



Recommendations from Evaluation of Current Service Authorization and Resource Allocation in Minnesota's Personal Care Assistance Program

Interim Report #1

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

Submitted by: The Lewin Group

March 31, 2009

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I. OVERVIEW AND PURPOSE

A. Project Overview

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 Medicaid State Plan Personal Care Assistance (PCA) program. This study analyzes the drivers of Medical Assistance expenditures in the State's PCA program and provides recommendations to inform legislation to strengthen the PCA program. While the study focuses primarily on PCA State Plan services, an important consideration includes 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.¹

This report is the first of several interim reports that Lewin will submit to DHS, in addition to a comprehensive final report. This first report includes findings from a national scan of PCA programs, analysis of Minnesota PCA program enrollment and expenditure data, interviews with state officials in Minnesota and other states with PCA programs, stakeholder interviews, and initial recommendations for the State. The remaining interim reports will focus on

- analyses and experiences of PCA workers and consumers and opportunities for improvement,
- information on provider agency perspectives and related recommendations to strengthen and improve provider-related components of the program, as well as
- analyses of the types of living arrangements in which individuals receive PCA services and recommendations surrounding the provision of PCA services in those arrangements.

The final report will synthesize the analyses of the several interim reports and make additional recommendations to strengthen and improve Minnesota's PCA program.

B. Methods

Lewin conducted both qualitative and quantitative research in a variety of areas to support development of this report.

- **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

¹ Commencing its work prior to the Lewin study, the Office of Legislative Affairs (OLA) conducted its own study of the PCA program and released the results of its study in mid-January 2009. In addition, several recommendations to amend the PCA program are included in Governor Pawlenty's 2010-2011 budget submission, and recommendations for PCA provider standards are provided in the Minnesota Department of Health, February 2009 report to the Minnesota Legislature. This Interim Report does not comment or reflect on the findings and/or recommendations included in any of these documents.

policy and legislative actions that had an impact on the PCA program from 1977 to the present (see **Appendix A**).

- **Data from DHS.** 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 2002-2007.² The data included:
 - Demographic data including the individual’s Medical Assistance eligibility classification (e.g., disabled, elderly), their age, and limited information on living arrangement (e.g., information on whether the individual lives with a responsible party to assist with activities of daily living as well as the setting— institution or community – in which the individual receives services);
 - Assessment data, including individuals who were assessed but did not receive PCA services (for 2007 only);
 - Service agreement data, which provides information about the amount of approved PCA services as well as the duration of the authorization (i.e., service agreement span);
 - 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.

- **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 conducted interviews in person, when possible, or by phone. Stakeholder interview questionnaires are in **Appendix B**.

We consulted these diverse stakeholders to help identify issues to focus our research and develop preliminary recommendations for improvement in the PCA program. We summarize our findings from these interviews in Section V of this report.

- **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 the following programs:
 - Aging and Adult Services;
 - Adult Mental Health Services;

² These data were the same as those provided to the OLA for their report.

- Children’s Mental Health Services; and
- Managed Care and Payment Policy

Appendix C includes our State staff interview questionnaire.

- **Interviews with PCA program administrators in other states.** We interviewed directors and program staff of regular PCA 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. Our states interview questionnaire and summaries of each state’s program can be found in **Appendix D** and **Appendix E**, respectively.

II. CURRENT PROGRAM OVERVIEW

A. 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 PCA services were added 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:³

- Assistance with Activities of Daily Living (ADLs), including bathing, grooming, eating, transferring, mobility and positioning;
- Assistance with Instrumental Activities of Daily Living (IADLs) (e.g., meal planning and preparation, managing finances, shopping for food, clothing and other essential items, performing essential household chores);
- Health-related services (which include functions that can be delegated or assigned by a licensed health care professional under Minnesota State law⁴ 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

³ 2008 Minnesota Statutes, 256B.0655, Subdivision 2, "Personal care assistant services."

⁴ Minnesota Nurse Practice Act, 2008 Minnesota Statutes, Sections 148.171-148.285.

variety of service delivery arrangements, including the following (and described in more detail in **Appendix F**):

- **PCA Choice.** 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.
- **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. All individuals who share care have back up plans for situations in which sharing care is not possible. If the consumers use the PCA Choice option, each person must use the same fiscal intermediary.
- **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).

B. Legislative and Policy Changes Affecting the PCA Program

Several policy changes made by DHS have had a notable effect on the PCA program. We do not provide a comprehensive list of all PCA-related policy changes, but rather highlight selected measures -- those adopted in response to changing and growing needs of consumers, budgetary needs and pressures, and those that shaped the overall direction of the program.

Understanding the overall policy direction of the program and implications on program enrollment, expenditures, and integrity provides important context to inform our recommendations for future program improvement. The key legislative and policy changes affecting Minnesota's State Plan PCA program include the following:

- **Expansion of service delivery arrangements to enable the program to meet the needs of its growing and changing population.** As noted in the prior section of this report, Minnesota has modified its PCA program over time to allow for a variety of different service delivery arrangements: PCA Choice (established in 2000), Shared Care Option (implemented in 1999) and Flexible Use (in use since the 1990's), described in more detail in **Appendix F**. All of these changes were adopted to make the PCA program more flexible and better able to meet the varying needs of its consumers.
- **Development of a more robust authorization process.** Over time, Minnesota has developed a more rigorous PCA authorization process. When the program began, county public health nurses conducted assessments and determined the individualized monthly dollar amounts to authorize for each participant. In 1991, DHS instituted a more robust prior authorization system, requiring PCA service authorizations in hourly increments instead of monthly budgets. At the same time, beginning in 1994, DHS further required that public health nurses provide even greater attention to discrete allocations of service time by requiring that assessments identify service needs in 15-

minute increments⁵; these 15-minute determinations are then combined to develop hourly authorizations. Public health nurses utilize the monthly budget caps established in the home care decision tree to inform their allocation of hours for each consumer. (We describe the authorization process in more detail in **Section II.C.** of this interim report.)

- **Addition of behavioral health categories in the Home Care Rating Decision Tree.** The PCA program started serving a greater number of individuals with behavioral health needs in the 1990s. This trend continues as more people with behavioral health needs elect services in the community and as more children needing behavioral health interventions enroll in the program. This greater proportion of participants with behavioral health needs led DHS to include behavioral health categories in the PCA home care rating system in the early 1990s to take into account the complexity of behavioral health needs. The home care rating system uses an individual's assessed needs and then defines the maximum service dollar limit available to the person for PCA services. The current home care rating system takes into account the complexity of behavioral and medical needs, and allows for a greater number of hours necessary for individuals with a range of behavioral and medical needs.
- **Ability to Hire Certain Family Members.** Federal regulations prohibit a family member, defined as a "legally responsible relative,"⁶ from serving as a PCA.⁷ When the PCA program first began in Minnesota, individuals did not have the option of hiring parents of adult recipients, adult children, or adult siblings (all considered in relation to the PCA consumer) as PCAs, despite the fact that these individuals were not legally responsible relatives. However, in 1991, the Minnesota Legislature amended the PCA statute to allow the DHS commissioner to permit these three classes of family members to provide PCA services under a "hardship waiver"⁸.

In 2003, due to shortages in PCA workers, and to improve access and decrease the administrative burdens associated with reviewing hardship waiver requests, the State eliminated the hardship requirement. Currently, all PCA participants have the option of hiring these classes of family members to provide their PCA services. In accordance with the federal regulations, however, legally responsible relatives continue to be prohibited from serving as PCAs.

- **Home and Community-Based Services (HCBS) waiver expansion.** In the last three decades, the addition of home and community-based services waivers to the Medicaid

⁵ While services are budgeted hourly, PCA services are billed in 15-minute increments. As a result, public health nurses develop hourly budgets based on how long it takes for each individual to complete each PCA-supported activity (e.g., determine the number of minutes it takes each individual to perform an ADL such as bathing, grooming, etc and sum up to total hours to be authorized).

⁶ A legally responsible relative includes an individual who, when considered in relationship to the individual receiving PCA services, is the parent of the minor child, the spouse and the non-corporate legal guardian or conservator.

⁷ 42 CFR 440.167.

⁸ The criteria for a "hardship waiver" were:

- The relative changes the terms of his or her employment (e.g., goes from full time to part time with less compensation or resigns employment) in order to provide personal care;
- The relative incurs substantial expenses in providing care; or
- The relative is needed because of an inadequate supply of PCAs to provide support.

program significantly increased Minnesota’s and other states’ ability to provide a wide array of services, including PCA services, to individuals in the community.⁹ Beginning in the early 1980s, DHS developed five waiver programs under Section 1915(c) of the Social Security Act that permit individuals who otherwise would need to be institutionalized to receive care and services in the community. **Exhibit 1** provides descriptions of these waivers.

Exhibit 1: Minnesota Department of Human Services Home and Community-Based Waivers ^{a/}

Waiver	Inception	Covered Populations
Elderly Waiver (EW)	1982	People over the age of 65 years who require the level of care provided in a nursing facility
Developmental Disabilities (DD)	1984	Persons with mental retardation or a related condition who need the level of care provided in an ICF/MR
Community Alternative Care (CAC)	1985	Persons who are chronically ill or medically fragile who need the level of care provided in a hospital
Community Alternatives for Disabled Individuals (CADI)	1987	Persons with disabilities who require the level of care provided in a nursing facility
Traumatic Brain Injury (TBI)	1992	Persons with TBI who need the level of care provided in a specialized nursing facility or neurobehavioral hospital

Source: Minnesota Department of Human Services, Disability Services, Minnesota’s Home and Community-Based Waivers available at www.dhs.state.mn.us.

- Expansion of managed care programs for the elderly:** In Minnesota, Medical Assistance beneficiaries age 65 and older are generally required to enroll in a managed care program¹⁰. These programs include Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+)¹¹. Over the years, the State has continued to expand managed care for the elderly statewide and to require that individuals over 65 years enroll in and access services through these prepaid health plans. Unlike many other states, PCA services are included in some of the managed care products offered to Medical Assistance beneficiaries in Minnesota. ¹² **Appendix G** presents the key distinctions between the managed care programs for the elderly.

⁹ Waivers allow states to provide an array of services to participants, including services that are not otherwise authorized under the state’s Medicaid State Plan. There are a variety of limitations to the services that can be provided and the individuals who can participate, depending on the type of waiver. Waivers are generally referred to by the section of federal law that authorizes them (e.g., a “1915(c)” waiver).

¹⁰ Certain individuals over age 65 are not required to enroll in a managed care program; see Appendix G for a list of the reasons that an individual can be exempted from this requirement.

¹¹ Prior to January 1, 2009, Minnesota also had the Minnesota Senior Care (MSC), which was a precursor to MSC+ program (See Appendix G for a comparison of MSHO and MSC+ programs).

¹² Minnesota also operates the Minnesota Disability Health Options (MnDHO), a managed care program for Medical Assistance beneficiaries with disabilities, which also includes PCA services in its service package. Enrollment in MnDHO is voluntary.

C. Accessing PCA Services

1. Assessment and Authorization for Services

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 or MHSA) 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 individuals’ 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. home and community-based waiver program). All Medical Assistance beneficiaries are entitled to an annual assessment if they request one. **Exhibit 2** compares key components of the assessment process across the three different program types.

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.

Allowable personal care assistance activities include: assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs); assistance with health-related functions through hands-on assistance, supervision, and cueing; and redirection and intervention for behavior, including observation and monitoring.¹³ Medication set-up is not considered an allowable PCA service; however, time spent assisting a consumer to take medication under his or her own direction is a covered PCA service. Minnesota also reimburses for PCA time to accompany participants to medical appointments if PCA services are needed during the appointment time.

In Minnesota, assessors document the amount of services needed in 15-minute increments for each PCA service activity. Based on our conversations with stakeholders, this has posed a substantial challenge for public health nurses as the amount of time needed for each PCA recipient to complete a specific activity varies widely. Thus, completing the required assessment is both time-consuming and subject to the varying judgments of the public health nurse conducting the assessment.

With the exception of managed care programs, the recommendation for services is submitted to DHS for approval¹⁴. 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, discussed in greater detail below).

¹³ Minnesota Health Care Programs (MHCP) Provider Manual, Chapter 24: Home Care Services.

¹⁴ To the extent that health plans prior-authorize services, they do not need DHS approval.

Exhibit 2. Summary of Assessment Processes for PCA Services Across Programs through Which Consumer Accesses PCA Services

	State Plan PCA	Managed Care ^{a/}	HCBS Waiver
Who conducts the assessment?	County Public Health Nurses (PHNs) perform assessments using a uniform assessment tool, the Medical Assistance Health Services Assessment (MAHSA) tool.	For managed care members, the MCO is responsible for conducting the assessment. MCO must use a qualified assessor who is independent of a PCA provider agency. This may include: <ul style="list-style-type: none"> ▪ a county PHN, ▪ a county PHN under contract with the MCO, ▪ an MCO PHN, or ▪ the MCO Care Coordinator or Care Manager. The PCA assessment may occur during a Long Term Care Consultation or “LTCC” (waiver) assessment, with the MAHSA Tool used as a resource.	Individuals must maximize State Plan/managed care PCA services first. Assessment for these services follows the processes outlined in the State Plan/Managed Care descriptions. Authorization for PCA services for members on the waivers is based on the LTCC, which is used to identify what portion of PCA services that will be funded through the waiver versus through State Plan PCA. The assessment is conducted by the following: <ul style="list-style-type: none"> ▪ The MCO (for members receiving PCA services through a managed care plan) ▪ The LTCC team (for members not receiving PCA services through a managed care plan).
Assessment frequency	<p><u>Initial assessment</u>: required to be face-to-face.</p> <p><u>Reassessment</u>: required annually. However, a (telephonic) <i>Service Update</i>^{b/} may be substituted for the annual reassessment if there is no significant change in condition. A face-to-face is required every three years.</p> <p><u>Temporary service increase</u>: 45-day temporary increase in PCA services may be authorized if there is significant change. However, addition of days of service requires a face-to-face reassessment.</p>	<p><u>Initial assessment</u>: required to be face-to-face.</p> <p><u>Reassessment</u>: Same as State Plan PCA except that the Service Update approach is optional for MCOs. MCOs may require an annual face-to-face reassessment or use a different process for updating the assessment. A face-to-face is required every three years.</p> <p><u>Temporary service increase</u>: 45-day temporary increase in PCA services is optional for MCOs. They may require a different process for authorizing services.</p>	A face-to-face Long Term Care Consultation is required annually.

	State Plan PCA	Managed Care ^{a/}	HCBS Waiver
Service Planning/Limits	A home care rating is assigned during the assessment process using the personal care rating decision tree. The rating is based on the individual's assessed needs and defines the maximum service dollar limit available to the individual in developing his or her service plan.	Same as State Plan PCA. Individuals receiving PCA services both through a managed care plan and through a HCBS waiver must maximize PCA services provided by the MCO before accessing Extended PCA services.	Same as State Plan PCA. Individuals in waivers must maximize State Plan PCA before accessing Extended PCA services.
Authorization for Services	County PHNs recommend authorized services to DHS using the DHS authorization guidelines outlined in Minnesota Statutes, section 256B.0655.	Individuals conducting the assessment must submit documentation and care plan to the MCO for review and authorization. However, they must use the DHS authorization guidelines as used in the FFS State Plan PCA program.	The LTCC is followed, depending on the program through which the member accesses PCA services.
Request for Authorization	County PHN submits recommendation to DHS for approval.	The MCO is responsible for authorizing services.	The LTCC team submits recommendation to DHS for approval.
Communication to Providers and Consumers	Minnesota's MMIS generates letters to notify providers and consumers of the amount, duration and frequency of authorized PCA services.	The MCO notifies providers and consumers of the amount, duration and frequency of authorized PCA services.	Minnesota's MMIS generates letters to notify providers and consumers of the amount, duration and frequency of authorized PCA services.

a/ For purposes of this table, Managed Care programs include Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MCS+), and Minnesota Disability Health Options (MnDHO).

b/ Individuals using the PCA Choice Option may only use the annual face-to-face assessment and not the Service Update process.

Source: Clarification of Policy for Personal Care Assistance (PCA) Services for Managed Care Enrollees, DHS Bulletin #08-25-06, September 2, 2008.

2. The Home Care Rating Process

As part of the overall assessment process, Minnesota law requires the individual requesting PCA services to receive a home care rating.¹⁵ The home care rating system uses a personal care decision tree process (**Exhibit 3**) to take into account the complexity and existence of both behavioral and medical needs, and applies budget caps based on these factors. The budget caps, or maximum dollar limits, are established based on the average number of direct care hours that individuals with comparable needs received in a nursing facility, based on a study from May 1992.

3. Service Supervision

Under Minnesota's statutes, the Medical Assistance program covers PCA services, based on a physician's statement of need, provided by an individual who is qualified to provide the service. These services are to be supervised by a qualified professional (defined as a mental health professional, a registered nurse, or a licensed social worker) or by the recipient.¹⁶

In addition, Minnesota's laws governing PCA services specifically require supervision of the PCA by a qualified professional to assure appropriate service delivery and PCA capability to perform the needed services.¹⁷ Qualified professions must evaluate the PCA based on direct observation of the PCA's work or communication with the consumer served. An evaluation by the qualified professional is required within 14 days after the PCA initiates services for the consumer and every 30 days over the first 90-day service period. The qualified professional must provide a written evaluation at least once within 120 days following the last evaluation. In addition, the qualified professional must review care plans with the consumer every 120 days following care plan development and make revisions as necessary.

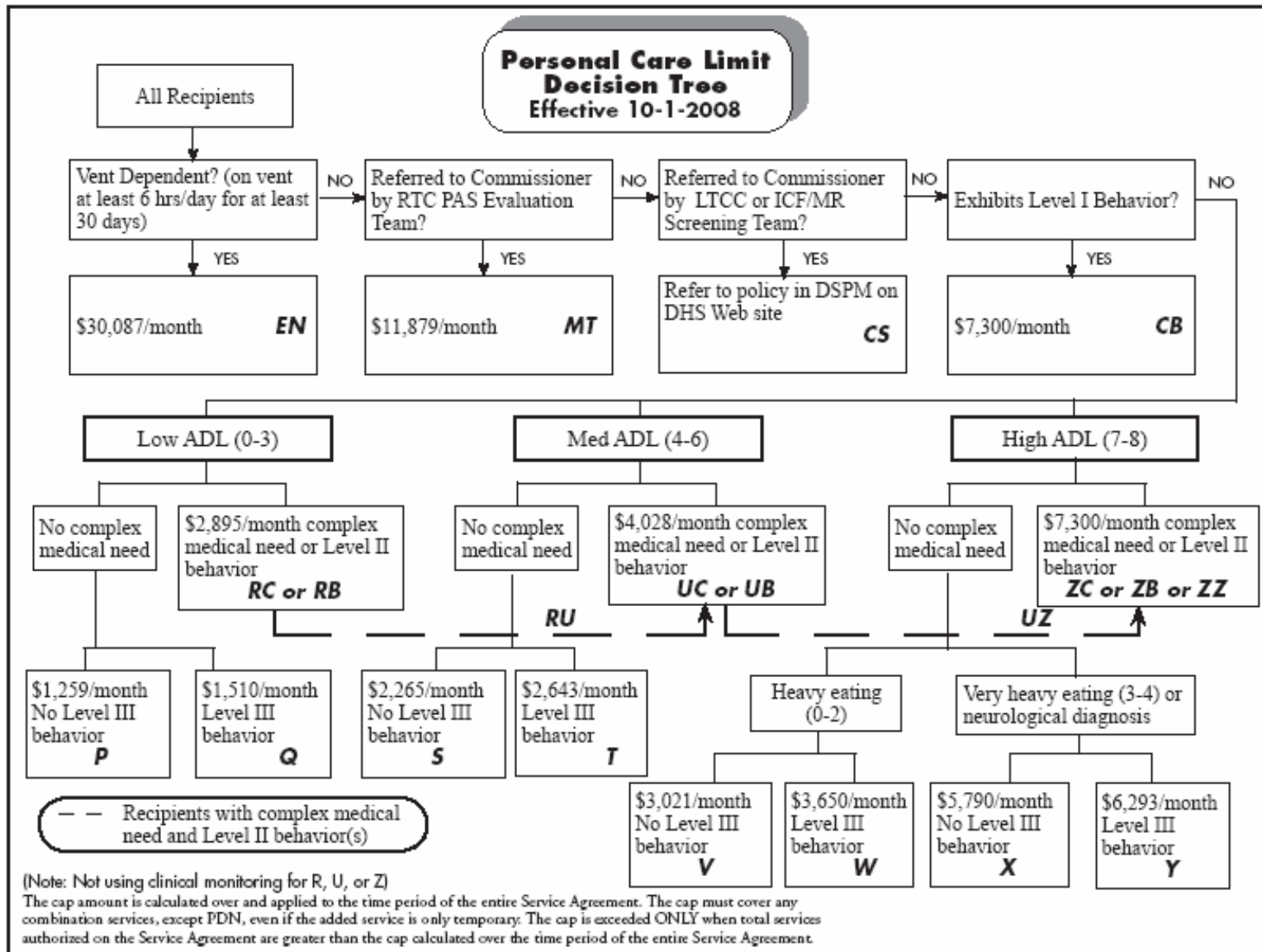
Based on conversation with DHS officials, it is our understanding that DHS allows supervision to be provided by either the individual or a qualified professional. It does not mandate supervision of services solely by a qualified professional.

