



Recommendations for Minnesota's Personal Care Assistance Program

Final Report

Prepared for: Minnesota Department of Human Services, Disability Services Division

Submitted by: The Lewin Group

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I. Executive Summary

Minnesota has a long history of implementing policies and programs to allow older adults and persons with disabilities to live in community settings rather than in institutions. The State's Personal Care Assistance (PCA) program, operated by the Minnesota Department of Human Services (DHS) Disabilities Services Division, is an integral part of the State's efforts to assist individuals to live in the community. Recognizing that the PCA program facilitates these goals, Minnesota has modified and enhanced its PCA program over the years. At the same time, and to a large extent as a result of the growth in the program, there has been increasing scrutiny around the operation of the program which, during 2009, culminated in a number of additional changes to the program.

In Summer 2008, the DHS hired The Lewin Group, and its subcontractor the University of Minnesota's Research and Training Center on Community Living, to conduct a study of its Personal Care Assistance program under its Medical Assistance State Plan¹, and to offer recommendations to DHS to strengthen the infrastructure and improve the integrity of PCA program services in Minnesota. Key areas DHS asked us to review included:

- The historical context of the program and policies, and how these have impacted the overall direction of the program;
- Service authorization and resource allocation;
- Workforce issues (e.g., PCA compensation, training, and qualifications); and
- Service delivery and living arrangements in which PCA services are provided.

The Lewin team pursued a multifaceted approach to collect qualitative and quantitative information for the study, including research on PCA program history, PCA program data analysis, PCA program stakeholder interviews, interviews with State of Minnesota staff in other programs, interviews with PCA program administrators in other states, focus groups of PCA consumers and workers, and a PCA provider agency survey.

Program Overview

The program traces its roots to 1978, when Minnesota added PCA services to the State's Medical Assistance program. At that time, PCA services were only available to adults with physical disabilities who were either able to direct their own care or who had a designated caretaker. Currently, all individuals eligible for Medical Assistance (Medicaid) or MinnesotaCare Expanded (a reduced-cost health insurance program for pregnant women and children), who are assessed and determined to require the type of assistance provided by the program, are eligible to receive services. PCA services can be provided through the fee-for-service program, Home and Community Based Services (HCBS) waiver programs, and prepaid health plans, depending on the program in which the individual is enrolled.

¹ We only peripherally reviewed PCA services covered through the State's Home and Community Based Services waivers, where services intersected with the State Plan program.

The PCA program provides personal care services to eligible individuals of all ages to allow them to continue to live independently in community settings as long as possible, including assistance with Activities of Daily Living and Instrumental Activities of Daily Living, health-related services; and observation, redirection, and behavioral interventions.

Between 2002 and 2007, the number of individuals using personal care services in the Minnesota Medical Assistance program more than doubled, growing at a rate of 21.5 percent annually. In 2002 the program served a total of 9,590 recipients, compared to 25,362 recipients served by 2007. The increase in users also drove similar increases in spending for fee-for-service PCA with spending increasing from approximately \$135 million to almost \$345 million between 2002 and 2007.²

2009 Legislative Changes

In 2009, the Minnesota Legislature made significant changes to strengthen accountability and program integrity in the PCA program, and also to bring about fiscal control. The changes include:

- **Modification of eligibility requirements and simplification of home care rating.** The 2009 legislation tightens the criteria for PCA program eligibility in an effort to refocus resources on those who need them the most. While the changes will result in loss of eligibility or a reduction in the number of approved hours for some PCA clients, the changes make the assignment of a home care rating much more transparent.
- **Documentation and training requirements for PCA workers and agencies.** Beginning July 1, 2009, all PCA workers (also termed "PCAs"), managers and supervisors are required to complete DHS-approved training. All PCA agencies are required to demonstrate compliance with training requirements for their workers prior to enrollment. Currently enrolled agencies have an 18-month period to comply.
- **Service verification and supervision requirements:** Specific requirements to address service oversight and monitoring are included in the 2009 legislation, including:
 - *Service verification:* Beginning July 1, 2009, legislation requires daily documentation of PCA services provided on DHS-approved timesheets, either electronic, Web-based, or paper format, signed by the worker, and responsible party (if applicable). The legislation also requires review by a Qualified Professional.³
 - *Qualified Professional supervision:* Effective January 1, 2010, all PCAs must be supervised by a Qualified Professional through training, direct observation, and consultation to assure that the PCA is knowledgeable and capable of providing the services to be assigned.

² Due to limitations in the comparability of data between the fee-for-service programs and managed care, we did not analyze PCA spending in managed care programs.

³ Under 2008 Minnesota Statutes 256B.0625, Section 19c, a "Qualified professional" means a mental health professional, a registered nurse, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant.

- **Responsible Party Requirements:** Beginning January 1, 2010, all PCA recipients who are under age 18, who are incapacitated, or who are determined through their assessment to be in need of a responsible party to direct and supervise their care, must appoint a responsible party. The Legislation also requires that the responsible party enter into a written agreement with a PCA agency outlining their roles and responsibilities.
- **Limitation on PCA Hours of Work:** The legislation limits the hours that a PCA can work to no more than 310 hours per month, regardless of whether the worker is employed by one or multiple agencies. Through the Governor’s allotment process, the maximum number of hours per month that a PCA can work was reduced to 275.⁴

Key Findings

Through our qualitative and quantitative research on the PCA program in Minnesota, we identified the following key findings:

1. **The PCA program plays an important role in the lives of consumers.** Minnesota’s PCA program has historically been, and continues to be, an integral part of the State’s efforts to assist individuals to live in the community. The program provides a wide array of services and supports, including assistance with activities of daily living, health-related services, and other supports.
2. **Consumers value the PCA Choice program because it provides them with a greater level of responsibility for their care; however, some need additional support to manage their PCA Choice option.** Through the PCA Choice option, consumers are able to hire, fire, and train their PCAs, and overall direct their own care. While consumers favored the PCA Choice program in terms of level of control and flexibility over the activities the PCA performs, they face challenges with their employer responsibilities and could benefit from additional support with back-up PCAs, and assistance with training and managing their PCAs.
3. **Low wages and minimal benefits pose challenges to the effective operation of the PCA program.** The major, recurring theme throughout our study was the impact of low wages and lack of benefits on worker recruitment and retention. In both the focus groups and the PCA provider survey, workers, organizations, and consumers identified low wages and limited access to benefits (health, dental, overtime, and paid time off) as significant challenges to PCA worker recruitment and retention.
4. **DHS lacks comprehensive real-time information and approaches to efficiently manage the PCA program.** As a result of the growth in the PCA program, the evolution of program options, and the expansion of mandatory managed care for the elderly, DHS has faced significant challenges in managing the program. We found that DHS lacks the information and processes that it needs to effectively and efficiently manage this important program. To strengthen overall program management and assess the impacts

⁴ Governor’s “Approved Unallotments & Administrative Actions General Fund by Omnibus Bill and Agency,” July 1, 2009, <http://www.mmb.state.mn.us/doc/budget/unallotment/6-09.pdf>. Lowers the cap on the number of hours a Personal Care Attendant (PCA) can work from the newly-enacted maximum of 210 hours per month to a maximum of 275 hours per month.

of ever-changing program policies and priorities, it is critical for DHS to address these challenges.

5. **The PCA program lacks sufficient supervision/oversight of workers to assure quality of care and assist in improving the services they provide.** DHS has faced challenges in being able to put in place adequate and sufficient quality assurance, and program integrity measures for the PCA program, particularly as the program has grown to serve a more diverse and far larger number of recipients than when it originally was implemented. We found lack of consistency in supervision and oversight of services and workers in several areas including, verification that workers were actually providing services, actual supervision of the activities being performed, and overall monitoring of the quality of services being provided.
6. **The PCA program lacks formal and consistent training for PCA workers.** Minnesota has struggled over the years with developing qualifications and training requirements for its PCA workers. Not requiring training, however, leaves consumers vulnerable to inappropriate service delivery and may also inhibit the development of a core of competent service providers.
7. **Consumers' needs are not always met due to a lack of adequate back-up plans and available workers.** Clients expressed challenges associated with having an appropriate and adequate back-up plan in place to implement when their usual PCA is not available. For program participants, who need assistance with eating, toileting, and other critical daily activities, the lack of a PCA to provide needed support can be catastrophic.
8. **The PCA program lacks consistency in individual assessments.** A uniform and robust assessment system is critical to assuring that individuals are receiving the right kinds of services in the right amount. Although Minnesota has a home care rating system and standardized tool for PCA assessments, assessment and service authorizations rely heavily on the judgment of the assessor to make appropriate determinations of the types and amounts of services.
9. **Service authorizations and reauthorizations are not always accomplished in a timely manner.** We learned that DHS is not always able to approve service authorization requests in a timely manner. This delay can be a critical problem for a program which provides care at home to vulnerable individuals, since delayed authorizations or reauthorizations could threaten delivery of needed care.
10. **Enrollment of PCA workers was not always accomplished in a timely manner.** During the study period, we found anecdotal evidence that PCA worker enrollments were often delayed, taking up to six weeks to process. DHS has since reviewed and restructured its PCA worker enrollment process, which they report has resulted in a new processing time of two-to-three days and the virtual elimination of the prior backlog.

Recommendations

Our interim reports presented over 50 recommendations to DHS to strengthen the PCA program. In this final report, we offer several overarching action items for DHS to consider implementing.

To develop these recommendations, we reviewed and analyzed the information gathered and the preliminary recommendations presented in the three interim reports. Given the number of changes that occurred in the PCA program during the time that we were conducting our study, we placed our final recommendations into one of two categories: (1) recommendations for program improvement; and (2) implementation strategies for 2009 legislative and related changes.

Recommendations for Program Improvement

We recognize that Minnesota, like many other states, is faced with scarce resources and competing priorities to meet the needs of the vulnerable populations it serves. As a result there is greater pressure on DHS to effectively monitor and manage the PCA program, which is critical to serving vulnerable people in less restrictive settings, and which has grown exponentially over the years. While the recommendations below would require an investment of staff and other significant resources, they are important in the long term to assure appropriate and effective management and are necessary to assure program integrity.

Improving Program Management

- 1. Develop and strengthen metrics and measurements to enable DHS to monitor program activities and changes on an ongoing basis:** Strong and uniform metrics and protocols are critical to ongoing program monitoring as well as to analyzing the impacts of key programmatic changes. This is particularly important given the changes to be implemented as a result of the 2009 legislative mandates. To achieve this, we recommend that DHS identify metrics to monitor the program on an ongoing basis and measure the program's effectiveness.
- 2. Improve coordination between the managed care and fee-for-service PCA programs.** To foster improved communication and dissemination of program information between managed care and fee-for-service programs, we recommend the DHS agencies responsible for the administration of the PCA program in these two environments meet regularly to review pertinent program information and data.
- 3. Explore implementing an electronic verification and program management system.** DHS lacks comprehensive, real-time information to enable it to effectively manage its PCA program. One apparently successful mechanism that several states are already using, and which several others are considering using, is an electronic verification and program management system. These systems have been shown to improve program and care management, as well as improve billing accuracy and service verification.
- 4. Establish a technical advisory workgroup on the PCA program.** We recommend that DHS establish an ongoing technical advisory workgroup composed of managed care and fee-for-service State program operations representatives, as well as PCA provider agency and consumer representatives, to provide input to DHS on policy and on other operational issues. The 2009 legislative mandates provide several topics on which the workgroup can focus its activities.

Ensuring an adequate workforce

5. **Implement strategies to improve compensation for PCAs.** Having a stable and qualified workforce is critical to the success of any long-term care service program. Minnesota's high PCA turnover rate affects the overall quality and effectiveness of the PCA program. To improve retention and quality of PCA services, DHS should implement strategies to improve compensation (wages and benefits) for all PCA workers.
6. **Explore establishing an online worker registry to improve access to a qualified pool of PCA workers.** Lewin recommends that DHS implement an online, searchable, PCA registry system that clients can use to find PCA workers with specific characteristics (e.g., by service area, qualifications, and "specialty," such as serving children or recipients with behavioral health needs), and that can also be used to locate back-up PCA workers.

Other recommendations

7. **Convene a housing task force to address the need for accessible and affordable housing for individuals with disabilities.** States throughout the nation are challenged by the difficulties of ensuring that there is sufficient affordable and accessible housing to meet the needs of individuals with disabilities who desire to remain at home in the community. While prohibited during the just-concluded 2009 legislative session, the difficulty of this issue is highlighted by the existence of "provider operated housing," where an organization provides both housing and related services, using some of the service-related reimbursement to support housing costs. DHS should establish an interagency task force to address issues related to the development of accessible and affordable housing, especially in cases where PCA clients may need to relocate to new housing.
8. **Develop and provide training to clients in the PCA Choice program to assist them in hiring, firing and supervising PCAs.** In the PCA Choice program, PCA clients have the ability to direct their own care, which means they are the employer of the PCA worker. PCA clients who choose this option may or may not be prepared to conduct the tasks of hiring, supervising, or terminating an employee. DHS training materials would help ensure that all PCA Choice consumers are able to fully manage their own services.
9. **Improve resources available to PCA agencies to manage the PCA program.** PCA provider agencies report that they do not always receive accurate responses to their questions. DHS should ensure that PCA provider agencies, particularly those that are small and have limited administrative staff, have access to clear, succinct information that will assist them in managing their programs.

Implementation Strategies for 2009 Legislative and Related Changes

10. **Monitor the program impact of 2009 legislative changes, especially in the areas of PCA eligibility criteria requiring individuals to have more severe ADL needs and quality oversight.** As DHS implements these eligibility changes, DHS should make an effort to identify whether PCA clients have unmet needs, or whether there are other patterns of care that appear to be emerging as a result of these changes.

- 11. Improve the consistency of service authorizations.** DHS currently requires assessors across PCA programs (e.g., fee-for-service and managed care) to use a standardized assessment tool for PCA service authorizations. However, the complex home care rating process and inconsistency in application of the tool among assessors leads to variability. The simplified home care rating process enacted in 2009 should help to reduce this variability. DHS should take steps to ensure that the new process is implemented in a consistent and timely manner across programs and across the state.
- 12. Require PCA provider agencies and PCA workers to complete standardized training on the PCA program.** The Minnesota Legislature in 2009 made significant changes to training requirements in the PCA program for PCA provider agencies, PCA workers, and Qualified Professionals in conjunction with these requirements. We recommend that DHS consider providing a variety of training options, tracking compliance with training mandates, and establishing a career path for PCA workers.
- 13. Establish transition and/or closure plan processes to enable DHS to be prepared for PCA agency recertification failures and discovery of provider operated housing.** We recommend that DHS establish a transition or closure plan to assist them in (1) identifying and providing ongoing PCA services in instances where a PCA agency is required to close or in (2) identifying and providing ongoing PCA and housing services in instances when a PCA agency is found to be a housing provider and is subsequently prohibited from continuing to provide one or the other of these services.

II. Introduction

Over the last decade, Minnesota's Personal Care Assistance (PCA) program has been changing dramatically. The PCA program has become an integral component of the State's efforts to provide both waiver and State Plan services in the most integrated settings appropriate to an individual's needs. Similarly, the PCA program has been assisting consumers who often prefer to remain at home rather than live in any type of institution, and who want to participate in activities of daily living with as few restrictions as possible. Recognizing that the PCA program facilitates these goals, Minnesota has modified and enhanced its PCA program over the years. At the same time, and to a large extent as a result of the growth in the program, there has been increasing scrutiny around the operation of the program which, during 2009, culminated in a number of additional changes to the program.

