheduled and unscheduled) site reviews to monitor ongoing compliance are appropriate functions of the Department's Licensing Division and will help create a more seamless regulatory and program integrity system for this Medicaid funded service with annual expenditures approaching $600 million.

After the 2012 Legislative session, however, the Department began working with stakeholders to redesign the current PCA program in order to better assist individuals maintain and increase their independence, enhance individual choice and provide maximum flexibility. The Department will introduce legislation to eliminate the current PCA program and create a new personal assistance services and supports program in the 2013 Legislative Session. The new service, called Community First Services and Supports (CFSS), will also significantly expand opportunities for individuals to self-direct more of their services by allowing them to choose a flexible spending budget. Individuals who choose this service model would have the option to bypass use of an agency provider and instead be the employer of their direct support worker. They would also be authorized to purchase goods and services consistent with their approved service plan. Individuals choosing this option would, however, be required to use the services of a Financial Management Services (FMS) entity under contract with the Department, to ensure compliance with state and federal employment related laws and other program requirements traditionally performed by an agency provider. (*It is important to point out that the CFSS model is still under development and the description of it in this report may not reflect the proposal that is ultimately introduced in the 2013 session or the program as it may be adopted by the 2013 Legislature*.)

Some studies of different state models of consumer-directed services suggest that allowing individuals to direct their personal care services is associated with significant improvements in a variety of outcomes – including consumer satisfaction, health status, and quality of life – for disabled and elderly Medicaid enrollees. However, many program integrity concerns remain for a model of services lacking external oversight, verification of services, or financial liability for improper payments that are generally the responsibility of traditional provider agencies.

In light of the current redesign of the PCA program, it is anticipated that the number of agency providers will be reduced as individuals elect to use financial management services in lieu of an agency provider. The potential impact is twofold: First, there may ultimately be fewer agency providers to be licensed under the new program, as individuals opt for the flexible spending

model. Second, as individuals begin using the services of the FMS entity – with some even assuming the role of employer of their direct support worker – responsibilities will need to be clarified for individuals, direct support workers and the financial management entities either in statute, through the contracts governing these support entities, or both. Although the current redesign of the PCA program does not require that these FMS entities be licensed, the Legislature may ultimately consider it because of the scope of the FMS entities' administrative functions under the contracts that affect individual safety and well-being in addition to the FMS entities' billing, tax, and legal responsibilities.

Recommendations:

- *The Legislature should require agency providers of PCA services, whether under the current PCA program or the new CFSS program, to hold a license from the commissioner beginning in January 2015, unless otherwise currently licensed under the Minnesota Department of Health (MDH). The Legislature should require the Department to develop, in consultation with stakeholders, proposed amendments to chapter 245A or other applicable statutory authority to establish the standards that will apply to these services and the specific license requirements that the providers must meet, and submit these recommendations to the Legislature by January 15, 2014.*

  Although the Department is recommending licensure of agency providers not otherwise licensed by the MDH, the Department believes it is important to complete the current development of the new CFSS program and obtain approval by the 2013 Legislature before developing standards for licensure. This will allow the Department additional time to determine licensure requirements within the context of the new personal assistance program, address remaining individual well-being and program integrity issues, and obtain input from stakeholders as part of this process.

- *The Legislature should adopt provisions that incorporate the following responsibilities for agency providers, service recipients, FMS entities, and direct support workers into the new program, either as part of licensure requirements or legislation governing the new CFSS program:*

  1. *<u>Consumer Education</u>: Individuals should be educated on their responsibilities relative to, but not limited to, selecting, dismissing, supervising, training and paying their worker when the individual acts as the employer of record; the need for proper documentation and retention of records for all goods and services purchased; and requirements to promptly notify the FMS entity of any changes in staffing or employment status of their worker.*

  2. *<u>Development of Direct Support Worker Standards That Enhance Individual Safety and Well-Being</u>: Current PCA direct care workers are required to pass a competency test and are provided training in nine key areas. That training, and the requirement for a background study under Minnesota Chapter 245C, should be required in the new CFSS for the direct support worker, regardless of whether the*

worker is hired by an agency or an individual assuming employer responsibilities for that direct support worker.

3. *Development of Quality Assurance Functions of the Financial Management Services entities: The contracts governing FMS entities should clearly address, among other things:*
    a. *the entity's obligation for monitoring the individual's continuing ability to fulfill his/her responsibilities under the flexible spending model of the new program;*
    b. *actions to be taken if it appears the individual is no longer able to fulfill such responsibilities;*
    c. *compliance with all documentation requirements imposed by state and federal law, and*
    d. *monitoring of budget expenditures to prevent overspending by the individual or spending on goods or services not authorized in the service plan.*

    In developing the responsibilities of the FMS entities, special consideration should be given to how, or whether, FMS entities will be expected to monitor the individual's well-being, ensure receipt of services in accordance with the service plan developed (e.g., through phone calls, on site visits) and identify possible neglect or exploitation.

4. *Oversight of FMS Entities: Following passage of legislation to implement the new CFSS model, the Legislature should consider the options for optimal oversight and monitoring of the FMS entities. Public accountability will be enhanced through some system of routine inspections of the performance of FMS entities to assure compliance with the quality assurance and program integrity expectations. This may be a through a system of monitoring for performance of the contracted services, or it could be through a licensing structure. The optimal oversight mechanism will best be determined following a review of this Legislature's final product related to CFSS.*

5. *Verification of Services and Adequate Documentation: The Legislature should adopt requirements for oversight and supervision of the service, which should include periodic, unscheduled visits by the agency provider or the FMS entity, in order to verify the presence of the direct care worker and delivery of the service.*

    As an alternative or in conjunction with periodic visits, the Legislature should consider requiring agency providers and FMS entities to utilize some form of electronic visit verification to help verify that services for which the state is being billed were actually provided to the individual, that the services were delivered in accordance with an approved service plan, and that the person delivering the service had the proper qualifications. Common requirements of an electronic verification system used in other states allow a provider to electronically document the service recipient's identity; the direct support worker's identity; the date and time the direct support worker begins and ends the delivery of services; the location of service delivery, and tasks performed by the service provider. An effective technological

verification should involve real time GPS, and more than a single time point confirming presence during a scheduled visit. Currently, too many clients are coerced into signing blank time sheets, and those same clients would be coerced to "call in or sign in" for caregivers without a real verification of their presence and provision of services.

6. *<u>"Dis-enrollment":</u> The Legislature should adopt standards for "administratively dis-enrolling" an individual who has failed to comply with program requirements under the "flexible spending model." Absent fraud, which might result in termination from the program in its entirety, the participant should be returned to the "agency-provider model" where most functions will instead be performed by an agency.*

7. *<u>Clarification of Financial, Civil and or Criminal Liability:</u> Applicable statutes, rules and or policy manuals should clarify who (agency provider, financial management services entity, individual recipient, direct support work) is financially liability for overpayments and improper claims under the flexible spending model.*

II. Legislation

2012 Laws of Minnesota, Chapter 247, Article 4, Section 49:

LICENSING PERSONAL CARE ATTENDANT SERVICES.
The commissioner of human services shall study the feasibility of licensing personal care attendant services and issue a report to the legislature no later than January 15, 2013, that includes recommendations and proposed legislation for licensure and oversight of these services.

III. Introduction

The question of whether to require licensure of agencies that provide Personal Care Assistance (PCA) services to individuals on Minnesota's Medicaid program has been considered several times over the past 20 years, with varying recommendations made. Medicaid funded programs for PCA services have been the subject of several audits and evaluations both in Minnesota and nationally over the past decade. State and federal audits of the PCA program consistently find issues relating to improper billing and claims submission, inadequate documentation, and insufficient program controls to analyze claims and maintain fiscal integrity.

Licensure for PCA agency providers was first proposed back in 1991, and again in 1997, but the high cost of implementing such reform was a barrier to implementing this regulatory oversight. Licensure was again raised in 2009 by reports from both the state Office of the Legislative Auditor and the Minnesota Department of Health, but cost was again cited as a significant barrier. Instead, the department's existing Medical Assistance provider enrollment requirements were cited in both reports as a framework for enhancing training, supervision and program oversight. Against this backdrop, the 2009 and 2010 Minnesota Legislature enacted comprehensive reform of PCA services to help people who need the service most get it in a cost-effective, quality-conscious manner. Changes were made to improve consumer protection and assure consumer health and safety through increased accountability, strengthened provider standards and training requirements for individual PCAs.