¹⁵ 2008 Minnesota Statutes, 256B.0655, Subd. 4.

¹⁶ 2008 Minnesota Statutes, 256B.0625, Subd. 19c.

¹⁷ 2008 Minnesota Statutes, 256B.0655, Subd. 13.

Exhibit 3. Home Care Rating



D. PCA provider requirements

Except for PCAs providing services in the PCA Choice program¹⁸, Minnesota statute establishes requirements for individuals to be eligible to provide PCA services. These include:

- **Age.** The individual must be at least 18 years old. An exception is made for individuals between 16 and 18 years if they have participated in a school-based job training program or completed a certified home health aide competency evaluation.
- **Training.** Minnesota's PCA statute requires that PCAs meet one of several PCA training and competency options, including the following: completion of a home health aide pre-service training program based on a curriculum approved by the Department of Health; be a nurse assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN); or, be determined by the personal care agency that he or she has the training, skills or experience necessary to perform PCA services.
- **Criminal Background Check.** The individual must pass a criminal background check.

Once these minimum requirements are met, individuals are registered as PCAs in the program. The State is permitted to set a higher threshold for education, training, and certification. However, there are currently no requirements that individuals be licensed or certified to provide services. During the 1990s, the Minnesota Department of Health (MDH) made several attempts to develop licensure standards for PCAs in an effort to standardize minimum qualifications. Based on discussions with individuals in the Disability Services Division and other stakeholders, it is our understanding that these efforts were not implemented for a number of reasons, including: the cost of implementing a licensure system; the concern that licensure would perpetuate a medical model in the PCA program; and concern that requiring PCA services to be provided by licensed personnel would further limit access to an adequate pool of workers to meet the growing demand.

Most of Minnesota's PCAs are associated with an agency or organization (family members providing PCA services may not be associated with an agency). PCA provider agencies include organizations who provide only traditional PCA services (known as Personal Care Assistance Provider Organizations or "PCPOs", which also include home health agencies), those who provide fiscal intermediary services under the PCA Choice option (i.e., PCA under a consumer-directed option), and those who provide both.

The number of PCA agencies in Minnesota has increased over the years, which raises challenges for the State in terms of assuring that workers meet the necessary qualifications, enrolling individual PCAs into the program, as well as monitoring service delivery both at the agency level and the PCA worker level. Interim Report #3, which will be based substantially on the results of a provider survey which will be conducted in the late winter/early spring of 2009, will provide significantly more detail on the operations of provider agencies that are involved in the PCA program and should enhance the information which is currently available about provider agencies.

¹⁸ These requirements do not apply to PCAs providing services in the PCA Choice program since PCA consumers choose their own PCAs. PCAs must meet the consumer's qualifications, which may or may not include these criteria.

III. RECENT TRENDS IN ENROLLMENT AND SPENDING IN MINNESOTA'S PCA PROGRAM

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, between 2002 and 2007. 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) (**Exhibit 4**).

Exhibit 4. Minnesota PCA Recipients, by Primary Source of Coverage and Age Group, CY 2002-2007

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

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

Among fee-for-service recipients, the rate of increase for those with State Plan personal care only was more than double that for home and community-based waiver recipients (22.8 percent versus 9.4 percent) (**Exhibit 5**).¹⁹

¹⁹ The number of fee-for-service recipients in Exhibit 5 and 6 differ as a result of calendar year versus state fiscal year.

Exhibit 5. Minnesota Fee-for-Service PCA Recipients by State Plan versus Waiver and Age Group, SFY 2002-2007

	2002	2003	2004	2005	2006	2007	Annual Rate of Change 2002-2007
Under Age 65	6,795	7,950	9,957	11,864	13,660	15,154	17.4%
State Plan	4,278	5,163	6,721	8,513	10,092	11,333	21.5%
HCBS Waiver	2,517	2,787	3,236	3,351	3,568	3,821	8.7%
Age 65 and over	570	739	1,137	1,656	1,855	1,949	27.9%
State Plan	263	306	556	1,003	1,170	1,336	38.4%
HCBS Waiver	307	433	581	653	685	613	14.8%
Total	7,365	8,689	11,094	13,520	15,515	17,103	18.4%
State Plan	4,541	5,469	7,277	9,516	11,262	12,669	22.8%
HCBS Waiver	2,824	3,220	3,817	4,004	4,253	4,434	9.4%

Source: The Lewin Group analysis of Minnesota State Plan Personal Care Assistant Services claims data for state fiscal years 2002-2007.

When examined from the perspective of their primary source of coverage (e.g., fee-for-service vs. managed care), the data shows a significant increase in the proportion of services being provided to individuals enrolled in managed care plans: between 2002 and 2007, the proportion of PCA recipients with services covered by managed care increased from 21 percent to 29 percent. For individuals 65 years of age and older, this increase is consistent with the State’s requirement that such individuals enroll in managed care plans and receive PCA services from these plans. It is notable, however, that there is an increase in managed care enrollment for individuals under age 65 as well, although not as substantial. (**Exhibit 6**).

Exhibit 6: Minnesota PCA Enrollment, Proportion of Individuals Receiving PCA Services, by Primary Source of Coverage 2002-2007 and Age Group

	2002	2003	2004	2005	2006	2007
Under Age 65	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Fee-for-service	95%	93%	93%	92%	91%	91%
Managed Care	5%	7%	7%	8%	9%	9%
Age 65 and over	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Fee-for-service	29%	24%	21%	20%	18%	16%
Managed Care	71%	76%	79%	80%	82%	84%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Fee-for-service	79%	75%	75%	74%	72%	71%
Managed Care	21%	25%	25%	26%	28%	29%

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

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. As a result, the remainder of our discussion about the characteristics of PCA users and their spending focuses on fee-for-service PCA provided through the State Plan or home and community-based services waivers.

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 (**Exhibit 7**). However, the spending per enrollee only increased by an average of 1.6 percent per year, because both the average units per enrollee and the spending per units grew modestly.

Exhibit 7. 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.

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 Medicaid PCA and HCBS waiver spending has increased at a rapid pace, the number of Medicaid 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 8**).

Between 2002 and 2007, Minnesota's long term care expenditures increased by 4.8 percent compared to the national average of 3.7 percent²⁰. Taking the longer view (1995-2007), however, Minnesota's rate of growth in Medicaid long term care spending fell below the national average

²⁰ Long Term Care Expenditure for NF, ICF-MR, State Plan Personal Care Services & HCBS Waivers Thomson Reuters (formerly Medstat)

rate of increase (5.9 percent in Minnesota compared to 7.4 percent nationally)²¹. Examined from an alternative perspective, Minnesota’s overall increase in spending from 2002-2007 remained in line with average annual percent of medical inflation during the period (4.7 percent)²² and, effectively, was lower than medical inflation when taking into account the 3.3 percent annual average increase in users during the period.

Exhibit 8. Minnesota Spending for Long Term Care Across Settings, 2002-2007

	2002		2007		Average Annual Percent Change	
	Users	Spending (000s)	Users	Spending (000s)	Users	Spending
Medicaid PCA and HCBS a/	7,365	\$990,643	17,103	\$1,636,930	18.4%	10.6%
Medicaid Nursing Facility	22,846	\$893,445	19,148	\$835,029	-3.5%	-1.3%
Medicaid ICF-MR	2,799	\$207,841	2,554	\$175,693	-1.8%	-3.3%
Total	33,010	\$2,091,929	38,805	\$2,647,652	3.3%	4.8%

a/ Users includes only fee-for-service PCA participants. Spending includes both State Plan personal care option and home and community-based waiver spending reported by Thomson-Reuters based on CMS Form 64 submissions.

Sources: The Lewin Group analysis of PCA users based on Minnesota State Plan PCA data from state fiscal years 2002-2007 and PCA and HCBS spending as reported by Thomson-Reuters based on CMS Form 64 for federal fiscal years (http://www.hcbs.org/moreInfo.php/source/150/doc/2375/Medicaid_HCBS_Waiver_Expenditures_FY_2002_through_).

Medicaid nursing facility users reported by the American Health Care Association based on OSCAR current resident estimates for December of the prior year (http://www.ahcancal.org/research_data/oscar_data/Pages/default.aspx).

Medicaid ICF-MR residents based on Research and Training Center on Community Living, Institute on Community Integration/UCEDD annual Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2007 (<http://rtc.umn.edu/docs/risp2007.pdf>).

Spending for nursing facility and ICF-MR based on Thomson-Reuters based on CMS Form 64 for federal fiscal years.

²¹ 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.

²² The medical inflation for 2002-2007 was from bls.gov.

Our analysis also revealed a number of trends worth further investigation:

An increasing percentage of individuals seeking PCA services do not receive authorization for services

As shown in **Exhibit 9**, 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 officials postulate that this may be occurring due to the fact that children who receive PCA services through the Consumer Support Grant program (“CSG,” a state-funded program) receive an assessment but do not receive authorizations for State Plan PCA services. Additional analysis of this trend is needed since it is significant and there is no current indication that the trend is leveling off.

Exhibit 9. Proportion of PCA Applicants That Do Not Receive Authorization for Services

	2002	2003	2004	2005	2006	2007	Difference 2002-2007
<18	11.5%	13.9%	13.5%	13.1%	14.2%	20.9%	9.5%
18-64	4.7%	5.4%	7.2%	6.5%	6.8%	7.9%	3.2%
65+	2.7%	3.0%	3.4%	3.0%	3.1%	3.9%	1.2%
Total	7.1%	8.2%	9.0%	8.3%	8.9%	12.2%	5.1%

a/ “Assessment Only” enrollees represent the number of enrollees who were assessed but for whom there is no authorization for PCA services for a variety of reasons, including they do not meet the functional eligibility requirements for PCA services.

Source: Lewin Group analysis of service agreement data and claim data from DSH.

A growing proportion of PCA users are being assigned to behavioral categories during the assessment process

The assessment process classifies behavioral health conditions based on the level of complexity, ranging from an individual who may cause physical injury to his or her own or another person’s body (Level I) to an individual who needs assistance, monitoring or prompting to initiate or continue tasks (Level III)²³.

²³ See 2008 Minnesota Statutes 256B.0655 Personal Care Assistant Services for definition of Level I and Level II behavior definition: <https://www.revisor.leg.state.mn.us/statutes/?id=256B.0655> and Disability Services Program Manual, Personal Care Assistance (PCA) Service Description for Level III behavior definition: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS electionMethod=LatestReleased&dDocName=id_000848.

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 10**). 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.

Exhibit 10. Proportion of PCA Users with Level I, II or III Behavior Based on Assessments

	2002	2003	2004	2005	2006	2007	Difference 2002-2007
<18	44.8%	55.3%	62.1%	65.3%	68.6%	74.9%	+30.1%
18-64	27.9%	31.3%	36.9%	38.2%	38.4%	39.1%	+11.2%
65+	22.8%	26.1%	28.1%	25.5%	26.1%	29.0%	+6.2%
Total	33.5%	38.9%	44.2%	45.4%	46.7%	50.1%	+16.6%

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

A smaller proportion of PCA users were assigned to the “High ADL” category during the assessment process

Individuals are classified as “Low ADL” if they need assistance with up to three limitations in activities of daily living, “Medium ADLs” if the 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 (**Exhibit 11**).

Exhibit 11. Proportion of PCA Users with High ADLS Based on Assessments

	2002	2003	2004	2005	2006	2007	Difference 2002-2007
<18	15.0%	14.4%	13.2%	13.2%	12.5%	12.0%	-2.9%
18-64	37.5%	30.6%	29.5%	30.4%	36.3%	26.1%	-11.4%
65+	33.2%	33.6%	32.5%	26.7%	23.0%	27.8%	-5.4%
Total	29.2%	26.9%	25.1%	23.1%	22.1%	23.0%	-6.2%

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

IV. FINDINGS FROM OTHER STATE PROGRAMS

The findings in this section of the report are the result of an iterative process that involved researching publicly available information and interviewing representatives from select States' PCA State Plan and Cash and Counseling PCA programs²⁴. We discuss our selections process and key findings from the interviews below.

Selection of States for Interviews

We conducted an environmental scan of the 35 states which offer the State Plan Personal Care Option and/or a Cash and Counseling (C&C) program.²⁵ 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. We conducted additional research on each of these state's programs so that we could most effectively use our interview time with state representatives. We shared a copy of our interview protocol with state representatives prior to our scheduled interviews (see **Appendix D**) and followed up with them after the interviews to gather additional information and/or documents which would assist understanding and analysis of their program(s). **Exhibit 12** shows the states selected for in-depth research and interviews.

²⁴ 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.

²⁵ 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.

Exhibit 12. Comparison of States Selected for Interviews

State	PCA State Plan	Cash and Counseling	Average Annual Growth in State Plan and C&C Programs (2002-2007) ^{a/}	PCA/C&C Spending as Percent of LTC Spending (2007) ^{a/}
Massachusetts	X		11.3%	16.4%
Michigan		X	5.9%	10.3%
New Mexico	X	X	13.6%	28.7%
New York	X		6.4%	15.0%
Oregon	X		18.3%	7.6%
Texas	X		7.1%	9.1%
Washington	X	X	9.3%	17.1%
Wisconsin	X		15.4%	10.7%
Minnesota	X		18.2%	11.5%
U.S.			11.3%	10.3%

a/ Source: Lewin calculations from Medicaid Long Term Care Expenditures FY 2007, Thomas Reuters

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
- 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. A brief summary of each state’s program(s) is also available in **Appendix E**.

Promoting 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.

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. Washington uses a tool known as CARE (Comprehensive Assessment Reporting Evaluation) for assessments for the PCA program as well as other long term care programs in the State. Washington's assessors ask open-ended interview questions to participants in an attempt to highlight each individual's needs and preferences. Assessors evaluate participants' ability to carry out ten activities of daily living (ADLs). The automated CARE system then places each participant into one of 17 classifications to determine the proper number of hours to authorize. An algorithm powers the tool, so there is little room for assessor subjectivity in assigning hours to an individual. State program managers report that the tool is highly effective and helps the State in achieving its goal of performing automated, consistent, objective assessments of all program participants.

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 and Massachusetts.

New York State uses a social model in developing assessments. The process requires a Home Care Social Assessment conducted by a social worker and a nurse's assessment. Both are required to assess the individual's need and assure development of a care plan that takes into account both the medical and social limitations and needs of the individual. The New York assessment process also requires a Home Assessment Abstract which focuses on the individual's home environment and its appropriateness as a setting for the patient to receive health and related services. The Home Assessment Abstract includes an outline for planning and developing a comprehensive listing of services needed by the individual.

In Massachusetts, an RN conducts a functional assessment, taking into account services provided by other agencies, and determines the hours of physical assistance the individual needs to perform each task and the frequency of services, using a standard evaluation form. An occupational therapist is also required to be present during the initial 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. As noted earlier in this report, Minnesota has also not implemented formal mandatory training, licensure, or certification requirements.

New York, however, appears to have a rigorous training curriculum for its personal care workers. The New York State Department of Health has an established curriculum for personal care workers (called the Home Care Core Curriculum), which was initially developed by the Department of Social Services and was later updated by the State Department of Health and other stakeholders. The State requires this Core Curriculum training regardless of payer source (including privately paid services if the private-pay consumer chooses to use an agency to provide the PCA worker). The components of the Basic Core Curriculum cover topics such as: theories of basic human needs; diversity; communication and interpersonal skills; caregiver observation, recording, and reporting; confidentiality; and personal care skills (e.g., client’s environment, infection control, etc.). Personal care workers who complete the training receive a “certificate” as evidence of completion. In addition, personal care workers complete ongoing in-service/refresher training. There was no indication from State personnel that they felt this requirement limited the availability of PCA 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 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.

In other states like New York and Washington, a decentralized approach to day-to-day program administration allows local entities (Local Social Services Districts in New York and Area Agencies on Aging in Washington) more flexibility to tailor program integrity and other quality assurance mechanisms to local needs. In New York, LSSDs submit an annual plan document to the State describing how the local district operates its PCA program and State staff conduct monitoring visits to maintain program oversight. In Washington State, cooperation and coordination between the State and Area Agencies on Aging (AAAs) early on was beneficial in passing on lessons learned for further expansion of the Cash and Counseling 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. We expect to gain additional insight into Minnesota consumer satisfaction with self-directed care in the PCA Choice program.

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 consumers 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.

Fiscal intermediaries and other entities or individuals who perform administrative functions on behalf of the consumer play a crucial role by providing tools and support to consumers to strengthen the program and assure that consumers are receiving the services needed. In Washington State's Cash and Counseling program, fiscal intermediaries are required to run monthly reports on current cash balances and rates of spending in the consumer's budget and to discuss this information with the consumer. This facilitates consumer monitoring of service use against their approved budget. Also, in Michigan's Cash and Counseling program, fiscal intermediaries provide monthly budget reports to consumers and support coordinators, and flags service use when it is 10 percent over or under budget. The consumer and the support coordinator are then able to use this information to modify the consumer's approved budget.

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 state's 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). **Appendix E** summarizes states ADL and IADL minimum requirements for personal assistance services).

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.

Personal care agencies who are performing fiscal intermediary (i.e., employer-related responsibilities) in consumer-directed programs may receive a monthly payment in addition to the wage amount per member. Also in consumer-directed programs, the consumer may have complete freedom to determine the personal care worker's wages or the state agency may provide a wage range (e.g., New Mexico's Consumer Delegated Model). In states where there is a collective bargaining agreement, the contract dictates the wage for the personal care worker. Massachusetts' collective bargaining agreement establishes the hourly wage, which varies by seniority, paid-time off and overtime-wage. In general, personal care workers do not receive benefits; while some agencies may provide benefits, we found no evidence in any of the states we interviewed that specifically require that personal care workers receive benefits.

V. KEY FINDINGS FROM ADVOCATES/STAKEHOLDERS INTERVIEWS

Consumers and providers of PCA services, as well as State and local staff and program advocates, have a strong vested interest in improving the PCA program to assure that adequate and appropriate services are available to meet the needs of an increasing population, and that the program is sustainable in the long-term. We understand that the perceptions of these groups, in addition to program data analysis and perspectives gained from other states, provide an important source of information on the operations of the State's PCA program.

Our primary source of information on the perspectives of consumers and PCA workers will emanate from our focus groups activities. Moreover, the provider survey will provide us with additional information on program operations directly from provider agencies. To gain perspectives from the balance of stakeholders, we conducted a series of in-person and telephone interviews.

We worked with DHS staff to identify a number of advocates and stakeholders. In some cases, interviews with some advocacy organizations led to referrals to other advocates and stakeholders. We conducted interviews with the following:

- **State agency personnel**, including staff from aging services, adult and children's mental and health services.
- **County staff**, including local public health department staff in both large urban and small rural counties. We interviewed individuals responsible for both program administrative functions as well as public health nurses (responsible for conducting assessments) at the county level.
- **Consumer advocacy organizations**, including representatives from the mental health, aging, and disabilities advocacy communities.
- **Provider groups**, including representatives from provider agencies, a managed care administrative service organization, and a health plan trade association.

Below, we discuss commonalities and themes that emerged from our interviews with stakeholders, some of which are similar to those identified in our State interviews.

Difficulties meeting the needs of and the growing population of individuals requiring behavioral health interventions.

We heard from consumer advocates, State personnel and county public health staff that there are increasing numbers of younger people with more complicated disabilities and behavioral health needs. This change poses challenges for public health nurses conducting assessments (in particular for persons with behavioral health needs), as well as for agencies which must provide PCA workers with appropriate experience to serve consumers with complex physical and behavioral health needs.

In addition, we found substantial concern that the State Plan PCA program has developed into a "catchall" program to fill in gaps when more appropriate services are not available. Most notably, advocates were concerned about the PCA program's ability to appropriately serve an

increasing number of children with behavioral needs (with PCA, at times, only serving as respite).