The Minnesota Department of Human Services (DHS), Disability Services Division contracted with The Lewin Group (Lewin) to conduct a study of the infrastructure of the State's Medical Assistance State Plan Personal Care Assistance (PCA) program.⁵ We partnered with the University of Minnesota's Institute on Community Integration on this study.

This final report analyzes the drivers of Medical Assistance expenditures in the State's PCA program and provides recommendations to strengthen the program. While the study focuses primarily on PCA State Plan services, important considerations include how other Medical Assistance Programs (e.g., home and community-based waiver programs) provide PCA services, and the interaction between those program requirements and the PCA State Plan program.

Our effort included the development of three interim reports:

- Interim Report #1 provided a national scan of PCA programs, analyses of Minnesota PCA program enrollment and expenditure data, findings from interviews with State officials in Minnesota and other states with PCA programs, findings from stakeholder interviews, and preliminary recommendations for the State.
- Interim Report #2 included findings from a series of 14 focus groups, conducted by the University of Minnesota's Institute on Community Integration, with recipients of PCA services and PCA workers in a variety of Minnesota Medical Assistance programs offering PCA services. The purpose of conducting these focus groups was to hear from workers about their experiences providing PCA services and from service recipients about their experiences receiving PCA services.
- Interim Report #3 presented provider agency perspectives and related recommendations to strengthen and improve provider-related components of the program based on a survey of PCA provider agencies. This report also included analyses of the types of living arrangements in which individuals receive PCA services and related recommendations.

⁵ We only peripherally reviewed PCA services covered through the State's Home and Community Based Services waivers, where services intersected with the State Plan program.

This final report synthesizes the analyses of the several interim reports. In the remainder of the report we:

- Provide an overview of Minnesota's PCA program, PCA provider agencies, and recent history related to enrollment and spending
- Report findings on interviews with representatives from other State PCA programs
- Present the Lewin team's findings related to the PCA program
- Offer recommendations to strengthen and improve Minnesota's PCA program
- Offer implementation strategies for 2009 Legislative and related changes.

III. Research Objectives and Methods

The objective of this study was to offer recommendations to DHS to strengthen the infrastructure and improve the integrity of State Plan PCA program services in Minnesota. DHS asked us to review:

- Program policy design, historical to current, and outcomes of changes made
- PCA provider qualifications and standards
- Service authorization and resource allocation
- Rates paid by the State for PCA services
- Service delivery
- Compensation of PCAs
- Training for PCAs
- Various living arrangements in which PCA services are provided

The Lewin team pursued a multifaceted approach to collect the needed qualitative and quantitative information, including:

- **Research on PCA program history.** Lewin conducted a thorough review of the PCA program's history. We received a wide variety of documents related to the PCA program from DHS upon contract award, from which we extracted historical information. We supplemented this information with information available on DHS' website, other Minnesota State government websites and discussions with State officials and stakeholders. Based on this information, Lewin produced a chronological history of policy and legislative actions that had an impact on the PCA program from 1977 to the present.
- **PCA program data analysis.** Lewin received individual level demographic and claims data for consumers who receive PCA services on a fee-for-service basis in Minnesota for the period of State Fiscal Year 2002-2007.⁶ The data included demographic data, assessment data, service agreement data, and the PCA program option in which the individual participates (e.g., PCA Choice, a consumer-directed option). In addition, the Department provided aggregate program enrollment data and hours of PCA service by age for those enrolled in and receiving PCA services through home and community-based services (HCBS) waivers, managed care, and the State Plan-only fee-for-service program, by calendar year. Based on this data and using other national data available to The Lewin Group for comparison purposes, we analyzed trends in utilization, enrollment, expenditures, and other factors for the period of 2002-2007.
- **PCA program stakeholder interviews.** Lewin interviewed representatives of health plan associations, advocates for persons with disabilities, as well as staff from county health departments located in both large metropolitan and smaller rural counties. We

⁶ These data were the same as those provided to the Office of Legislative Affairs (OLA) for their January 2009 report.

conducted interviews in person, when possible, or by phone. We consulted these diverse stakeholders to help identify issues to focus our research and develop preliminary recommendations for improvements in the PCA program.

- **Interviews with State of Minnesota staff in other programs.** In addition to staff in the Disabilities Services Division, Lewin also interviewed individuals within several other DHS divisions who represented the populations receiving PCA services and the programs through which PCA services are provided. Specifically, we spoke to representatives of Aging and Adult Services; Adult Mental Health Services; Children's Mental Health Services; and Managed Care and Payment Policy.
- **Interviews with PCA program administrators in other states.** We interviewed directors and program staff of PCA State Plan and PCA Cash & Counseling (i.e., self-directed PCA) programs in eight states to understand how other states design and operate their programs. Through these interviews, we gathered information about challenges, successes, and practices from other states to stimulate ideas for improving Minnesota's program. In total, we held ten teleconference interviews with representatives from eight different states.
- **PCA consumer and PCA worker focus groups.** We conducted a series of 14 focus groups, conducted by the University of Minnesota's Institute on Community Integration, with recipients of PCA services and PCA workers in a variety of Minnesota Medical Assistance programs offering PCA services. The purpose of conducting these focus groups was to hear from workers about their experiences providing PCA services and from service recipients about their experiences receiving PCA services.
- **PCA provider agency survey.** In Spring 2009, The Lewin Group conducted a confidential online survey of all of the approximately 5,000 Medical Assistance long-term care providers, including the approximately 900 of whom provide PCA services. The survey included questions about providers of PCA services, sources of revenue, service delivery, characteristics of PCA clients, PCA wages and benefits, recruitment and retention, program management and oversight.

IV. Program Overview and Recent Trends

Overview of Minnesota's PCA program

Minnesota has a long history of implementing policies and programs to allow older adults and persons with disabilities to live in community settings rather than in institutions. The State's Personal Care Assistance (PCA) program, operated by the Minnesota Department of Human Services, Disabilities Services Division, is an integral part of the State's efforts to assist individuals to live in the community.

The program traces its roots to 1978, when Minnesota added PCA services to the State's Medical Assistance program. At that time, PCA services were only available to adults with physical disabilities who were either able to direct their own care or who had a designated caretaker. Currently, all individuals eligible for Medical Assistance (Medicaid) or MinnesotaCare Expanded (a reduced-cost health insurance program for pregnant women and children), who are assessed and determined to require the type of assistance provided by the program, are eligible to receive services. PCA services can be provided through the fee-for-service program, Home and Community Based Services (HCBS) waiver programs, and prepaid health plans, depending on the program in which the individual is enrolled.

The PCA program provides personal care services to eligible individuals of all ages to allow them to continue to live independently in community settings as long as possible. Personal care assistance services include:⁷

- Assistance with Activities of Daily Living (ADLs), including bathing, grooming, eating, transferring, mobility and positioning;
- Assistance with Instrumental Activities of Daily Living (IADLs), including meal planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores;
- Health-related services, which includes functions that can be delegated or assigned by a licensed health care professional under Minnesota State law⁸ to be performed by a PCA, such as assistance with medication that is self-administered, tracheotomy suctioning, intervention for seizure disorders, etc.; and
- Observation, redirection and behavioral interventions.

Individuals can receive PCA services in community settings which include, but are not limited to, their home, a foster care home, school, work, or other locations outside the home where the recipient engages in their daily activities. Traditionally, consumers of PCA services obtain PCA staff through an agency, which hires, fires, trains, pays and schedules the hours of PCA workers who provide service on a one-to-one basis. To accommodate the changing and varying needs of PCA consumers, Minnesota's PCA program also allows for services to be provided through a variety of service delivery arrangements, including the following:

⁷ 2008 Minnesota Statutes, 256B.0655, Subdivision 2, "Personal care assistant services."

⁸ Minnesota Nurse Practice Act, 2008 Minnesota Statutes, Sections 148.171-148.285.

- **PCA Choice Option.** In the PCA Choice program, consumers are able to independently hire, fire, and train the PCAs who provide their care. The PCA Choice option gives consumers a greater level of responsibility in managing their care while providing a fiscal intermediary to assist in handling the employment and management-related functions of their PCA. In Minnesota’s PCA Choice program, Personal Care Provider Organizations (PCPOs) perform the fiscal intermediary services and are the employer of record for the PCAs.
- **Shared Care Option.** The Shared Care Option allows two or three consumers of PCA services living in the same setting to share the same personal care assistant.
- **Flexible Use Option.** Under the Flexible Use Option, many consumers of PCA services can use their approved PCA hours flexibly within a service authorization period to accommodate their varying needs and schedules (e.g., varying the amount of care received month-to-month within a six-month authorization period).

To qualify for services under Minnesota’s PCA program, individuals must be eligible for Medical Assistance, be determined to need PCA services both medically and functionally (based on an assessment of need), have a plan of care identifying the amount, duration and frequency of services needed, and receive an authorization for services.

Minnesota conducts assessments using a standardized tool (the Medical Health Services Assessment Tool) to determine whether an individual needs PCA services and the amount, duration and frequency of the services needed. Fee-for-service and managed care organizations use the same assessment tool and generally the same processes for determining an individual’s need for PCA services to assure consistency and efficiency between assessing agencies. This also prevents gaps in services when consumers move from county-to-county or transition between programs (e.g., managed care vs. fee-for-service vs. HCBS waiver program). All Medical Assistance beneficiaries are entitled to an annual assessment if they request one. The assessment process includes a review and documentation of health status (social and medical), determination of need, and the identification of appropriate services. Based on the assessment, a care plan is developed which includes a recommendation concerning the amount, duration, and frequency of services needed by the consumer.

With the exception of managed care programs, the recommendation for services is submitted to DHS for approval.⁹ DHS approval serves as the formal authorization for services. Each individual’s authorization is subject to a budget cap based on the individual’s medical and behavioral functional level (i.e., the home care rating).¹⁰ The home care rating system uses a personal care decision tree process to take into account the complexity and existence of both behavioral and medical needs, and applies budget caps based on these factors. The Minnesota Legislature revisited the budget caps, or maximum dollar limits, during the 2009 session. The Legislature also eliminated the previous requirement that all services be authorized in 15-minute increments.

⁹ To the extent that health plans prior-authorize services, they do not need DHS approval.

¹⁰ 2009 Minnesota Statutes, 256B.0655, Subdivision 4, “Authorization; personal care assistance and qualified professional.”

In 2009, the Minnesota Legislature also made an effort to refocus the limited program dollars on individuals with the greatest needs. The legislative changes simplified the home care rating process by assigning a pre-set, base number of hours to each home care rating. After a base number of approved hours, individuals will receive an additional 30 minutes per day for each dependency in a critical activity of daily living, complex-health related function, and/or behavior issue they have.¹¹

Minnesota's PCA Provider Agencies

A variety of provider agencies participate in the Minnesota PCA program. Personal care services can be provided by Home and Community Services (HCS) providers, Personal Care Provider Organizations (PCPO), Home Health Agencies (HHA) and a small number of other types of provider organizations. These agencies provide PCA services in all of Minnesota's 87 counties. As expected, there are more agencies providing PCA services in areas of the State with greater population density and fewer in areas with a smaller number of residents who may seek PCA services.

Minnesota's Medical Assistance PCA program includes both seasoned and new PCA provider agencies. Of the agencies that participated in our provider survey, almost three in five (55 percent) reported that they have participated in the program for more than five years and more than a quarter (30 percent) have participated for more than 10 years. Eight percent of providers have provided Medical Assistance PCA services for more than 20 years. Although we were unable to determine whether this is representative of overall Medical Assistance participating providers, we surmise that agencies that have participated longer may have been more likely to voluntarily participate in the survey.

Recognizing that agency size has implications for administrative aspects of the program, such as administration and training, one of the major demographic issues that we examined in this survey was the size of the agencies providing PCA services in Minnesota's PCA program. Of the survey respondents, a quarter have 10 or fewer employees; another quarter (22 percent) reported that they have 11-25 employees; slightly more than half (53 percent) have 26 or more employees; and more than 10 percent have more than 200 employees. Importantly, smaller agencies were probably underrepresented in this sample; our extrapolation of the total number of PCA workers in the Minnesota Medical Assistance program from respondent data suggests that a greater proportion of larger agencies may have participated in the survey.

We also gathered information on the number of full- and part-time employees. Other than for one-worker agencies, where employees were primarily full-time, approximately 75 percent of PCA workers in all agencies were part-time.

In 2009, the Minnesota Legislature implemented new training requirements for PCA workers and PCA agencies. Effective January 1, 2010, all PCA workers must complete standardized training prior to enrollment which includes:

¹¹ 2009 Minnesota Statutes, 256B.0655, Subdivision 4, "Authorization; personal care assistance and qualified professional."

- Basic first aid
- Vulnerable adult training
- Child maltreatment training
- OSHA universal precautions
- Basic roles and responsibilities of PCAs
- Emergency preparedness
- Orientation to positive behavioral practices
- Fraud issues
- Completion of time sheets

Personal care assistants must also complete training on the specific needs of an individual recipient within the first seven days of providing services to that individual.

All PCA provider agencies (including owners, managing employees, and qualified professionals) will have to complete DHS-designed trainings prior to agency enrollment in the program. Agencies that have already enrolled with the State will have to complete the trainings within 18 months of the effective date of this section (December 2010). All PCA provider agency billing staff will be required to complete training about financial management of the PCA program.

Recent Trends in Enrollment and Spending in Minnesota’s PCA program

Between 2002 and 2007, the number of individuals using personal care services in the Minnesota Medical Assistance program grew at a rate of 21.5 percent annually, more than doubling. While personal care recipients with services provided through managed care programs increased at a faster pace than under fee-for-service (29.9 percent versus 18.9 percent), the fee-for-service recipients had a much greater increase in the number of users (10,449 versus 5,323). Similarly, while the proportion of individuals enrolled in managed care plans under age 65 grew at 37.9 percent annually between 2002 and 2007, compared to those age 65 and over growing at 27.9 percent annually, the number of managed care recipients age 65 and over had a much greater increase in the number of users (3,951 versus 1,372)¹² (**Exhibits 1 and 2**).

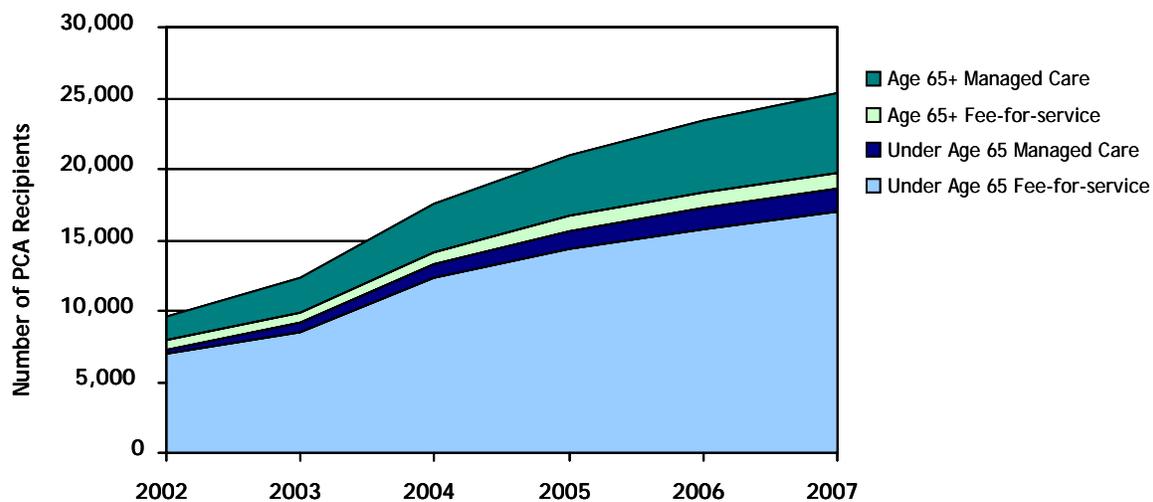
¹² Medical Assistance beneficiaries age 65 and older are generally required to enroll in a managed care program. Unlike many other states, PCA services are included in some of the managed care products offered to Medical Assistance beneficiaries in Minnesota.