Despite those changes, the 2012 Legislature directed the commissioner of human services to "study the feasibility of licensing personal care attendant services and issue a report to the legislature no later than January 15, 2013, that includes recommendations and proposed legislation for licensure and oversight of these services." (2012 Laws of Minnesota, Chapter 247, Art. 4 Sec. 49) This signals ongoing concerns about provider qualifications, individual well-being and program integrity.

This report provides an overview of the PCA program and the Department of Human Services' current proposal to dramatically redesign the PCA program and expand options for individuals to direct and control their supports, thereby decreasing their dependence upon traditional agency providers. The report then discusses the previous studies that have pointed to instances of fraud, abuse or lack of oversight in the administration of the program and also summarizes recent reform efforts undertaken by the Department to address these concerns. Finally, the report concludes with a review of previous studies exploring licensure of personal care services, recommends licensing agency providers of the redesigned personal care assistance services in the future, and offers recommendations that enhance both individual well-being and program integrity to be considered in designing an expanded consumer-directed option.

IV. Overview of the Personal Care Assistance Program

Personal Care Assistance (PCA) is a service administered by the Minnesota Department of Human Services (the Department). Personal care assistants provide services and support to help people who need assistance in activities of daily living (ADL), health-related procedures and tasks, observation and redirection of behaviors, and instrumental activities of daily living (IADL) for adults and children. PCA services are funded by Medical Assistance (MA), MinnesotaCare expanded benefits and Alternative Care (AC).[1] Most PCA services are provided by staff who are not required to meet any specific educational requirements. These staff work for provider agencies that must meet certain training and staffing requirements under the PCA program; however, these agencies are not required to be licensed by DHS. In state fiscal year 2012, the state paid approximately $580 million for these services.

A. Current State Plan Option for Personal Care Assistance Services

Since the mid-1970s, states have had the option to offer personal care services under their Medicaid State plans. PCA services were added to the Minnesota Medical Assistance (MA) program in 1978 and were originally intended to prevent unnecessary and more costly nursing home admissions of nonelderly adults (ages 18-64) with physical disabilities who could direct their own care. Since that time, PCA services have expanded and now provide assistance and support to persons with disabilities, elders, children, people with a mental illness, and others with special health care needs living in a community setting.

Minnesota's PCA program has its roots in a consumer-directed model, meaning the individual service recipient plays a primary role in directing the delivery of the service. In the initial years of the PCA program, the individual service recipient would find a nurse from an agency to complete the assessment for eligibility and services, and if approved for PCA services, would find and hire their own support worker(s). These individual workers would bill the Department directly. In the late 1980s as the program continued to grow, the Legislature adopted changes to require individual PCAs be employed by an agency. In addition, assessments had to be completed by a Public Health Nurse employed by the county or lead agency. The PCA agency provider was the employer of record for the PCA and was responsible for billing the Department for the services; supervising and paying the individual PCA, and returning any overpayments. This agency model has remained the norm for services provided under the PCA program.

Staff who provide PCA services are not required to meet any educational or licensure requirements. These staff work for agencies that must meet certain training and staffing requirements under the PCA program. PCA agency providers are not required to be licensed but they must enroll as a Medicaid provider with the Department and meet other requirements under state law; currently, there is no fee charged to enroll as a PCA agency provider. Individual PCA

[1] Medical Assistance (MA) is Minnesota's Medicaid program. It is jointly funded by state and federal government to provide health care services to people with low incomes. MinnesotaCare is a publicly subsidized health plan for people who do not have access to affordable health care coverage. Alternative Care assists Minnesotans 65 years and older who meet income and asset requirements to receive community services instead of moving into a nursing home.

workers are required to be employed by an agency, register with the Department through provider enrollment for claims purposes, complete a background study and pass a basic competency training test covering nine key areas. Some PCA agency providers may be licensed through the Minnesota Department of Health (MDH) in order to also provide home health care services to private pay or Medicare-eligible individuals. Those non-Medicaid funded services are licensed and regulated by MDH. However, as of December 2012, less than 10% of the 555 enrolled PCA agency providers (45 out of 555) were licensed by MDH.

B. Other Personal Assistance Programs With a Consumer-Directed Emphasis

To meet the needs of other individuals enrolled in MA for assistance with personal care needs and activities of daily living, Minnesota offers disabled individuals who are enrolled in a home and community-based waiver a more flexible, consumer-directed personal support option than what is offered under the PCA program. The waiver service, Consumer Directed Community Supports (CDCS), was first made available in 1997 to people with developmental disabilities. Now, each of the home and community-based waivers offers CDCS. This service option gives individuals receiving waiver services an option to develop a plan for the delivery of their waiver services within an individual budget, and purchase them through a fiscal support entity who manages payroll, taxes, insurance, and other employer-related tasks as assigned by the individual. CDCS allows individuals to substitute individualized services for what is otherwise available in the traditional menu of services in the waiver programs.

In addition, some individuals who might otherwise receive PCA services or private duty nursing services through MA or waiver services may be eligible to forgo enrolling in PCA or private duty nursing services and instead choose a state funded program, the Consumer Support Grant. This program offers significant flexibility in selecting and paying for personal support services in exchange for receiving a budget that is almost 50% less than the average service amount authorized under the PCA or private duty nursing program.

Table 1 summarizes these three distinct programs and service options.[i]

Table 1. Overview of CURRENT Personal Support Options under Medical Assistance

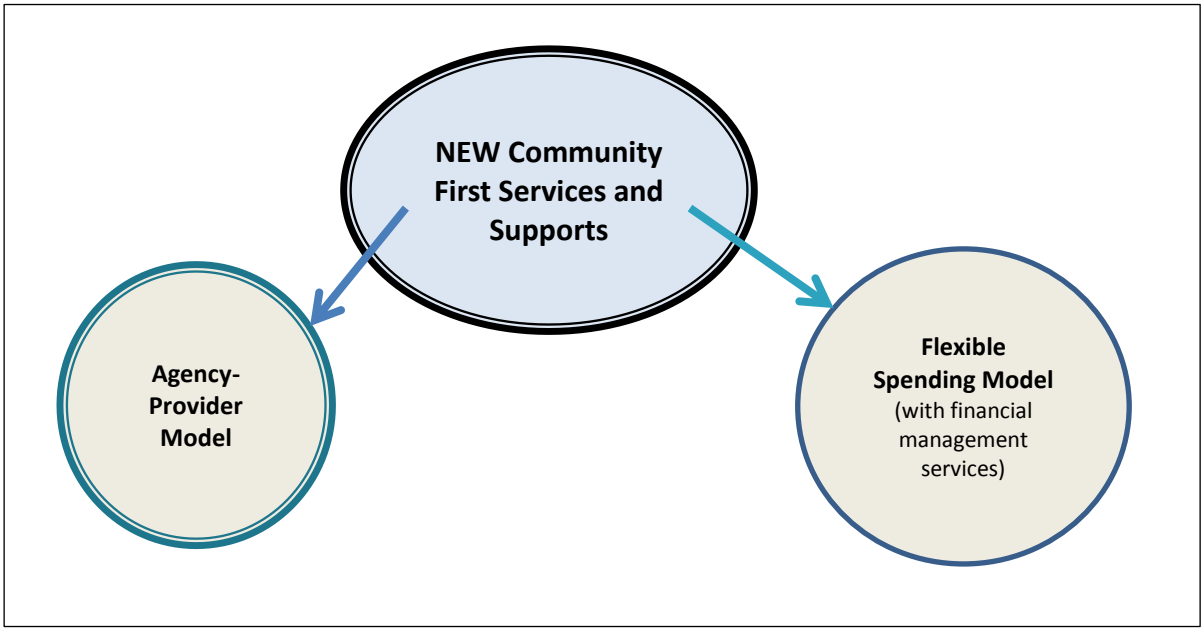
STATE PLAN SERVICE: Personal Care Assistance Service	**WAIVER SERVICE: Consumer Directed Community Support Service**	**STATE FUNDED PROGRAM: Consumer Support Grant**
Traditional Agency *PCA Choice Agency* *Agency with Choice* *Payroll Model* *Fiscal Conduit*		
LEAST Consumer Direction → **MOST Consumer Direction**		
Individuals who are eligible for PCA services may choose from two models, depending on the level of self-direction the individual desires: Traditional Agency and "PCA Choice Agency". Consumers of traditional agency PCA services are authorized a service amount by an assessment and then contact an agency to obtain staff to assist in meeting their needs with daily activities. The agency is responsible for recruiting, hiring, training, supervising and paying the individual PCAs and is the employer of record. The PCA Choice option also has a service amount authorized but gives individuals a greater level of responsibility in managing their services while providing a fiscal intermediary to assist in handling the employment and management-related functions of their PCA. The individual usually finds the potential PCA worker he/she wants to assist them and directs the person to an agency to be hired under the PCA Choice Option.	Individuals receiving home and community-based waiver services may choose to receive PCA services or a service option called "Consumer Directed Community Services". Consumer Directed Community Supports (CDCS) is a service that gives individuals more flexibility in planning, and responsibility for directing, their services and supports, including hiring and managing direct care staff. CDCS may include conventional goods and services, as well as self-designed services that provide needed support to recipients. Individuals are given a service budget and given great flexibility in deciding how, when and from whom they will receive the assistance that is needed. There are three models for waiver recipients to choose from, with increasing levels of individual direction associated with each. The individual is the employer of record and retains full control over all aspects (recruits, hires, trains, evaluates, schedules) of the support staff, but buys assistance from a financial service entity, certified by the Department, for payroll and insurance functions and assistance managing state and federal tax and payroll functions.	The Consumer Support Grant (CSG) Program is a state-funded alternative to Medicaid home care services of home health aide, personal care assistance, and private duty nursing. The individual must have functional limitations that require ongoing support in order to remain living in a community setting, and cannot be receiving waiver services, home health aide, PCA or private duty nursing services, or participating in managed care. PCA or private duty nursing funds are calculated and converted into a cash grant, which is generally about half of the PCA or private duty nursing service budget. The grant provides significant flexibility to purchase goods and services to meet the individual's needs. Individuals may hire their own staff, or pay family members to provide personal care services. Individuals work with their county to review expenditures and there is no formal role for an agency in this program.
In state fiscal year 2012, approximately 34,000 people received PCA services under the Medicaid State Plan option at some point during the year (24,000 in Fee For Service and the rest in managed care) and approximately 550 PCA agencies that provided services to one or more MA-eligible individuals. The average yearly payment for PCA services per individual was $18,549, or approximately $1,545 a month.	In state fiscal year 2012, approximately 3,600 individuals receiving waiver services used the CDCS service option at some point during the year (approximately 3,400 in fee for service and the rest in managed care). There were 15 Fiscal Support Entities assisting these individuals. The average yearly payment for "personal assistance" services under CDCS per individual was $20,837, or approximately $1,700 a month.	In calendar year 2011, approximately 1,400 individuals each month received a Consumer Support Grant, and the average monthly grant was $848.[ii]