Lack of sufficient training opportunities for personal care workers

We heard from all stakeholders that, as the needs of the PCA population increase, it has become more difficult to recruit appropriately trained workers, particularly with respect to workers who can provide behavioral health interventions. Furthermore, stakeholders felt that there are no incentives for PCA agencies to develop appropriate training or for PCA workers to attend training (e.g., lack of adequate payment for agencies to provide training or payment for personal care workers to attend training).

Lack of consistency in assessment and services authorization

We found differing understandings among stakeholders regarding the assessment process, in particular concerning the requirement for face-to-face assessments. This is further accentuated by perception that there is a built-in incentive for public health nurses to conduct face-to-face assessments because of the differential payment amount between face-to-face initial assessments and reassessments (which may be conducted telephonically). (On the other hand, public health nursing staff noted that the reimbursement amount was too low and does not reflect the amount of time needed to conduct a face-to-face assessment.)

Stakeholders also raised concern about the level of subjectivity in conducting assessments and determining the duration and amount of services needed. They were particularly concerned about DHS delays in authorizing services once the assessor submitted the recommendation for services²⁶.

We were also informed of a lack of coordination during the assessment process for the population with behavioral health needs. Stakeholders perceive that while these individuals 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 established strong system for coordinating development of a care plan and authorizing services for such individuals weakens comprehensive planning and delivery of services for these individuals.

Concerns about robust and uniform data reporting parameters and accessibility of data

Advocates expressed concern about data reporting parameters, particularly as they relate to reporting of enrollment and spending data. One specific issue involved how individuals who are assessed, but not authorized, for services are reflected in enrollment counts. Advocates are concerned that this “assessment only” group is often included in analyses, thereby overstating the true ongoing enrollment in and utilization of PCA services.

²⁶ DHS officials report that changes to these processes have been made since our discussions with advocates. We have not, however, detailed the nature, or assessed the effectiveness, of these changes.

Consumer advocates expressed concern that the nature and extent of information collected by the State on the PCA State Plan program is more extensive than that collected related to PCA services provided by managed care plans. Moreover, stakeholders expressed concern over the fact that what data is collected on the two programs is neither combined nor comparable, thereby causing a gap in program analysis that hinders comprehensive program understanding and planning. We experienced similar difficulties in our efforts to gain a complete understanding of the two programs. Given that the elderly are, with some exceptions, required to enroll in prepaid health plans and PCA services are provided through those health plans, this does cause a gap in program analyses and does not allow for comprehensive program planning.

Another data concern raised relates to readily available information about PCA provider agencies. We gathered from our interviews and conversations throughout this project with various State staff, that there continues to be a significant increase in the number of PCA agencies participating in the program. However, information is not readily available about these providers to assess program capacity, agency performance, or implications of policies that impact the various types of providers. This could potentially have an impact on program integrity (e.g., strengthening and monitoring provider participation requirements).

Also in relation to provider data, we understood from advocates that there are delays in enrolling PCA workers. We heard anecdotally that, to provide a degree of ongoing cash flow and meet the needs of consumers, some provider agencies were allowing PCA workers to begin working although they were not yet enrolled, and were then using one PCA worker's number to bill for PCA services provided by a number of workers. To the extent that this is true, such actions could create substantial difficulties in the long run, impede the effectiveness of required background checks, and limit the usefulness of analyses of PCA worker activities. Another gap we identified is lack of in-depth information/reporting about living arrangements of PCA recipients. Availability of these data would be useful in evaluating program integrity and developing a robust oversight and program integrity plan for the PCA program.

Lack of a strong program integrity process

One reverberating concern from all stakeholders interviewed was the lack of a rigorous program integrity system to assure that services are delivered appropriately, that consumer protections are followed, and that the opportunity for fraud and abuse is minimized. We were presented with several anecdotes as evidence of the lack of a strong program integrity process including, for example:

- Personal care workers may bill for, and be paid for, providing more than 24 hours of care per day;
- Lack of consumer choice in or potential coercion related to the provision of PCA services as a result of the consumer living in a home which is owned by the agency providing PCA services;
- Perceived DHS backlog in enrollment of individual PCAs resulting in delayed service provision, the inappropriate use of an existing personal care worker's provider identification number to initiate services, or the perceived need for a PCA agency to take on inappropriate financial and programmatic risk pending enrollment of the PCA; and

- Lack of professional supervision of the PCA by a qualified professional. DHS reported that, consistent with Minnesota statutes²⁷, it permits supervision of PCA services to be performed by either the individual receiving services or a qualified profession; however, our impressions from interviews is that advocates and stakeholders believe that supervision of PCA services by a qualified professional is required and not currently enforced by DHS.

²⁷ 2008 Minnesota Statutes, 256B.0625, Sub.19c.

VI. PRELIMINARY RECOMMENDATIONS

With a fragile economy, tight Medicaid budget, and increasing numbers of enrollees, the Governor's Office, the Legislature, and DHS leaders must make decisions concerning how to sustain a viable and robust PCA program to meet the needs of a changing population while, at the same time, maintaining its long-term cost-effectiveness. Minnesota is not unique in experiencing this challenge. Meeting this challenge should, however, be eased by the fact that, while stakeholders in Minnesota's PCA program clearly emphasize different concerns based on their perspectives on, and the nature of their participation in the program, we found a substantial degree of overlap between and among their concerns.

This section outlines our preliminary recommendations based on the reviews, interviews and analyses that we have conducted during this phase of our analysis. We recognize that full consideration of the preliminary recommendations in this Interim Report will require additional resources from DHS. We also need to emphasize that these preliminary recommendations may change, be refined, and/or added to based on findings as we complete the balance of our study (e.g., consumer and PCA focus groups as well as the PCA agency survey).

We also recognize that some recommendations may be implementable more quickly than others depending on a variety of factors including, but not limited to, their complexity, the state's budgeting process, the need for implementing legislation, parallel program changes currently under way, and other competing priorities. To assist DHS in assessing this issue, our Final Report, will estimate the extent and nature of resources needed, as well as prioritize the recommendations.

Our recommendations (summarized in **Exhibit 13**) are based on the following key principles:

- Develop systems to assure that limited resources are distributed equitably and consistently to individuals, based on consumers' needs;
- Develop systems to assure that individuals providing services have the right training and qualifications necessary to meet the needs of consumers;
- Develop monitoring and outcome measures and systems (including data reporting parameters) to allow analysis of PCA services (e.g., utilization and spending) across programs and promote accountability in the expenditure of public dollars; and
- Continue to promote strong and effective collaboration among all stakeholders in the PCA programs.

Please note that the following discussion does not include recommendations related to program integrity. Recommendations in this area will follow after an analysis of the results of the provider survey.

Exhibit 13. Summary of Preliminary Recommendations

Topic	Finding	Discussion	Recommendations
Assessments and Service Authorization	Lack of consistency and objectivity across assessments and service authorization parameters.	<p>A uniform and robust assessment system is critical to assuring that individuals are receiving the right kinds of services in the right amount. Currently, while Minnesota has a uniform and robust home care rating system, 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.</p> <p>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.</p>	<ol style="list-style-type: none"> 1. Assure that policies affecting assessment and authorization for services are uniformly distributed to counties assessors and MCOs. 2. Require and fund assessment training to assure consistent application of standards for assessment and authorization. One approach could be to develop a “train the trainer” model with “certified PHN trainers” located in each county. 3. Research and evaluate the use of a standardized, automated, integrated assessment tool (e.g., Washington State) for implementation in Minnesota. DHS will also need to train staff on the tool. Key components could include: <ul style="list-style-type: none"> • Eligibility; • Assessment findings; • Plan of care/authorize hours. [DHS could initiate this process using an RFI].
PCA Training and Qualifications	Lack of <i>formal</i> training requirements for PCAs.	Minnesota has struggled over the years with developing qualifications and training requirements for its PCAs. Not requiring training, however, leaves consumers vulnerable to inappropriate service delivery and may also inhibit the development of a core of competent service providers.	<ol style="list-style-type: none"> 1. Require all PCAs to be trained prior to providing services. PCAs can receive a “certificate” following completion of training. Require documentation of training prior to enrollment of the PCA by DHS into the program. 2. Develop a basic/core training curriculum for PCAs (see NY model). Assure that training addresses specific components for traditional versus PCA Choice. Core training should also include basic

Topic	Finding	Discussion	Recommendations
	Lack of <i>sufficient, standardized training</i> opportunities for personal care workers	As a result of the fact that Minnesota has not mandated that its PCAs receive training, there are limited opportunities for PCAs to do so. However, stakeholders may be concerned that mandating training now, without providing sufficient avenues for PCAs to receive the training, will result in a reduction of the workforce.	<p>information about the Medicaid program, PCA program requirements and provide basic skills training.</p> <ol style="list-style-type: none"> 3. Establish a phase-in period and/or limited grandfathering provisions. 4. Require periodic refresher training.
	Difficulties meeting the needs of an increasing population requiring behavioral health interventions	The increase in the number of younger people served who need more behavioral interventions, has been challenging, as these individuals generally require a PCA workforce with more focused skills.	<ol style="list-style-type: none"> 1. In collaboration with the adult and child mental health departments, as well as other stakeholders, develop a training curriculum for PCAs providing services to adults and children with behavioral health (BH) issues. 2. Evaluate if broad-based training on BH curriculum should be required for all PCAs or whether it should be established as a subcategory of PCA training/certification for only those planning to provide services to these populations.
External Collaboration	Involving stakeholders in PCA program development and operations on an ongoing basis can help identify problems early and improve program operations	Minnesota’s PCA program is county/locally-based. Service provision involves county public health nurses, other county administrators, local provider agencies, various State agencies and programs, managed care organizations and waiver program managers. Ultimately, however, DHS is the agency that primarily drives policies for the program. Because there are so many stakeholders in this program, it is critical to involve them on an ongoing	<ol style="list-style-type: none"> 1. DHS should establish/re-establish workgroups or technical advisory committees that meet on a regular basis to provide feedback on the PCA program, ensure consistency in program implementation, and address problems as they arise. 2. Develop a listserv where counties and MCO assessors and other program managers can share information. Include a Q&A section for state staff to respond.

Topic	Finding	Discussion	Recommendations
Data Reporting	Lack of consistent reporting and analysis of PCA utilization and spending.	<p>basis to assure that policy and program changes do not have unintended consequences.</p> <p>Stakeholders in Minnesota’s PCA program have identified that the nature of data that is available to assess the program is not consistent across all parts of the program. Our review of the data available to us confirms this assessment. A critical component to help strengthen Minnesota’s PCA program is the development of additional, consistent data reporting to allow comparison of key measures across programs and to help shape policy and provide State staff and other interested parties with the information needed to better understand the interplay of various parts of the program.</p>	<ol style="list-style-type: none"> 1. Establish an ongoing internal workgroup to include managed care, and fee-for-service state program operations representative to: <ul style="list-style-type: none"> • Develop policy; and • Address other operational issues between delivery systems. 2. Develop data reporting and analysis protocols for evaluating trends in PCA services within and across programs, including: <ul style="list-style-type: none"> • Data about shared care use; • Data about family members serving as PCA workers; • Key measures to allow comparison between managed care and fee-for-service data; • Data about individuals who received an assessment but were determined not eligible for PCA services; • Data identifying various living arrangements; and • Data on specific PCA activities performed. 3. Develop consistent ongoing management reports for review by the Internal Workgroup to allow analysis and comparison of PCA use trends between and among programs (e.g., FFS vs. managed care).

VII. NEXT STEPS

The preliminary findings and initial recommendations included in this First Interim Report will be influenced by our ongoing study of Minnesota's PCA programs. Ongoing activities to inform final recommendations include:

- **Continued data analysis:** We continue to refine our understanding of Minnesota's data as it pertains to PCA programs. In particular, we are working with managed care program staff to gain a better understanding of available data and how to interpret data related to individuals enrolled in prepaid health plans and relate it to the information which is available for individuals enrolled in the fee-for-service program.
- **Focus groups:** We are conducting a series of focus groups of both consumers and PCA workers to obtain qualitative information about the program directly from individuals receiving services and those providing direct care. In conducting these focus groups, we are seeking participation from individuals living in urban and rural settings, receiving and providing services through differing program models, and belonging to various ethnic groups. Including this wide array of participants should give us overall, as well as targeted perspectives on service delivery, challenges, and opportunities for improving the program.
- **Provider survey:** We are conducting a PCA provider survey to obtain data from agencies and organizations providing PCA and PCA Choice services, including their perspectives on training, recruitment and retention of workers, wages, benefits, administrative challenges of the programs, as well as information about how to improve Minnesota's PCA program.
- **Report on living arrangements and program integrity strategies:** Given the limited data currently available on living arrangements, part of the provider survey will attempt to identify the interplay between PCA service delivery and provider-owned living arrangements, particularly as these arrangements may pose challenges and conflicts for providers, the State, and consumer choice.

All of these activities will culminate in a Final Report detailing findings and recommendations to improve the program.

VIII. APPENDICES

- A. Summary of PCA History
- B. Minnesota Stakeholder and County Interview Questionnaire
- C. Minnesota State Staff Interview Questionnaire
- D. States PCA and Cash-and-Counseling Interview Questionnaire
- E. States PCA and Cash and Counseling Program Summaries
- F. Minnesota PCA Program Options Summary
- G. Comparison of Minnesota Managed Care Program for the Elderly

Appendix A: Summary of PCA History

History of Personal Care Assistant Services under Minnesota Medical Assistance

(Emphasis is on shaded items.)

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
July 1, 1977	<p>PCA services begin as a state plan service, but are limited to adults with physical disabilities who are able to direct their own care. PCA services are also limited to a maximum of 200 hours per week (approximately 7 hours per day) and are staffed by independent PCAs who have registered with the Department of Human Services (DHS).</p> <ul style="list-style-type: none"> ▪ This system of independent PCAs remains in place until 1988. 	Vietnam veterans and other Minnesotans who had experienced traumas that resulted in physical disabilities pushed to have more support to live in the community.
1978	<p>The category of services called personal care services is added to the Medical Assistance (MA) program. Personal care services are listed as a distinct category of home care services under state MA statutes and rules. People who are consumers of personal care services are either capable of directing their own care or have a designated person who directs their care.</p>	To address the unique circumstances of persons who are consumers of this type of home care services
July 1, 1984	<p>DHS implements the Waiver for People with Mental Retardation and Related Conditions home and community-based waiver program.</p> <ul style="list-style-type: none"> ▪ DHS changed the name of the waiver to the Developmental Disabilities (DD) waiver during its renewal in 2008 to more accurately reflect the needs of those who receive services through it. The waiver serves both children and adults. ▪ Extended PCA services are a covered benefit; individuals who receive the DD waiver are eligible for a greater number of authorized PCA hours than the state plan can provide. The number of extended PCA hours given is based on an individual's home care rating and is decided at the county level. Another example of extended services is if a beneficiary needs more than one PCA at the same time. 	
April 1, 1985	<p>DHS implements the Community Alternative Care (CAC) home and community-based waiver program.</p> <ul style="list-style-type: none"> ▪ For children and adults who are chronically ill, designed to serve persons with disabilities who would otherwise require the level of care provided in a hospital. ▪ Extended PCA services are a covered benefit. ▪ The CAC waiver was originally only for children (Children's Alternative Care waiver - Katie Beckett), but it was converted to both children and adults (under 64) in the 1990's when one of the recipients turned 18. 	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
October 1, 1987	<p>DHS implements the Community Alternatives for Disabled Individuals (CADI) home and community-based waiver program.</p> <ul style="list-style-type: none"> ▪ For children and adults who would otherwise require the level of care provided in a nursing facility. ▪ Extended PCA services are a covered benefit. 	
1987	<p>A Home Care Licensure Law was written which included a Home Care Bill of Rights. The licensure law was originally supposed to include PCPOs but advocates successfully pushed to exempt those agencies.</p>	
1988	<p>County Public Health Nurses (PHNs) began doing Home Care Cost Assessments. Through this process, a monthly dollar cap was determined and sent to the department for authorization. Providers were systematically billing up to the cap. At this time the PCPO was the enrolled provider and the PCPO paid the PCA.</p>	
1988	<p>The eligible population for PCA services expands to include children and adults who are not able to direct their own care. Originally, it was mandatory for all consumers of PCA services to be able to direct their own care. The TEFRA program (originally called Children's Home Care Option) begins, allowing some children with disabilities who live with their families to be eligible for Medical Assistance without counting parent's income. Some parents are required to pay a fee, depending on income.</p>	<p>To increase access to care for children</p>
1991	<p>A more robust prior authorization (PA) system is instituted for all PCA services. PCA services are now authorized in hourly increments rather than monthly. PCPOs begin doing PCA assessments which creates a conflict of interest.</p>	<p>Cost containment Note: This is the original PA statute which has been amended several times since then</p>
1991	<p>The PCA Hardship Waiver is instituted, allowing family members to be paid as PCAs. Only parents of adult children and adult siblings need to apply for hardship waivers. More distant family members can act as PCAs without a hardship waiver. Parents of minor children, spouses, and legal guardians are not permitted to act as PCAs.</p>	<p>Note: MN has never allowed parents of minors, spouses, or legal guardians to be PCAs.</p>
1991	<p>The Minnesota Department of Health (MDH) develops a rule for licensure of personal care services provided under the state Medical Assistance program. The PCA licensing rule only applies to Medical Assistance-reimbursed services. <u>This rule was never implemented.</u></p>	<p>To attain minimum safety and quality of care standards</p>

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
1991	<p>1991 statute required that personal care services be provided through a personal care provider agency unless there is no choice of vendor. PCPOs were required beginning in 1988, but individual PCAs could continue to be enrolled until at there were at least two PCPOs in each county to assure choice of provider. By 1991 every county had at least two PCPOs available to choose from.</p> <p>This statute also creates the home care rating decision tree. The decision tree includes vent dependent, regional treatment level of care, pre-admission screening level of care, and complex behavior.</p>	
April 1, 1992	<p>DHS implements the Traumatic Brain Injury (TBI) home and community-based waiver program.</p> <ul style="list-style-type: none"> ▪ Extended PCA services are a covered benefit. 	
1992	<p>MDH minimizes license fees for small providers by obtaining updated revenue data for fiscal year 1991 from all registered home care providers.</p>	<p>The 1992 legislature expressed concerns about the impact of these fees on small providers.</p>
1992	<p>A cost effectiveness test is added to the PCA program.</p> <ul style="list-style-type: none"> ▪ Note: under HCBS waivers, the entire program has to be cost-effective. ▪ Although it was in statute, the cost effectiveness test was never widely. The decision tree was used instead. 	<p>Allegations of fraud</p>
1992	<p>Cost of living allowances are eliminated.</p>	
1993	<p>Authorization for complex behavior home care rating and authorization was split into 3 categories; level 1, level 2 and level 3 behaviors</p> <ul style="list-style-type: none"> ▪ Level 1 - behavior that causes injury to self, physical injury to others, or destruction of property ▪ Level 1 behavior required supporting documentation. ▪ Level 2 - behavior that includes unusual or repetitive habits, withdrawn behavior, or offensive behavior ▪ Level 2 behaviors must be exhibited on a daily basis and interfere with the completion of personal care services. ▪ Level 3 behavior includes cognitive issues like forgetfulness and redirection. 	<p>Prior to 1993, Level 1 and 2 behaviors were all included in the complex behavior category which allowed someone to receive up to 14.5 hours per day. Certain behaviors (such as withdrawn or offensive behaviors) didn't seem to require that many hours, so they were separated. The number of authorized PCA hours for Level 2 behaviors was dependent on how many ADLs the person was dependent in.</p>