Exhibit 1. Minnesota PCA Recipients, by Primary Source of Coverage and Age Group, CY 2002-2007

	2002	2003	2004	2005	2006	2007	2002-2007 Change	
							Number	Percent
Under Age 65	7,285	9,154	13,242	15,620	17,288	18,688	11,403	20.7%
Fee-for-service	6,941	8,537	12,289	14,345	15,718	16,972	10,031	19.6%
Managed Care	344	617	953	1,275	1,570	1,716	1,372	37.9%
Age 65 and over	2,305	3,204	4,252	5,278	6,117	6,674	4,369	23.7%
Fee-for-service	678	764	901	1,055	1,128	1,096	418	10.1%
Managed Care	1,627	2,440	3,351	4,223	4,989	5,578	3,951	27.9%
Total	9,590	12,358	17,494	20,898	23,405	25,362	15,772	21.5%
Fee-for-service	7,619	9,301	13,190	15,400	16,846	18,068	10,449	18.9%
Managed Care	1,971	3,057	4,304	5,498	6,559	7,294	5,323	29.9%

Source: The Lewin Group analysis of DHS-provided aggregate data for Minnesota Personal Care Assistant Services for calendar years 2002-2007.

Exhibit 2. Minnesota PCA Recipients, by Primary Source of Coverage and Age Group, CY 2002-2007



Source: The Lewin Group analysis of DHS-provided aggregate data for Minnesota Personal Care Assistant Services for calendar years 2002-2007.

The increase in users also drove similar increases in spending for fee-for-service PCA with spending increasing from approximately \$135 million to almost \$345 million (Exhibits 3 and 4) between 2002 and 2007.¹³ However, the spending per enrollee only increased by an average of 1.9 percent per year, because both the average units per enrollee and the spending per units grew modestly.

¹³ Due to limitations in the comparability of data between the fee-for-service programs and managed care, we did not analyze PCA spending in managed care programs.

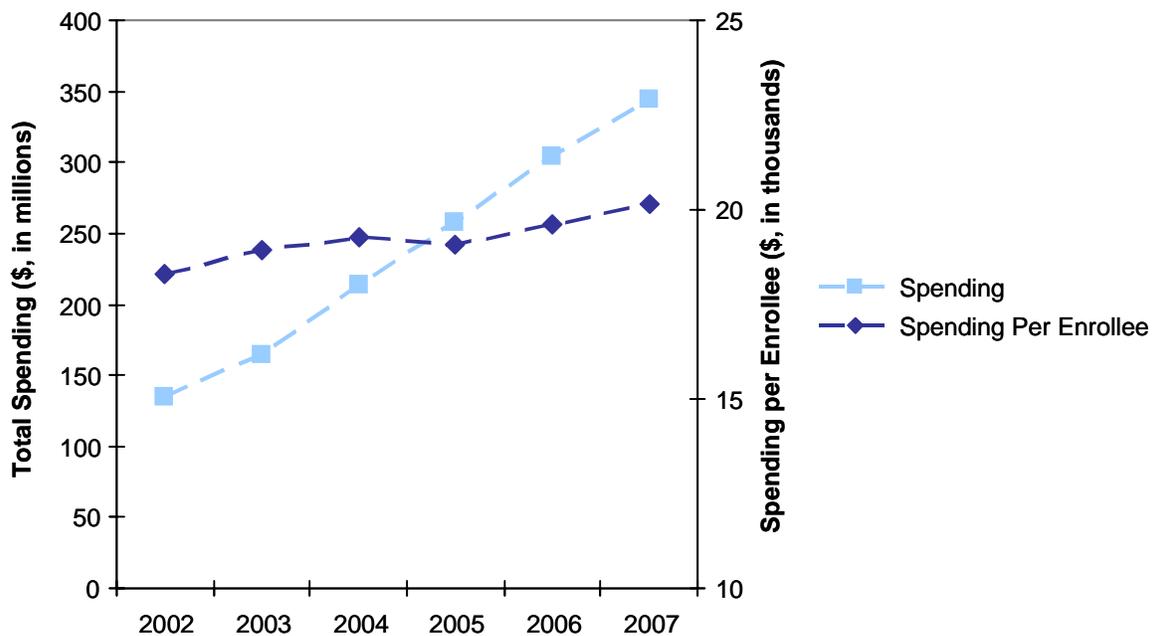
**Exhibit 3. Minnesota State Plan Fee-for-Service PCA Enrollment,
Approved Services and Spending 2002-2007^{a/}**

State Fiscal Year	Enrollment	Spending (000s)	Units (000s)	Spending per Enrollee	Units per Enrollee	Spending per 15 Minute Unit
2002	7,365	\$134,775	37,196	\$18,299	5,050	\$3.62
2003	8,689	\$164,433	44,001	\$18,924	5,064	\$3.74
2004	11,094	\$213,856	57,295	\$19,277	5,165	\$3.73
2005	13,520	\$257,638	69,128	\$19,056	5,113	\$3.73
2006	15,515	\$304,333	80,583	\$19,615	5,194	\$3.78
2007	17,103	\$344,202	89,288	\$20,125	5,221	\$3.85
Change from 2002-07	132.2%	155.4%	140.0%	10.0%	3.4%	6.4%
Annual rate of change	18.4%	20.6%	19.1%	1.9%	0.7%	1.2%

a/ Includes data for enrollees with service agreements and actual service units used during the fiscal year. Does not include any "units" for "assessments only." The analysis excludes data for services for individuals enrolled in managed care and reimbursed by a prepaid health plan.

Source: The Lewin Group analysis of Minnesota State Plan PCA data from fiscal year 2002-2007.

Exhibit 4. Fee-for-Service PCA Spending, 2002-2007

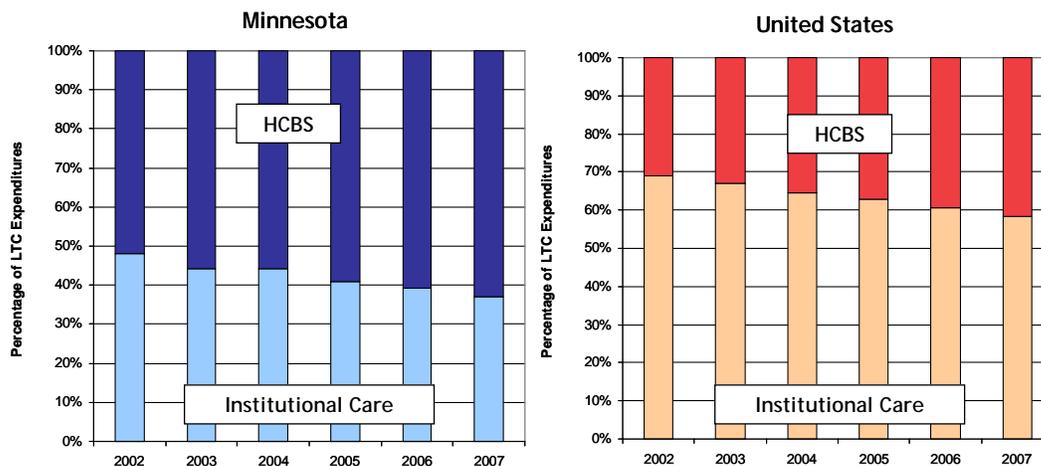


Source: The Lewin Group analysis of Minnesota State Plan PCA data from fiscal year 2002-2007.

Growth in the use of personal care services needs to be placed in the broader context of shifts from institutional settings to community settings. While Medical Assistance PCA and HCBS waiver spending has increased at a rapid pace, the number of Medical Assistance users of nursing facility services and Intermediate Care Facilities for persons with Mental Retardation

(ICF-MR) services, as well as spending, actually declined, offsetting much of the increase (Exhibit 5). Between 2002 and 2007, Minnesota’s long term care expenditures increased by 4.8 percent compared to the national average of 3.7 percent.¹⁴ Taking the longer view (1995-2007), however, Minnesota’s rate of growth in Medical Assistance long-term care spending fell below the national average rate of increase (5.9 percent in Minnesota compared to 7.4 percent nationally).¹⁵ Examined from an alternative perspective, Minnesota’s overall increase in spending from 2002-2007 remained in line with the average annual percent of medical inflation during the period (4.7 percent)¹⁶ and, effectively, was lower than medical inflation when taking into account the 3.3 percent annual average increase in users during the period.

Exhibit 5. Percent of Total Long-Term Care Expenditures Spent on Home and Community-Based Services



Source: The Clearinghouse for Home and Community-Based Services Medicaid Long-Term Care Expenditure Data, FY 2002 - FY 2007.

We also noted the following trends:

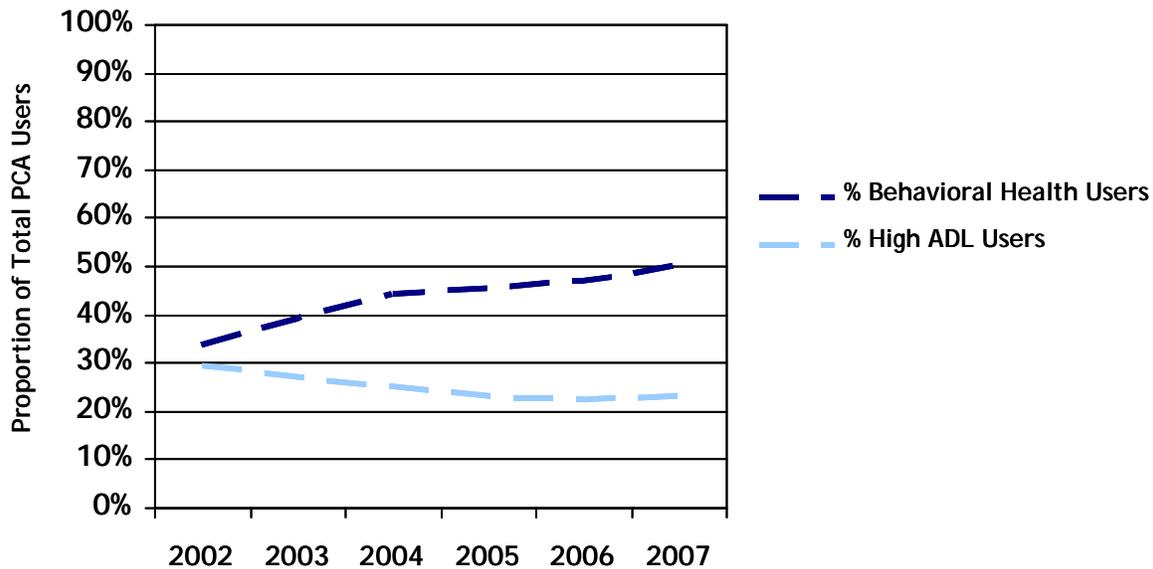
A smaller proportion of PCA users were assigned to the “High ADL” category during the assessment process (Exhibit 6). Individuals are classified as “Low ADL” if they need assistance with up to three limitations in activities of daily living; “Medium ADL” if they need assistance with four to six ADLs; and “High ADL” if they need assistance with seven to eight ADLs. This decline in the number of individuals categorized with high ADL need affects all age groups, but particularly working age adults, and could signal an overall change in the nature of the population being served by the PCA program. The 2009 eligibility changes are likely to result in a higher average severity of need among PCA clients in the oncoming years.

¹⁴ Long Term Care Expenditure for NF, ICF-MR, State Plan Personal Care Services & HCBS Waivers Thomson Reuters (formerly Medstat)

¹⁵ Medicaid Long Term Care Expenditures FY 2007 Author: Burwell, Brian; Sredl, Kate; Eiken, Steve, 2008. Source: Thomson Reuters (formerly Medstat) URL: http://www.hcbs.org/moreInfo.php/type_tool/129/ofs/10/doc/2374/Medicaid_Long_Term_Care_Expenditures_FY_2007. 1995 data is from historical spreadsheet for 1995 from MedStat.

¹⁶ The medical inflation for 2002-2007 was from bls.gov.

Exhibit 6. Proportion of PCA Users with Behavioral Health and High ADL Needs



Source: The Lewin Group analysis of Minnesota State Plan PCA data from fiscal year 2002-2007.

A growing proportion of PCA users are being assigned to behavioral categories during the assessment process. Consistent with the anecdotal evidence that we received during our stakeholder interviews, the proportion of PCA users with a behavioral issue noted in their assessment increased over the 2002-2007 period, particularly among children (**Exhibit 6**). Given the severity of some of these behaviors, many stakeholders expressed concern about the appropriateness of the PCA program to meet these needs and/or commented on the need to ensure appropriate training for PCAs so that they are able to meet the changing service needs of program participants. It is important to note that in 2009, the Minnesota Legislature made changes to the PCA program’s home care rating system, which will likely reduce the proportion of PCA users with behavioral health needs. The Legislature also directed DHS to develop alternative approaches to meeting the needs of individuals with behavioral issues.

An increasing percentage of individuals seeking PCA services do not receive authorization for services. An increasing percent of individuals assessed, particularly among children, do not receive approval for PCA services for a variety of reasons (e.g., they do not meet functional eligibility criteria for PCA services). While there are a number of hypotheses that can be formulated concerning why this has occurred (e.g., changes in the nature and extent of services that are being provided by local schools; inconsistent understanding of the criteria for program participation), DHS should further examine this trend to identify its causes.

2009 Legislative Changes

In 2009, the Minnesota Legislature made significant changes to strengthen accountability and program integrity in the PCA program, and also to bring about fiscal control. We summarize the relevant changes here, although we also note them in other sections of the report as appropriate. The changes include:

- **Modification of eligibility requirements and simplification of home care rating.** The 2009 legislation tightens the criteria for PCA program eligibility in an effort to refocus resources on those who need them the most. While the changes will result in loss of eligibility or a reduction in the number of approved hours for some PCA clients, the changes make the assignment of a home care rating much more transparent.
- **Documentation and training requirements for PCA workers and agencies.** Beginning July 1, 2009, all PCA workers (also termed "PCAs"), managers and supervisors are required to complete DHS-approved training. All PCA agencies are required to demonstrate compliance with training requirements for their workers prior to enrollment. Currently enrolled agencies have an 18-month period to comply.
- **Service verification and supervision requirements:** Specific requirements to address service oversight and monitoring are included in the 2009 legislation, including:
 - *Service verification:* Beginning July 1, 2009, legislation requires daily documentation of PCA services provided on DHS-approved timesheets, either electronic, Web-based, or paper format, signed by the worker, and responsible party (if applicable). The legislation also requires review by a Qualified Professional.¹⁷
 - *Qualified Professional supervision:* Effective January 1, 2010, all PCAs must be supervised by a Qualified Professional through training, direct observation, and consultation to assure that the PCA is knowledgeable and capable of providing the services to be assigned.
- **Responsible Party Requirements:** Beginning January 1, 2010, all PCA recipients who are under age 18, who are incapacitated, or who are determined through their assessment to be in need of a responsible party to direct and supervise their care, must appoint a responsible party. The Legislation also requires that the responsible party enter into a written agreement with a PCA agency outlining their roles and responsibilities.
- **Limitation on PCA Hours of Work:** The legislation limits the hours that a PCA can work to no more than 310 hours per month, regardless of whether the worker is employed by one or multiple agencies. Through the Governor's allotment process, the maximum number of hours per month that a PCA can work was reduced to 275.