C. Redesigning the Personal Care Assistance Program

The 2011 Legislature directed the Department of Human Services (DHS) to reform Medical Assistance, the state's Medicaid program. In 2012, the Department released *Reform 2020: Pathways to Independence*, a comprehensive set of reform initiatives. Goals of *Reform 2020* include: community integration and independence; improved health; reduced reliance on institutional care; maintained or obtained employment and housing; and long-term sustainability of needed services through better alignment of available services that most effectively meet people's needs.

As part of *Reform 2020*, personal care assistance will be redesigned to maintain and increase independence, enhance individual choice and provide maximum flexibility. New service-option flexibility within the benefit will provide people new tools to meet their needs more efficiently. The new service, called Community First Services and Supports (CFSS), is authorized under section 1915(k) of the Social Security Act and will expand opportunities for individuals to self-direct more of their services.

In the fall of 2012, the Department began working with stakeholders to develop the new program. The Department will introduce legislation to eliminate the current PCA program and create the new CFSS program in the 2013 Legislative Session. As part of the redesign, the new program will allow individuals more opportunities to self-direct their services in ways that were previously only available to waiver recipients under the Consumer Directed Community Support option (described above). The diagram below shows how the new CFSS program will offer two distinct models from which individuals may choose: an agency-provider model and a "flexible spending model" in which the individual will choose how their budget is spent on supports and services and receive services from a financial support entity under contract with the Department.



The option to choose a flexible spending budget and to further choose whether to assume employer responsibilities for their direct support worker are key differences from the current PCA program. Those who choose the flexible spending model must use a financial management services (FMS) entity under contract with the Department. An individual who assumes the responsibilities of employer of their direct support worker will be the employer of record and will be responsible for finding, hiring, training, supervising and dismissing his or her direct support worker and other employer-related functions that maybe required under the new program.

Some studies of different state models of consumer-directed services suggest that allowing individuals to direct their personal care services is associated with significant improvements in a variety of outcomes – including consumer satisfaction, health status, and quality of life – for disabled and elderly Medicaid enrollees.[iii] However, many program integrity concerns remain for a model of services lacking external oversight, verification of services, or financial liability for improper payments that are generally the responsibility of traditional provider agencies. See, e.g the Federal Office of Inspector General's recent November 2012 overview of Medicaid funded Personal Care Services (PCS) and program integrity issues, which includes a finding that, "OIG's Office of Investigations and many State Medicaid Fraud Control Units report that the increasing volume of fraud involving PCS has become a top concern. The most commonly reported schemes involve conspiracies between PCS attendants and Medicaid beneficiaries to submit claims for services that either were never provided or were not allowed under program rules."[iv] Concerns regarding fraud and abuse are discussed later in this report.

Table 2 summarizes how responsibilities are assigned under the current PCA program, the home and community-based waiver when using the Consumer Directed Community Support service, and under the *proposed* CFSS Flexible Spending Model.[2] It is expected that the CFSS "Agency-Provider Model" will retain many of the features of the current PCA agency model shown in column one; therefore, it is not included in the CFSS column.

Finally, it is important to point out that the CFSS model is still under development and the chart may not reflect the proposal that is ultimately introduced in the 2013 session or the program as it may be adopted by the 2013 Legislature.

[2] More information about these programs is available from the Disability Services Division at www.dhs.state.mn.us.

Table 2. Responsibilities Under the Current PCA Program, the Waiver CDCS Option and the *PROPOSED flexible spending model under CFSS Program.* *(FSE= Fiscal Support Entity; FMS entity=* proposed *Financial Management Services Entity[model still under development])*

Tasks	State Plan PCA: *Traditional Agency*	1915c Waiver Service Option: *Agency with Choice/FSE*	1915c Waiver Service Option: *Payroll Agent/FSE*	***PROPOSED**: State Plan Community First Services and Supports (CFSS) *flexible spending model*** *(subject to change)
Average number of individuals, 2012	34,000 (est.)	3,400 (est.)		TBD – not everyone will choose the flexible spending model
Average monthly benefit, 2012	$1,545.00 (est.)	$1,700.00 (est.)		$1545.00 (est.)
# of Agencies Providing Services	550 (est.)	15 FSEs		# of FMS Entities - TBD
Is Agency licensed – Current or Proposed?	No current licensure requirement	No current licensure requirement, but the FSEs must be "certified" by DHS		FMS Entities will not be licensed but will enroll with MN Health Care Programs
Is the individual Support Worker required to be licensed to provide this service?	No, but the PCA must be employed by an agency and must register with DHS provider enrollment to be paid by MA	No. Support Worker can be employed by the FSE or, more commonly, is the employee of the individual who uses FSE for help with payroll functions.		Direct Support Workers will be unlicensed staff employed by the individual or the FMS and must register with DHS provider enrollment to be paid by MA
Recruit and Advertise for Staff	Agency	Agency and/ or Individual	Individual	Individual
Hire, Terminate/ Discharge, Supervise, Schedule and Train Staff; Ongoing Direction of Daily Tasks; Employee evaluation	Agency	Agency + Individual	Individual	Individual
Responsibility to authorize service plan	Lead Agency, Tribes, Managed Care Organizations	Lead Agency, Tribes, Managed Care Organizations	Lead Agency, Tribes, Managed Care Organizations	Lead Agency, Tribes, Managed Care Organizations
Complete Background Study as per 245 C for PCAs, and all direct support workers	Agency	Not Required	Not required	FMS entity
Enroll in MA as a Provider	As a PCA Provider Agency	As an FSE	As an FSE	As an FMS entity
Collects time cards	Agency + Individual	Agency + Individual	Individual + FSE	Individual + FMS entity
Verify and Keep records of hours worked by PCA	Agency	Agency	FSE	Individual + FMS entity
Verify Services Were Delivered	Agency + Individual	Agency + Individual	Individual	Individual + FMS entity
Submit claims to DHS. Process checks for the staff & vendor; Pay staff/vendors. Document bills, receipts, audit trail	Agency	Agency	FSE	FMS entity
Financially liable for claims issues and overpayments?	Agency	FSE	FSE	FMS entity
Responsible for Taxes-payroll (State, Fed, FICA); Insurance (liability and workers comp)	Agency	Agency	FSE, on behalf of Individual	FMS entity
Train or provide support to the individual to be a common law employer	Agency is the employer	Agency is the employer	FSE, or non-paid	FMS entity