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
1994	Authorization of PCA hours changes from hourly increments to 15 minute increments.	Budget crisis, to produce cost savings Note: PCA statutes provided for 1994, 1995 and 2008
1995	Governor Carlson proposes eliminating TEFRA medical assistance and PCA services for children and adults who are unable to direct their own care (persons with developmental disabilities, TBI, mental illness, Alzheimer's, etc.). He is unsuccessful (see below).	
1995	Spending on PCA services is cut by 22%, effective July 1996. The legislature tried to eliminate authorization for behaviors, claiming that all individuals with behavioral issues were supposed to go into waivers.	Targeted program cuts from the 1995 session
1996	PCA cuts are reinstated before they go into effect.	Overwhelming grass roots action by persons with disabilities and their families
1996	County PHNs replaced the PCPOs for doing PCA assessments. Home Care Nurse Consultants remained and continued to review and authorize home care services. This is when the conflict of interest actually was resolved.	
1997	The Minnesota legislature enacts a law authorizing MDH to create a licensure category for PCA providers. This is the second time the legislature tried to license PCAs, but consumers and advocates successfully fought against it because it focused on the "medical model." Also, the cost of licensing PCAs prevented the law from ever being implemented.	Advocates do not want PCA services to be considered medical care. In their opinion, PCA services are social services. If MDH regulates PCAs, they feared a medical model would be adopted.
1997	<p>The Minnesota Senior Health Options (MSHO) program begins in Minnesota Medical Assistance (MA). This is a managed care program for people aged 65 and older who are eligible for MA and enrolled in Medicare Parts A and B or who have MA only.</p> <ul style="list-style-type: none"> ▪ MSHO includes PCA services as a benefit. MSHO organizations are required to provide the same level of PCA services. ▪ MSHO is offered in all but four counties: Beltrami, Clearwater, Hubbard, and Lake of the Woods. ▪ As of September 2008, enrollment in MSHO was 36,303. ▪ MSHO is a voluntary alternative to the mandatory MSC/MSC+ and Part D provided an opportunity for most to be enrolled in a SNP so many duals have Medicare and Medicaid provided by same SNP. 	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
1999	Olmstead Decision, U.S. Supreme Court ruling in <i>Olmstead v. L.C.</i> , states have an obligation to ensure that people with disabilities are not forced to remain institutionalized when a more integrated setting is appropriate. This ruling pushed states to improve home and community-based supports through activities such as allowing family members to be paid caregivers and increasing the reimbursement of services.	A PCA task force recommended these changes. The Olmstead Decision had little effect.
1999	Flexible use of PCA services is implemented and recipients may use their approved hours flexibly within the service authorization (one year) to meet their needs and schedules for medically necessary covered services. Now, services can be saved for non-school days, planned extended need such as vacation, etc. This also helps people use the full amount of services authorized even when there is a disruption in service.	
1999	Shared care is implemented, which allows two or three recipients to choose to share services in the same setting at the same time from the same personal care assistant. Shared care applies to both state plan and waived PCA services. <ul style="list-style-type: none"> ▪ Note: The law change occurred in 1997. Implementation occurred in 1999. 	
1999	Legislation passed giving recipients of PCA services the option of using a fiscal agent, also called a PCA Choice Provider, instead of a traditional PCA provider to bill the state for PCA services and to pay and withhold taxes from PCAs and Qualified Professionals.	
2000	PCA Choice was implemented, expanding flexibility for PCA services. <ul style="list-style-type: none"> ▪ PCA Choice allows recipients to be responsible for the hiring, training, firing, and supervising of their personal care assistant staff rather than obtaining personal care assistant staff through an agency. ▪ Consumers who choose to use the consumer-directed PCA Choice option are required to choose a fiscal intermediary. 	
2001	The Minnesota Disability Health Option (MnDHO) is added to Minnesota Medical Assistance (MA). MnDHO is a managed care program for people with physical disabilities who are eligible for MA. <ul style="list-style-type: none"> ▪ People who are eligible for both MA and Medicare may enroll. ▪ MnDHO includes PCA services as a benefit. ▪ MnDHO is only offered in Hennepin, Ramsey, Anoka, Dakota, Carver, Scott, and Washington counties. In September 2008, 1,033 enrollees. 	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2001	<p>Changes are made to the hardship waiver requirement (which allows relatives to be PDNs). As of 2001, the only relatives who are permitted to be PDNs are parents of minor children, spouses, and non-corporate legal guardians or conservators who are RNs. These groups are required to obtain a hardship waiver. This change was for Private Duty Nursing not PCA.</p> <p>From the statute: These groups can be reimbursed as PDNs and not be considered to have a service provider interest for purposes of participation on the screening team.</p>	<p>Unemployment was at an all-time low, so it became difficult to find people to be PDNs since they could potentially make more money and earn benefits at other jobs.</p> <p>MN was the first state to allow this.</p>
2001	<p>Health related functions under the direction of a qualified professional, such as an MD or RN, are added as covered PCA state plan services.</p> <ul style="list-style-type: none"> ▪ Note: This has been allowed since 1991, the name just changed from complex medical needs to health related functions. 	
2001	<p>MA eligibility is expanded to include about 20,000 more children and the income standard for the elderly and disabled is increased.</p>	
2001	<p>Options Initiative: A DHS proposal to provide additional choices and strengthen home and community-based services for persons with disabilities under the age of 65 who are in nursing homes so they can remain in the community or move out of an institution if they choose.</p> <ul style="list-style-type: none"> ▪ An estimated 1,300 people would use of community-based services and supports to move out of nursing homes in the next four years as a result of the Options Initiative. <p>Components of the initiative:</p> <ul style="list-style-type: none"> ▪ Long term care consultation: needs assessment and service planning conducted before a nursing facility admission, to prevent the long-term placement of people under age 65 years in nursing facilities, hospital swing beds, and certified boarding care facilities; to ensure persons are made aware of community-based options available; and to assist individuals to make an informed decision about where they want to live. ▪ Medical Assistance rehabilitation option: provides enhanced mental health services through expanded flexible support services in the community ▪ Relocations service coordination: assists people to plan for their move and ensure that the necessary services and supports are in place to meet their needs in the community ▪ Shelter needy option: financial supplement to people moving from nursing facilities so they can access affordable housing in the community. 	
2001	<p>The regulation of Rule 36 facilities (community residential mental health facilities) changed. A 90-day limit on stays is implemented, long-term stays are ended, and models are developed to serve individuals in the community instead of in facilities.</p>	<p>Work group was put in place, goal of optimizing the role of Rule 36 programs in the overall mental health system.</p>

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2001	<p>Rehab Option: The MA program is expanded to cover adult rehabilitation services, crisis services, medication monitoring, and independent living skills training. The MA program is also expanded to provide payment for staff travel time so that MA services can be provided in non-clinical settings.</p> <ul style="list-style-type: none"> ▪ An estimated 15,000 people would receive expanded services and 5,000 people would receive services for the first time. 	
2001	<p>The DD waiver was allowed “open enrollment” from March through April at which time 5,000 people from the waiting list were added to the waiver.</p>	<p>Advocates pushed to bring this about. The state was very surprised to find that counties managed to add 5,000 people in such a short amount of time.</p>
2002	<p>Vent (EN), Preadmission Screening (CS), and Full RTC (MT) home care ratings are added to the PCA program, which increase accuracy in capitation rate for a recipient’s home care needs. These dollar caps are higher than those given in the past and accommodate the ongoing support a person with a mental illness who was moving from a Regional Treatment Center (RTC) to the community would need.</p> <ul style="list-style-type: none"> ▪ These ratings have always been allowed since 1991, but there were clarifications made via a policy bulletin in 2002. ▪ The EN home care rating is a category assigned to persons who meet the criteria for being ventilator-dependent. ▪ The CS home care rating is a category to allow a monthly dollar cap for home care services to be based on the amount Medical Assistance would reimburse for a nursing care facility or Intermediate Care Facility. ▪ The MT home care rating is a category assigned to persons determined to be at the level of care provided in a RTC. This rating may be authorized for persons upon discharge from a RTC or who are residing in the community. 	
2002	<p>Responsible party, someone who is capable of providing the support necessary for someone who is unable to direct their own care to live in the community, must live with the recipient as a pre-requisite for getting PCA services.</p>	
2002	<p>The allocation of new DD waiver diversion slots is delayed until January 2003 (originally planned for July 2002), and the availability of DD waiver turnover slots is delayed by 180 days.</p>	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2002	<p>A county share of 10% of total costs (20% of the non-federal share) is enacted for placements of people with disabilities under age 65 in nursing facilities that have exceeded 90 days.</p> <ul style="list-style-type: none"> ▪ This contributed minimally to increased PCA use. ▪ Despite this county share, MN still has over 2,000 people under age 65 in nursing facilities. 	To put a financial incentive on counties to keep people under age 65 out of nursing facilities
2003	<p>A county share of 10% of total costs (20% of the non-federal share) is established for long term placements of people in Intermediate Care Facilities for Persons with Mental Retardation with seven or more beds.</p> <ul style="list-style-type: none"> ▪ MN no longer has large ICF/DD facilities. The largest number of beds in a facility is currently 16, and there are very few facilities of this size. Most others have 6-8 beds. ▪ This county share had a minimal effect on use of PCA services. 	
2003	<p>The implementation of the Home Care Targeted Care Management benefit is delayed for home care recipients. More stringent requirements are put in place for MA day treatment.</p> <ul style="list-style-type: none"> ▪ Home Care targeted case management has yet to be implemented although a state plan amendment has been approved. ▪ This had a minimal effect on PCA services. 	
2003	<p>Waiver growth is limited. 600 DD waiver diversion slots are eliminated for FY04-05, TBI slots are capped at 150 per year, and the average monthly growth in the CADI waiver is limited to 95 slots over the June 30, 2003 levels during the FY 04-05 biennium.</p> <ul style="list-style-type: none"> ▪ Priority for available resources is given to people relocating from institutions or at imminent risk of institutional placement. ▪ Waiver slot limits have a negative impact on people who look to the PCA program to access necessary supports for living independently in the community because fewer people have access to these supports. ▪ When the legislature enacts these types of limits, state plan PCA services are used more. 	
2003	<p>A 1% rate reduction is implemented in the FY 03 funding levels for Continuing Care programs, including Intermediate Care Facilities for Persons with Mental Retardation, Home and Community-Based Waivered Services, Day Training & Habilitation Services, Consolidated Chemical Dependency Treatment Funded services, Alternative Care, and Deaf and Hard of Hearing grants.</p>	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2003	Alternative Care Program Changes: New cost sharing requirements are implemented through premium changes. The option to stay on alternative care is eliminated for people who are eligible for the Elderly Waiver. Alternative Care estate recovery/liens, similar to those used for MA, are implemented.	
2003	<p>Adult mental health residential treatment is restructured to:</p> <ul style="list-style-type: none"> ▪ convert some community residential treatment facilities to facilities where more intensive treatment, short of hospitalization, could be provided or to permanent housing ▪ increase the county share for use of institutions for mental diseases (IMDs) to 20% of the non-federal share (this is 20% of total since IMDs are not eligible for federal financial participation). <ul style="list-style-type: none"> - This provision was delayed until July 1, 2004. 	
2003	<p>The PCA hardship waiver is eliminated, improving access to services while decreasing administrative burdens.</p> <ul style="list-style-type: none"> ▪ Parents of adult children and adult siblings may provide personal care assistance services to a family member without applying for a PCA Hardship Waiver, if they meet the criteria to work as a PCA. The spouse, parent of a minor child, and the responsible party may not serve as the PCA. 	Staff shortages, low reimbursement
2003	Social workers are added as qualified professionals and are able to supervise PCAs, both improving access to supervision of care and providing appropriate professional supervision of PCA services.	
2003	Changes are made to the Flexible Use option to reduce the consumer's ability to use up all of their hours before the end of their yearly authorization by shortening the authorization period to 6 months (rather than 12 month authorizations).	
2003	Responsible parties (RPs) are no longer required to live with recipients of PCA services and are able to delegate responsibilities. This allows elderly individuals who do not live with family greater flexibility in the program, since their family is able to direct their care, and evaluate and monitor PCA services on their behalf. This also allows responsibility to be transferred for periods of time, which helps RPs who have employment obligations or other life events that prevent them from temporarily being able to meet RP responsibilities.	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2004	<p>Elderly Waiver (EW) Services are moved into the Prepaid Medical Assistance Program (a version of Minnesota Medicaid managed care). DHS is required to issue requests for proposals for collaborative service models between counties and managed care organizations to integrate EW services and additional nursing services into the PMAP.</p> <p>PMAP expansion caused health plans to gain more members over age 65 and to provide more home and community-based services. As more people over 65 entered health plans and as Minnesota Senior Health Options expanded, health plans began to complain that PCA expenditures were too high.</p>	<p>Note: The 2005-2006 change in users aged 65+ is much lower than it is for other age groups (7.6% vs. 15%) and in 2006-2007, it actually declines 4%. This is probably because the state is unable to get very good managed care encounter data and therefore only provides FFS data.</p>
2004	Mental health rates are simplified.	
2004	<p>Grant dollars are available for the development of training videos for the PCA program. Annual plans are made with local Public Health Nursing experts to be used in the video. The Disability Services Division (DSD) staff helps to plan, develop, and implement videos for PCA and interpreter services.</p>	
2004	PCA training for Public Health Nurses begins.	
2004	<p>Work begins on a re-codifying statute and meetings begin with internal stakeholders to discuss PCA redesign.</p>	
2004	PMAPs are permitted to temporary disenroll from health plans.	
June 28, 2005	<p>All individual PCAs must enroll with DHS as non-pay-to providers and must be affiliated with the PCA agency that employs them. PCA agencies are required to bill with their treating providers' ID numbers on the claim. This policy change necessitates background studies for all PCAs and allows Surveillance and Integrity Reviews (SIRS) to track which PCAs provide which services to which recipients.</p>	
July 15, 2005	<p>The local county share is reduced from 20% to 10% of the non-federal share of costs, for the cost of placements in ICF-MR with seven or more beds that have exceeded 90 days.</p>	
September 1, 2005	<p>Out of home placement options are eliminated from the Alternative Care program service menu, including assisted living services, adult foster care, and residential care settings. The amount of income and/or assets a person can have to be considered eligible for the program is reduced. The Alternative Care program estate recovery policy is aligned with the current protocol for Medical Assistance, and the application of liens is appealed.</p>	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2005	<p>Managed care health plans propose elimination of flexible use of PCA hours. Flexible use is maintained, but is limited to a 6 month period instead of a 12 month period. By restricting flexible use, the amount of services a person can use in a 6 month period is reduced due to of delays in finding PCAs, high turnover, and other barriers to access and use of PCA services.</p> <ul style="list-style-type: none"> ▪ This new flexible use policy was not officially implemented until 2006. 	<p>A 2005 Bailit Health Study cites charges of fraud in PCA services made by managed care health plans. Also, cuts are made to flexible use to produce cost savings, which were to be used to buy back MNCARE eligibility cuts that were made in the previous legislative session.</p>
2005	<p>The Minnesota legislature maintains the 2003 limitations on new allocations of the disability waiver programs for the 2006 and 2007 biennium for three of the four disability waivers. The Community Alternatives for Disabled Individuals (CADI) waiver is limited to 95 new allocations per month, the Traumatic Brain Injury (TBI) waiver is limited to 150 new allocations per year, and the Developmental Disabilities (DD) waiver is limited to 50 diversions each year of the biennium for individuals at imminent risk of institutional placements. No new allocations are given for the DD waiver for expected growth.</p>	
2005	<p>Private vendors can provide relocation service coordination to individuals relocating from an institution.</p>	
2005	<p>Expansion of MA for autism services is delayed, and MA is limited for children's foster care.</p>	
2005	<p>All home and community-based services receive a 2.26 percent rate increase, which improves and maintains access to services and increases wages of direct care workers. The structure of payment for home and community-based services is changed by aggregate waiver budget methodology.</p>	<p>PCA services were seen as the "least expensive" and "easiest to access".</p>
2005	<p>The PCA and home care statutes are re-codified so that each service area has its own statute. This marked the first step in redesign of the PCA program and allowed for greater ease in program administration.</p>	
2005	<p>Quality assurance authority is expanded, giving DHS the authority to suspend, deny, or terminate a PCA provider for non-compliance with a policy, rule, regulation, or law. Before this time, DHS' only authority to act was under fraud and abuse.</p>	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2005	<p>All PCA providers must use DHS developed timesheets or submit their version for approval. This change educated providers on documentation requirements and made it easier to prove fraud or abuse in falsification of timesheets. A statement about falsifying documents being a federal crime must be included on all timesheets.</p> <ul style="list-style-type: none"> This policy was not officially implemented until 2006. 	<p>Authorizations were being overturned through appeals where physicians ordered excessive amounts of PCA services in comparison to actual in home PHN-PCA assessment.</p>
2005	<p>Physician order changes to “statement of need”, improving clarity on how services are assessed and how amounts of needed services are determined. Prior to this, This new policy clarified the physician’s role and responsibility in PCA service authorization as the verifier of medical need.</p> <ul style="list-style-type: none"> This policy was not officially implemented until 2006. 	
2006	<p>The Minnesota Disability Health Option (MnDHO) and Minnesota Senior Health Options (MSHO) are expanded. The elderly waiver is moved into managed care.</p>	<p>Concerns about individual PCA identification numbers and the use of the PCA as a staffing model (pooling PCA hours)</p>
2006	<p>Regional training workshops on PCA services, or PCA Guideposts, are offered in six locations twice per year.</p>	
2006	<p>PCA to Waiver legislation passes, allowing individuals using this service delivery model access to a new waiver slot for CADI or TBI.</p>	
2007	<p>The 2005 mandates for limitations on the CADI and TBI waiver programs expired.</p>	
2007	<p>The MnDHO pilot project is extended for an additional two years to July 1, 2009.</p>	
2007	<p>Self-directed personal supports option is enacted. This is the 1915 (j), which has not been sent in as a request to CMS yet (as of November 2008), so it will not be implemented for a while.</p>	
2007	<p>Portions of the PCA rule are moved to statute and outdated language is clarified.</p>	
2007	<p>Policies are established for PCA supervision, training, employee prohibition, and agency requirements. During the 2007 legislative session, language passes requiring providers of Independent Living Skills (ILS), foster care waiver service, prevocational services, structured day services, and supported employment services to meet basic health, safety, and protection standards. The providers must meet the new standards by agreeing to apply their 245B license to the waiver services, or by completing a certification process that verifies the provider has the appropriate policies and procedures.</p>	
2007	<p>Legislation passes penalizing counties 25% of reimbursement for late PCA assessments.</p>	

Date of Policy or Legislative Action	Description of the Policy or Legislative Action	Rationale for the Policy or Legislative Action
2008	The Minnesota Department of Labor and Industry (DOLI) clarifies language for workers compensation responsibility and liability.	
2008	Legislation passes requiring MDH and DHS to report on recommendations for PCA provider standards.	
January 1, 2009	The new Budget Allocation Methodology will be implemented. As part of the new methodology, the department has included a safety net feature, which will allow counties to spend more of their allocation without the fear of overspending.	The statewide percentage of funds allocated but not used has been growing at a steady rate since 2004. This growth is likely due to the fact that counties are spending cautiously; counties must pay back any portion of their allocation that they spend in excess of their allowable budget. The department is working to diffuse the growth in unspent allocation.
2009	Program redesign will take place to improve clarity, transparency, integrity, consumer safety, and quality of care.	

Appendix B:
MN PCA Stakeholder and County
Interview Guides

MN PCA Stakeholder Interview Guide

Background

The Lewin Group, a health care and human services consulting firm in the Washington, DC area, is under contract with the Minnesota Department of Human Services Disability Services Division to identify improvements to their Medicaid State Plan Personal Care Services (PCS) program. We are conducting a series of interviews to supplement our data analysis on the project. We are interviewing state staff and county staff, advocates, PCA providers, and PCA consumers to get a sense of the major challenges in the program.

1. Please tell us about your organization
2. How does your organization interact with the PCA program?
3. How long has this relationship existed? How has it changed over time?
4. What works well in the PCA program?
5. What are your recommendations for improving the PCA program?

Service authorization process

1. What works and what doesn't?
2. Are the timeframes reasonable?
3. Are the amount of services authorized adequate?

Location services are provided

1. To what extent do you believe PCA services are not available in settings where they are needed?
2. Are there other locations where services should be provided?

Payments and fees

1. Are rates adequate – how to you determine their adequacy (e.g., benchmark against other states, anecdotally, input from your membership)?
2. How do they compare with private pay rates?
3. What issues if any have you seen as a result of a provider offering both housing and PCA services?

Adequacy of pay and benefits for PCAs

1. Do you think PCA salary/pay rates are adequate?
2. Do you think benefits are adequate to meet client needs? What are the gaps?
3. How do you determine their adequacy (e.g., benchmark against other states, anecdotally, input from your membership)?

PCA workforce

1. What additional training is needed?
2. Who should provide this training?
3. How can recruiting be improved?
4. Are there parts of the State where recruitment is a particular challenge?

Amount of consumer choice

1. Are providers culturally sensitive?
2. What are the barriers you see to the use of consumer directed services option?

Minnesota Counties Staff Interview Guide

The Lewin Group, a health care and human services consulting firm in the Washington, DC area, is under contract with the Minnesota Department of Human Services Disability Services Division to identify improvements to their Medicaid State Plan Personal Care Services (PCS) program. We are conducting a series of interviews to supplement our data analysis on the project. We are interviewing state staff and county staff, advocates, PCA providers, and PCA consumers to get a sense of the major challenges in the program.