¹⁷ Under 2008 Minnesota Statutes 256B.0625, Section 19c, a "Qualified professional" means a mental health professional, a registered nurse, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant.

V. Findings from Other States

As part of our research, we researched publicly available information concerning, and interviewed representatives from eight States' PCA State Plan and Cash and Counseling PCA programs.¹⁸ We found that while each State's program design and implementation is unique, Minnesota's PCA program is not significantly different from other states.

To select the states, we began by conducting an environmental scan of the 35 states which offer the State Plan Personal Care Option and/or a Cash and Counseling (C&C) program.¹⁹ As a first step, we conducted a literature search to gather information concerning the programs' start dates, spending, PCA qualification requirements, county-level involvement in the programs, and entities or individuals responsible for service planning and authorization to provide a wide variety of factors from which to base our selection of states for in depth research and interviews.

We then identified general parameters for state selection, incorporating additional areas of DHS interest such as options concerning regulating PCA provider qualifications, alternatives for service authorization processes (e.g., quarter-hourly, hourly, or monthly) and neighboring state program structures and policies. Our focus was, therefore, not to select states that were specifically similar or different from Minnesota. Rather, our goal was to select states with varying experiences to enrich our understanding of program structure, operations, challenges, and perspectives. The final eight states chosen in consultation with DHS staff for additional research were: Massachusetts, Michigan, New Mexico, New York, Oregon, Texas, Washington, and Wisconsin.

Findings from State Research and Interviews

Our interviews focused on a number of issues which were not generally available as the result of a literature search or which we felt would benefit from a discussion rather than solely a review of requirements. Among the areas which we probed during our interviews are the following:

- Administration of the PCA program, including roles and responsibilities of various agencies (at the state and/or local level) in conducting assessments and authorizing services
- The level of PCA services integration across programs (e.g., whether individuals can receive services both through State Plan PCA and HCBS waivers, as in Minnesota)
- PCA worker hiring processes, training requirements, reimbursement (both at the agency level and at the worker level, when applicable and available), and benefits

¹⁸ The Cash and Counseling program provides Medicaid beneficiaries who have disabilities with more choices about how to receive help to perform activities of daily living. The program started with three states as a CMS demonstration in 1998, and expanded to 12 additional states in 2004. The Deficit Reduction Act (DRA) of 2005 authorized Cash and Counseling provision, allowing a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services based on a written plan of care for individuals who have been determined to need these services.

¹⁹ Of these 35 states, 20 operated only State Plan PCA programs, 7 operated only Cash and Counseling programs, and 8 operated both State Plan PCA and Cash and Counseling programs.

- Program integrity mechanisms used, particularly in relation with monitoring personal care worker activities and ensuring payment only for appropriately delivered services

Finally, we discussed some of the challenges and “best practices” the states have used or were considering using in their PCA programs. For our purposes, we use the term “best practice” broadly to identify processes or policies that states have implemented which, in the view of program managers, have addressed specific challenges or led to the program’s overall success.

Specific commonalities and themes emerged from these interviews and are discussed in more detail below. For each of these themes, we provide specific context in relation to Minnesota where applicable.²⁰ Our findings are as follows:

- **Programs make efforts to promote consistency and objectivity across assessments and service authorizations.** Some of the state program managers interviewed expressed concern about how to maintain consistency across assessments and authorizations, particularly given the diverse needs of consumers and dependence on the subjectivity of the assessor. Consistency across assessments has also been raised as a concern by DHS staff, county staff involved in the PCA program, and advocates in Minnesota. One strategy to promote consistency is that Washington State has adopted an assessment protocol which staff believe reduces the level of disparities among assessors, helps distribute available hours as fairly as possible, and reduces errors in the overall process.
- **Some States use a multi-disciplinary assessment and service planning approach.** States are striving to take a more holistic approach to conducting assessments and service planning that takes into account not only consumers’ medical needs, but also social needs and the living environment in which care will be provided. Examples of such states include New York, which requires assessments by a social worker and a nurse, and Massachusetts, which requires that a nurse and an occupational therapist participate in the assessment.
- **Few states have formal training requirements for PCAs.** Despite some concerns about quality and consistency of care, it appears that many states have resisted implementing required training or licensure requirements for PCAs. In addition, more formal licensure or training requirements were generally viewed as barriers to addressing shortages of direct care workers and allowing certain family member (those not “legally responsible” for the consumer) to provide services. Prior to 2009, Minnesota had not implemented formal mandatory training, licensure, or certification requirements. New York appears to have a rigorous training curriculum (called the Home Care Core Curriculum) for its personal care workers.
- **Involving stakeholders in PCA program development on an ongoing basis can help identify problems at an early stage, promotes cooperation in resolving them and, overall, improves program operations.** In two states, Massachusetts and New Mexico, program staff noted that active involvement of stakeholders and advocates has strengthened their PCA programs. Massachusetts developed a PCA Improvement Workgroup, which includes 25 stakeholders (consumers, providers, and advocacy organizations) that meet monthly with State administrators to discuss priority issues

²⁰ A brief summary of each state’s program(s) is also available in Interim Report #1.

and concerns for the PCA program. New Mexico's stakeholder workgroup supports both the State Plan personal care and Mi Via (Cash and Counseling) programs, and was instrumental in shaping the design of the Mi Via program.

- **Consumer direction promotes participant satisfaction with services.** While we did not perform an independent comparative data analysis between consumer-directed programs and traditional PCA programs, not unexpectedly, state representatives reported that consumer-directed programs are popular among consumers. For example, New Mexico's Cash and Counseling program staff noted that participants in that program are satisfied and rarely choose to return to the traditional Medicaid PCA program. Minnesota's PCA Choice option, established in 2000, also allows PCA participants to choose to direct their own care, thereby providing an option for consumers to have more control over their personal care services.
- **In consumer directed programs, fiscal management services relieve consumers of the burden of employment-related activities and support program integrity.** Reducing the administrative burden of payroll from consumers allows them to focus on hiring, firing, and supervision of PCAs, as well as on direct care activities they wish the PCA to support (within their authorized service plan and hours). This is a strong feature and, in states that have consumer-directed programs, including Minnesota, use of a fiscal intermediary is a requirement for participation in consumer-directed programs. In Minnesota, PCA Choice consumers work with a DHS-authorized fiscal intermediary who bills the state for PCA services and pays/withholds taxes for all PCA staff, relieving participants of these responsibilities.
- **Minimum Level of Care requirements for personal care services vary by state.** Overall, we found that the level of care needed to receive State Plan personal care service varies greatly by state. This makes it difficult to make comparisons among states. For example, some states require that a minimum level of assistance be needed to qualify for services (e.g., requiring an individual to need assistance with a minimum number of Activities of Daily Living [ADLs] or Instrumental Activities of Daily Living [IADLs]), but states' definitions of ADLs or IADLs may differ. For example, Massachusetts and New Mexico base functional eligibility in part on limitation in at least two ADLs, however the states' lists of ADLs differ slightly. Oregon, on the other hand, requires a limitation in at least only one ADL. Other states use an algorithm or other automated tool to determine the level of need, as well as the level of services, that an individual would receive. These automated tools may classify individuals into specific groups (e.g., as the Washington and Michigan tools do) or assign a score to an individual indicating their level of need (e.g., Texas).
- **Personal care agency rates and worker's wages and benefits vary by state.** States approach rate setting and wages differently depending on the program option (e.g., self-directed personal care versus tradition personal care option), executive and/or legislative branch involvement in setting rates and wages, and in some circumstances, unionization.

VI. Key Findings

Lewin researched the PCA program history, analyzed program data, interviewed stakeholders, advocates and program staff, conducted focus groups of PCA workers and consumers, and surveyed PCA provider agencies. Through all of these sources, we gathered information about what is working in the PCA program and areas that need to be improved. In this section, we summarize our key findings.

Table 1. Key Findings

Key Findings
1. The PCA program plays an important role in the lives of consumers
2. The PCA Choice program meets the needs of a specific set of consumers
3. Low wages and minimal benefits pose challenges to the effective operation of the PCA program
4. DHS lacks comprehensive real-time information and approaches to efficiently manage the PCA program
5. The PCA program lacks sufficient supervision/oversight of workers to assure quality of care and assist in improving the services they provide
6. The PCA program lacks formal and consistent training for PCA workers
7. Consumers' needs are not always met due to a lack of adequate back-up plans and available workers
8. The PCA program lacks consistency in individual assessments
9. Service authorizations and reauthorizations are not always accomplished in a timely manner
10. Enrollment of PCA workers were not always accomplished in a timely manner

1. The PCA program plays an important role in the lives of consumers

Minnesota's PCA program has historically been, and continues to be, an integral part of the State's efforts to assist individuals to live in the community. The program provides a wide array of services and supports, including assistance with activities of daily living, health-related services, and other supports. These services are essential to the health, safety and well-being of those served and, more importantly, allow individuals with physical, intellectual and developmental disabilities, as well as older adults, to stay in their homes and community, and avoid care in more restrictive and more costly settings.

PCA workers and consumers described a vast array of tasks provided under the program including, but not limited, to:

- **Assistance with daily life activities:** including providing support with personal hygiene and grooming; assistance with housekeeping by completing tasks such as sweeping, mopping, dusting, cleaning the bathroom, doing dishes and laundry; and assistance with grocery shopping, cooking and eating;
- **Assistance accessing health care and health related tasks:** including providing support to people who use G tubes including cleaning, maintenance and monitoring of the G tube; maintaining catheters; assisting with the self-administration of medications, monitoring the use of medications to treat a variety of health issues such as diabetes; and helping consumers go to medical appointments and obtain medications;

- **Physical and behavioral interventions:** including assistance with range of motion exercises, physical activities and other interventions requested by physical and occupational therapists, observation or consumers for episodes needing redirection, and providing redirection due to behaviors; and
- **Support community integration:** including providing support to the PCA recipient to participate in recreation and leisure activities.

Through the focus groups we conducted, we heard from both recipients and workers about the importance of the program in supporting recipients to live successfully in the community. For example, recipients expressed that PCAs played significant roles in their lives by helping them improve and maintain their health. This includes PCAs taking them to and from doctor and specialist appointments (sometimes great distances away if the person lives in a rural area), assisting them with range of motion and other mobility exercises, transferring and lifting them when they need assistance to prevent injuries and sores, and using assistive technology and equipment to help them get around their homes and communities. We also heard from parents/family members about the important role PCAs play in helping them with their children that have challenging behavior or severe medical conditions. The PCA program provides much needed respite for parents and family members. Workers also described finding their work and the services they provide rewarding as a result of the close relationship that they develop with the recipients whom they support.

2. **Consumers value the PCA Choice program because it provides them with a greater level of responsibility for their care, however, some need additional support to manage their PCA Choice option**

The PCA Choice option is Minnesota’s self-directed model through which recipients who are able to, with some support or the help of a responsible party, hire, fire, and train their PCAs, and overall direct their own care. The PCA Choice option gives consumers a greater level of responsibility in managing their care while providing a fiscal intermediary to assist in handling the employment and management-related functions. Even with the help of fiscal intermediaries that assist with administrative functions (e.g., computing pay and taxes and paying wages), recipients who participated in our focus groups expressed that, while they favored the PCA Choice program in terms of level of control and flexibility over the activities the PCA performs, they face challenges with their employer responsibilities and could benefit from additional support. Specific areas recipients noted as needing additional support include:

- **Assistance with back-up PCAs:** Recipients in the focus groups indicated that under PCA Choice, they receive little assistance from an agency with emergency situations (e.g. parent gets sick or a PCA leaves suddenly); and
- **Training on managing/training PCAs and administrative functions:** Recipients expressed that they do not always have the experience or knowledge to perform important tasks including, interviewing and hiring of PCAs, and paperwork associated with directing their own PCA care.

Most recipients expressed a desire to have support and assistance through resources, greater training and individualized support from the state or an entity responsible for providing such support.

3. Low wages and minimal benefits pose challenges to the effective operation of the PCA program

Workers, PCA provider agencies, and consumers all identified low wages and limited access to benefits (health, dental, overtime and paid time off) as significant challenges to finding and keeping PCA workers. While there are some variations in the relative importance of each factor depending on the type of program in which a PCA worker is employed (i.e., the Traditional PCA program versus the PCA Choice program) and the region of the State in which the employee resides (Greater Minnesota versus the Seven-County Metropolitan Area²¹), the overall importance of these issues remains constant.

Wages: Based on our survey of Minnesota PCA provider agencies, the average PCA worker wage reported is \$10.80 per hour (\$11.35 for workers employed by PCA Choice agencies and \$10.31 for workers employed by Traditional PCA agencies). In a single wage earner four-person family, this wage is close to the 2009 Federal Poverty Level of \$22,050.²² For comparison, in 2007 nationally the median hourly wage for PCAs was \$8.88 per hour and for all direct care workers (including nursing aides, orderlies, attendants, home health aides, and personal home care aides) the median hourly wage was \$10.48 per hour.²³ We also found that wages in Greater Minnesota were somewhat lower than in the Seven-County Metropolitan Area (24 percent of wages were below \$10.00 per hour in Greater Minnesota while less than 10 percent of wages reported in the Seven-County Metropolitan Region were below \$10.00 per hour).

During the focus groups, many workers and consumers indicated that these pay levels were not adequate given that kind of supports that these workers were providing to Minnesota's most vulnerable citizens. Several PCA participants suggested the need for pay scales that rewarded working with people who have greater support needs, such as challenging behavior and severe physical and medical needs. PCA workers also expressed the desire to have more consistency in pay across organizations and PCA service types (e.g., fee-for-service, private pay, PCA Choice, managed care).

Benefits: We also asked PCA provider agency survey respondents to report on which benefits they offer to full- and part-time employees. It is noteworthy that almost a third of agencies reported that they do not offer any benefits to full-time employees. Moreover, part-time employees receive significantly fewer benefits than full-time employees, which is an important distinction given that approximately 75 percent of all PCAs work only on a part-time basis.

Approximately 45 percent of all responding PCA agencies reported that they offer health insurance to their PCA workers, with Traditional PCA agencies reporting that they offered health insurance benefits almost twice as often as PCA Choice agencies. Dental coverage exhibited the same patterns as health insurance coverage, although agencies reported that they offered dental coverage about half as often as they reported offering health insurance benefits.

²¹ The Seven-County Metropolitan Area includes Anoka, Washington, Ramsey, Hennepin, Carver, Scott, and Dakota counties; Greater Minnesota refers to the remaining Minnesota counties.

²² Federal Register, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201, also available at <http://aspe.hhs.gov/poverty/09poverty.shtml>

²³ Facts, Vol. 4, No. 3, January 2009. Bronx, NY: PHI.

PCA workers reported varied experiences with benefits offered by their employer. Nearly all workers who participated in the focus groups indicated that they were either not offered health insurance benefits, or that the insurance options they were offered were too expensive, and so they did not utilize them. Many were without insurance, several said they just go to the emergency room when they are sick, some said they have second jobs with health benefits, and others had health insurance through a spouse or another coverage option such as Veterans Affairs. Nearly unanimously, PCA workers expressed the need to have affordable health insurance..

The implications of these issues is clearly significant for the operation of the PCA program, as demonstrated by their effects on recruitment, retention, and turnover. Difficulties in recruitment, and then subsequent low retention and high turnover rates, increase the costs of the PCA program (e.g., additional costs for training new and replacement workers). Moreover, the continual replacement of workers negatively impinges on the quality and continuity of care that can be provided in the program.