V. Program Audits Highlight Potential for Fraud and Abuse

Medicaid funded programs for personal care services have been the subject of several audits and evaluations both in Minnesota and nationally over the past decade. This is due in part to the significant growth in program expenditures and number of people served as states move away from institutional living settings.[v] Audits of the PCA program consistently find issues relating to improper billing and claims submission, inadequate documentation, and insufficient program controls to analyze claims and maintain fiscal integrity. Concerns about fraud and abuse have been focused on instances in which PCAs are not providing authorized services to enrollees but are billing for these services, and instances in which people may be hiring family members to provide many PCA hours as a way to provide family members with a source of income rather than meet a true need of the Medicaid enrollee.

In 2002, the U.S. Department of Health and Human Services conducted an audit of Minnesota's PCA services. The audit concluded: "Based on our sample results, the State had no assurance that payments for personal care service claims during [federal fiscal year 1999] were proper and that compliance requirements were fully met."

In 2005, the PCA program was identified by the Medicaid Fraud Control Unit (MFCU) of the state Attorney General's Office as the most problematic of all of the state's health care programs in terms of fraud and abuse.[vi]

In 2008 the Minnesota Legislature directed the Office of the Legislative Auditor (OLA), to evaluate how well the services are being administered. The OLA's report, released in 2009, found that the services have been subject to minimal state regulation and oversight, even though expenditures have grown significantly and the program is vulnerable to fraud and abuse. The evaluation found many areas of concern, including:

- PCA services remain unacceptably vulnerable to fraud and abuse, and improper payments for services have been a significant problem.
- Provider agencies are allowed to administer PCA services without demonstrating their understanding of state requirements.
- The Department has implemented a weak quality assurance review program for PCA services and has not taken sufficient steps to ensure high quality services and protect vulnerable recipients.

The OLA report noted that Department fraud staff spend a majority of their time investigating PCA issues and have documented many vulnerabilities with PCA services, including:

- PCAs who report hours worked in excess of actual hours worked;
- agencies that do not keep sufficient records documenting services billed;
- PCAs that discourage individual service recipients from reporting absences to the agency provider when the PCA does not show up for work;
- agencies that tell individual service recipients they are eligible for fewer hours of service than had actually been approved, and then bill the state for services not performed; and

- individual service recipients who sign blank time cards.

According to the report, "PCA services already consume a disproportionate share of DHS's investigative resources…. [and] state investigators generally believe that there are greater vulnerabilities in PCA services than in most other Medicaid services."[vii] The OLA report included numerous recommendations to address fiscal integrity issues, service quality, supervision and training of PCAs and managerial staff in the provider agency. [viii]

At the federal level, investigating fraud within the personal care assistance program has been a focus of the U.S. Department of Health and Human Services Office of Inspector General (OIG). Over the past six years the federal OIG has focused audit resources on Medicaid payment for PCA services administered in various states. In November 2012, the federal OIG office released a report, Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement[ix], summarizing their work in this area. The OIG concluded that their audit and evaluation work revealed a pattern of improper payments linked to lack of compliance with state policies and requirements and found that existing controls designed to prevent improper payments are ineffective. The report made several recommendations to the federal Centers for Medicare & Medicaid Services (CMS), including that CMS provide more oversight of the program, standardize aspects of the program (e.g., PCA qualifications, background checks, require PCAs to enroll or register with the state) and provide states with more data to help with payment analyses. According to the report,

> *[The federal] OIG and the [state MFCUs] have noted an increasing amount of fraud cases involving [PCAs]. As of 2010, MFCUs had more open investigations involving [PCA] fraud than any other type of Medicaid service, with more than 1,000 investigations nationwide. In a recent survey, MFCUs cited fraud occurring in home and community-based settings, consisting mostly of [PCA] fraud, as a top fraud concern affecting their States [based on MFCU responses to a survey conducted through the US DHHS-OIG].*
>
> *Cases investigated by [the federal] OIG's Office of Investigations and discussions with multiple MFCUs indicate that the most common fraud schemes involve conspiracies between [PCA] attendants and beneficiaries. In a growing number of instances, the beneficiaries are being charged as co-conspirators because they accepted cash or other benefits in exchange for participating in the fraud. These cases appear to be especially prevalent in States using CMS-approved home and community-based service waivers that allow relatives of beneficiaries to be their [PCA] attendants. In many of these cases, investigation reveals that the beneficiaries do not appear to have the medical conditions or physical limitations documented on their assessments and therefore are not eligible for [PCA services ….based on interviews with State officials and recommendations submitted to States by MFCUs in Missouri, Louisiana, Ohio, and Washington].*[x]

VI. Summary of Recent PCA Reform Efforts

The desire for increased individual control by people using the service, flexible budgeting and minimal oversight of services is oftentimes in conflict with a desire to have safeguards in place to protect individuals and ensure proper use of public funds. For example, increased training and regulatory requirements are viewed as potential barriers to ensuring an adequate supply of workers. Nonetheless, in 2008, the Minnesota Legislature directed the Department of Health (MDH), in consultation with the Department, to develop recommendations for provider standards for personal care assistant services.[xi]

In reviewing previous reports and studies of the PCA program dating back to at least 1998, and drawing upon the stakeholder work that the Department was engaged in at that time around PCA and related services, MDH noted that, "The primary concern that we heard in 1999 and continues to be a concern is ensuring that there are adequate safeguards to protect the recipients of PCA services, balanced with the recipients' desire to remain as independent as possible."[xii] MDH also found that staff with limited amounts of training provide most of the PCA services and that PCA agencies vary significantly in the way they trained their employees.[xiii] To address individual safety concerns, MDH recommended that PCA training requirements be expanded to include a core curriculum that *all* PCAs must complete.

MDH also recommended that individual PCAs, who often provide hands-on care to vulnerable adults and children without being directly supervised, be screened for criminal and maltreatment history and undergo a background check *before* the person can provide services and bill MA for those services. Similarly, MDH recommended mandatory training (versus the voluntary training then in place) and background checks for a wider range of owners, managers and supervisors to help ensure providers are prepared to undertake this service delivery.

Incorporating the recommendations from the MDH and OLA reports into policy changes that the Department was already developing for the PCA program, the 2009 and 2010 Minnesota Legislatures enacted comprehensive reform of PCA services to help people who need the service most get it in a cost-effective, quality-conscious manner. The following is a summary of key implementation outcomes of these reform efforts[xiv]:

- Enhanced Training Requirements. Training is now required for provider agency owners, managing employees and supervisors, as well as individuals PCAs before providing services. A nine-part online training module is available in multiple languages for PCAs, as is the competency test they must pass before they can begin providing services. Over the past 2 years, more than 55,000 individuals have taken the online training course for PCAs. In addition, new provider agency owners, operators and managing parties, qualified professionals, and individual PCAs must pass a background study completed by the Department prior to providing PCA services.

- Audit and Financial Integrity Measures. The Department has expanded its auditing efforts to monitor limits on PCA services. The Department uses the Medicaid

Management Information Systems (MMIS) to manage fee-for-service authorizations and expenditures. The Department's database systems have built-in edits to validate PCA data and claims and increase the financial integrity of PCA services. The reports look for denials of provider claims for exceeding the "24 hour limit", which happens if any PCA provider claims more than 24 hours of services for one individual PCA worker in one day and also indicate if any individual is receiving over 24 hours of PCA services in one day based upon claims submitted. A second report looks for denials of provider claims exceeding the "275 hour limit", which happens if any PCA provider is claiming over 275 hours for an individual PCA in a calendar month, in violation of current program rules. These reports can help identify providers who may be engaging in patterns of fraudulent billing activities.