Questions

1. Please describe the role of your county in the PCA program. Are there aspects of your county's program that are different other counties? If so, please explain.
2. What is your role in the PCA program operations? How long have you been in your position?
3. [If not already covered] What is the role of county public health nurses? Are you adequately staffed and are they appropriately trained? Do you have recommendations for staffing levels and/or training?
4. What changes have you seen in your PCA program over the past 5-10 years? For example, changes in:
 - a. spending per user
 - b. numbers of consumers in the program or requesting to be in the program
 - c. needs of consumers in the program
 - d. availability of PCAs
5. How do the PCA program and the waiver programs interact in your county?
6. We understand that counties have waiver funding caps, correct? How does this affect use of PCA services in your county?
7. What are your biggest challenges in the PCA program in your county?
8. The following are challenges at the state level - what are your county experiences in relation to these challenges?
 - a. Changing PCA program population (increase in behavioral needs)
 - b. Shared care option
 - c. Quality assurance
 - d. Program integrity
 - e. Adequate supply of PCAs to serve the people in your county
9. What unique approaches have you implemented in your county to meet the PCA program demands in your county?

What are your recommendations for improving the PCA program?

Appendix C
Minnesota State Staff Interview Guide

State Staff Interview Guide

The Lewin Group, a health care and human services consulting firm in the Washington, DC area, is under contract with the Minnesota Department of Human Services Disability Services Division to identify improvements to their Medicaid State Plan Personal Care Services (PCS) program. We are conducting a series of interviews to supplement our data analysis on the project. We are interviewing state staff and county staff, advocates, PCA providers, and PCA consumers to get a sense of the major challenges in the program.

Questions

1. Please briefly describe your program area.
 - a. How does your office's primary focus area (e.g., managed care or mental health, etc.) interact with the PCA Program?
2. What is your role in the PCA program operations?
3. Describe how PCA services are delivered for people in your program area.
 - a. How have your program policies affected delivery of PCA services and vice versa?
 - b. What are some of the challenges you face? Are they statewide?
4. How do you interact with counties in relation to the PCA program? What are some of the challenges you face?
5. What is the interaction between your program area and PCA providers? What are some of the challenges you face?
6. What are some of the challenges faced by those you serve in relation to PCA providers? (e.g., PCAs do not appear to be appropriately trained; managed care members have different challenges in accessing PCA providers)
7. What are some of the anticipated major policy/program changes in your primary focus area and how do you see these affecting the PCA program? (e.g., managed care expansion)
8. What are your recommendations for improving the PCA program?
9. What are some of the best practices or opportunities you think the PCA program can benefit from?

**Appendix D:
State PCA and Cash and Counseling
Interview Questionnaire**

Interview Questions for PCA and Cash and Counseling State Interviews

Background/Introduction

1. Please tell us about your PCA program and its history.
2. How long has your PCA Program been in operation?
3. How many consumers participate in the program?
 - a. What are their characteristics (e.g., age, type of disability, disability level)?
 - b. For C&C programs only, is your program statewide?
 - c. If the program isn't statewide, how many counties/regions currently participate?
4. What are the eligibility requirements for PCA?
5. Are there any restrictions on the types of disabilities that consumers can have in order for them to be permitted to participate in the program? If so, please describe.
6. How have the personal care needs of consumers changed over time (e.g. disability types, ages, services rendered)?
7. Have you made any significant changes in the program since it began?
 - a. If so, what changes were made and why?
8. What services are rendered under your PCA program?
 - a. Assistance with activities of daily living (ADLs):

• dressing	• positioning
• grooming	• transferring
• bathing	• toileting
• eating	• mobility
 - b. Assistance with instrumental activities of daily living (IADLs): clothing, and other items, homemaking tasks, communicating by telephone or other means, getting around and participating in community activities.

• meal planning and preparation	• communicating by telephone or other means
• managing your finances	• getting around
• shopping for food, clothing and other items	• participating in community activities
• homemaking tasks	
 - c. Assistance in health-related functions by a licensed health care professional such as a nurse or doctor: special skin care, non-sterile catheter care, tube feedings and respiratory assistance.

- d. Redirection and intervention for behavior issues which require observation and monitoring – reminders to do activities of daily living or redirection of behavior that is potentially harmful to you or others.
- e. Other (describe)_____

PCA Providers

1. Who is eligible to provide PCA services?
 - a. What are the qualifications required?
 - b. What are the training requirements? Frequency?
 - c. Can family members be PCAs? (Describe limitations)
2. What licensure/certification is required, if any? (Include background checks)
3. What entity is responsible for setting and monitoring licensure/certification/training (e.g., state/local, other)?

Service Location

1. Where can PCA services be provided (e.g., living arrangements, at work)?
2. If services can be provided in different settings, are there variations in the services that can be provided in these settings?
3. Does the state have difficulty obtaining PCA services in some or all parts of the state?

Payment

1. What rates does the state pay for PCA services?
 - a. Do they vary by region?
 - b. How is the rate determined (components of rate – benefits, etc. and are they adequate?)
 - c. How comparable are the rates to private pay rates?
2. What are PCAs paid for direct services?
3. How does the state authorize or allocate resources (e.g., per diem, hours of service, etc.)?
4. What benefits are available to PCAs (e.g., health insurance, time off)?
 - a. Does the availability of these benefits vary by region, type of provider organization, or other factor?
 - b. Is compensation available for all available benefits (e.g., leave or sick days paid)?
5. Does the program include cost-sharing and if so, is this a barrier to obtaining services?

Consumer Control

1. To what extent do program participants have choice and control in their service delivery?
 - a. How do you measure or evaluate this ability?

- b. If they are unable to direct their own service, may they assign someone to make these decisions for them?
2. Can consumers hire, train, and negotiate payment for PCAs? Describe.
3. If the consumer hires the PCA, what types of technical support are available to ensure the quality and efficiency of the consumer's care?

Program Data

1. How much does each user spend, both on average and the distribution, and by user characteristics? (Request documentation if possible)
2. How often are rates updated?
 - a. What role do rate changes and the amount of approved hours in changes in spending per user play?
3. What differences have been noted in spending per individual user and has this changed over time by setting (e.g., own home versus provider owned or leased housing)?
4. What differences have been noted in spending per individual user and has this changed over time by county?
 - a. What is the role of the county public health nurses and the relationship to county waiver funding obligations?

Program Operation

1. What is the process for developing and authorizing the PCA care plan developed for the consumer? And who is involved?
 - a. How frequently is this plan reviewed?
 - b. Does the consumer play a role in the plans development?
2. What are the allowed caseloads/ratios?
 - a. For the counselors/care manager or like party?
 - b. For PCAs?
 - i. Are shared PCA services allowed?
 - ii. If services can be shared, what are the limitations?
3. What back-up services are in place in the event that a PCA cannot make an appointment?
4. What strategies have you implemented to assure program integrity/quality assurance for your PCA program?
 - a. Have you conducted any surveys or studies to determine the level of satisfaction with your program?
 - b. Have you had any program integrity problems?
 - i. If so, how have you addressed the problems?
 - c. What other problems have you had in the program (implementation, education of PCAs and PCA consumers)?

5. Are there particular approaches you have used or plan to use in implementing your program that you would recommend to other states?
6. What aspects of your program do you consider to be best practices?

Appendix E
State PCA and Cash and Counseling
Programs Summaries

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State Comparison Summary-Table 1

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
State Plan PCA Programs				
Massachusetts State Plan	<ul style="list-style-type: none"> ▪ The evaluation is typically performed in the consumer’s home using a standard statewide form called the “MassHealth PCA Standard Evaluation” form which takes into account the consumer’s functional abilities and limitations as well as services provided by other agencies. Using this form, an RN evaluates and determines the number of minutes of physical assistance the consumer needs to perform a task, and the frequency per day each task is performed in a week (7 day period). ▪ MassHealth requires that an occupational therapist be present in the initial evaluation. 	<ul style="list-style-type: none"> ▪ MassHealth contracts with Personal Care Management (PCM) agencies to provide a variety of support services for the consumer but the consumer chooses which PCM agency they work with and the PCM agency chooses one fiscal intermediary. ▪ The PCM agency evaluates the consumer’s need for PCA services, explains the rules of the program, and informs the consumer of his/her responsibilities as an employer. ▪ The PCM agency periodically assesses if the consumer is able to manage the program independently, and provides ongoing skills training to help him/her manage the PCA program. 	<ul style="list-style-type: none"> ▪ No specific training requirements, but a PCA must be willing to receive training from the consumer on how to perform various consumer-specific tasks. ▪ If needed, the PCM agency will instruct the consumer on how to train the PCA. 	<ul style="list-style-type: none"> ▪ PCM agencies and the FIs conduct annual satisfaction surveys as required in their contracts with MassHealth. MassHealth is exploring the development of a Quality Assurance Review Team. MassHealth conducts site visits and performance evaluations bi-annually. ▪ FIs have monthly reporting requirements set by MassHealth that are monitored on an ongoing basis. ▪ MassHealth also review any duplicate payments or payments made that are not in compliance with contract requirements (in coordination with program integrity office).

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
New Mexico State Plan	A third-party assessor conducts all the assessments in New Mexico. The service plan is developed by the personal care agency in conjunction with the member and approved by the designated NM Medicaid Utilization Review Agent.		<ul style="list-style-type: none"> ▪ PCAs must be credentialed but do not have to be licensed by the Medicaid agency. ▪ Under the <i>consumer-directed model</i>, there are no training requirements. The consumer is responsible for making sure the PCA is able to provide care in his/her preferred way. ▪ In the <i>consumer-delegated model</i>, PCAs must pass a written competency test within the first three months of employment and receive a minimum of 12 hours of training annually. The PCA is also required to be trained in CPR and first aid within the first 3 months of employment. 	<ul style="list-style-type: none"> ▪ The State conducts on site personal care agencies monitoring, on a regular basis. ▪ NM Medicaid is considering creating a new Quality Assurance Bureau to assure the safety, welfare, and health of all consumers and specifically those in the personal care program. ▪ The State conducts consumer satisfaction surveys three months into their entry into the program. ▪ The State agency conducts phone calls to consumers to ensure that they are receiving adequate care. An active stakeholder workgroup of 70 to 100 people meets on a quarterly basis to address any issues in customer satisfaction and program management, and to consider program improvements. ▪ The State conducts frequent utilization reviews to identify cases of fraud and abuse as early as possible. ▪ A tri-agency council comprised of the managers and division directors from the NM Medicaid Division, Developmental Disabilities Supports Division, and Department of Health meet weekly with PCO financial and consultant contractors to discuss any cases of fraud or abuse.

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
New York State Plan	<ul style="list-style-type: none"> ▪ Decentralized assessment process, i.e., performed by Local Social Services Districts (county or New York City) for the personal care and CDPAP (consumer-directed) programs. ▪ LSSD performs a social assessment and conducts or arranges for completion of a nursing assessment. The social assessment assesses the environment in which services will be provided, as well as the availability of informal supports and other formal supports to meet the recipient's needs. The nursing assessment includes a review and interpretation of the physician's orders and an assessment of the recipient's need for assistance with personal care services tasks. The nurse conducting the assessment also makes a recommendation as to the frequency, duration and amount of services needed. ▪ NY State maintains overall management, monitoring, and oversight 		<ul style="list-style-type: none"> ▪ All Personal Care Workers who are employed by a home care or personal care agency are required to receive training and be certified to provide services. ▪ Curriculum requires a minimum 40 hours of training, which includes 16 hours of Basic Core Curriculum. ▪ Components of Basic Core Curriculum include, e.g., theories of basic human needs; diversity; communication and interpersonal skills; caregiver observation, recording and reporting; confidentiality; and personal care skills (e.g., client's environment, infection control, etc.). ▪ PCWs must also complete ongoing in-service/refreshers training. ▪ Upon completing of the curriculum and training, PCW receives a "certificate" of completion. ▪ NY State requires further specialized training if a PCW provides services to certain populations. 	<ul style="list-style-type: none"> ▪ New York City and several of the suburban LSSDs conduct consumer satisfaction surveys and operate a complaint hotline. During its periodic, borough-based re-procurement process, New York City uses these surveys and complaint records as one factor in determining with which provider agencies they should continue to contract for personal care services. ▪ State staff conducts on-going on-site monitoring visits of LSSDs to review case records for programmatic compliance. ▪ Several districts use the Sansport time clock system to monitor PCW hours.

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
	responsibility, e.g., NY State requires each LSSD to prepare an Annual Plan Document. The Plan documents how each local district operates its personal care services program.			
Oregon State Plan	Case managers are responsible for personal care service eligibility, assessment, care planning, service authorization, and care implementation. The elderly and persons with physical disabilities are assessed using an electronic assessment tool; the assessment tool for other populations is not automated.	The local agencies (e.g., AAAs or Centers for Independent Living) provide training to all consumers who need help in directing their care. STEPS, the series of training modules, teach employer skills to people who receive in-home services	<ul style="list-style-type: none"> ▪ Consumers are responsible for training their own PCAs. ▪ To be a PCA, an individual must demonstrate that he/she is capable of safely and adequately providing authorized services. A PCA's qualifications are judged by both the consumer and the local agency responsible for coordinating the care. 	<ul style="list-style-type: none"> ▪ Consumers must also sign vouchers to confirm that care was provided before any payments can be made. ▪ State conducts consumer satisfaction survey ad hoc.
Texas State Plan	<ul style="list-style-type: none"> ▪ Each of 11 regional offices performs a standardized assessment, using a standardized form. Upon completion of the assessment, the case manager or social worker determines the level of care required. ▪ The case manager currently authorizes hours based on estimates for completing the service tasks. 		<ul style="list-style-type: none"> ▪ The State does not require formal training or certification of community-based personal attendants. ▪ The State requires licensing of home health and personal care agencies that employ provide personal care workers. 	<ul style="list-style-type: none"> ▪ The State monitors participants' needs in each personal care program at various intervals (e.g., 90 days for consumer directed care participants; 6 months for PHC program participants). ▪ The State periodically reviews authorization information. The State conducts annual consumer satisfaction surveys.

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
Washington State Plan	<ul style="list-style-type: none"> ▪ Assessments are performed by case managers employed by the State or AAAs. ▪ WA uses an automated tool called CARE (Comprehensive Assessment Reporting Evaluation). ▪ Based on consumer's responses to interview questions on the tool about preferences and assessor's evaluation of participant's ability to carry out ADLs, the CARE system automatically classifies the individual and determines the proper number of hours to authorize. 		<ul style="list-style-type: none"> ▪ State requires 2 hour orientation, 28 hours of care-giving training, and 2 hours of safety training. ▪ All PCAs are also required to complete 10 hours of continuing education annually 	<ul style="list-style-type: none"> ▪ State conducts regular internal claims review process to look for duplicate payments. ▪ The State also operates a center for quality assurance whose staff members travel to all regional offices and AAAs to review files and provide training. ▪ AAAs must conduct regular quality assurance reviews. Washington is considering an automated system to tie assessment and care planning processes to participant outcomes.
Wisconsin State Plan	<p>A supervisory registered nurse (RN) employed or sub-contracted by the county conducts a home care assessment on each participant who requests personal care services.</p>		<ul style="list-style-type: none"> ▪ There is no licensure requirement for a personal care worker. ▪ The State Medicaid agency is also looking into requirements for personal care specialization and competency-based training for personal care workers. ▪ Personal care services provided by certified nursing assistants (CNAs) under the home health benefit are subject to caregiver laws and competency-based training 	<ul style="list-style-type: none"> ▪ Wisconsin Medicaid requires an RN supervisor to evaluate, coordinate, and supervise personal care services for each consumer. ▪ The Medicaid-certified provider must document quality assurance activities as well as all services provided and reimbursed. ▪ The State conducts consumer satisfaction surveys.

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
			<p>requirements.</p> <ul style="list-style-type: none"> Medicaid-certified personal care agencies provide consumer-specific training tailored to the type of service the personal care worker will be providing. Alternatively, the agency may pay for outside training of employed or contracted personal care workers. Personal care workers must complete a minimum of 40 classroom hours of training (at least 25 of which must be devoted to personal and restorative care) or have six months of equivalent experience. 	

Cash and Counseling Programs

Michigan Cash & Counseling	A support coordinator employed by a waiver agent performs a level of care determination (LOC) in the presence of a registered nurse or social worker on an annual basis.	Each consumer is assigned a support coordinator to provide case management services and help develop the consumer's plan of care.	<ul style="list-style-type: none"> State-required training includes: first aid, universal precautions, and CPR. DVDs and workbooks available for self-training. Some waiver agents contract with a home health care provider to conduct the training. State requires additional certification or licensing is for medical care and other services such as home modifications. 	<ul style="list-style-type: none"> State program staff develops and reviews monthly trends containing enrollment demographics. Fiscal intermediaries (FI) provide monthly budget reports to the support coordinators and participants. If a participant spends 10 percent more or less than their monthly budget, the FI flags the budget for review by the support coordinator. The support coordinator may adjust the participant's budget to better meet the participant's needs, and is also responsible for reporting fraud. University of MI is conducting a quality of life survey.
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	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
New Mexico Cash & Counseling	<p>The State contracts with a third party assessor to conduct an assessment of individual's need for personal care services.</p> <p>The service plan is developed by the personal care agency in conjunction with the member and approved by the designated NM Medicaid Utilization Review Agent.</p>	<p>Consultants work with consumers to develop and revise individual budgets. Consultants assist the consumer during the development of his/her own specific service and support plan.</p> <p>Consumers also have the option of appointing a representative and being part of a peer support group.</p>	<ul style="list-style-type: none"> ▪ No specific training requirements. ▪ Consumers are responsible for training their PCA on how they want their care delivered. ▪ Consumers can request that their PCA receive specific formal training, such as CPR. 	<ul style="list-style-type: none"> ▪ Consultant is required to meet with the consumer at least quarterly (two times per year must be face-to-face). ▪ A State-contracted financial management agency monitors budget utilization and reports on over/underutilization of services. ▪ Consumer satisfaction survey is conducted 3 months after entry into the program. ▪ State agency conducts frequent phone calls to the consumer to ensure that consumers are receiving adequate care. ▪ The third party assessor conducts frequent consumer utilization reviews and identifies any cases of fraud as early as possible just as in the PCO program. ▪ A tri-agency council comprised of the managers and division directors from the New Mexico Medicaid Division, Developmental Disabilities Supports Division, and Department of Health) also meets weekly program's financial and consultant contractors to discuss and resolve fraud or abuse cases.

	Assessment	Care Management, Oversight and Consumer Support	PCA Training Requirements and Practices	Program Integrity & Quality Assurance Strategies
Washington Cash & Counseling	<ul style="list-style-type: none"> ▪ Case managers employed by the State or by the Seattle/King County AAAs conduct assessments of all potential C&C participants using the CARE assessment tool to determine eligibility and service hour levels. ▪ The State calculates the cash value of the authorized hours, which the consumer can use, to address needs identified in the CARE assessment. 	<ul style="list-style-type: none"> ▪ Washington uses a single contracted agency that provides both consultant and fiscal intermediary support for all participants. ▪ Cash & Counseling participants meet with a consultant who provides assistance in the development of an individualized spending/care plan and budget. The consultant provides assistance in locating and arranging for the purchase of goods and services. 	<ul style="list-style-type: none"> ▪ Within 120 days of employment the PCA must successfully complete 28 hours of care giving training, and 4 hours of safety training. ▪ All PCAs are also required to complete 10 hours of continuing education annually. 	<ul style="list-style-type: none"> ▪ Fiscal intermediaries are required to run monthly reports on the current cash balance and rate of spending for each of the consumer's budget and discuss with consumers. ▪ Consumers sign their PCAs' timesheet before it is submitted. ▪ The contracted consultant agency conducts quarterly C&C consumer satisfaction surveys.