Recruitment and Retention: Respondents to our PCA provider survey reported that low pay was the single most important issue related to recruitment and retention. Interestingly, more agencies reported that low pay was a significant factor in retention than reported that it was a significant factor in recruitment. In focus groups, nearly all of the PCA recipients identified low wages and lack of benefits such as affordable health care, paid time off and overtime as important factors that contribute to their inability to find and keep good staff. Several shared stories of losing PCAs because they found a job with better pay or access to employer paid benefits. Recipients were passionate about these issues and several expressed that PCA workers needed to be treated as professionals and have the benefits that go with their high levels of responsibility.

Turnover: Turnover is an enormous problem for direct care workers throughout the nation. Findings from national studies have found turnover rates between 40 and 71 percent for direct care workers across the aging and disability service sectors. Our study shows that turnover is a significant challenge in the Minnesota PCA program as well and, in fact, may be a greater problem than for direct care workers generally. Not surprisingly, we found that PCA Choice programs have lower turnover rates than Traditional PCA programs: more than 40 percent of Traditional PCA programs have turnover rates of greater than 50 percent while less than 30 percent of PCA Choice agencies reported similarly high turnover rates.

4. DHS lacks comprehensive real-time information and approaches to efficiently manage the PCA program

With the growth in the PCA program, the evolution of program options, and the expansion of mandatory managed care for the elderly, the need for accurate, consistent and comprehensive data and management approaches has become increasingly important. However, in large part due to the rapid pace of change in this program, DHS has faced significant challenges in maintaining and developing such capabilities.

In fact, throughout our qualitative review of the PCA program and quantitative analyses, we found that DHS lacks the information and processes that it needs to effectively and efficiently

manage this important program. We found a lack of coordination between agencies responsible for PCA services in the managed care and fee-for-service delivery systems. Moreover, the data that DHS collects in relation to PCA services is insufficient to allow complete and effective program management and monitoring. The key areas where we found gaps or inconsistent understanding include:

- **Managed care and fee-for-service:** All individuals 65 years and older are required to enroll in managed care and, unlike in many states, managed care plans in Minnesota cover PCA services. As a result, about one-third of consumers access PCA services through the managed care delivery system. However, we found that staff responsible for administering the managed care program, and those administering the fee-for-service PCA program, have not established ongoing information and data sharing processes.

In fact, research conducted in relation to PCA services in the fee-for-service environment rarely take into account or include analysis of PCA services in managed care. In our attempt to analyze PCA utilization and spending data across both parts of the program, we found that the nature and extent of information collected by the State on the fee-for-service program is more extensive than that collected in relation to PCA services provided by managed care plans. While in and of itself, this is not surprising since managed care reporting is often different in scope than that related to fee-for-service, we found that the data collected on the two programs is neither combined nor comparable; thereby causing a gap in program analysis that hinders comprehensive program understanding and planning. Furthermore, it makes it difficult to determine the true utilization and costs for services in the program. This lack of uniform data collection, interpretation and reporting presents a major challenge to effectively managing the program, particularly given the expansion of mandatory managed care for the elderly population.

- **Recipient data:** We found lack of consistency in understanding recipient enrollment, service authorization, and utilization data. For example, how individuals who are assessed, but not authorized, for services are reflected in enrollment counts was a key concern of advocates and posed data analysis challenges for us. For example, inappropriately including the “assessment only” group overstates PCA enrollment in the program, while understating per capita utilization data. We were also unable to get a clear interpretation of this “assessment only” group, such as, the reasons why they do not meet PCA program eligibility requirements, or whether they are receiving services through a different fund source (e.g., grant-funded programs such as the Consumer Support Grant). Our interviews with advocates also confirmed a lack of clarity and common understanding of recipient data used by DHS.
- **PCA provider agency data:** Throughout our study and, in particular, in performing the PCA agency survey, we found that there is a lack of readily available, consistent information about the universe of providers who provide PCA services under the Medical Assistance program. For example, lack of readily available data on enrollment type, and the various options through which these agencies provide PCA services (e.g., Traditional PCA versus PCA Choice option) limits DHS’ ability to target training and communication about the various program options. It also limits DHS’ ability to effectively assess program capacity, agency performance, or implications of policies that may impact the various types of providers differently.

- **Living arrangements data:** Claims data do not provide a meaningful enough breakdown of living arrangements in the community to be able to adequately track personal care service use in the various types of living arrangements. Lack of tracking poses challenges to identifying, analyzing and understanding similarities and differences between PCA services provided by a housing services provider versus PCA services provided in other settings. Lack of data also poses limitations to analyzing differences in types of clients served in those settings in comparison to other settings, as well as any differences in utilization between clients with similar needs served in the two different types of settings.

5. The PCA program lacks sufficient supervision/oversight of workers to assure quality of care and assist in improving the services they provide

DHS has faced challenges in being able to put in place adequate and sufficient quality assurance and program integrity measures for the PCA program, particularly as the program has grown to serve a far larger number of recipients than when it originally was implemented. In addition, the PCA recipient population has changed to include more individuals with behavioral health needs, thus suggesting that there is a need for PCA worker supervision of a more focused nature than that which might have been required in the earlier days of the program.

We found a lack of consistency in supervision and oversight of services and workers in several areas, including verification that workers were actually providing services, actual supervision of the activities being performed, and overall monitoring of the quality of services being provided.

- **Service verification:** Provider agencies reported using a variety of methods to verify that PCAs provide services, including having clients sign timesheets, doing spot checks, and managers monitoring workers. Providers also identified a mix of activities to verify that PCAs provided services including nurse supervision, Qualified Professional²⁴ visits and calling clients.
 - While providers report having mechanisms in place to verify service delivery, there appear to be no mechanisms to assure the adequacy or validity of any of these methods. Given the growth in the program, the current level of service verification is insufficient to assure accountability, and potentially could create opportunities for abuse.
- **Qualified Professional supervision:** Our interviews with stakeholders revealed a lack of professional supervision of PCAs by Qualified Professionals. DHS reported that, consistent with Minnesota statutes,²⁵ it permits supervision of PCA services to be performed by either the individual receiving services or a Qualified Professional; however, our impression from interviews is that advocates and stakeholders believe that supervision of PCA services by a Qualified Professional is required and not currently

²⁴ Under 2008 Minnesota Statutes 256B.0625, Section 19c, a "Qualified professional" means a mental health professional, a registered nurse, or a licensed social worker as defined in section 148B.21. As part of the assessment, the county public health nurse will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant.

²⁵ 2008 Minnesota Statutes, 256B.0625, Subdivision 19c, "Personal care."

enforced by DHS. Participants in our focus groups also suggested that they rarely saw qualified professionals supervising PCA workers and that, in some instances, the “supervision” was provided in group settings without consumers being present.

In an effort to specifically address these two areas, the Minnesota Legislature in 2009 has adopted requirements to address service oversight and monitoring, including:

- **Service verification:** A requirement for daily documentation of PCA services provided on DHS approved timesheets, either electronic, Web-based, or paper format. Documentation requirements include dates, times, activities performed and signature of the worker, recipient and responsible party (if applicable). The legislation also requires review by the Qualified Professional and submission of the documentation on a monthly basis;²⁶ and
- **Qualified Professional supervision:** A requirement that, effective January 2010, all PCAs be supervised by a Qualified Professional who, through training, direct observation, and consultation, can assure that the PCA is knowledgeable about and capable of providing the services assigned. The legislation also requires periodic supervision of service delivery by the Qualified Professional, establishes requirements for evaluation of the PCA worker and requires that appropriate actions be taken to assure the provision of appropriate, approved, and quality services.²⁷

6. The PCA program lacks formal and consistent training for PCA workers

Prior to the 2009 Legislative Session, Minnesota had considered developing qualifications and training requirements for its PCA workers several times, but had not adopted an overall training policy. Lack of a training requirement leaves consumers vulnerable to inappropriate service delivery and may also inhibit the development of a core of competent service providers. We heard consistently from advocates, PCA workers, and consumers that lack of formal consistent and comprehensive training was a key concern. Although the Legislature has adopted several provisions concerning PCA worker training²⁸, and DHS is in the process of developing the appropriate training protocols, we have included our findings on this subject to document the input that we received during the course of our study.

- PCA workers who participated in our focus groups described vastly differing experiences with respect to how their employer trained them to be PCAs. Some had absolutely no training or orientation and were just expected to deliver support. Others received a limited amount of orientation/training from their employer, including for example, being asked to read a PCA manual, shadow another PCA, complete answers to questions that were provided to them with their paycheck and turn them in to their employer, or learn specific skills from hospital staff before a client is discharged from the

²⁶ 2009 Minnesota Statutes, 256B.0659, Subdivision 12, “Documentation of personal care assistance services provided.”

²⁷ 2009 Minnesota Statutes, 256B.0659, Subdivision 14, “Qualified professional; duties.”

²⁸ 2009 legislation also enacted requirements related to PCA agency (2009 Minnesota Statutes, 256B.0659, Subdivision 21, “Requirements for initial enrollment of personal care assistance provider agencies”) and Qualified Professional (2009 Minnesota Statutes, 256B.0659, Subdivision 14, “Qualified professional; duties.”) training.

hospital. Some PCAs received three hours of training before working as a PCA on topics such as rotating a person in bed, changing bed covers, washing clothes, assisting with toileting, and helping the person get in/out of a wheelchair.

- Not inconsistent with our focus group results, our PCA provider survey showed that most agencies that responded reported that they provide initial training for their employees (81 percent for Traditional PCA and 64 percent for PCA Choice). About half of the respondents report that they provide training on an ad hoc basis, about half report that they provide training annually, and about half report that they provide training more than annually.²⁹
- We also asked providers about the training topics they covered. Over 90 percent reported that they provided training in privacy and confidentiality, documentation of service and consumer rights and responsibilities. The results of the survey also showed, however, a lack of training in several important safety areas (e.g., basic life safety and health) and general program areas (e.g., Medical Assistance/PCA program overview, cultural sensitivity, and skills training). Overall, PCA Choice agencies reported providing significantly less skills training.
- Nearly all PCA workers who participated in the focus groups expressed that they would like more opportunities for training and education. They indicated that they felt they could gain more knowledge and acquire more skills that would assist them in providing better support to PCA service recipients through training. Several suggested that Minnesota require certification for PCAs; others suggested that agencies pay higher wages to workers who are certified.
- Both PCA workers and stakeholders expressed the need for more training related to individuals who have challenging behavior and mental health issues. Most workers indicated they never received this type of training, but many supported individuals who exhibited these behaviors and the workers did not feel adequately prepared to meet their clients' needs.
- In addition to a lack of adequate training, most of the workers said they received little to no supervision and that no one really ever watched them do their work. They relied most heavily on feedback from recipients they served or parents of recipients. Many indicated that they thought someone was supposed to come and observe them once a month but that they rarely, if ever, had heard or seen anyone from the organizations in which they were employed. This lack of supervision also reduces the opportunities a PCA worker has to be guided, directed and to learn the specific skills they need to perform their job and provide adequate support to PCA recipients.

The recent passage of PCA legislation in Minnesota that requires basic training for all PCA workers provides an excellent opportunity for the State to build a successful training program that will give PCAs a set of professional guidelines and ethical practice standards.

²⁹ Providers were allowed to select multiple answers to this question, so total does not add to 100 percent.

7. Consumers' needs are not always met due to a lack of adequate back-up plans and available workers

- In our PCA consumer focus groups, clients expressed challenges associated with having an appropriate and adequate back-up plan in place to implement when their usual PCA is not available. Recipients talked about using provider agencies as their back-up plans, calling 911 or relying on family members or close friends to assist them when their PCA did not show up or when they had an emergency. Recipients who did not have family members shared how this lack of support resulted in them being more vulnerable because they had to rely on agencies to supply back-up services, and these agencies were often inconsistent and unreliable. Many expressed they could not participate in PCA Choice because they were simply not able to ensure their own back-up staff in case of emergencies.
- Both service recipients and family members/legal representatives talked about how life stops when their PCAs fail to show up for work or when they quit. Parents shared how they had lost jobs because they often had to stay home to care for their child as a result of not having a PCA, and recipients talked of having to be hospitalized because they had to have help and they had no PCA. For program participants, who need assistance with eating, toileting, and other critical daily activities, the lack of a PCA to provide needed support can be catastrophic.

8. The PCA program lacks consistency in individual assessments

A uniform and robust assessment system is critical to assuring that individuals are receiving the right kinds of services in the right amount. Currently, Minnesota has a uniform and robust home care rating system and standardized tool for PCA assessments, the Medical Health Services Assessment Tool. At the same time, assessment and service authorizations rely heavily on the judgment of the assessor to make appropriate determinations of the types and amounts of services. The only real limiting factor is the budget cap established in the home care rating system.

It is notable that under the current system, both fee-for-service and managed care organizations use the same assessment tool and generally the same processes for determining individuals' need for PCA services. Following these same processes promotes consistency and efficiency among assessing agencies and prevents gaps in services when consumers move from county-to-county or transition between programs (e.g., managed care vs. fee-for-service vs. home and community-based waiver program). Under the fee-for-service program, DHS approves each individual's assessment, which amounts to another "check" in the system.

Nonetheless, PCA program stakeholders raised several concerns about the assessment process, including the consistency of assessments, potential for subjectivity among assessors and equity of authorized services across the State. Specifically, stakeholders raised the following concerns:

- **Variance in approved PCA hours.** Stakeholders were concerned about the level of subjectivity in conducting assessments and determining the duration and amount of services needed. We heard comments about PCA clients making appointments with assessors who were known to be more generous with approved hours.

- **Unclear guidance about the assessment process.** Our interviews found that stakeholders had different understandings of the assessment process, in particular concerning the requirement for face-to-face assessments.
- **Lack of coordination for individuals with behavioral health needs.** Stakeholders perceive that while individuals with behavioral health needs are served through various programs and agencies and often have care coordinators, there is no coordination between public health nurses at the county level who are conducting assessments for PCA services and existing care coordinators. Stakeholders were concerned that the lack of an established, strong system for coordinating development of a care plan and authorizing services for such individuals weakened comprehensive planning and delivery of services for these individuals.

While individualized service planning is integral to a consumer-focused service such as personal care services, a system that relies primarily on an individual's judgment is more likely to be perceived as leading to inappropriate services (either not enough approved services or more services than required to meet the individual's needs) than one that incorporates additional internal checks and balances.

9. Service authorizations and reauthorizations are not always accomplished in a timely manner

Delayed authorizations and reauthorizations can hinder the ability of PCA provider agencies to meet the newly identified or ongoing needs of their clients. Of concern, therefore is the fact that almost one third of responding PCA provider agencies reported that authorizations sometimes or never are completed on time. This delay can be a critical problem for a program which provides care at home to vulnerable individuals, since delayed authorizations or reauthorizations could threaten delivery of needed care.

In our stakeholder interviews, we heard that some PCA provider agencies try to meet the needs of their clients while waiting for service authorizations to be approved. In these cases, agencies may provide services at their own risk prior to DHS authorization and may be unable to be reimbursed for these services. For smaller PCA agencies (note that over half of the agencies responding to the provider survey have 25 employees or less), service authorization delays may create cash flow problems. Moreover, stakeholders reported that DHS rarely denies authorization for an individual whose assessment indicates need for PCA services.

While we did not ask specific questions about PCA service authorization in the managed care setting, providers reported through the provider survey that often information about service authorization processes in managed care conflicts with instructions for the fee-for-service program. Respondents also stated that managed care entities add another administrative layer, resulting in delayed authorization which impacts service delivery.

10. Enrollment of PCA workers was not always accomplished in a timely manner

During the interview portion of our study, several stakeholders suggested that there was a backlog in DHS enrollment of individual PCAs, often taking up to six weeks to process an individual PCA application. DHS was aware of this backlog and, since our initial interviews, the DHS Provider Enrollment Personal Care Attendant Enrollment Specialists worked to

restructure the enrollment process. Provider Enrollment reports that enrollment time has decreased to two-to-three days, and the previous backlog has been virtually eliminated.