In addition to post-payment review of claims noted above, the Department adopted new requirements and audit procedures for PCA agency providers at the time of enrolling or at annual re-enrollment including:

- ✓ verification that owners, managers, or qualified professionals are in good standing with the U.S. Department of Health and Human Services Office of Inspector General;
- ✓ verification that all owners, managers, qualified professionals and personal care assistants passed a background study Under Minnesota Chapter 245C prior to providing services;
- ✓ verification of all qualified professionals licensure, and
- ✓ submission of copies of bank statements, insurance policies, bonds and Secretary of State's registration.

- Provider enrollment standards. The new PCA provider enrollment standards are designed to increase service quality, and provider agencies may be terminated for noncompliance.

- PCA provider database. The Department developed a PCA provider database that now tracks both current and historical PCA provider information, including: service agreement history, enrolled PCA staff, billing history, claims history and other provider/recipient demographics which are updated at least on a monthly basis. Information obtained from the database will be incorporated into easily retrievable reports that can also be used by the Department staff to generate public reports on a regular basis.

VII. Previous Efforts at Requiring Licensure for PCA Providers

Notwithstanding the changes described above that the Department has made in its administration of PCA services to ensure individual health and well-being and also address fraud, abuse, and payment-related compliance problems, concerns about these issues persist. As discussed in Section IV, there are currently no requirements that individuals or agencies be licensed or certified in order to provide PCA services solely to Medicaid-eligible individuals. However, agencies that provide similar personal care services to private pay and Medicare-eligible individuals, even if they also provide PCA services to MA eligible individuals, are required to obtain a Home Care license through the Minnesota Department of Health (MDH).[xv]

A. Feasibility of Licensing PCA Providers Has Been Studied Several Times – With Varying Results

Licensure is one form of regulating an occupation when required for the safety and well-being of the citizens of Minnesota.[xvi] Often a balancing is undertaken between enacting regulations that help ensure competency in skills and costs of regulating such oversight.

The question of whether to require licensure of PCA agency providers who do not also hold a home care license through MDH has been considered several times over the past 20 years, with varying recommendations made. For example, shortly after the PCA program adopted an agency-provider model in the late 1980s, the Minnesota Legislature raised the issue of licensure for these agencies. Legislation passed in 1991 required the Departments of Human Services and Health to jointly promulgate a rule for licensure of PCA services under the State Medical Assistance program.[xvii] The report recommended licensing of PCA provider agencies and recommended standards for providers of these services, but joint rulemaking was never undertaken and the services remained unlicensed in part because of the cost associated with implementing the licensure requirement.[xviii]

The 1997 Legislature mandated that MDH create licensure for Medicaid-funded PCAs, similar to its oversight of private pay and Medicare-funded home health services. Draft rules were prepared after stakeholder engagement; however, the high cost of implementing such reform was again cited as a barrier to following through with the recommendations.[xix]

In 2009 a report by the Office of the Legislative Auditor found "that the services have been subject to minimal state regulation and oversight, even though expenditures have grown significantly and the program is vulnerable to fraud and abuse." Nonetheless, the OLA report did not recommend licensure – owing in part to the even-higher cost of implementation than was proposed in 1997 due to the significant growth in the program since then.[xx] (See Appendix A)

The 2009 report on provider standards by MDH, summarized in Section VI, also considered anew whether licensure was the appropriate mechanism for regulating the PCA program.[xxi] MDH rejected licensure of PCA agency providers, citing both the high cost to implement and other ways to achieve the same oversight: "Since [the Department] has an existing registry of PCAs and enrollment processes for PCA agencies, building on those requirements would provide additional assurances that basic health and safety standards have been met." (See Appendix B)

B. 2012 Minnesota Legislature Mandated Reconsideration of Licensure

As summarized above, the Department has enacted many program changes to address service quality and enhance fiscal integrity safeguards. Despite these changes, ensuring individual safety and well-being and reducing provider fraud remain ongoing concerns. Moreover, some agency providers have expressed support for formal licensure to ensure compliance with standards and provide some consistency to ongoing quality oversight of these services. Thus, the 2012 Legislature directed the Department to explore licensure of PCA services. This signals ongoing concerns about provider qualifications, individual well-being and program integrity. Developing a licensure requirement for PCA providers also recognizes the potential for enhanced oversight that now exists under the Department's Office of Inspector General (OIG). That

reorganization removed fraud investigations of providers and recipients from the program policy areas and consolidated them in one Division under the Department's OIG, alongside the Licensing Division, which licenses, monitors and investigates maltreatment in human services programs. Other factors that point to a need to re-examine licensure despite the 2009 recommendations of both the OLA and MDH reports include:

- The federal OIG office continues to find significant program integrity lapses with state PCA programs and recommends increased oversight at both the state and federal levels.
- The Department's own OIG staff, through its Medicaid Surveillance and Integrity Review Section (SIRS), continues to expend staff resources analyzing claims post-payment in order to address the inappropriate use of Medicaid payments. In 2012, SIRS took action that resulted in 6 PCA agency providers being terminated from the MA program in 2012.
- Despite the provider enrollment requirements outlined above in Section III, there are limits on the ability of the Department's provider enrollment staff to perform a regulatory function. According to the OLA report,

  [Department] staff told us they review the applying agency's bank balance and verify the credentials of the agency's "qualified professionals," but they do not independently verify agency compliance during the enrollment process with many of the other enrollment requirements in state rules. For some agency enrollment requirements—such as having a grievance process—[Department] officials told us they monitor compliance through quality assurance reviews (which would only be conducted after agencies have started providing services). [xxii]

In addition, the number of provider agencies administering PCA services is increasing, and in 2012 only 8% of them were otherwise licensed through MDH. The OLA report noted, "The increase in the number of relatively small PCA agencies [serving fewer than 15 fee-for-service recipients] has raised questions about whether these agencies have the required management skills to comply with PCA requirements…." [xxiii]

Requiring providers to apply for a license, pay a fee, and show compliance with enrollment policies and quality assurance standards in advance of commencing operations, is the function of licensing. Licensing provides a regulatory infrastructure that is more comprehensive than enrolling as a Medicaid provider. Evaluating applications and provider readiness for engaging in the delivery of personal care services, engaging in periodic (scheduled and unscheduled) site reviews to monitor ongoing compliance are appropriate functions of the Department's Licensing Division and will help create a more seamless regulatory and program integrity system for this Medicaid funded service with annual expenditures approaching $600 million.

As discussed above, when previous reports have considered whether to require licensure for PCA agency providers, the increase in the number of providers and the costs associated with implementing and regulating this large number of providers has been cited as a reason to forgo a licensure requirement. However, there has been a change in how the Department's licensing activities are funded that minimizes this historical concern. Prior to the 2011 Special Session,

licensing fees for providers licensed by the Department were deposited into the state general fund and most licensing activities were funded out of the state general fund. The fees did not cover the costs related to licensing activities. During the 2011 Special Session, the legislature adjusted licensing fees (nearly all were increased) to cover more of the actual costs for licensing and directed the funds collected to a State Government Special Revenue Fund (SGSRF) used to fund licensing activities. Thus, the licensing fee pays for a significant amount of the regulatory functions, minimizing the outlay of state general fund dollars otherwise required to implement licensure.

C. The Redesigned PCA Program and Its Impact on Requiring Licensure for Agency Providers

Notwithstanding the emphasis on consumer directed services under the new Community First Services and Supports (CFSS) program, the Department has indicated that individuals will still be able to choose a "traditional" agency provider option if the individual does not, or is not yet ready to, choose the flexible spending model, which may include assuming employer related tasks such as recruiting, hiring, training, scheduling and supervising their own direct support worker. An option for a traditional agency provider is also necessary to ensure that individuals who are restricted from accessing a flexible spending model due to misuse or inability to comply with program rules nonetheless have access to personal care assistance services. Previous reports discussed above have recommended exempting from licensure any agencies that are already licensed through MDH, which would reduce the number of agencies needing licensure for PCA services.

Thus, licensure of agency providers must be considered in the context of changes slated for the current PCA program and must complement the new services and provider models that are developed, including an expansion of consumer-directed options. The current redesign of the PCA program suggests that the number of agency providers will be reduced as more individuals choose how to spend their budget on supports and services and elect to use financial management services in lieu of an agency provider. The potential impact is twofold: First, there may ultimately be fewer agency providers to be licensed under the new program, as individuals opt for the flexible spending model and financial and administrative support services of a Financial Management Services (FMS) entity that is under contract with the Department. Second, as individuals begin using the services of the FMS entity – with some even assuming the role of employer of their direct support worker – responsibilities will need to be clarified for individuals, direct support workers and the financial management entities either in statute, through the contracts governing these support entities, or both.