State Comparison Summary-Table 2

	Required Level of Care/Need (Assistance with Activities of Daily Living "ADLs" and/or Instrumental Activities of Daily Living "IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
State Plan PCA Programs			
Massachusetts State Plan	<ul style="list-style-type: none"> ▪ Member’s disability is permanent or chronic in nature and impairs member’s functional ability to perform ADLs or IADLs. ▪ Member requires physical assistance with two or more ADLs. <ul style="list-style-type: none"> - ADLs: (1) mobility, including transfers; (2) medications; (3) bathing/grooming; (4) dressing or undressing; (5) range-of-motion exercises; (6) eating; and (7) toileting.¹ - IADLs: (1) Household services—physically assisting with household management tasks; (2) meal preparation—physically assisting member in preparing meals; (3) transportation—accompanying the member to medical providers; and (4) special needs—assisting with care and maintenance of wheelchairs and adaptive devices, completing paperwork required for receiving personal care services, and other special needs approved by MassHealth agency as being instrumental to the health of the member.² 	<ul style="list-style-type: none"> ▪ MassHealth pays Fiscal Intermediary a rate that includes the PCA wage plus an additional amount above the wages to cover payment of the employer’s taxes and workers’ compensation. This additional amount, called Employer Expense Component (EEC) is calculated by the Division of Health Care Finance and Policy.³ 	<ul style="list-style-type: none"> ▪ Wages are determined by contract under a collective bargaining agreement between the PCA Quality Homecare Workforce Council and SEIU. Agreement on a collective bargaining contract was reached in October, 2008 and the PCA union contract was ratified on November 25, 2008. ▪ PCA wages increased from \$10.84 per hour to \$11.60 per hour, effective July 1, 2008. ▪ PCAs receive time and-a-half, for time worked on certain holidays - Independence Day, Thanksgiving, Christmas, and New Year’s Day.

¹ Commonwealth of Massachusetts, MassHealth Provider Manual Series, Personal Care Manual, Section 422.403 (02.01/06).

² Commonwealth of Massachusetts, MassHealth Provider Manual Series, Personal Care Manual, Section 422.410 (02.01/06).

³ The new wages and rates for the duration of the collective bargaining agreement (through June 30, 2011) can be viewed on the Massachusetts Division of Health Care Finance and Policy website at www.mass.gov.

	Required Level of Care/Need (Assistance with Activities of Daily Living “ADLs” and/or Instrumental Activities of Daily Living “IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
New Mexico State Plan	<ul style="list-style-type: none"> ▪ Individuals must have Medicaid nursing facility level of care based on: <ul style="list-style-type: none"> - Limitations in at least 2 ADLs; and - An assessment of 8 nursing facility clinical factors. ▪ Activities can include, but are not limited to: assistance with bathing, dressing, grooming, eating, toileting, shopping, transporting, caring for assistance animals, cognitive assistance and communicating; and ▪ Individuals may be physically capable of performing ADLs or IADLs but may have limitations in performing activities because of a cognitive impairment. Personal care services, in that case, can include cuing and supervision.⁴ 	<ul style="list-style-type: none"> ▪ In the PCO consumer-directed (CD) program, State pays the agency a flat rate of approximately \$200 per month per consumer to handle the employer-related tasks such as tax filing, W2 documentation, etc. ▪ In the consumer-delegated program, the Medicaid program reimburses personal care agencies approximately \$13 per hour. 	<ul style="list-style-type: none"> ▪ CD Model: consumer negotiates wage ▪ Consumer delegated model: State requires agencies pay the PCA a minimum of \$8.50/hr (out of the \$13/hr paid to the agency) ▪ In both programs, PCAs only receive benefits if their agencies provide them.
New York State Plan	<ul style="list-style-type: none"> ▪ Individual requires some or total assistance with: (1) personal hygiene; (2) dressing and feeding; and (3) nutritional and environmental support functions, based on a nursing and social assessment.⁵ 	<ul style="list-style-type: none"> ▪ State establishes maximum rates by region. ▪ A county may, with State approval, pay lower rates than those approved by the State. 	<ul style="list-style-type: none"> ▪ The New York State Department of Health does not control PCW wages or benefits through the rate setting process. ▪ The agency which hires PCW is responsible for establishing wage and benefit levels. ▪ Benefits may vary and may include healthcare benefits, day care, sick days, and/or other benefits.

⁴ New Mexico Administrative Code, Title 8, Chapter 315, Part 4, Section 9 (8.315.4.9 NMAC) and 8.312.2-UR Long Term Care Services Utilization Review Instructions for Nursing Facilities.

⁵ New York Codes, Title 18, Part 505 (18 NY Comp. Codes R. & Regs. 505.14)

	Required Level of Care/Need (Assistance with Activities of Daily Living “ADLs” and/or Instrumental Activities of Daily Living “IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
			<ul style="list-style-type: none"> ▪ PCWs in New York City belong to a union and their benefits are generally more generous and stable than in many other parts of the State. ▪ Neither the State Plan personal care program nor waiver programs directly pay PCWs for travel time, although agencies may find ways of compensating PCWs for travel costs, such as offering gas cards.
Oregon State Plan	<p>The individual must require assistance with one or more of the following personal assistance services:</p> <ul style="list-style-type: none"> ▪ Personal assistance services include: (1) basic personal hygiene; (2) toileting, bowel and bladder care; (3) mobility, transfers, repositioning; (4) nutrition; (5) medication and oxygen management; and; (6) delegated nursing tasks. ▪ Individuals who meet the above criteria can also receive assistance with (1) housekeeping tasks; (2) arranging for medical appointments; (3) observing health status and reporting changes to physician; (4) first aid/emergencies; and (5) cognitive assistance or emotional support.⁶ 	<ul style="list-style-type: none"> ▪ The agency rate varies by type of services provided (e.g., a range of \$15-17 per hour for homecare services and \$15-19 for personal care). ▪ Rate is based on collective bargaining contract. 	<ul style="list-style-type: none"> ▪ Rate varies by population. ▪ As of 2008, PCAs serving the elderly and persons with physical disabilities receive payments of \$10.20 per hour, an amount negotiated under a collective bargaining agreement. ▪ For PCAs serving the non-elderly population, payments are determined through a legislative budgeting process and are not subject to the collective bargaining agreement. There have not been any major changes to the rate in recent years and it remains at \$8.92 per hour. ▪ No benefits provided.

⁶ Oregon Administrative Rules, Chapter 411, Division 34 (OAR 411-034-0030 and OAR 411-034-0020).

	Required Level of Care/Need (Assistance with Activities of Daily Living "ADLs" and/or Instrumental Activities of Daily Living "IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
Texas State Plan	<ul style="list-style-type: none"> ▪ Individuals must need assistance with at least one of the following personal care tasks: (1) bathing; (2) dressing; (3) grooming; (4) routine hair/skin care; (5) preparing meals; (6) feeding; (7) exercising; (8) self-administration of medications; (9) toileting; and (10) transferring/ambulating. ▪ A score is derived based on the functional assessment of the individual which determines whether an individual is functionally eligible for services and their level of service. Individuals are placed in priority vs. non-priority status based on their level of need (there are 20 levels for priority and 20 levels for non-priority consumers). 	<ul style="list-style-type: none"> ▪ The TX Health and Human Services Commission establishes agency rates for the consumer-directed personal care program. Rates effective August 1, 2008 the agency rate for for non-priority as well as priority consumers participating in the consumer directed option is \$110 per month.⁷ 	<ul style="list-style-type: none"> ▪ <u>Non priority</u> (Effective 8/1/08): <ul style="list-style-type: none"> - Rates range between \$9.61/hr to 10.61/hr depending on client's level. - For consumer directed option the consumer budget is \$8.81 times the approved hours over the 12-month period and the consumer negotiates wages. - No benefits included. ▪ <u>Priority</u> (Effective 8/1/08): <ul style="list-style-type: none"> - Rates range from \$10.67/hr to \$11.67/hr. - For consumer directed option, the consumer budget is \$9.87 times the approved hours over the 12-month period and the consumer negotiates wages. - No benefits included. ▪ In the consumer directed option, participants may provide their workers with benefits though their budget does not include benefits.

⁷ Payment rates, published by the Texas Health and Human Services Commission, by priority versus non-priority as well as participate levels, are available at www.hhsc.state.tx.us/Medicaid/programs/rad.

	Required Level of Care/Need (Assistance with Activities of Daily Living “ADLs” and/or Instrumental Activities of Daily Living “IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
Washington State Plan	<ul style="list-style-type: none"> The automated Comprehensive Assessment Reporting Evaluation (CARE) assessment tool places each participant into one of four classification groups: (1) cognitive performance; (2) clinical complexity; (3) mood/behavior symptoms; and (4) activities of daily living.⁸ 	<ul style="list-style-type: none"> Agency rates based on collective bargaining between the State and SEIU. May depend on type of agency, e.g., home health agencies receive \$17.39 per hour per person to cover PCA wages and other administrative costs. 	<ul style="list-style-type: none"> By statute, all results of collective bargaining between the SEIU and the State are also uniformly applied to all individual providers (IPs) and agencies (including non-unionized agencies). PCAs receive \$10 to \$11 per hour depending on seniority. IPs have a choice of either a Multi-Employer Health Benefits Trust Plan (a Taft-Hartley Plan) or the Washington Basic Health Plan (BHP is a state administered plan).⁹
Wisconsin State Plan	<ul style="list-style-type: none"> Based on an assessment of the individual’s level of functioning with respect to ADLs or IADLs as determined by the Long Term Care Functional Assessment Screen which takes into account the individual’s level of functioning.¹⁰ 	<ul style="list-style-type: none"> The State Medicaid agency generally determines personal care service rates as part of the budgeting process. Historically, the agency has requested annual 1 to 1.5 percent increases for personal care rates. The agency then allocates a budget to each county in the state. 	<ul style="list-style-type: none"> Personal care agencies negotiate wages with individual PCAs. Rates vary by PCA qualification: \$16 per hour for personal care workers; \$41 per hour for registered nurses. PCAs receive reimbursement for travel and supervision costs.

⁸ Washington Administrative Code, Chapter 388-106.

⁹ http://www.hchcw.org/docs/CMS.DSW.Grant.Health.Coverage.Analysis.final_4.5.06.pdf.

¹⁰ Wisconsin Department of Health Services regulations, DHS 107.112.

	Required Level of Care/Need (Assistance with Activities of Daily Living “ADLs” and/or Instrumental Activities of Daily Living “IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
States Cash & Counseling programs			
Michigan Cash & Counseling	Individuals assigned a level of care based on results of the Minimum Data Set for Home Care (MDS-HC) algorithm which includes but is not limited to an assessment of function domains (i.e., ADLs, IADLs). ¹¹	<ul style="list-style-type: none"> Fiscal intermediaries are paid typically \$650 - \$850 per year, per participant. 	<ul style="list-style-type: none"> Each participant works with their care manager to negotiate wages with the individual personal care service worker or with the agency that employs the worker. The average wage for personal care service workers is \$10/hr.
New Mexico Cash & Counseling	<ul style="list-style-type: none"> To be eligible for NM’s Cash & Counseling program (Mi Via), an individual must participate in an <u>HCBS waiver</u>. Cash and counseling is only available through the waivers. The State operates waivers for the elderly and disabled, those who are medically fragile and for individuals with developmental disabilities, traumatic brain injury (TBI) and AIDS. (Note: Waiver and State Plan PCA services are mutually exclusive) 		<ul style="list-style-type: none"> Under the Mi Via program, consumers must pay PCAs \$8.50-\$14.67 per hour. To pay a PCA outside of that range, a consumer must provide an acceptable reason for the requested increase. Consumers are also responsible for researching and ensuring payment of minimum wage, both State, federal, or in some instances, “living wage.” As an “unofficial benefit,” consumers may pay higher wages to their PCAs, allowing them to buy health insurance through the State coverage initiative (SCI), a public-private partnership that provides affordable health insurance products for small employers who have previously

¹¹ “Michigan Project Creates Screening System and Develops and Tests Quality Measures for Home Based Medicaid Patients,” RWJF, September 2006. Diagram of MiChoice Algorithm available at http://interrai.org/applications/mi_choice_diagram.pdf.

	Required Level of Care/Need (Assistance with Activities of Daily Living "ADLs" and/or Instrumental Activities of Daily Living "IADLs)	Personal Care Agency Rate	Personal Care Worker Wage and Benefits
			<p>been unable to afford coverage for their employees.</p> <ul style="list-style-type: none"> ▪ PCAs do not receive overtime pay.
Washington Cash & Counseling	<ul style="list-style-type: none"> ▪ See Washington State Plan, above. 	<ul style="list-style-type: none"> ▪ Agency rates are subject to collective bargaining with SEIU. Home health agencies receive \$6.00 per hour per person to cover overhead, in addition to bargained wage amount. ▪ Counseling/fiscal intermediary agency is paid an amount equal to five percent of each consumer's budget to cover their overhead costs. 	<ul style="list-style-type: none"> ▪ Individual PCAs are represented by the SEIU; wages are set by collective bargaining agreements. ▪ Currently, PCAs receive an average of \$10.50 per hour of service. ▪ The State provides full health insurance benefits to PCAs who consistently work a minimum of 86 hours per month for State consumers; consultants (who assist consumers with program management) participate in their employer benefit plans.

Massachusetts' Personal Care Attendant Program

Program Background

The Massachusetts Personal Care Attendant (PCA) program is a Medicaid state plan service that began in the 1970s and has been in operation for more than 30 years. Administered through MassHealth (Massachusetts' public health insurance program that includes Medicaid and SCHIP), the PCA program helps people with permanent or chronic disabilities remain in their homes and communities while managing their own personal care. In fiscal year 2005, State program staff reported that the program served 13,700 consumers at a cost of \$244 million, accounting for approximately 14 percent of all Medicaid long term care spending in Massachusetts¹². Since 2005, the program has seen an estimated annual growth of 10 percent in the number of participants, to approximately 16,000, and a 29 percent increase in expenditures to \$314 million in fiscal year 2008.

Approximately 24 percent of PCA consumers in the program are over age 65, 14 percent are under 22 years old, and the remaining 62 percent are between the ages of 22-64 years. Recently, the biggest increase in PCA consumers has been among the elderly. One explanation for this is that more elder services agencies have applied to become Personal Care Management agencies (agencies responsible for evaluating MassHealth members' need for PCA services) and are evaluating more elderly persons for the program.

Personal care attendants (PCAs) provide physical assistance to consumers for MassHealth-approved tasks. These tasks include certain activities of daily living (ADLs) such as mobility, bathing/grooming, dressing/undressing, passive range-of-motion exercises, taking medications, eating, and toileting. Tasks may also include instrumental activities of daily living (IADLs) such as laundry, shopping, housekeeping, meal preparation, transportation to medical providers, and other special needs. Personal care attendants can provide services in a variety of settings, including the workplace, as long as the PCA is physically assisting the individual with ADL or IADL activities. A PCA cannot perform tasks for a consumer if he/she is in a hospital, nursing facility, or a MassHealth-funded adult day health, day habilitation, adult foster care, or group adult foster care program.

Program Operations

Under MassHealth 28 Personal Care Management (PCM) agencies and three fiscal intermediaries (FIs) work together to help consumers successfully self-direct their PCA services. MassHealth contracts with PCM agencies to provide a variety of support services for the consumer but the consumer chooses which PCM agency they work with and the PCM agency chooses one fiscal intermediary. The PCM agency evaluates the consumer's need for PCA services, explains the rules of the program, and informs the consumer of his/her responsibilities as an employer. The PCM agency also periodically assesses if the consumer is able to manage the program independently, provides ongoing skills training to help the consumer manage the PCA program, and works with the consumer to develop a written Service Agreement. The Service Agreement describes the roles and responsibilities of the consumer, the surrogate (if

¹² As reported by State of Massachusetts PCA program staff.

any), the PCA, the PCM agency, and the FI, and includes a backup plan if the consumer's regularly scheduled PCA is unable to work.

MassHealth contracts with the FI agencies to help the consumer with his/her employer required tasks related to employing a PCA. This includes receiving and processing PCA activity forms (timesheets), preparing PCA paychecks and direct deposits, filing and paying the consumer's share of state and federal taxes (including unemployment insurance), buying worker's compensation insurance for the employer, and issuing the PCA a W-2. With the assistance of the FI, the consumer pays his/her PCA using MassHealth funds.

A consumer may select the consumer-delegated option or the consumer-directed option of PCA services. In the consumer-delegated option, the FI performs all employer-required tasks while in the consumer-directed option the consumer performs these tasks on his/her own.

Regardless of the option chosen, all consumers must send in their activity forms to the FI for processing. In the consumer-delegated option, the FI issues a check in the PCA's name for his/her services. In the consumer-directed option, the FI issues a check to the consumer in his/her own name. The check includes payments for all PCAs and their services as well as tax payments. All consumers in both options are completely responsible for hiring, training, and scheduling PCAs. The PCM agency is available to teach consumers how to perform these tasks. If the PCM Agency determines that the consumer needs assistance managing their responsibilities, the consumer must name a surrogate (who may be a spouse, parent, or other family member, friend, or neighbor, but cannot be the PCA). The consumer is ultimately in control of what MassHealth-approved tasks their PCA performs but cannot set PCA authorized hours or payment rates, or authorize raises, benefits, vacation, sick time, etc.

Although MassHealth directly administers the state plan PCA program, personal care services in Massachusetts can be provided or administered through other agencies and programs under different rules. The Executive Office of Elder Affairs provides personal care services through the Elder Care waiver. Participants can receive both Elder Care waiver and Medicaid state plan PCA services as long as they are not duplicative. An individual's need for personal care services under the elder services waiver are assessed by Aging Service Access Points (ASAPs) who contract with the Executive Office of Elder Affairs and provide services through various vendor contracts with the ASAPs. The Department of Mental Retardation (DMR) also operates a Residential Habilitation waiver which includes personal care services provided by the DMR vendor. Local governments are not involved in the delivery of PCA services.

Before an individual can receive MassHealth state plan PCA services he/she must first be deemed eligible through a PCA evaluation conducted by a registered nurse (RN) employed through the PCM Agency. MassHealth requires that an occupational therapist be present in the initial evaluation. The evaluation is typically performed in the consumer's home using a standard statewide form called the "MassHealth PCA Standard Evaluation" form which takes into account the consumer's functional abilities and limitations as well as services provided by other agencies. Using this form, the RN evaluates and determines the number of minutes of physical assistance the consumer needs to perform a task, and the frequency per day each task is performed in a week (7 day period). Based on this evaluation, the RN then calculates the total number of hours per week and hours per night (midnight to 6:00 AM) of PCA services that the consumer requires. The individual and his/her doctor must then sign the evaluation before it is

sent to MassHealth for review. Upon review, MassHealth may approve, modify, or deny the request for PCA services. The consumer has the right to appeal a request that is denied or modified by MassHealth. If approved for PCA services, MassHealth sends a notice to the consumer, the FI and the PCM Agency explaining the number of approved hours per week. A prior authorization for PCA services is typically authorized for up to one year, but may be authorized for a period of greater than one year if MassHealth determines, based on the prior authorization submission, that the consumer is medically stable and is over the age of 22.

MassHealth authorizes daytime personal care services in 15-minute increments and nighttime services in one-hour increments. Minutes of personal care service are rounded up to the next 15 minute or hour depending on the time that care is provided. A consumer may use more or less hours in a given week because he/she has an allotted number of hours for the year. If a consumer requires more hours as a result of changes in his/her medical condition or living situation, he/she can request an adjustment through the PCM agency, who then submits an adjustment request to MassHealth. A change requires a partial review (rather than a full re-evaluation).

Personal Care Providers

Consumers hire PCAs in accordance with state laws. PCAs can be of any age allowed under state labor laws, but legally responsible relatives¹³, surrogates, and PCM agency or FI employees cannot act as PCAs. There are neither state qualifications nor background checks required for PCAs. PCM agencies are required to instruct consumers on how to obtain background checks on PCAs and how to screen PCAs. Since adoption of a regulatory amendment permitting such employment, consumers have hired over 2,000 family members as PCAs since September 2006. Although there are no state qualifications for PCAs, a PCA must be able to understand the consumer's needs and act responsibly. There are no set training requirements, but a PCA must be willing to receive training from the consumer on how to perform various consumer-specific tasks. If needed, the PCM agency will instruct the consumer on how to train the PCA.

PCAs in Massachusetts voted to unionize in November 2007. The PCA Quality Homecare Workforce Council and SEIU entered into a collective bargaining process. Agreement on a collective bargaining contract was reached in October, 2008 and the PCA union contract was ratified on November 25, 2008. Wages for PCAs are now determined through the collective bargaining agreement reached between the PCA Quality Homecare Workforce Council and the Service Employees International Union (SEIU). The Council and the FIs are in the process of informing consumers of the increase in the statewide wage to be paid to PCAs. PCA wages increased from \$10.84 per hour to \$11.60 per hour, effective July 1, 2008. MassHealth pays FIs a 15 minute rate that includes the PCA wage plus an additional amount above the wages to cover payment of the employer's taxes and workers' compensation. This additional amount, called Employer Expense Component (EEC) is calculated by the Division of Health Care Finance and

¹³ A legally responsible relative is either a spouse, legal guardian or parent of a minor child

Policy.¹⁴ PCAs receive a differential, equal to time and a half, for time worked on certain holidays - Independence Day, Thanksgiving, Christmas, and New Year's Day.¹⁵

In addition to PCA wages, there is language in the collective bargaining agreement regarding health insurance coverage for PCAs. The collective bargaining agreement requires the State to conduct a study of the health insurance needs of the PCAs in Massachusetts during the first year of the agreement and, based on the findings of the study, to implement a means to provide health insurance coverage to eligible PCAs. The collective bargaining agreement also takes into account any fiscal restraints the State may have in this area.