While this problem has currently been resolved, it is important to assure that it does not recur. It is important to note that the existence of such a backlog can leave the impression that program integrity is not an important aspect of program operations. For example, it was reported to us that some situations had occurred where agencies allowed the PCA to begin to work without being enrolled in the program. This has several serious implications, ranging from services being provided by an individual who may not be appropriate to do so, to an agency deciding to inappropriately use an existing personal care worker's provider identification number to initiate and bill for services, to the perceived need for a PCA agency to take on inappropriate financial and programmatic risk pending enrollment of the PCA. Alternatively, if a PCA agency does not allow services to be provided until PCA enrollment is approved, needed PCA services may go unprovided. This is particularly serious in situations where the consumer has been receiving services and now needs a new PCA worker to continue these services.

VII. Recommendations for Improvements to the PCA program

Over the course of our study, we gathered input from PCA program participants, PCA provider agency staff, PCA workers, DHS program staff, stakeholders, advocates, and PCA program staff in other states. In our interim reports, we presented over 50 recommendations to DHS to strengthen the PCA program in Minnesota. In this final report, we offer several overarching action items for DHS to consider implementing.

To develop our overall recommendations, we reviewed and analyzed the information gathered and the preliminary recommendations presented in the three interim reports, combining and modifying recommendations where appropriate. We then separately identified those recommendations that were consistent with actions taken in the 2009 Minnesota legislative session and/or that DHS was already addressing. Since these recommendations have, essentially, already been independently addressed, rather than outlining the rationale behind them, we are providing implementation strategies that should be considered as DHS works to implement the changes. These strategies are included in Table 3 and are discussed in greater detail in the Section B of this portion of the report.

We then prioritized our remaining recommendations by first assessing whether the recommendation would have a high, medium or low impact on PCA program participants (either or both clients and PCA provider agencies). We then further ranked each of the recommendations based on our assessment of their implementation costs (low to high), implementation time frame (short-term or long-term, with one year being considered the distinguishing factor between the two) and challenges in implementation (again, low to high). The highest priority recommendations were those that we determined would have a high impact on the program and which would have relatively low implementation costs, required a relatively short time to implement and which would be relatively easy to implement. We discuss these recommendations in greater detail in Section A below.

Recommendations for Program Improvement

We grouped our final set of recommendations into three overall categories: improving program management, ensuring an adequate workforce, and other recommendations. These recommendations are listed in the table below and are discussed in greater detail below. Please note that, while we are not presenting a group of recommendations to address program integrity issues, many of our recommendations have program integrity aspects; those recommendations with program integrity aspects are noted with an asterisk in the table below (Table 2).

Table 2. Recommendations For PCA Program Improvement

Recommendations for Program Improvement
Improving Program Management
1. *Develop and strengthen metrics and measurements to enable DHS to monitor program activities and changes on an ongoing basis
2. *Improve coordination between managed care and fee-for-service PCA programs
3. *Explore implementing an electronic verification and program management system
4. Establish a technical advisory workgroup on the PCA program
Ensuring an adequate workforce
5. Implement strategies to improve compensation for PCAs
6. Explore establishing an online worker registry to improve access to a qualified pool of PCA workers
Other recommendations
7. Convene a housing task force to address the need for accessible and affordable housing for individuals with disabilities
8. Develop and provide training to clients in the PCA Choice program to assist them in hiring, firing and supervising PCAs
9. Improve resources available to PCA agencies to manage PCA program

* Denotes recommendation that improves program integrity

Improving Program Management

A critical component to help strengthen Minnesota’s PCA program is the development of additional, consistent data and reporting and management tools to assist the Department in its efforts to better manage the program. We believe that the improved data and organizational and management approaches recommended below will allow DHS to compare key measures across program components, to help shape policy and to provide State staff and other interested parties with the information needed to better understand the interplay of various parts of the program. We are providing four specific recommendations to address this issue.

1. *Develop and strengthen metrics and measurements to enable DHS to monitor program activities and changes on an ongoing basis*

Discussion: Strong and uniform reporting measures and protocols are critical to ongoing program monitoring as well as analyzing the impacts of key programmatic changes. We found that DHS does not have uniform, comprehensive metrics and reporting protocols to track program activity on an ongoing basis. This is particularly important given the changes to be implemented as a result of the 2009 legislative mandates.

To achieve this, we recommend that DHS develop metrics to manage the program on an ongoing basis, assess the effectiveness of programmatic changes, as well as observe trends in the PCA program. To assure that the measures are comprehensive, we recommend that DHS work in collaboration with other State agencies responsible for administering programs affecting various populations and delivery systems (e.g., managed care, behavioral health, children’s services, etc.). Recommended measures for consideration include:

- Trends in the number of individuals by age group receiving PCA services as compared to the Medical Assistance population as a whole;
- Trends in the number and type of agencies providing PCA services;
- Trends in PCA service utilization, including the types of PCA activities provided, to gain better understanding of the types of services being used by recipients in various programs as well as to analyze unmet needs;
- Comparisons of service authorization, utilization, timeliness of assessments and authorization, expenditures, etc., between managed care and fee-for-service;
- Trends in the number of individuals who received an assessment but were determined not eligible for PCA services, and the reasons for ineligibility;
- Trends in the number of individuals who lose PCA services as a result of the 2009 assessment changes, and transition to other programs to meet their needs, including any breaks in service continuity;
- Differences in service authorizations and utilization between recipients who have family members serving as PCA workers in comparison to other PCA recipients;
- Trends in the use of various program options, such as shared care use, Traditional PCA, and PCA Choice; and
- Understanding of various living arrangements, populations served in those living arrangements, and comparisons between service utilization among those living in different settings

Implementation Strategies: Given 2009 Legislative mandates and other program priorities facing DHS, it is likely that staff will not be able to implement all the metrics that they would like, as quickly as they would like. DHS will, therefore, need to prioritize the measures, and then determine what additional resources will be needed to complete the effort (e.g., the extent to which data is already available to populate the measure, identification of IT resources needed to produce the information). Where data and processes are lacking, DHS should determine the data to be collected, as well as establish definitions, protocols, and timeframes for collecting the data.

Resource Requirements: DHS currently has robust systems resources. However, the effort to identify, define, and implement changes to track the newly-established metrics could be significant, although it is difficult to assess exactly how much work effort would be required. It will be important to prioritize and phase-in changes carefully, so as not to disrupt current operations. To achieve this, it is important to include IT staff in discussions to identify what resources would be required and how the desired changes may impact ongoing day-to-day operations.

2. Improve coordination between managed care and FFS PCA programs

Discussion: We found a lack of consistent and ongoing coordination among DHS divisions responsible for delivery of PCA services in the managed care and fee-for-service programs. Without this level of coordination, there is insufficient knowledge and understanding about how the services are delivered in the two programs as well as the inability to identify best

practices in one part of the program that could be applied more universally. Some PCA program partners (e.g., PCA provider agencies and other stakeholders) also expressed concerns that the programs were operated differently: while the nature of these differences, if any, is unclear, it is unlikely that DHS will be able to identify and appropriately address these differences with the limited amount of coordination that currently exists among the various divisions responsible for the PCA program.

The need for ongoing collaboration is even more critical given continued expansion of managed care services for the elderly throughout the State. Moreover, although we did not specifically evaluate the coordination between the fee-for-service PCA program and PCA services provided under waiver programs because our charge was to review the State Plan PCA program, it is quite likely that similar communication gaps exist in these relationships.

To foster improved communication and dissemination of program information between managed care and fee-for-service programs, we recommend that the DHS divisions responsible for the administration of the PCA program in the fee-for-service and managed care environments meet regularly to review pertinent program information and data. Part of the responsibilities of this group should include:

- Identifying critical issues to be brought before the technical advisory workgroup (see recommendation below);
- Assuring that impacts in the PCA managed care system, as well as the fee-for-service system, are considered in program development, monitoring and evaluation;
- Identifying best practices in either the fee-for-service and managed care delivery systems that could have more universal application;
- Identifying and assessing differences between the two systems to determine whether they should be permitted (and clearly communicated), or whether they pose unnecessary barriers and should be discontinued; and
- Overall, assuring that policies and practices affecting the PCA program in either or both delivery systems are communicated clearly and consistently.

Implementation Strategies: One of the issues we encountered in our study is the ad hoc nature of the collaboration between the Disability Services Division, the Managed Care and Payment Policy Division and other divisions responsible for administration of the PCA program. As a result, we strongly recommend that the divisions establish regularly-scheduled meetings/discussions among the involved parties. Key individuals from all involved divisions should be identified to participate in these meetings. These key partners should include but not be limited to, individuals with policy expertise in each of the areas, as well as key individuals in legal, provider enrollment and information technology areas.

Resource Requirements: Because this is an internal workgroup we do not envision the need for additional resources, although it may require reallocation of resources and shifting of responsibilities on a long-term basis to continually improve collaboration.

3. *Explore implementing an electronic verification and program management system*

Discussion: DHS lacks comprehensive, real-time information to enable it to effectively manage its PCA program. This lack of information inhibits DHS' ability to ensure that scarce State resources are used in the most efficient and effective manner possible. Of comparable significance is the fact that the lack of information in the PCA program, where services are provided in the home with limited supervision and oversight opportunities, makes it more difficult for the State to ensure that consumers are receiving appropriate, timely and quality care.

One apparently successful mechanism that several states are already using, and which several others are considering using, is an electronic verification and program management system. For example, South Carolina has operated its "Care Call" system since 2003 in its Independence Plus program³⁰ and Oklahoma is currently in the process of expanding its pilot Interactive Voice Response/Authentication program statewide.³¹ While both these programs operate in a fee-for-service environment, the State of Tennessee's Medicaid program, TennCare, which operates in a managed care environment, has included a recommendation in its 2009 budget to establish an electronic visit verification system for its HCBS waiver program.³²

These web-based programs operate by establishing a voice-interactive system which requires the service provider, in this case the PCA, to call-in to the system upon arriving at the consumer's home (or other location where service is authorized to be provided). At that time, the PCA enters certain worker and consumer identifying information, the system confirms the location of the service delivery and notes that service provision is beginning. At the end of the assignment, the PCA again calls into the system and logs out.

Based on the analyses conducted of the South Carolina and Oklahoma programs, the states experienced several program and financial benefits which could also accrue to Minnesota if it were to adopt a similar approach. Several examples of such benefits are highlighted below:

- **Program and care management:** These systems will enable provider agencies and the State, on a close to real-time basis, to evaluate whether authorized services are being delivered, who is delivering the services, whether there are trends in the nature of services being provided, as well as to address many other program and care management questions. These types of management reports should improve the ability of the State and its provider agencies to improve care delivery, on both an overall and consumer-specific basis. In addition, if the State were to require both fee-for-service and managed care plans to use comparable systems, the State would then have a ready source of consistent information for its PCA program, regardless of its delivery mode.

³⁰ See "State Policy in Practice, South Carolina's Care Call;" Rutgers Center for State Health Policy; Susan Reinhard and Ann Bemis, June 2005; available at <http://www.cshp.rutgers.edu/Downloads/6800.pdf>; accessed June 30, 2009

³¹ See "Interactive Voice Response/Authentication: A Pilot Study," June 2008, Oklahoma Department of Human Services, Office of Planning, Research and Statistics;" available at <http://www.crossroads.odl.state.ok.us/cgi-bin/showfile.exe?CISOROOT=/stgovpub&CISOPTN=6466&filename=6681.pdf#search=%22Information%22>; accessed June 30, 2009

³² See TennCare 2009 budget recommendations, available at <http://www.tennessee.gov/tenncare/forms/tenncarebudget09.pdf>; accessed June 30, 2009

- **Service verification:** Use of an automated system simplifies the service verification process and enhances its accuracy. For example, the automated check-in and check-out system could substitute for the requirement that clients sign timesheets. Moreover, using an automated system makes it less likely that a client will be pressured to sign an inaccurate timesheet and makes it more likely that time reported as being spent on providing care will be more accurate since it will be based on a logging-in and logging-out process rather than memory.
- **Improved billing:** The data needed for billing is generated directly from the logging-in and logging-out process, thus streamlining the billing process, which should significantly reduce the administrative workload of the PCA agencies. Improving the speed of claims submission will also improve the cash flow for these agencies (similarly, of course, it will result in an increase in cash outflow from the State).
- **Worker registries and back-up systems:** One of our other recommendations (see below) is for DHS to establish a worker registry so that consumers are able to identify potential PCA workers for both routine service delivery and back-up purposes. Since electronic verification systems require that the system be aware of all authorized PCA workers, it might be possible to use the worker identification portion of such a system as part of a worker registry. These systems can also be structured so that an emergency alert is generated when a worker does not report to the service delivery location of a high-risk consumer.

Implementation Strategies: We recommend that DHS take several steps to explore the desirability of implementing an electronic verification and program management system. The first step would be to familiarize staff with the experiences of states with current programs. Based on the information gathered from that process, we recommend that DHS develop a Request for Information (RFI) to gather up-to-date information from vendors concerning the capabilities of their products, implementation timeframes, integration with existing systems, etc. DHS should also engage their stakeholders in this process to identify other issues that might not be apparent to the State and to promote an understanding of the benefits that such a system could provide. If the approach continues to appear valuable, the State could issue a Request for Proposals (RFP) to solicit bids from vendors. We would further recommend that DHS consider implementing any such system on a pilot basis first, to ensure that State-specific issues are worked through prior to full implementation.

Resource Requirements: Both South Carolina and Oklahoma report that they experienced program savings when they implemented their systems, primarily as the result of more accurate service billing. In the Oklahoma pilot, for example, the State experienced an overall reduction in the cost per member per month, a function of an eight percent decrease in the number of visits billed offset by an increase in the number of units billed per visit. We would expect, therefore, that Minnesota would also experience savings. These savings could be used to reduce overall State expenditures or to improve the program (e.g., to increase wages and benefits, which, as our other findings demonstrate, are significant issues in worker recruitment and retention). It is also possible that Minnesota could negotiate a contract with a vendor who would be willing to implement an electronic verification and monitoring system on a contingency basis, resulting in minimal up front costs to the State.

DHS would need to devote staffing resources to implementing a system. We would expect that familiarization with the experiences of other states and developing an RFI would require the part-time dedication of staff over several months. Overall DHS staff requirements should be limited due to the fact that they should be able to build on the experiences and documentation from other states.

4. Establish a technical advisory workgroup on the PCA program

Discussion: Similar to many states, DHS has historically used workgroups as a forum for shaping program changes and program policy. DHS does, in fact, already have an Expert Panel which includes numerous stakeholders that addresses many of the policy issues surrounding the PCA program. The 2009 legislative mandates provide several additional opportunities for the workgroup to focus its activities and for DHS to seek input in implementing the requirements, and to monitor their impact on the PCA program on an ongoing basis.

Because there are multiple partners involved in the PCA program (e.g., managed care organizations, various departments within DHS, PCA provider agencies, counties), it is important to involve their perspectives as well as gain their buy-in in the program policy, measures and reporting protocols outlined in the above recommendation. Furthermore, other partners would be able to assist DHS in understanding and identifying pitfalls or challenges regarding program policies and implementation strategies. For example, managed care entities should be involved in providing feedback on measures related to PCA services provided to consumers enrolled in managed care, to assure that these entities have or can put systems in place to collect the desired data that can be comparable across plans and between fee-for-service State Plan services and managed care services.