D. New CFSS Program and Implications of Creating a Flexible Spending Model for Attendant Services and Supports

As discussed in Section IV, Minnesota currently allows for budgeting and flexible spending on personal support services only as a service option under the home and community-based waiver programs or for those who participate in the state funded Consumer Support Grant program. The new PCA program is likely to incorporate many of the same features as the waiver service – Consumer Directed Community Support (CDCS) – described above and will have a significant emphasis on allowing individuals to hire, train and supervise their own support workers.

Because it is still being developed, it remains unclear how much, or how little, external oversight or assumption of financial liability by a provider agency acting as an employer of record will remain.

Concerns about Fraud and Budget Mismanagement Exist in Consumer-directed Spending Models: As with the CDCS service for a small portion of Minnesota's waiver recipients, the new PCA program is intended to make a consumer-directed flexible spending option more widely available beginning in January 2014 to thousands of individuals currently on the PCA program. Although early studies of consumer-directed demonstration projects in various states found little evidence of fraud[xxiv], the federal OIG's November 2012 report, discussed above, has found the opposite:

> *Additionally, [the federal] OIG and the [state] MFCUs are encountering a new fraud scenario in States with self-directed Medicaid service models (i.e., those in which beneficiaries have decisionmaking authority over certain services and are directly responsible for managing their services with the system of available supports) and particularly in those States that send payment for [PCA] services directly to the beneficiaries instead of the attendants. Although State Medicaid programs in these States require beneficiaries to give the payments to the [PCA] attendants, cases in which beneficiaries submit false claims for services that were never provided are now being prosecuted. In such cases, the beneficiaries typically forge the [PCA] attendants' names and then deposit the checks into their own bank accounts. In States allowing self-directed [PCA] models, additional controls may be necessary to ensure that services both are necessary and are provided.*[xxv]

In addition, in 2004 the Minnesota Office of the Legislative Auditor released an evaluation of Minnesota's early experience with implementing the CDCS waiver service. The report concluded that the Department "lacks sufficient controls over Consumer Directed Community Supports … [leading] to questionable purchases, inequitable variation in how counties administer Consumer Directed services, and unmet prospects for cost efficiencies. We recommend that the department design additional safeguards and evaluate how well its proposed controls work before implementing the Consumer Directed option statewide."[xxvi] Following this report, the Department made numerous changes to the CDCS program when it was implemented on a statewide basis in 2005 to help address program integrity issues. However, there has been no subsequent evaluation of that service to determine the effectiveness of the policy changes implemented in the wake of that report on reducing fraud or questionable purchases and improving cost efficiencies.

Thus, it will be imperative to incorporate program integrity controls as part of redesigning the PCA program in order to address concerns noted by federal OIG audits, Minnesota OLA audits, the Department staff, and stakeholders. While the vast majority of PCA agency providers, their staff and individuals receiving PCA services adhere to program rules and requirements, failure to adopt consistent quality assurance measures and oversight controls, as the Department moves to an expansion of self-directed care with flexible spending and individual budgets, could have unintended consequences. At a minimum, the controls should include: clear, external responsibilities for authorizing services and verifying service delivery; a clear delineation of

employer and recipient responsibilities in the various models; and an assignment of liability (financial, civil, and criminal) for overpayments – the most consistent fiscal integrity issue cited by audits.

Role of Financial Management Services (FMS) in Flexible Spending Models: Designing a program that increases an individual's ability to direct and control their supports with budgeting and spending authority while decreasing dependence upon traditional agency providers involves removing responsibility for some or all of the functions typically performed by the agency provider. The State must then decide who will assume responsibility for these functions. To assist individuals choosing a flexible spending model, and to provide additional support to individuals who choose to assume the responsibilities of an employer, the Department intends to issue a request for proposals to identify a limited number of entities with which to contract for purposes of administering financial management services to individuals under CFSS.

In a review of best practices in consumer-directed models commissioned by the federal Centers for Medicare & Medicaid Services, the authors found that nearly all of the key informants and the written literature emphasized the importance of the two main categories of supports: information and support associated with understanding and operationalizing the benefit (e.g., counseling) and help with the financial and legal tasks associated with hiring a worker (financial management services or FMS). [xxvii] Although there are a variety of models for FMS entities, the goal is the same: to ensure that participants choosing a consumer-directed option with flexible spending and budget authority hire and reimburse their direct care workers appropriately and meet the legal responsibilities of an employer.

As the redesigned PCA program is developed and presented to the Legislature, more information about the full scope and nature of these FMS entities will become known, and other issues relating to consumer protection, well-being and fiscal integrity may need to be addressed by the Legislature. Although the current redesign of the PCA program does not require that these FMS entities be licensed, the Legislature may ultimately consider it because of the scope of the FMS entities' administrative functions under the contracts that affect individual safety and well-being in addition to the FMS entities' billing, tax, and legal responsibilities.

VIII. Recommendations

The 2012 Minnesota Legislature directed the Department to "study the feasibility of licensing personal care attendant services and issue a report to the legislature no later than January 15, 2013, that includes recommendations and proposed legislation for licensure and oversight of these services." This report summarizes the state and national attention given this program area for the past two decades, highlighting longstanding areas of concern and recent efforts undertaken by the Department to address these concerns.

In the past, the large number of providers and the associated cost of licensing these providers have been cited as the main reasons for not adopting a licensure requirement. Changes in the licensing fee model, described above, mitigate the impact of requiring licensure on the State's general fund. Moreover, in light of the current redesign of the PCA program, it is anticipated that the number of agency providers will be reduced as individuals become educated about the

consumer-directed flexible spending model and receive the training and support they need to successfully participate in this model.

The potential impact is twofold: First, there may ultimately be fewer agency providers to be licensed under the new program, as individuals opt for the flexible spending model. Second, as individuals begin using the services of the FMS entities, responsibilities will need to be clarified for individuals, direct support workers and the FMS entities either in statute, through the contracts governing these support entities, or both. Although the current redesign of the PCA program does not require that these FMS entities be licensed, the Legislature may ultimately consider it because of the FMS entities' billing, tax, and legal responsibilities, all of which would enhance protections for individual service recipients under the new program.

Recommendations:

- *The Legislature should require agency providers of PCA services, whether under the current PCA program or the new CFSS program, to hold a license from the commissioner beginning in January 2015, unless otherwise currently licensed under the Minnesota Department of Health (MDH). The Legislature should require the Department to develop, in consultation with stakeholders, proposed amendments to chapter 245A or other applicable statutory authority to establish the standards that will apply to these services and the specific license requirements that the providers must meet, and submit these recommendations to the Legislature by January 15, 2014.*

  Although the Department is recommending licensure of agency providers not otherwise licensed by the MDH, the Department believes it is important to complete the current development of the new CFSS program and obtain approval by the 2013 Legislature before developing standards for licensure. This will allow the Department additional time to determine licensure requirements within the context of the new personal assistance program, address remaining individual well-being and program integrity issues, and obtain input from stakeholders as part of this process.

- *The Legislature should adopt provisions that incorporate the following responsibilities for agency providers, service recipients, FMS entities, and direct support workers into the new program, either as part of licensure requirements or legislation governing the new CFSS program:*

  1. *<u>Consumer Education</u>: Individuals should be educated on their responsibilities relative to, but not limited to, selecting, dismissing, supervising, training and paying their worker when the individual acts as the employer of record; the need for proper documentation and retention of records for all goods and services purchased; and requirements to promptly notify the FMS entity of any changes in staffing or employment status of their worker.*

  2. *<u>Development of Direct Support Worker Standards That Enhance Individual Safety and Well-Being</u>: Current PCA direct care workers are required to pass a*

competency test and are provided training in nine key areas. That training, and the requirement for a background study under Minnesota Chapter 245C, should be required in the new CFSS for the direct support worker, regardless of whether the worker is hired by an agency or an individual assuming employer responsibilities for that direct support worker.