There are no copayments or cost-sharing in the Massachusetts PCA program. However, the State's Medicaid Buy-In program, CommonHealth, has premiums. Many CommonHealth enrollees are in the PCA program as well. Many people enroll in the CommonHealth program because of the personal care benefits, which most private insurance plans do not cover. An estimated 62 percent of PCA recipients have SSI and 20 percent are in CommonHealth.

Quality Assurance

Overall, consumers report being satisfied with Massachusetts' PCA program. PCM agencies and the FIs conduct annual satisfaction surveys as required in their contracts with MassHealth. Both have received mostly positive feedback thus far. MassHealth's PCA Quality Home Care Workforce Council has also recently conducted a consumer survey and report overall satisfaction with the PCA program.

MassHealth is exploring the development of a Quality Assurance Review Team. The QA team will allow FIs to monitor and enhance policies, procedures, and regulations. The PCM Agencies have performance based contracts in place that include performance standards and measures. MassHealth conducts site visits and performance evaluations bi-annually. The review process for FIs is more stringent. They have monthly reporting requirements set by MassHealth that are monitored on an ongoing basis. To promote program integrity, MassHealth has a system in place for handling fraud in conjunction with the Bureau of Special Investigations (BSI) within the Office of the State Auditor. MassHealth also works closely with its program integrity office to review any duplicate payments or payments made that are not in compliance with contract requirements. PCM agencies and FIs report any suspicion of fraud directly to MassHealth for review. MassHealth may take action to terminate PCA services in cases where the BSI has conducted an investigation and determined that fraud was committed by the consumer/surrogate.

Challenges and Best Practices

State representatives describe their biggest challenge in administering the PCA program to be insufficient resources. As of October 2008, MassHealth employs two staff members to oversee

¹⁴ The new wages and rates for the duration of the collective bargaining agreement (through June 30, 2011) can be viewed on the Massachusetts Division of Health Care Finance and Policy website at www.mass.gov.

¹⁵ Prior to the collective bargaining agreements, the Division of Health Care Finance and Policy conducted rate reviews every two years and rates generally increased each year. However with the new agreement, it is still unknown how often the state will review PCA rates.

the program at the State level, monitor the PCM and FI contracts, and work with other MassHealth units around quality assurance activities.

Despite limited resources, the Massachusetts Personal Care Attendant program offers several best practices that may assist other states in the operation of their programs:

- The program prides itself on its strides in providing worker's compensation for PCAs. Worker's compensation is seamless to the consumer, and MassHealth pays a \$300 per worker per year premium for coverage. All PCAs are immediately covered upon hire regardless of the length of time the consumer has been in the program. Massachusetts has obtained a specific classification code for PCAs where the Massachusetts rating bureau sets and reviews the rates for this classification, which currently solely encompasses PCAs working for consumers in the MassHealth PCA program. With one agent and one carrier involved with all consumers in the consumer-delegated option, data management and tracking capabilities are greatly enhanced.
- Massachusetts' PCA program works closely with stakeholders and has developed the PCA Improvement Workgroup, which is a group of 25 stakeholders that meets monthly with State administrators to discuss priority issues and concerns from the PCA program, and ways to address. The workgroup includes consumers, providers, and advocacy organizations and works with the assistant secretaries of Massachusetts' Executive Office of Health and Human Services and the Executive Office of Elder Affairs.
- The Workforce Council is developing a web-based directory of PCAs that will assist consumers in identifying an experienced PCA when they need services. The Workforce Council is also charged with evaluating the PCA program and submitting a report to the legislature by the end of 2008.
- The Workforce Council is in the process of surveying PCAs in Massachusetts, and will be assessing and developing training for PCAs.
- The State has developed a PCA Consumer Handbook that is available on the MassHealth website at www.mass.gov/masshealth.
- MassHealth conducts trainings for PCM Agencies and FIs regarding performance measures, including best practices derived from the performance evaluations.
- MassHealth has also conducted trainings regarding employer and employee rights and responsibilities. These trainings are mainly directed at PCM skills trainers, and include a panel of State and federal representatives from the federal and state labor divisions, the Department of Revenue, the Department of Unemployment, the Attorney General's Fair Labor Division, the Disabilities Persons Protection Services, the Bureau of Special Investigations, and the Workers' Compensation agent and carrier. It is an opportunity for skills trainers to ask questions pertinent to their work with consumers, and receive responses from knowledgeable professionals in the fields of employment.

For more information on Massachusetts' Personal Care Attendant Program, please contact Lois Aldrich at Lois.Aldrich@state.ma.us or (617) 222- 7440

Michigan's Self-Determination in Long-Term Care Program (Cash and Counseling)

Program Background

The MI Choice Waiver (Medicaid State Plan) program began operations in 1998 as the home and community-based services for the elderly and disabled (HCBS/ED) waiver program. In December 2006, to “empower MI Choice participants through person-centered planning and control over service provision and resource utilization”¹⁶ an amendment to the 1915 (c) Elderly and Disabled waiver initiated Michigan’s cash and counseling pilot, known as Self-Determination in Long-Term Care (LTC). The Cash and Counseling program targets persons ages 65 and over and persons with disabilities ages 18 and over in the MI Choice waiver program statewide. Self-Determination is available to all participants in the MI Choice Waiver. As of December 2008, less than 5 percent of the MI Choice waiver population participates in the Self-Determination in LTC program and the majority of those participants are over age 60. Enrollment continues to increase throughout the State.

Since its inception, the Self-Determination in LTC program has operated its waiver services through waiver agents. The Michigan waiver is operated through an Organized Health Care Delivery System. The State contracts with waiver agents, which include Area Agencies on Aging (AAAs), other agencies serving the elderly or persons with mental illness, and other home services agencies. An individual waiver agent serves each service area, and contracts with personal care assistance (PCA) providers within their region. Four waiver agents ran the four initial Cash and Counseling sites – Detroit Area of Aging, Burnham Brook, Tri-County Office in Aging, and UPCAP Services. As of December 2008, 21 waiver agents (in 21 services areas) contract with the State to serve 627 consumers in the statewide program.

Through written subcontracts, the waiver agents contract with PCA providers and thus verify that providers meet the waiver application specifications established by the Michigan Department of Community Health. Each consumer is assigned a support coordinator (employed by a waiver agent) to provide case management services and help develop the consumer’s plan of care. Two fiscal intermediaries contract with the waiver agents to also assist consumers. The fiscal intermediaries pay providers when services are authorized by the participant and serve as employer agents for participants who directly employ workers.

Participants in the Self-Determination in LTC program use their allocated budgets to purchase a broad range of services at the nursing facility level of care, including:

- Homemaker services
- Respite services
- Environmental modifications
- Non-medical Transportation
- Goods and services (medical supplies and equipment not covered under the Medicaid State Plan)
- Chore services

¹⁶ http://www.cashandcounseling.org/about/participating_states/michigan

- Private duty nursing
- Fiscal intermediary services
- Personal care
- Community living supports

There are other services available for waiver participants that are not included in their budgets; these are:

- Home delivered meals
- Personal emergency response system
- Counseling
- Training
- Adult day health

Program Operations

To participate in the Self-Determination program, participants must meet Medicaid eligibility standards and undergo the MI Choice functional assessment. Participants must be at least 18 years old, and their income may not exceed 300 percent of the SSI Federal Benefit Rate (FBR) or 100 percent of the Federal Poverty Level (FPL)¹⁷. A support coordinator employed by the waiver agent performs a level of care determination (LOC) in the presence of a registered nurse or social worker on an annual basis. Once the LOC is determined, the support coordinator develops each individual's care plan and budget based on their needs through the person centered planning process.¹⁸ In areas where there is a Long Term Care Connection (Michigan's Aging and Disability Resource Center [ADRC]), the LOC is conducted by the ADRC prior to referral to a waiver agent.

Any HCBS waiver participant may opt for the Self-Determination program. Self determination is a choice, and no assessment determines who can participate. The self-determination option is open to everyone enrolled in the MI Choice waiver, and support coordinators encourage individuals to try self-directed care during the care planning process. A participant may "Opt In/Out" of the Self-Determination program at any time. If they are unable to self-direct, the participant may appoint someone to direct their care for them.

If a person opts for the Self-Determination program, a support coordinator works with him or her to develop and revise budgets. The waiver agent authorizes the participant's care plan, and the individual signs a Self-Determination Agreement outlining the roles and responsibilities of the Waiver program entity and participant. Participants use their budgets to hire personal care assistants, contract with preferred providers, make home modifications, and select from other waiver services which best meet their needs. The support coordinators and fiscal intermediaries (FIs) support the participants in managing their respective budgets. The caseload of support

¹⁷ http://www.michigan.gov/documents/mdch/1915-c_HCBS_Waiver-6-2007_205659_7.pdf

¹⁸ Michigan Department of Community Health, which administers Developmental Disability (DD) services, uses a different assessment than that used for the MI Choice Waiver to determine eligibility for DD services.

coordinators varies by agency; however, 30 to 60 clients per support coordinator appears to be the average.

The FI ensures that the consumer manages his or her finances and that providers meet the requirements in the hiring process. The FI receives the care plan and handles paying taxes, worker's compensation, unemployment insurance, and payroll, and does the reporting. The fiscal intermediary controls the financial transactions for the participant. There are two FIs which contract with waiver agents in the Cash and Counseling program, and their fees typically range from \$650 - \$850 a year per participant.

Personal Care Providers

Providers must be 18 years old and capable of performing the functional services of a personal care assistant. In addition, they must be trained in first aid, universal precautions, and CPR. If a participant has a "do not resuscitate" order, the CPR training may be waived. Family members, except spouses and parents of minor children, can provide personal care assistant services. Regardless, all providers must undergo a criminal background check.

The services administered determine the type of training required. For home care services, personal care assistants use DVDs and workbooks to self-train; some waiver agents contract with a home health care provider to conduct the training. For medical care and other services such as home modifications, the State requires additional certification and licensing (home nursing needs a nursing certification, building modifications needs a builders' license, etc.).

The Self-Determination in LTC program does not set personal care service worker wages. Each participant works with their care manager to negotiate wages with the individual personal care service worker or with the agency that employs the worker. The average wage for personal care service workers in this program is \$10 per hour.

Quality Assurance

To ensure that participants are receiving the right level and proper quality of care, the State has implemented several quality assurance measures. Program staff develops a monthly trend presentation containing enrollment demographics. In addition, fiscal intermediaries provide monthly budget reports to the support coordinators and participants. If a participant spends ten percent more or less than their monthly budget, the fiscal intermediary flags the participant's budget for support coordinator review. The support coordinator may adjust the participant's budget to better meet the participant's needs, and is also responsible for reporting fraud. The University of Michigan is currently performing a quality of life study, surveying participants about whether their level of care is being met, relationships with support workers, activities and community integration, personal relationships, dignity/respect, autonomy, privacy, and security within the program.

Challenges and Best Practices

The Self-Determination in LTC program faced challenges as it expanded statewide. Initially, program staff devoted considerable time to the four AAAs who served as waiver agents during the pilot. When 17 more waiver agents were added, State staff were unable to provide the same level of support as they had during the pilot. They therefore modified their approach, using the models in place and focused more time on training support coordinators and participants.

Through the development of the Self-Determination in LTC program, Michigan gained vital insight into the personal care arena. Through implementation and maintaining the Self-Determination in LTC program, Michigan has developed “best practices.” Below are examples of best practices highlighted during the interview:

- Establishment of an effective program requires obtaining the buy-in and commitment from participating agencies. One of the most effective ways of doing so was to assist the participating agencies financially (e.g., the initial four pilot agencies received grant funding to develop the program). The initial four agencies then mentored the 17 new agencies. These remaining 17 agencies were awarded small grants to cover the cost of training staff.
- All forms, participant education materials and other relevant information are available across the State for new waiver agents to use.
- On-going technical assistance calls and individual support are provided by the program staff to all waiver agents.
- Sharing information with other states through the Cash and Counseling National Program Office (www.cashandcounseling.org), has provided the State with technical assistance, resources, and provider training.

For more information on Michigan’s Self-Determination in Long-Term Care Program, please contact Tari Muniz at MunizT@michigan.gov or (517) 335- 5671

New Mexico's Personal Care State Plan Option

Program Background

To meet the needs of Medicaid enrollees who require personal care services, New Mexico operates both a Personal Care Option (PCO) and a Cash and Counseling (Mi Via) program under its State Plan.¹⁹ PCO and Mi Via expenditures totaled \$206 million and accounted for approximately 24 percent of New Mexico's Medicaid long term care spending in 2007.²⁰ As of October 2008, the PCO program had over 12,000 participants with expenditures totaling over \$232 million annually as reported by program staff.

New Mexico implemented its Personal Care State Plan Option program in 1999. Until 2004, the program was administered by the Medical Assistance Division of the Human Service Department. Administration of the program has since moved to the newly formed Aging and Long Term Services Division (ALTSD) in the Department. The program serves all categorically needy groups who qualify for Medicaid except children.

The PCO program assists consumers with disabilities or functional limitations. It provides a range of services to consumers unable to perform some or all activities of daily living (ADLs) including bathing, dressing, grooming, eating, and toileting. The program also provides assistance with independent activities of daily living (IADLs) including shopping, non-medical transportation, caring for assistance animals, cognitive assistance, "cueing" or monitoring, and communicating.

Program Operations

Eligible consumers must meet income criteria, nursing home functional eligibility requirements (level of care) and require assistance with at least two ADLs. Consumers must not be receiving Medicaid HCBS or Pre-PACE/ PACE (Program of All-inclusive Care for the Elderly) services. Assessment for the PCO program is separate from that conducted for waiver programs, although State staff are interested in moving to one universal assessment process. A third-party assessor, Loveless Health, conducts all the assessments in New Mexico.

In the PCO program, there are 3 levels of need for various activities – low, medium, and high. These levels, determined through the assessment, are instrumental in determining a consumer's care plan. Hours of care are established based on a consumer's assistance requirements with ADLs and IADLS. Consumers may request supplemental units of care but need medical documentation or reason for their request. PCO services are allocated in 15-minute units. Most consumers, on average, are authorized 35 hours per week of personal care services.

Under the PCO program, the Personal Care Service Plan (PCSP) is developed by the consumer or surrogate, and/or legal guardian or family members as appropriate, in conjunction with the

¹⁹ State fiscal year 2007 data as reported by Thompson Reuters based on CMS for 64 submissions. (Data does not provide cash and counseling expenditures separately.)

²⁰ This paper primarily focuses on describing the Personal Care Option program. While we comment on the Mi Via program where appropriate, a complete description of that program is included in a separate paper in this Appendix.

Personal Care Agency and approved by the designated New Mexico Medicaid Utilization Review Agent.

PCO services can be delivered under a consumer-directed or consumer-delegated model. Personal care agencies may offer either or both of the models:

- Under the consumer-directed model, the consumer is responsible for interviewing, hiring, training, firing, and scheduling the personal care attendant (PCA). The consumer is also responsible for developing a back-up plan in case his/her PCA is unavailable, reporting incidents to the agency, verifying timesheets, ensuring that the PCA has undergone a criminal background screening, and obtaining a signed agreement that the PCA will not provide services under the influence of drugs or alcohol. The consumer-directed model was used by only four percent of PCO consumers in 2005 but has grown to 18 percent in 2008.
- Under the consumer-delegated model, the agency is responsible for employing, scheduling, firing, and training the PCA, as well as other employer-related tasks described above.

Personal Care Providers

Under the consumer-directed model, there is no training requirement as the consumer is responsible for making sure the PCA is able to provide care in his/her preferred way. In the consumer-delegated model, PCAs must pass a written competency test within the first three months of employment and receive a minimum of 12 hours of training annually. The PCA is also required to be trained in CPR and first aid within the first 3 months of employment.

PCAs must be credentialed but do not have to be licensed by the Medicaid agency. They must also undergo a criminal background check that agencies are responsible for administering. Both PCO and Mi Via PCAs must also be checked against the abuse registry.

In the PCO consumer-directed program, a personal care agency is paid a flat rate of approximately \$200 per month per consumer to handle the employer-related tasks such as tax filing, W2 documentation, etc. The consumer negotiates the wage level with his/her PCAs. In the consumer-delegated program, the Medicaid program reimburses personal care agencies approximately \$13 per hour; the agencies must pay a minimum of \$8.50 per hour to PCAs. PCAs only receive benefits if their agencies provide them.

Quality Assurance

To ensure that consumers are receiving the best personal care services and support available, both the PCO and the Mi Via program have quality assurance mechanisms in place. In the PCO program, personal care agencies are monitored on-site, on a regular basis. Any incidences of wrong-doing are reported to Adult Protective Services (APS). New Mexico Medicaid is also considering creating a new Quality Assurance Bureau to assure the safety, welfare, and health of all consumers and specifically those in the personal care program.

The State assesses consumer satisfaction with surveys administered to consumers three months into their entry into either the PCO or Mi Via program. Phone calls are also made to the consumer from the State agency to ensure that consumers are receiving adequate care. In addition, an active stakeholder workgroup of 70 to 100 people meets on a quarterly basis to address any issues in customer satisfaction and program management, and to consider program improvements.

The State attempts to achieve program integrity through two mechanisms. First, the third party assessor conducts frequent utilization reviews to identify cases of fraud and abuse as early as possible. Second, a tri-agency council comprised of the managers and division directors from the New Mexico Medicaid Division, Developmental Disabilities Supports Division, and Department of Health meet weekly with PCO and Mi Via financial and consultant contractors to discuss any cases of fraud or abuse.

Challenges and Best Practices

Providing adequate personal care for individuals with brain injuries, mental health issues and behavioral problems is a challenge in both the PCO and Mi Via programs. Program administration also poses a challenge because the program is so vast. In spite of these challenges, consumers are happy with the PCO program.

The PCO consumer-directed program has seen an increase in participants in recent years. Accounting for four percent of PCO participants in 2004, the consumer-directed option is now used by 18 percent of participants. This program approach has resulted in a decrease in monthly care plan costs by several hundreds of dollars and, overall, State staff believe that most consumers appear to be healthier than when they first entered the program.

For more information on New Mexico's Personal Care State Plan Option, please contact Marise McFadden Marise.McFadden@state.nm.us or (505) 476-4706

New Mexico's Cash & Counseling Program

Program Background

New Mexico's Cash and Counseling program, known as Mi Via, is the State's Medicaid Self-Directed Waiver program. It began enrollment in December 2006 with a goal of 400 enrollees by the end of the initial grant period in 2009. The State's newly formed Aging and Long Term Services Division (ALTSD) leads oversight of the program through a Tri-Agency partnership that includes the New Mexico Department of Health and the New Mexico Human Services Department. Local governments are not involved in the authorization or implementation of Mi Via. As of September 2008, Mi Via had 639 participants. In 2007, total personal care expenditures (including cash and counseling) was \$206 million. The personal care services program accounted for about 29 percent of Medicaid long term care spending in 2007, including services under the cash and counseling program and the Medicaid State Plan personal care program.²¹

Program Operations

Individuals have the option of receiving personal care services through HCBS waivers or through Mi Via. However, they may not also receive personal care through the State personal care option (PCO) as the programs are mutually exclusive. To be eligible for Mi Via, an individual must participate in an HCBS waiver .²²

Before an individual can receive care under Mi Via, Loveless Health, the State's third party assessor, must assess his/her abilities and ensure that the individual is in need of personal care services.

The Mi Via program provides consumers with the option to control their own personal care services. With their monthly budget, consumers are able to use funds to hire personal assistant services, make home modifications, and purchase other services that would help them live independently. Consultants work with consumers to develop and revise individual budgets. Consultants assist the consumer during the development of his/her own specific service and support plan. Consumers also have the option of appointing a representative and being part of a peer support group.

A consumer's budget allocation under the Mi Via program is based upon the waiver he/she is transitioning from as well as his/her age. When a consumer transitions his or her PCA services from their regular waiver program to Mi Via, case management costs are removed and on average, the consumer's allocated budget is reduced by 10 percent. Even with this, some consumers are unable to utilize their entire budget allotment. State representatives hypothesize that this may be because Mi Via gives an individual greater flexibility in utilizing their budget on a broad range of services (e.g. physical therapy).