The role of the workgroup may also include, but not be limited to: providing input on the measures for assessing the impact of the legislative and other changes in the PCA program and for DHS to provide feedback on results on an ongoing basis; reviewing data/management reports to develop a common understanding of program operations and the impact of program changes, and to help shape ongoing policy development to continue to strengthen the PCA program.

Implementation Strategies: DHS should consider establishing this technical advisory workgroup as an outgrowth of the existing Expert Panel. Since the Expert Panel is already constituted, this approach will allow DHS to establish the workgroup on a timely basis. Moreover, workgroup participants are already familiar with the PCA program, which should enable them to provide advice and perspectives quickly; an important aspect given the statutorily-established aggressive implementation timeframes. To focus the discussion and expertise, subgroups of fewer individuals can work on specific programmatic issues such as training, data, program integrity, and other issues that emerge.

Resource Requirements: This recommendation would require a commitment of time from existing resources. However, our experience throughout this study is that Minnesota has a variety of strong advocacy groups with broad representation, who all share a common goal of making the PCA program sustainable on a long-term basis to meet the needs of the vulnerable populations served, and that this time will be well-spent.

Ensuring an adequate workforce

A stable and qualified provider workforce is also essential to the effective operation of the PCA program. Improving the desirability of the PCA profession, through training and certification, as well as improving compensation levels, can help Minnesota develop a PCA workforce that individuals select as a chosen career. We are providing two specific recommendations to address this issue.

5. Implement strategies to improve compensation for PCAs

Discussion: We learned that low wages and limited access to affordable health insurance and other benefits are viewed by service recipients, PCA workers and their employers as significant barriers to finding and keeping PCA workers in Minnesota. People who worked in and received all types of PCA services in Minnesota (e.g., PCA Choice, Traditional PCA services, managed care) identified wages and benefits as key problems. Service recipients and PCA workers also identified low wages and lack of access to health care benefits as critical problems that contribute to health and safety issues.

Having a stable and qualified workforce is critical to the success of any long-term care service. One of the strongest predictors of direct support worker turnover is wages.³³ While Minnesota's PCA workers appear to have average wage levels above the national average, the program still has a high PCA turnover rate (with over 40 percent of organizations reporting a turnover rate of greater than 50 percent). This turnover rate affects the overall quality and effectiveness of the PCA program.

Implementation strategies: In an effort to improve retention and the quality of PCA services, DHS should consider strategies to improve compensation (wages and benefits) for all PCA workers. We recognize the difficulties of increasing compensation in these difficult financial times and, thus, our implementation strategies do not generally call for across-the-board increases. Rather, we have tried to target the options to promote the kinds of changes that we believe will improve the quality of the program by rewarding PCA longevity and skills development. Some suggestions for DHS include:

- **Identify options for building wage increases and incentives into the PCA program** which could be based on completion of required introductory training, completion of training based on the service needs of specific groups of PCA recipients, and/or completion of a certification or credentialing program. As a starting point, DHS could review the National Alliance for Direct Support Professionals' (NADSP) credentialing framework that distinguishes among direct support professionals who are (1) registered, (2) certified, and (3) specialists.³⁴
- **Reimburse PCAs for a defined set of activities** that are related to, but are not, direct support service delivery (e.g., time spent in training, travel time in certain

³³ Hewitt, A., & Larson, S.A., Edelstein, S., Seavey, D., Hoge, M.A., & Morris, J. (2008). *A synthesis of direct service workforce demographics and challenges across intellectual/developmental disabilities, aging, physical disabilities, and behavioral health*. Washington, DC: The Lewin Group.

³⁴ More information on the NADSP credentialing framework, including a credentialing guidebook, is available at: <http://www.nadsp.org/credentialing/index.asp>

circumstances, mileage for transporting PCA service recipients to/from community activities and appointments).

- **Identify methods to increase access to, and reduce the costs of, health insurance benefits for PCAs** by allowing PCAs access to the State employee health plan, providing an exemption to MinnesotaCare eligibility requirements to allow PCAs to enroll even if they do not otherwise meet these requirements, or developing other pooled plan options that will drive down costs. More information can be found in the 2009 DHS report entitled: Costs and Options for Insuring Minnesota's Long-Term Care Workforce.

Resource Requirements: Overall, as noted earlier, our recommendations and implementation strategies make an effort to balance the needs of the PCA program to develop and maintain a stable, well-trained and well-supervised workforce with the State's current financial limitations by recommending targeted increases to support the kinds of changes that we believe will enhance the ongoing operation of the program.

We understand that Minnesota and other states are facing extremely difficult financial times. Thus we recognize how difficult an across the board wage increase for all PCAs would be, given the fiscal note attached to such a request. However, we also recognize that wages and benefits cannot be ignored as critical solutions to the challenges MN faces with respect to the recruitment and retention of PCAs. Our recommendation is that MN explore ways in which incentives can be provided to those PCAs that complete required training and/or a credentialing or certification process. Providing increased wages based on these additional training/certification requirements can greatly reduced the fiscal note associated with the change in policy because not all PCAs will be eligible, not all will be interested in completing the extra requirements, and turnover of PCAs limits the pool of eligible applicants.

Even though we are not recommending such an across-the-board increase, for illustrative purposes we have estimated that an average \$1 increase in PCA worker wages, after taking into account related increases in FICA and other wage-based expenses, would increase PCA program costs by approximately eight percent. Based on 2007 fee-for-service program costs only, this would result in a \$27 million increase in the costs of the PCA program, before taking into account the likely parallel increases that would occur in the managed care and waiver programs. In addition to the program-related costs of these recommendations, there would also be increasing demands on staff time to structure and monitor the delivery of these program enhancements.

6. Explore establishing an online worker registry to improve access to a qualified pool of PCA workers

Discussion: We identified a need for a structured system through which PCA clients can identify workers that participate in the PCA program, to hire them on a permanent or temporary basis. For clients who are new to the program, including those who are able to pay privately, a worker registry would allow them to identify workers that may be available in their area of the State and who have met State enrollment requirements such as generalized training and background checks. Additionally, a worker registry would allow PCA clients to access back-up workers when their usual PCA has planned or unplanned absences. An effective

worker registry would be available to PCA clients on-line or through a toll-free telephone number. The registry would include information on the location of the PCA worker, the worker's availability, and any specific training the worker has completed (e.g. specialized training for individuals with behavioral health needs).

Several states have developed registries of PCA workers that clients can access to search for workers to cover their planned and unplanned gaps in care. According to a 2006 AARP Public Policy Institute report, at least 12 states operate or are developing PCA provider registries.³⁵ One example highlighted is Washington State's Home Care Quality Authority (HCQA) Referral Registry, a web-based system which contains short entries for PCA providers from 21 counties who have completed background checks, interviews, and introductory training.

In addition, five states (Connecticut, Massachusetts, New Jersey, Rhode Island, and Vermont) have developed a collaborative, web-based provider registry of over 20,000 PCA providers called Rewarding Work.³⁶ Consumers and agencies can search the database of potential employees for a fee (ranging from \$10 for one month of access to \$90 for one year of access). Individual PCAs are responsible for listing information on the site and the site's administrators do not verify the accuracy of providers' self-reported qualifications. There are notably no background check requirements for providers who post listings on the Rewarding Work website.

A few states (including California, Pennsylvania, New Hampshire, and New Jersey) have developed or attempted to develop pools of back-up workers that PCA clients access directly when needed.³⁷ Public authorities in two different California counties implemented two of the most successful systems. First, Alameda County contracted with an agency to provide a 24-hour hotline and a pool of on-call workers for urgent, short-notice, and planned PCA absences. The county pays the agency an increased fee-for-service rate each time a worker tends to an urgent client need within two hours. Clients are not expected to pay for use of the back-up pool, but the hours of service delivered by back-up workers are deducted from the client's monthly authorized hours. As another example, San Francisco County employs a back-up pool of PCA workers and clients call the county public authority directly to request a PCA for both urgent and planned absences. County staff members do not answer calls 24 hours per day, but they do check messages frequently during non-business hours.³⁸

Implementation Strategies: Minnesota already has a human services information site available to its citizens (www.MinnesotaHelp.info) which individuals can access to locate, among many other resources, agencies that provide PCA services. Expanding this site to include a searchable worker registry should reduce implementation costs given that a major part of the infrastructure and staffing are already established. In the event that DHS implements an

³⁵ Seavey, Dorie and Vera Salter, *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*. Rep. no. 2006-19. AARP Public Policy Institute, October 2006.

³⁶ Rewarding Work website, accessed June 25, 2009 <<http://www.rewardingwork.org/>>.

³⁷ Seavey, Dorie and Vera Salter, *Bridging the Gaps: State and Local Strategies for Ensuring Backup Personal Care Services*. Rep. no. 2006-19. AARP Public Policy Institute, October 2006.

³⁸ Malone, Joelyn with Medstat, *California - Local Programs Providing Back-Up Assistance Promising Practices in Home and Community-Based Services*, March 31, 20003.

electronic verification and program management system, a worker registry could also be part of that system.

In considering establishment of such an on-line registry, DHS should consider the following types of issues:

- As part of its PCA worker enrollment process, DHS could allow PCAs to “opt in” to inclusion in the registry, recognizing that some PCA workers may not be interested in working for other clients. We recommend that DHS not allow any non-enrolled providers to be included.
- Those enrolled workers who opt in should receive a login name and be able to control the information listed on their “profile.” For instance, PCAs should be permitted to list contact information and general information about their location. In addition, PCAs should have responsibility for indicating their availability (e.g., willingness to work weekends and nights, ability to travel to a client’s home within one-to-two hours notice) and areas of particular expertise (e.g., behavioral health care).
- The system should have built-in edits to confirm that each PCA worker who lists a specialty has actually completed the required training for that specialty. For instance, DHS can program the website to contain a list of all workers who have completed the state’s behavioral health training. Only these individuals should have the option of listing expertise in behavioral health care.
- The site should clearly display a disclaimer that all individuals in the registry are enrolled with the State, but the specifics of their expertise and availability are self-identified.

Resource Requirements: DHS will encounter some costs in setting up a provider registry as described above. For example, DHS will have to pay for the cost of augmenting the current MinnesotaHelp.info website . In addition, it will be necessary to build a connection between the state’s provider enrollment system and the registry, which will involve a fee. To offset some of the cost, DHS should consider implementing small fees for each individual who accesses the database. DHS could opt for monthly or annual fees, but we recommend that they be minimal to encourage use of the registry.

Other recommendations

7. *Convene a housing task force to address the need for accessible and affordable housing for individuals with disabilities*

Discussion: States throughout the nation are challenged by the difficulties of ensuring that there is sufficient affordable and accessible housing to meet the needs of individuals with disabilities who desire to remain at home in the community. Minnesota is no exception. The challenge is even more demanding when one is working to find accessible and affordable housing for individuals who are receiving Medical Assistance and, therefore, have significantly more limited means available to them to pay for housing than the average citizen.

In Minnesota, the importance of this issue is substantiated by the existence of what is termed “provider operated housing.” As we identified during our research, this type of housing

situation – where an organization provides both housing and related services – has inherent conflicts of interest built into it. As an example, we heard from stakeholders that residents can be threatened with eviction when home or personal care services are reduced – presumably because the funds flowing from the billing of these health care services are being used to support the housing costs and, with the reduction of services, are no longer available to do so.

The Minnesota Legislature’s 2009 enactment of statute to prohibit any agency that provides personal care services to also control or operate the housing in which a PCA consumer resides³⁹ provides a degree of protection for vulnerable individuals since it should minimize the number of occurrences of provider operated housing. However, given that there is no formally established registration, certification or licensure of these types of housing entities in Minnesota (other than registration as a “Housing with Services” provider⁴⁰), it may be difficult to identify such situations. Moreover, the prohibition against provider operated housing does not ameliorate the conditions which promoted the establishment of such approaches but, rather, exacerbates the problem.

Implementation Strategies: DHS should establish an interagency task force to address issues related to availability of accessible and affordable housing. This task force should include representatives from the various divisions in the Department, including the Disabilities Services Division, the Aging and Adult Services Division and the Chemical and Mental Health Services Division. In addition, representatives from the Department of Developmental Disabilities, the Minnesota Housing Finance Agency, and other state agencies involved with supporting bonding and other financing for affordable housing should be asked to participate. Finally, consumer advocate representatives (such as those from Independent Living Centers, the American Association for Retired Persons and the Minnesota Disability Law Center), as well as operators of current housing services, should also be included on the task force.

The task force should focus its work in several areas, including:

- Identifying the current availability of accessible and affordable housing in various parts of the State. Housing that may have been developed for the mentally ill or the developmentally disabled should be catalogued, as well as housing that may be managed with lesser degrees of supervision. Over time, this information should be catalogued on a regional or county-specific basis.
- Assessing the kind of regulation and supervision under which these housing services currently operate and developing the parameters under which various types of housing services should operate in the future. For example, while “Housing with Services” providers register, there does not appear to be any initial review of the competency of the housing providers, nor is there any ongoing review of the adequacy of the housing or the services that are provided in these settings. A housing unit which is accessible and affordable, but which is not tied to health care service delivery, however, may not warrant any additional regulation or supervision other than routine building code inspection.

³⁹ 2009 Minnesota Statutes, 256B.0659, Subdivision 3, “Noncovered personal care assistance services.”

⁴⁰ 2008 Minnesota Statute, 144D, “Housing with services establishment.”

- Projecting the current and future need for accessible and affordable housing so that the State can plan for future needs. Consistent with this needs analysis would be the development, as appropriate, or recommendations concerning financing and other programs to support the development of additional housing opportunities. For example, any existing requirements for State-supported housing construction could be expanded to promote accessible and affordable housing goals.
- Identifying information resources, such as the kinds of standards that should be incorporated in newly-constructed or renovated housing, to assist individuals and organizations who are interested in developing accessible and affordable housing.

Given that these kinds of housing issues exist nationwide, we recommend that the task force include a review of activities and approaches in other states to increase the breadth of experience that will be brought to the discussion.

Resource Requirements: The resources required for the establishment of a task force are primarily staff-related. In addition to the time of the representatives from the various state agencies who would be appointed to the task force, agency staffs would need to prepare for meetings, gather and disseminate information to the task force members, assist task force members in the development of recommendations and prepare various reports. We would expect that the task force would meet for approximately one year, with meetings being held more frequently during the earlier months. While, overall, we estimate that the total staff time, spread out over several agencies, would be the equivalent of approximately two full-time equivalent employees, the actual workload could be absorbed into the ongoing activities of current staff.

8. Develop and provide training to clients in the PCA Choice program to assist them with hiring, firing, and supervising PCAs

Discussion: PCA Choice clients have the ability to direct their own care, which means they are the employer of the PCA worker. PCA clients who choose this option may or may not be prepared to conduct the tasks of hiring, supervising, or terminating an employee. PCA Choice participants in our focus group specifically expressed a need for greater support in these areas.

DHS does currently distribute a PCA Program Consumer Guidebook to PCA Choice participants. The Guidebook, also available online,⁴¹ includes information on:

- Hiring the PCA, including sample interview questions;
- Training and communicating with the PCA;
- Scheduling PCA staff and tasks, including sample staffing and task work plans;
- Evaluating the PCA performance and offering suggestions for correcting poor performance;
- Terminating or firing the PCA; and

⁴¹ Personal Care Assistance (PCA) Program Consumer Guidebook.
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_027532

- Required record keeping, including timesheets and file retention requirements.

Implementation Strategies: In addition to the information available in the Guidebook, DHS should consider making interactive training modules available to PCA Choice clients. The training could cover the same topics as are included in the Guidebook, but could present situations that allow PCA clients to test themselves on their understanding of the material and/or roll-play certain scenarios. DHS staff or contractors could lead or develop the training, and should consider including a PCA consumer as a panelist, who could offer specific examples of challenges in and strategies for employing PCAs.