3. *Development of Quality Assurance Functions of the Financial Management Services entities: The contracts governing FMS entities should clearly address, among other things:*
    a. *the entity's obligation for monitoring the individual's continuing ability to fulfill his/her responsibilities under the flexible spending model of the new program;*
    b. *actions to be taken if it appears the individual is no longer able to fulfill such responsibilities;*
    c. *compliance with all documentation requirements imposed by state and federal law, and*
    d. *monitoring of budget expenditures to prevent overspending by the individual or spending on goods or services not authorized in the service plan.*

    In developing the responsibilities of the FMS entities, special consideration should be given to how, or whether, FMS entities will be expected to monitor the individual's well-being, ensure receipt of services in accordance with the service plan developed (e.g., through phone calls, on site visits) and identify possible neglect or exploitation.

4. *Oversight of FMS Entities: Following passage of legislation to implement the new CFSS model, the Legislature should consider the options for optimal oversight and monitoring of the FMS entities. Public accountability will be enhanced through some system of routine inspections of the performance of FMS entities to assure compliance with the quality assurance and program integrity expectations. This may be a through a system of monitoring for performance of the contracted services, or it could be through a licensing structure. The optimal oversight mechanism will best be determined following a review of this Legislature's final product related to CFSS.*

5. *Verification of Services and Adequate Documentation: The Legislature should adopt requirements for oversight and supervision of the service, which should include periodic, unscheduled visits by the agency provider or the FMS entity, in order to verify the presence of the direct care worker and delivery of the service.*

    As an alternative or in conjunction with periodic visits, the Legislature should consider requiring agency providers and FMS entities to utilize some form of electronic visit verification to help verify that services for which the state is being billed were actually provided to the individual, that the services were delivered in accordance with an approved service plan, and that the person delivering the service had the proper qualifications. Common requirements of an electronic verification system used in other states allow a provider to electronically document the service

recipient's identity; the direct support worker's identity; the date and time the direct support worker begins and ends the delivery of services; the location of service delivery, and tasks performed by the service provider. An effective technological verification should involve real time GPS, and more than a single time point confirming presence during a scheduled visit. Currently, too many clients are coerced into signing blank time sheets, and those same clients would be coerced to "call in or sign in" for caregivers without a real verification of their presence and provision of services.

6. *"Dis-enrollment": The Legislature should adopt standards for "administratively dis-enrolling" an individual who has failed to comply with program requirements under the "flexible spending model." Absent fraud, which might result in termination from the program in its entirety, the participant should be returned to the "agency-provider model" where most functions will instead be performed by an agency.*

7. *Clarification of Financial, Civil and or Criminal Liability: Applicable statutes, rules and or policy manuals should clarify who (agency provider, financial management services entity, individual recipient, direct support work) is financially liability for overpayments and improper claims under the flexible spending model.*

Implementation Language for Licensure

245A.043. Home and Community-Based Personal Care Assistance Services

Subdivision 1. **Licensure Requirement.** Entities providing services under the Personal Care Assistance Program under sections 256B.0625 subdivision 19a, 256B.0625 subdivision 19c, and 256B.0659 or their successor provisions, must obtain a license according to this chapter, unless licensed under chapter 144A. The licensure according to this section shall be implemented by January 1, 2015.

Subdivision 2. **Stakeholder Consultation.** The commissioner shall consult with stakeholder groups to gather input related to the development of these standards and shall propose statutory language and an implementation plan to the legislature by January 15, 2014.

APPENDIX A. Excerpts from the 2009 Office of the Legislative Auditors Report: *Personal Care Assistance: Evaluation Report* on Whether to Recommend Licensure for PCA Agencies (pp 91-93)

"Regulation of PCA agencies has been a recurring issue for the Legislature. Most of Minnesota's personal care services are provided by unlicensed staff who work for unlicensed agencies. The 1991 Legislature required the departments of Human Services and Health to jointly promulgate licensing rules for personal care services funded by Medical Assistance.[7] In 1992, DHS issued a report stating that 'minimum safety and quality of care standards can be attained most efficiently and cost effectively through licensure of agencies, rather than through licensure of individuals.'[8] DHS recommended licensure of agencies that provide up to 75 percent of their personal care services through Medical Assistance. DHS staff told us that, largely because of cost concerns, legislation to implement these recommendations did not pass.

"The 1997 Legislature required the Department of Health to draft rules on licensure of personal care providers for the Legislature's consideration.[9] The department did so, and it estimated that the annual cost of administering a licensure program for 150 PCA agencies would be about $1 million.[10] According to DHS staff, the Legislature did not appropriate funds to cover these costs and licensure was not implemented. Nonetheless, from 1997 to 2008, the only personal care agencies exempted in law from state licensure requirements were agencies that served one individual under the Medical Assistance program.[11]

"In 2008, the Legislature exempted all providers of Medicaid-funded PCA services from licensure requirements.[12] The law says this exemption will remain in effect until PCA provider standards are implemented, based on recommendations due from the Department of Health by February 15, 2009. We do not know which standards the Department of Health will recommend, or what it might cost to implement these standards. Although the Legislature could require PCA agencies to obtain state licenses,

> • **Approaches other than licensure of PCA agencies might be less expensive and equally effective at improving agencies' compliance with state requirements.**

"Licensure is arguably the most restrictive form of state regulation for agencies or professions. In the past, the Legislature has mandated—but not appropriated funding for—the licensure of PCA agencies. With the recent increase in the number of PCA agencies, the cost of administering licensure would probably be much greater now than it was when the Legislature previously decided that licensure would be too expensive.

"PCA agencies need greater oversight, and their key staff should be well trained in state policies. Toward this end, chapters 3 and 4 recommended (1) more investigations and quality assurance reviews of PCA agencies and (2) mandatory participation by PCA agencies in DHS's intensive training courses for agency officials. We think these would be good starting points for improving compliance and accountability. At a time when the state faces significant budget constraints, it would be more cost-effective to build on existing DHS mechanisms for improving compliance—namely, the PCA provider enrollment process, training courses for PCA agencies, and quality assurance reviews of PCA agencies—than by beginning a new licensing process. If DHS's initial steps do not have the intended effects, however, legislators should consider requiring PCA agencies to be licensed or obtain some type of certification."

APPENDIX B. Excerpts from the 2009 Minnesota Department of Health Report: *Personal Care Assistants: Recommendations for Provider Standards* on whether to recommend Licensure for PCA Agencies (pp 6-7)

"Before discussing our recommendations for standards, we must first address the issue as to what type of regulation is needed.

"Recommendation: The Minnesota Dept of Human Services shall retain the authority to regulate and oversee all PCA services that exclusively use MA dollars. References to PCA in licensure statutes (Minn. Stat. Sec 144A.43-144A.47) shall clearly state exemption from licensure for MA PCA services.

"One of the first items to address is whether licensure is the appropriate form of regulation. Licensure is a very restrictive form of state regulation for agencies or professions.

"Minnesota Statutes, Chapter 214, lists the following criteria for regulation: The legislature declares that no regulation shall be imposed upon any occupation unless required for the safety and well-being of the citizens of the state. In evaluating whether an occupation shall be regulated, the following factors shall be considered:

> 1) whether the unregulated practice of an occupation may harm or endanger the health, safety and welfare of citizens of the state and whether the potential for harm is recognizable and not remote;
>
> 2) whether the practice of an occupation requires specialized skill or training and whether the public needs and will benefit by assurances of initial and continuing occupational ability;
>
> 3) whether the citizens of this state are or may be effectively protected by other means; and
>
> 4) whether the overall cost effectiveness and economic impact would be positive for citizens of the state. (Minn. Stat. Sec. 214.001, subd. 2)

"Finally, Chapter 214 states that "if the legislature finds after evaluation of the factors identified in subdivision 2 that it is necessary to regulate an occupation not heretofore credentialed or regulated, then regulation should be implemented consistent with the policy of this section in modes in the following order:

> 1) creation or extension of common law or statutory causes of civil action, and the creation or extension of criminal prohibitions;
>
> 2) imposition of inspection requirements and the ability to enforce violations by injunctive relief in the courts;
>
> 3) implementation of a system of registration whereby practitioners who will be the only persons permitted to use a designated title are listed on an official roster after having met predetermined qualifications; or

> 4) implementation of a system of licensing where by a practitioner must receive recognition by the state of having met predetermined qualifications, and persons not so licensed are prohibited from practicing.

"The provisions in Chapter 214 about occupational regulation show the state's policy that the least restrictive form of regulation be imposed. MDH concludes that the best form for PCA and PCA services regulation remains the enrollment or registry that currently exists through DHS, not to separately license all PCAs and PCA agencies. DHS should strengthen its oversight as will be addressed in this report's recommendations for standards. PCA services are a MA benefit best regulated by DHS in its administration of the state's MA program.