Resource Requirements: DHS should not need to incur large costs to implement this additional training. CMS has designed and published several training packages designed to support individuals and families who self-direct their own care.⁴² In addition, the University of Minnesota in collaboration with the University of Illinois, published a curriculum called, "Find, Choose and Keep Good Direct Support Professionals," which provides information, resources and content that people who self-direct can use in developing and using effective strategies to find and support their PCAs. Individuals and families from Minnesota who self-direct were involved in the design and development of this training program. With relatively little effort to tailor these materials to the PCA program, DHS could make these resources available to PCA clients.

9. Improve resources available to PCA agencies to manage PCA program

Discussion: PCA provider agencies report that they are not always sure where to go with questions and that they do not always receive accurate responses to their questions. Moreover, because many PCA agencies are small, and thus have limited administrative staff to handle their questions, and a large proportion are new to the program, and, therefore, are likely to have more questions than more-established agencies, it is critical that DHS be as clear as possible when communicating about the PCA program.

Implementation Strategies: Some suggestions for DHS include:

- **Establish dedicated PCA program call center staff.** The Medical Assistance Provider Call Center/helpdesk supports all providers that participate in the Medicaid program. Call center staff are trained to be generalists and able to answer questions on a variety of topics. We recommend that DHS develop a subset of call center staff who are dedicated to the PCA program and to whom specific PCA-related calls can be routed when a generalist is unable to assist a caller.
- **Monitor questions to identify areas that require clarification.** DHS should develop a process to periodically (e.g., quarterly or semi-annually) review questions that are posed to the provider call center. This process can identify areas in which providers need additional guidance from DHS.
- **Distribute a provider newsletter.** DHS should prepare and distribute periodic PCA provider newsletters or identify additional avenues to communicate changes (e.g.

⁴² These resources are available on the Direct Care Worker Resource Center website <http://dswresourcecenter.org> by searching for "consumer direction."

listserve), which could contain program updates, reminders on program requirements (e.g., required training), and other items of interest to PCA providers. Distributing the newsletter electronically will keep production costs low.

- **Create a PCA portal on the MN-ITS site.** DHS is already in the process of developing a section of MN-ITS that will be dedicated to the PCA program. This portal can provide a clearinghouse for PCA program-related materials, including program requirements, guidance for providers, training materials, provider newsletters, and other official DHS communications. We recommend that DHS consider creating an interactive element to the PCA provider portal, where provider agencies can pose questions to DHS.
- **Educate public health nurses (PHN) about programs changes.** County public health nurses indicated that they often get questions about the PCA program, including the billing process, and do not know how to assist agencies. Since county public health nurses will likely continue to receive questions about the PCA program, DHS should educate them, through training or DHS bulletins, about how to assist provider agencies when they have questions.

Resource Requirements: Our recommendations would require some initial redistribution of internal DHS efforts. Overtime, however, we expect that the clarity that these changes would bring to the program will decrease staff time devoted to agency education.

Implementation Strategies for 2009 Legislative and Related Changes

In the 2009 session, the Minnesota Legislature enacted legislation changing several key policies affecting the PCA program. Several of these changes are consistent with the recommendations we developed over the course of our study. In this section, we offer some suggestions for DHS to consider as the Department implements these changes over the coming months.

Table 3. Implementation Strategies

Implementation Strategies for Recommendations based on 2009 Legislative and Related Changes

1. Monitor the program impact of 2009 legislative changes, especially in the areas of PCA eligibility criteria requiring individuals to have more severe ADL needs and quality oversight
 2. Improve the consistency of service authorizations
 3. Require PCA Provider Agencies and PCA workers to complete standardized training on the PCA program
 4. Establish transition and/or closure plan processes to enable DHS to be prepared for PCA agency recertification failures and discovery of provider operated housing
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1. Monitor the program impact of 2009 legislative changes and Governor Pawlenty's allotment process, especially in the areas of PCA eligibility criteria requiring individuals to have more severe ADL needs and quality oversight

Brief description of the legislative changes: The 2009 legislation tightens the criteria for PCA program eligibility in an effort to refocus resources on those who need them the most. The changes are expected to result in loss of eligibility or a reduction in the number of approved

hours for some PCA clients. In addition, beginning January 1, 2010, a Qualified Professional, who has completed standardized DHS-designed training, must supervise all personal care assistants. This change is designed to improve the consistency of PCA oversight across PCA provider agencies. The legislation also limits an individual PCA worker from working more than 310 hours per month, regardless of the number of agencies and clients the PCA assists.⁴³ Through the Governor's allotment process, the maximum number of hours per month that a PCA can work was reduced to 275.

Implementation strategies: As DHS implements these changes, we recommend that DHS monitor the impact of the changes on the program to inform future policy decisions. To do so, DHS should consider the following activities:

- **Conduct a consumer satisfaction survey.** After the eligibility changes have been in place for 12-18 months, DHS should survey PCA clients about their experiences with the program and whether their needs are being met (given the reductions in approved hours). DHS should consider using the same survey tool as was used in 2003 (and perhaps augmenting the survey by including new questions), which would allow a comparison over time.⁴⁴
- **Conduct a PCA worker survey.** After the changes have been in effect for the same 12-18 months, DHS should survey workers on their experiences. For example, DHS could investigate whether the Qualified Professional requirement has helped workers improve their services, whether the monthly hour limitation has affected them, and whether workers have looked outside the PCA program for other sources of income.
- **Review complaints.** DHS should monitor PCA program complaints to identify patterns that emerge that may result from the program changes. For example, DHS should work with the Adult and Child Protective Services groups to monitor complaints that emerge through those programs that are related to PCA services.
- **Analyze program data.** DHS should review PCA program data on an ongoing basis to identify changes in service utilization patterns, such as increases in emergency room use or in mental health services. DHS should also examine whether there is a change in the number of workers per client, based on the new limitations on hours.

DHS should also make an effort to identify those individuals who have lost services, what other services, if any, they accessed and whether they appear to be in need of services which they have been unable to access. Monitoring the impact on individuals with behavioral health needs will be particularly important, as the legislation reduces eligibility based on this criterion. Legislation accompanying these changes directs DHS to develop alternative services, particularly for clients with behavioral needs. One alternative that DHS could consider would be expanding one of its existing waivers to serve this population.

At the same time, DHS should be cognizant that the legislative changes move the PCA program toward one that is more focused on individuals with intense needs for assistance with activities

⁴³ 2009 Minnesota Statutes, 256B.0659, Subdivision 11, "Personal care assistant; requirements."

⁴⁴ Minnesota's 2003 PCA Consumer Survey.

http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs_id_029338.pdf

of daily living. Because the program eligibility requirements are more strict, the remaining pool of participants will have higher needs, on average, than prior to the changes. DHS should expect to see and should quantify/analyze service authorization and service use changes for those remaining in the program on an ongoing basis.

2. Improve the consistency and timeliness of the service authorizations and reauthorizations

Brief description of the legislative change: The 2009 legislation made changes to the home care rating system that simplify the authorization process by assigning a pre-set, base number of hours to each home care rating. This change should make PCA assessments less time-consuming, more straightforward and transparent, and should reduce the variability (or perceived variability) in the service authorization process.

DHS is also in the process of developing and implementing an automated assessment process that would apply to all Minnesota long-term care programs, including the PCA program. Use of this universal assessment tool, known as the Comprehensive Assessment (COMPASS) tool, for the PCA program will enhance program equity by removing the subjective analysis of individual assessors and promote equitable distribution of resources across program participants. At the same time, the tool should reduce administrative burdens on the State and its county-based assessors and should enable the State to more efficiently capture standardized program data. Additionally, DHS will be able to compare the care needs of PCA program participants with other individuals who receive publicly funded long-term care services. Although the tool is still in the planning stages, DHS plans to automate the COMPASS tool and link it directly to Minnesota's Medicaid Management Information System (MMIS). Also, in the 2009 Legislative session, funds were appropriated for development of the information system changes needed to implement this tool. It is expected that full implementation of all required systems changes and enhancements will be completed in approximately the next two years.

Implementation strategies: In addition to implementing the 2009 legislative changes and continuing work to implement COMPASS, we recommend that DHS take the following additional actions:

- **Enhance assessor training.** Require (and/or fund) assessment training to assure consistent application of standards for assessment and authorization. DHS could make the training program available on-line so that assessors could complete the training at any time. An on-line module would allow new staff to access the training easily and would make the training available for existing staff who would like to refresh their memory on certain sections of the tool. Another approach could be to develop a "train the trainer" model with "certified PHN trainers" located in each county.
- **Monitor authorizations across FFS and managed care.** Currently, DHS staff approve authorizations for the fee-for-service program; managed care organizations approve the authorizations for their members. DHS should periodically monitor a sample of authorizations to identify whether there are inappropriate variations in the amount or nature of service units being authorized between the two programs.
- **Consider strategies to expedite reauthorizations.** Given that DHS rarely denies reauthorizations, DHS may consider implementing a "spot check" process for

reauthorizations (e.g., conducting a detailed review only for reauthorizations that increase services by 10 percent or more). This approach would free up staff time so that DHS authorizers could focus on initial service authorizations.

On a related note, DHS should consider incorporating living arrangement questions and criteria into the assessment process so that duplication of services can be identified and avoided. Adding this information should also facilitate the analysis of the nature of and extent of services needed and provided to individuals in different living arrangement settings.

3. Require PCA provider agencies and PCA workers to complete standardized training on the PCA program

Brief description of the legislative change: The Minnesota Legislature in 2009 made significant changes to training requirements in the PCA program for PCA Agencies, PCA workers, and Qualified Professionals.

- **PCA provider agency requirements:** Effective July 1, 2009, all agencies seeking enrollment in the PCA program are required to provide documentation that their PCA workers, Qualified Professionals, and managers have completed DHS-mandated training. PCA agencies who are already enrolled in the program must assure that existing personnel comply with training requirements within 18 months of the effective date of the legislation (i.e., by December 2010); however, new hires must meet the training requirements prior to being hired.⁴⁵ Additionally, the legislation requires the DHS to review training (and other required enrollment documentation) annually.⁴⁶
- **PCA worker requirements:** The Legislature mandated that, beginning January 2010, PCA workers complete standardized training before enrolling in the program. The legislation requires training in basic first aid; vulnerable adult, child maltreatment; OSHA universal precautions; basic roles and responsibilities; emergency preparedness; orientation to positive behavior practices; fraud and timesheet completion. In addition, PCA workers must also complete training and orientation specific to the needs of the recipient served within seven days after services begin.⁴⁷
- **Qualified Professional requirements:** The Legislature mandates that Qualified Professionals complete training approved by DHS on basic PCA program information within six months of being hired by the PCA agency. Qualified professionals who have completed the required training with a previous PCA agency employer within three years do not need to re-complete the training.⁴⁸

Implementation Strategies: Recognizing the detailed legislative requirements, our recommendations focus on activities to be considered in conjunction with implementing these mandatory training requirements:

⁴⁵ 2009 Minnesota Statutes, 256B.0659, Subdivision 21, "Requirements for initial enrollment of personal care assistance provider agencies."

⁴⁶ 2009 Minnesota Statutes, 256B.0659, Subdivision 22, "Annual review for personal care providers."

⁴⁷ 2009 Minnesota Statutes, 256B.0659, Subdivision 11, "Personal care assistant; requirements."

⁴⁸ 2009 Minnesota Statutes, 256B.0659, Subdivision 13, "Qualified Professional; qualifications."

- **Accessibility of training:** We recommend providing several options through which training can be accessed. This is particularly important given the rural nature of many parts of the State and competing demands, particularly for PCAs who work non-traditional business hours (e.g., nights and week-ends). Training options should include in-person sessions and self-study modules (web-based or other) to provide ample opportunity for compliance. DHS should also offer alternative times and days for in-person/classroom options to accommodate work schedules, particularly during the implementation period.
- **Automate training compliance tracking and/or reporting for both PCA agencies and PCA workers:** Documentation of training should be reflected in the provider and worker enrollment databases, to allow DHS to track compliance by current providers and workers as well as compliance with annual documentation requirements for both new and existing providers. Compliance strategies could include automated issuance of notices to providers with upcoming annual review dates, and holding payment pending submission of documentation for non-compliant providers. This documentation also provides the infrastructure around which an incentive program could be structured if resources are available. It also provides the infrastructure to allow recognition of specialized skill sets, such as PCAs who specifically work with children or individuals with intellectual or development disabilities. For workers who have completed specialized training, these specializations could be noted in the worker registry.
- **Establish a career path for PCA workers:** We recommend DHS explore creating a statewide career development program (basic, advanced, and specialized curriculum) to improve worker retention, working through the Minnesota State Colleges and Universities (MNSCU) and other educational institutions or other private entities. To identify potential external vendors, DHS could consider issuing an RFI to gauge the level of interest and seek information about various curricula that could be offered by educational institutions or private entities.

4. Establish transition and/or closure plan processes to enable DHS to be prepared for PCA agency recertification failures and discovery of provider operated housing

Brief description of the legislative change: The Minnesota Legislature made several changes in 2009 related to PCA agency operations designed to protect consumers of PCA services by ensuring that they receive quality services provided by appropriately licensed providers with no conflicts of interest. Specifically, these changes are:

- PCA agencies are not permitted to own or otherwise control the housing in which a PCA consumer resides⁴⁹; and
- PCA agencies must be recertified annually by the DHS Commissioner. If a PCA agency does not resubmit the required information, or is otherwise found to no longer meet the

⁴⁹ 2009 Minnesota Statutes, 256B.0659, Subdivision 3, "Noncovered personal care assistance services."

requirements of a PCA provider agency, the agency is to be suspended or terminated from the program.⁵⁰

These changes, however, may have the unintended effect of prohibiting the provision of PCA services to consumers in need, and doing so in an environment which is not conducive to planning for the provision of continuing services.

Implementation Strategies: We recommend that DHS establish a transition or closure plan to assist them in (1) identifying and providing ongoing PCA services in instances where a PCA agency is required to close or in (2) identifying and providing ongoing PCA and housing services in instances when a PCA agency is found to be a housing provider and is subsequently prohibited from continuing to provide one or the other of these services. Minnesota already has a model upon which to base such a plan in its nursing facility closure plan. This plan should include the following components:

- Requirements that PCA providers make client names, contact information and responsible party information available to the State. Consideration should be given to whether or how the State could be assured that it will have the required information even in the event that an agency is not cooperative during the closure period.
- Processes to identify and provide, or contract for, temporary PCA services for consumers, including having mechanisms to know what kind of services a consumer needs.
- Plans to move personal belongings, medical equipment, medication, records, etc. in the event that the consumer is required to move.
- Processes, including transportation, to assist clients in their search for a new residence
- Processes, and perhaps funding, to maintain what was formerly provider operated housing while a search for new housing is undertaken.

⁵⁰ 2009 Minnesota Statutes, 256B.0659, Subdivision 22, "Annual review for personal care providers."

VIII. Looking Ahead

With the aging of the population and increasing number of people living with disabilities, combined with the progression of care from institutions to community settings, personal care services such as those provided in Minnesota's Personal Care Assistance program are here to stay. Over the past several decades, Minnesota's PCA program has grown significantly, adapting to the changing needs of its eligible population. The program provides the backbone to Minnesota's success in transforming its long-term care system to one focused on community-based services. The PCA program continues to evolve with major 2009 legislative changes to the program's structure and eligibility. With implementation of these legislative changes and other recommendations incorporated in this report, DHS will have the tools to operate a more efficient and effective program, as well as the information needed to monitor and evaluate the program so that it can evolve to meet future needs.