"Regarding the times when licensure is appropriate, there must not only be significant harm warranting such protection, but the profession must have a distinct scope of practice and entry qualifications. Finally, the license requirement must be cost effective. In Minnesota, the costs of licensing activities administered by the state are paid for by the licensees through fees. Minn Stat. §16A.1285, subd. 2 further states that regulatory or licensure costs must be recouped so that funds are not under-recovered or over-recovered and are assessed every two years. MDH concludes that it is not economically prudent to license PCAs or PCA agencies. DHS has reported that there are over 35,000 individuals providing PCA services and over 600 PCA agencies currently enrolled as MA providers. Implementing licensure for this large of a number would be very costly. In the 1999 MDH Report, the cost estimates to implement were over $1 million and at that time, the number of providers was estimated to be 150. Since DHS has an existing registry of PCAs and enrollment processes for PCA agencies, building on those requirements would provide additional assurances that basic health and safety standards have been met."

APPENDIX C: "Technical Assistance Triggers" From the DHS 1915(j) Consumer-Directed Advisory Task Force Final Report (October 20, 2008)

Technical Assistance Triggers *The application of the below gradation scale is dependent on the severity of the issue at hand. The grid should not be viewed as a solely progressive approach to dealing with the identified issue. FM=Financial Management, CM= Case Manager or Home Care Targeted Case Manager, SP= Support Planner (formerly Flexible Case Manager), QP= Qualified Professional.*

Issue	Option 1	Option 2	Option 3
Overspending	Retrain and follow-up Reassess	FM/ CM/ SP/QP required or change in responsible party Increase Audits	Disenroll
Purchase items not on plan	Retrain and follow-up Reassess	FM/ CM/ SP/QP required or change in responsible party Increase Audits	Disenroll
Unallowed Purchases	Retrain and follow-up Reassess	FM/ CM/ SP/QP required or change in responsible party Increase Audits	Disenroll
Lack of recordkeeping	Retrain and follow-up Reassess	FM/ CM/ SP/QP required or change in responsible party Increase Audits	Disenroll
Plan not followed	Retrain and follow-up Reassess	FM/ CM/ SP/ QP required or change in responsible party Increase Audits	Disenroll
Underutilization	Retrain and follow-up Reassess	FM/ CM/ SP/ QP required or change in responsible party Increase Audits	
Unfit caregiver	Assess Health and Safety	Change in caregiver	Disenroll
Unfit Responsible party	Assess Health and Safety	Change in responsible party	Disenroll
Health and Safety Issue	Assess and Report Implement changes to protect participant	Case manager assesses caregiver and responsible party and makes changes	Disenroll
Not following Labor laws	Retrain Assign FM or Case Manager	Report to Dept of Labor	Disenroll
Blatant Fraud/Misuse	Assign FM or Case Manager Report to fraud unit	Disenroll	

ENDNOTES

[i] In addition, there are other "personal support" services provided to Minnesotans under various home and community-based waivers and other parts of the State's Medicaid plan. Some of these services, like PCA services, are provided by unlicensed "direct care" workers who typically enter a person's home and provide hands-on care to help the person remain at home and avoid hospital or other institutional stays. The Department is currently undertaking steps to license providers of waiver services, such as those identified above, many of whom have been previous unlicensed if the consumer was not on a Developmental Disabilities waiver. Specifically, Minn Stat 245D licensure standards require providers of 12 currently unlicensed home and community-based services to obtain a 245D license prior to delivering services. Minnesota Statute Chapter 245D establishes foundation licensing standards, effective 2014, to ensure and protect the health, safety and rights of persons receiving home and community-based services governed by chapter 245D. These standards apply regardless of the funding source for the service. This means that home and community-based services, as identified in Chapter 245D apply the standards where they have funding from the state, private pay, or another funding source.

[ii] *Personal Care Assistance: Evaluation Report*, St. Paul, MN : Office of the Legislative Auditor, State of Minnesota, Program Evaluation Division, 2009. Available online at http://www.auditor.leg.state.mn.us/ped/pedrep/pca.pdf

[iii] Nadash, P & Crisp, S. (2005) *Best Practices in Consumer Direction.* Cambridge, MA: The Medstat Group. Commissioned by CMS and The Assistant Secretary for Planning and Evaluation. Available online at: http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/Section648_Report.pdf http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/Section648_Report.pdf.

[iv] *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (OIG-12-01), November 20120 at page ii and available online at https://oig.hhs.gov/reports-and-publications/portfolio/portfolio-12-12-01.pdf

[v] OLA report at p. 16. The OLA determined that expenditures had grown from $153 million in 2002 to approximately $400 million in 2007, and recipients had increased from less approximately 4,500 to over 11,000 during that same time period. In SFY 2012, the average monthly caseload for State Plan PCA program was 22,000, and expenditures were $580 million.

[vi] Ibid at p 43, citing in a footnote to: Department of Human Services, *Health Care Services Study: Findings and Strategies for Savings* (St. Paul, January 2005), 40.

[vii] *Personal Care Assistants: Recommendations for Provider Standards***,** Minnesota. Dept. of Health. Compliance Monitoring Division, St. Paul, MN : Compliance Monitoring Division, Minnesota Dept. of Health, (2009), 56. Available online at http://www.health.state.mn.us/divs/fpc/2009pcafinalrpt.pdf *Personal Care Assistance: Evaluation Report* at p 56.

[viii] The OLA made numerous recommendations, including: DHS should promptly and regularly analyze claims data to identify improper payments, and should also conduct more quality assurance reviews and investigations of PCA agencies; the Legislature should establish mandatory training requirements for PCA assessors and the provider agencies that administer PCA services, and DHS should identify topics that all personal care assistants need to understand. PCA agencies and service recipients should arrange for training in these topics, as needed.

[ix] *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (OIG-12-01)

[x] Ibid. at p 5.

[xi] Laws of MN 2008, chapter 230,secs. 6 and 7

[xii] *Personal Care Assistance: Evaluation Report* at p 4.

[xiii] Ibid.

[xiv] The Department was required to report to the Legislature on the progress of implementing the PCA reform efforts, including the following topics mandated by 2009 Laws of Minnesota, Chapter 79, Art. 8, Sec. 76 and 80 (2). See, *Personal Care Assistance Services - A Report to the 2010 Minnesota Legislature,* Minnesota Department of Human Services, Disability Services Division, St. Paul, MN (2010) available online at http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_149239.pdf and *Personal Care Assistance Services - A Report to the 2011 Minnesota Legislature,* Minnesota Department of Human Services, Disability Services Division, St. Paul, MN (2011)available online at http://archive.leg.state.mn.us/docs/2011/mandated/110487.pdf

[xv] Minn. Stat. §144A.43 –144A.47
[xvi] Minnesota Chapter 214
[xvii] Laws of Minnesota, 1991, Ch.292, Art. 7, sec. 8.
[xviii] A Report to the Legislature on Recommendations for a Personal Care Services Licensure Rule, available online at http://archive.leg.state.mn.us/docs/pre2003/mandated/920219.pdf
[xix] As Requested by the 1998 Minnesota Legislature, A Draft of Proposed Rules For a Unique Licensure Category for Providers of Personal Care Assistant Services Funded under the Medical Assistance Program available online at
[xx] *Personal Care Assistance: Evaluation Report*,
[xxi] *Personal Care Assistants: Recommendations for Provider Standards*
[xxii] *Personal Care Assistance: Evaluation Report* at p 52-53.
[xxiii] Ibid.
[xxiv] A.E. Benjamin, "Consumer-Directed Services At Home: A New Model For Persons With Disabilities," *Health Affairs*, 20, no.6 (2001):80-95; Congressional Research Service, "Long-Term Care: Consumer-Directed Services Under Medicaid," (January 2005), p. 27. Available online at www.law.umaryland.edu/marshall/crsreports/.../rl322191212005.pdf
[xxv] *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (OIG-12-01)p. 13
[xxvi] *Medicaid Home and Community-Based Waiver Services for Persons With Mental Retardation or Related Conditions*: *Evaluation Report*, St. Paul, MN : Office of the Legislative Auditor, State of Minnesota, Program Evaluation Division, 2004 at p. 53.
[xxvii] Nadash & Crisp at p 32.