²¹ State fiscal year 2007 data as reported by Thompson Reuters based on CMS for 64 submissions. (Data does not provide cash and counseling expenditures separately.)

²² The State operates waivers for the elderly and disabled, those who are medically fragile and for individuals with developmental disabilities, traumatic brain injury (TBI) and AIDS.

Personal Care Providers

Although there are no specific training requirements, Mi Via consumers are responsible for training their personal care attendant (PCA) on how they want their care delivered. They can request that their PCA receive specific formal training, such as CPR.

Personal care attendants may be family members and friends who are not “legally responsible” for the consumer. All PCAs must have a criminal background check that agencies are responsible for administering as well as a check against the abuse registry.

Under the Mi Via program, there is an established range (about \$8.50-\$14.67 per hour) which the consumer may pay his/her PCA. To pay a PCA outside of that range, a consumer must provide an acceptable reason for the requested increase. Consumers are also responsible for researching and ensuring payment of minimum wage, both State, federal, or in some instances, “living wage.”

Under the terms of the waiver, the Centers for Medicare and Medicaid Services (CMS) precludes the State from offering benefits to PCAs. The State will request CMS review this restriction as the waiver comes up for renewal. As an “unofficial benefit,” consumers may pay higher wages to their PCAs, allowing them to buy health insurance through the State coverage initiative (SCI), a public-private partnership that provides affordable health insurance products for small employers who have previously been unable to afford coverage for their employees. The program does not cover overtime payment.

Quality Assurance

For quality assurance purposes, a consumer’s Mi Via consultant is required to meet with him/her at least quarterly (two times per year must be face to face). In addition, Mi Via’s financial management agency, Public Partnership Limited, monitors budget utilization and reports on underutilization as well as overutilization of services. The Mi Via program allows consumers to determine their own definition of “health and safety.” Consumers are thereby responsible for reporting any cases where their health or safety is compromised.

In both PCO and Mi Via programs, consumers are surveyed three months after entry into either program to assess overall satisfaction. Phone calls are also made frequently to the consumer from the State agency to ensure that consumers are receiving adequate care. The stakeholder workgroup created to support both PCO and Mi Via also helps to ensure that Mi Via is addressing the needs of its consumers.

To maintain program integrity, the third party assessor conducts frequent consumer utilization reviews and identifies any cases of fraud as early as possible just as in the PCO program. A tri-agency council comprised of the managers and division directors from the New Mexico Medicaid Division, Developmental Disabilities Supports Division, and Department of Health) also meets weekly with PCO and Mi Via financial and consultant contractors to discuss and resolve any cases of fraud or abuse.

Challenges and Best Practices

A challenge for the Mi Via program is providing sufficient personal care for individuals with brain injuries and individuals with behavioral mental health issues. Administration of such a flexible program also poses a challenge for the Tri-agency council. There have been cases of exorbitant spending of program funds and other abuses that the council and workgroup address regularly. In spite of these challenges, consumers and program administrators are satisfied with the program. Consumers tend not to switch back into traditional waivers and State program managers note that they believe that participants of the program are healthier than when they began.

For more information on New Mexico's Cash & Counseling Program, Mi Via, please contact Marise McFadden Marise.McFadden@state.nm.us or (505) 476-4706

New York's Personal Care and Consumer Directed Personal Assistance Program

Program Background

The New York Personal Care program began operations in 1978. At that time, the personal care program transitioned from Title XX to the Medicaid program in part as a way to address Title XX cost constraints. To provide consumers with additional flexibility and freedom in their care, the State developed its Consumer Directed Personal Assistance Program (CDPAP). Originally established as a demonstration in the 1980s, CDPAP became a Medicaid State Plan option in 1996, and expanded statewide. Under CDPAP, with the exception of certain family members, participants have the flexibility to choose their aide and make informed choices regarding management of the services they receive, as well as recruiting, training and managing their personal care worker.

State Plan personal care services are available to waiver participants if personal care services are not included within that particular waiver service menu. Some waiver programs, such as those structured for persons with developmental disabilities, do not include personal care services as a waiver service and, thus, these services must be provided through the State Plan program.²³

By 2006, New York's personal care program had over 82,000 participants and the CDPAP had approximately 10,000 participants. Expenditures in 2005 were approximately \$2.4 billion annually, or approximately 26 percent of New York's Medicaid LTC budget. Currently, program expenditures are increasing as enrollment declines. The expenditure increases are a direct result of New York's implementation of rate increases to address personal care worker (PCW) recruitment and retention challenges. The decrease in enrollment in the State Plan personal care services program is due to recipients opting to participate in the CDPAP and in waiver programs which include personal care services in their menu of waiver services.

Home Care Support Services (HCSS), provided under the Traumatic Brain Injury (TBI) and Nursing Home Transition and Diversion (NHTD) waivers, is available to non-self-directing waiver participants who (1) require supervision, cueing or monitoring as a discrete service or who need assistance with personal care tasks and who also require supervision, cueing, or monitoring or (2) who need monitoring as an independent task when no personal care services tasks are being performed. Self-directing waiver participants who require assistance with personal care but have no need for supervision, cueing or monitoring, must receive those services through the state plan Personal Care Services Program or CDPAP administered by the local social services district.²⁴

²³ The Office of Mental Retardation and Developmental Disabilities offer services to adults and children with disabilities, including Medicaid-funded HCBS waiver services. These services include residential habilitation, day habilitation, prevocational services, supported employment, respite services, environmental modifications, adaptive equipment, plan of care support services, family education and training, and consolidated supports and services. OMRDD services description available at www.omr.state.ny.us.

²⁴ Description of Home and Community Support Services (HCSS) available at www.health.state.ny.us

Program Operations

Local social services districts (county or New York City-based) conduct the programmatic eligibility assessments for the personal care and CDPAP programs.²⁵ Both programs use a standardized State assessment form; however, local variations are permitted.

Receipt of a physician's order attesting to the medical need for services initiates the personal care services assessment process. The Local Social Services District (LDSS) must then perform a social assessment and conduct or arrange for completion of a nursing assessment. The social assessment assesses the environment in which services will be provided, as well as the availability of informal and other formal supports to meet the recipient's needs. The nursing assessment includes a review and interpretation of the physician's orders and an assessment of the recipient's need for assistance with personal care services tasks. The nurse conducting the assessment also makes a recommendation as to the frequency, duration and amount of services needed.

The participant must be medically stable, self-directing or have someone acting in that capacity on their behalf, and be able to be maintained safely in their home with the provision of services. The nurse then develops the plan of care based on the physician orders and the social and nursing assessments. The care plan incorporates diagnoses, recommendations for care and services, as well as the hours of service required. The care plan serves as the authorization for services; services are authorized in 15-minute and hourly increments and entered into the State's eMedNY MMIS system. Participants living in the same housing unit are permitted to share personal care workers; however, services provided are based on each participant's authorized services.

The care plan service authorization follows the consumer to various settings, including school, work, and community activities, among others. If consumers are living in a residence or participating in a program which provides some or all of the services which would otherwise be provided by a PCW, they are not eligible to receive personal care services through the State Plan program.²⁶

Case managers coordinate services for traditional personal care, working primarily with the home care agencies which are responsible for providing care and ensuring backup services. Caseloads vary, with no minimum or maximum caseloads established. Typically, New York City has a larger ratio of participants to case managers than upstate New York because of the volume of participants in New York City.

As mentioned earlier, CDPAP provides consumers with greater flexibility in managing the services they receive, as well as in employment, supervision and management of their PCW. To participate in the CDPAP program, consumers must be able and willing to make informed choices regarding the management of the services they receive, or have a legal guardian,

²⁵ Local districts also perform financial eligibility determinations.

²⁶ Some living arrangements, such as adult homes, are required to provide a limited amount of personal care services. In these instances, only personal care services above and beyond those being provided by the living arrangement can be authorized.

designated relative, or other adult able and willing to help them make informed choices. The participant will also be in charge of recruiting, hiring, training, supervising and terminating caregivers, and must arrange for back-up coverage when necessary, arrange and coordinate other services, and keep payroll records. To assist them, the fiscal intermediary (FI) acts as the employer of record and performs claims processing activities. The FI also provides general training/management support of the consumer-directed program for the consumer, and provides guidelines for PCWs to perform their job.

The rates for services are set by the New York State Department of Health based on annual cost reports. These rates tend to be lower than private rates. Rates reflect regional variations. In addition, local districts are permitted to establish alternative rates: these rates must be lower than the State-established rates and must be approved by the Department of Health. The State does not require copayments or cost-sharing by participants.

Personal Care Providers

All Personal Care Workers who are employed by a home care or personal care agency are required to receive training and be certified to provide services. The New York State Department of Health has an established curriculum for PCWs (called the Home Care Core Curriculum) which was initially developed by the Department of Social Services and was later updated by the State Department of Health and other stakeholders.

This Curriculum requires a minimum 40 hours of training, which includes 16 hours of Basic Core Curriculum. The components of the Basic Core Curriculum cover topics such as: theories of basic human needs; diversity; communication and interpersonal skills; caregiver observation, recording and reporting; confidentiality; and personal care skills (e.g., client's environment, infection control, etc.).

The State requires PCW Home Care Aid Core Curriculum training regardless of payer source (including privately paid services if the private-pay consumer chooses to use an agency). PCWs must also complete ongoing in-service/refreshers training. Upon completing of the curriculum and training, the PCW receives a "certificate" of completion. The State requires further specialized training if a PCW provides services to certain populations such as individuals with Traumatic Brain Injury (TBI) and when providing HCSS services (i.e., 6 hours of in-service training per year for personal care aides and HCSS workers). The home care or personal care agency is responsible for training personal care workers that they employ or for verifying their successful completion of required training provided by another agency.

The New York State Department of Health does not control PCW wages or benefits through the rate setting process; rather, the agency which hires them is responsible for establishing wage and benefit levels. Benefits may vary and may include healthcare benefits, day care, sick days, and/or other benefits. Personal Care Workers in New York City belong to a union and their benefits are generally more generous and stable than in many other parts of the State. Neither the State Plan personal care program nor waiver programs directly pay PCWs for travel time, although agencies may find ways of compensating PCWs for travel costs, such as offering gas cards.

Under CDPAP, participants have a choice of the providers they hire. However, Medicaid beneficiaries directing their own personal assistance services in New York may not hire their spouse, parent, son, or daughter (or son- or daughter-in-law). The participant may hire another relative if that relative is not living in the home or resides in the home only because the amount of care needed makes their presence necessary. In New York's future cash and counseling demonstration, the State is considering whether to allow participants to hire currently excluded family members not living in the same home as the resident (unless the amount of service requires residence in the home) to provide personal care assistant services. There is no information at this time regarding the wage level or other benefits for personal care workers under a cash-and-counseling option.

Quality Assurance

Some districts, primarily New York City and several of the suburban districts, conduct consumer satisfaction surveys and operate a complaint hotline. During its periodic, borough-based re-procurement process, New York City uses these surveys and complaint records as one factor in determining with which provider agencies they should continue to contract for personal care services.

State DOH Personal Care Services Program and CDPAP staff conduct on-going on-site monitoring visits of LDSSs to review PCS and CDPAP case records for programmatic compliance. The Office of the Medicaid Inspector General and Office of the State Comptroller audit the personal care and CDPAP programs to ensure program integrity. Several districts in New York State have also implemented program integrity strategies. For example, several districts use the Sansport time clock system to monitor PCW hours. Upon completion of services, the PCW records his or her time, with the participant's endorsement, using the Sansport system. This system aids in assuring the accurate reporting of the provision of services.

Challenges and Best Practices

The personal care and CDPAP programs as a whole have faced challenges. As in many states, New York PCWs have a high turnover rate. New York has worked to address this challenge by increasing wages and benefits to recruit and retain these workers. New York State pays personal care agencies a rate add-on specifically directed to improving recruitment and retention. Agencies are required to attest that the add-on payments are used for recruitment and retention activities, and spending is subject to post-audit review. New York State also recognized the need for development of a career ladder so that individuals can continue to provide services in this field and meet the growing need for services as well as personal growth. This is evidenced by the establishment of the Core Curriculum with which all personal care workers in the State (both Medicaid and privately paid) are subject to.

New York State is working to achieve a balance between maintaining regulatory control and oversight in the personal care program, while allowing flexibility at the local level to operate the program. Their approach builds on the strengths of local districts and communities in serving their residents while maintaining the integrity of the program and regulatory control within the single state agency at the State level. New York State operates a decentralized assessment system, allowing local entities the flexibility to perform assessments and other programmatic

functions. The State then maintains overall management, monitoring, and oversight responsibility. For example, New York State requires each of its local districts to prepare an Annual Plan Document. The Plan documents how each local district operates its personal care services program, thereby providing State staff with information needed for oversight and improvement activities, as well as information on best practices that they can use in their work with other local districts. At the same time, the report identifies required program parameters, thereby guiding local districts as to the needed components of their program.

For more information on New York's Personal Care and Consumer Directed Personal Assistance Programs, please contact Kathy Sherry at kas12@health.state.ny.us or (518) 474-5271.

Oregon's State Plan Personal Care Program

Program Background

Oregon's State Plan Personal Care program serves three distinct populations: 1) the elderly and persons with physically disabilities; 2) those with developmental disabilities (DD); and, 3) those with mental health issues. Personal care services provided to the elderly and persons with physically disabilities are managed by Area Agencies on Aging (AAA), while services provided to the other populations are authorized and managed by other local agencies (e.g., Centers for Independent Living for DD populations). All populations receive the same individualized case management and undergo similar assessment processes for determining their level of care needs; however, there are fundamental differences in the payment to and available support of personal care attendants (PCA) serving distinct population groups.

In SFY 2007, the program reported an estimated 3,600 unduplicated participants of which about 1,500 were the elderly and persons with physical disabilities, 1,100 had developmental disabilities, and 1,000 with mental health issues. Program expenditures for the past fiscal year amounted to \$4.4 million, spread relatively proportionally among the three populations served, with the group comprised of elderly and persons with physical disabilities accounting for the greatest expenditures.²⁷

Under the State Plan, consumers receive assistance with a variety of activities of daily living (ADLs) including basic personal hygiene, toileting, mobility, nutrition, medication, and oxygen management, and delegated nursing tasks. Assistance with these services enables an individual to move into or remain in his/her own home. Personal care services cannot be used if an individual is receiving assistance in a licensed residential service program, sub-acute care facility, nursing facility, or medical institution. Shopping, transportation, money management, mileage reimbursement, and other services not directly pertinent to a consumer's health or activities of daily living are not supported under this program.

Personal care services are also available through various waivers. However, the same individual may not receive personal care through a waiver and the State Plan. Available waivers include a home and community-based services (HCBS) waiver serving the elderly, two HCBS waivers for individuals with developmental disabilities, and three waivers for children.

Program Operations

To be eligible for the State Plan personal care program, an individual must require assistance with one or more ADLs. The assessment is conducted by a case manager prior to admission to the program and must be updated annually thereafter.

Overall, case managers are responsible for personal care service eligibility, assessment, care planning, service authorization, and care implementation. Upon a request for personal care service, the case manager meets with the individual to assess the individual's ability to perform daily tasks. After assessing the individual's service needs, the case manager identifies the

²⁷ Figure does not include cost of wages, workers compensation, Social Security payments, etc

resources available to meet the individual's needs and determines if he or she is eligible for personal care services.

The elderly and persons with physical disabilities are assessed using an electronic assessment tool; the assessment tool for other populations is not automated. If deemed eligible for personal care services, the case manager prepares a service plan identifying those tasks for which the individual requires assistance and determines the monthly number of authorized hours of service. Individuals are limited to a maximum of 20 hours of services per month and hours do not rollover from month to month. If a consumer requires more than the maximum 20 hours per month, it is recommended that he/she be switched into an alternate waiver program that provides more hours, as stand-alone PCA services are not considered appropriate. When enrolled in a waiver program, these individuals are then evaluated for more appropriate service options.

An eligible individual must also be a Medicaid recipient. All populations receiving State Plan personal care are in direct control of their own care. Consumers are responsible for identifying, interviewing, screening, hiring, scheduling work periods, training, and terminating his/her own PCA. The consumer is also responsible for tracking and confirming the service hours worked by his or her PCA. Consumers must also sign vouchers to confirm that care was provided before any payments can be made. The local agencies (e.g., AAAs or Centers for Independent Living) provide training to all consumers who need help in directing their care. STEPS, a series of training modules, teaches employer skills to people who receive in-home services.

Personal Care Providers

To be a PCA, an individual must demonstrate that he/she is capable of safely and adequately providing authorized services. A PCA's qualifications are judged by both the consumer and the local agency responsible for coordinating the care. A qualified PCA may be employed through a contracted In-Home Care Agency or enrolled as a homecare worker or personal care attendant under an individual provider number. PCAs may include family members who are not legally responsible for the consumer.²⁸ All PCAs must also undergo a criminal background screening.

As a result of a 2004 ballot measure, the State negotiated an agreement that unionized the segment of home care workers who provide services to the elderly and persons with physical disabilities. As of 2008, PCAs serving the elderly and persons with physical disabilities receive payments of \$10.20 per hour, an amount negotiated under a collective bargaining agreement. The agency rate is a contracted rate based on types of services provided by the PCA (e.g., a range of \$15-17 per hour for homecare services and \$15-19 for personal care). For PCAs serving the non-elderly population, payments are determined through a legislative budgeting process and are not subject to the collective bargaining agreement. There have not been any major changes to the rate in recent years and it remains at \$8.92 per hour. There are no benefits available to PCAs.

²⁸ Legally responsible relatives include parents or a legal guardian of a minor child and spouses

Quality Assurance

Although there are no explicit quality assurance mechanisms in place in Oregon's State Plan personal care program, the State and local agencies work to uphold the quality and integrity of the program. Agencies scrutinize PCA qualifications to make sure that consumers of the program receive services from qualified providers. Close attention is also paid to document completion and accuracy as well as strict following of Office of Inspector General (OIG) exclusion lists.

The State Plan personal care program does not conduct consumer satisfaction surveys on an ongoing basis. In December 2004, however, results from a 2003 survey for in-home services (the elderly, physically and developmentally disabled populations) were released. While consumers had a high level of satisfaction with the quality of in-home services that they received, 42 percent stated that they needed more assistance with ADLs than was being provided.²⁹

Challenges and Best Practices

Administrators of Oregon's State Plan personal care program have expressed concern about the degree of oversight and management of the program, most likely attributed to the fact that the program is limited to authorizing no more than 20 hours of personal care per month. Because benefits are very limited and competing priorities in other program areas, significant resources are not dedicated to management and oversight of the program in comparison to other Medicaid programs. Many consumers and administrators view the program as simply a funding source and not necessarily a comprehensive program.

The State Plan program has also been challenged with determining exactly what a "natural support" entails (especially for children) and how such supports should be worked into the service hour allocations. There have also been issues of making exceptions with regards to making certain personal care activities "allowable" dependent on a consumer's unique circumstances, as well as standardizing case management across the State.

In spite of all its challenges, Oregon's State Plan personal care program offers several best practice lessons from which other states can learn. The program sees its separate children assessment process, modeled after Washington State, as a highlight of the program's efficiency and specialization. The program also prides itself on the network of online tools available to consumers to guide them through the personal care process. These tools include a home care registry and training (STEPS) applications that are updated regularly.

For more information on Oregon's State Plan Personal Care Program, please contact Angela Munkers at Angela.P.Munkers@state.or.us or (503) 945-6985

²⁹ Oregon In-Home Survey 2004, http://www.oregon.gov/DHS/spd/pubs/inhome_survres.pdf

Texas Primary Home Care Program

Program Background

Personal care services are provided under multiple state programs in Texas. The primary Texas State personal care assistance program is called the Primary Home Care Program (PHC), which began in 1979 and is among the oldest and largest Medicaid state plan personal care programs. PHC serves adults whose chronic health problems impair their ability to perform activities of daily living. Another program providing personal care is the Community Attendant Services (CAS) program. This program, available to both children and adults, began operations under the provisions of Section 1929(b) of the Social Security Act, but was closed to new enrollment in 1993. Consumer directed services became available in 2002 with establishment of the Consumer Managed Personal Assistant Services program (CMPAS). Through PHC, CAS and CMPAS, providers supply services such as escort, home management, and personal care services. Services exclude medical or technical services. Personal care services are also available through STAR+PLUS, a Medicaid managed long-term care program which also serves dual eligible members, and the Program of All-Inclusive Care for the Elderly (PACE).

In August 2007, the PHC and CAS programs had 59,055 and 42,089 participants respectively. Participation in PHC is expected to increase approximately 5% each year; however, CAS participation is projected to stay approximately the same due to the program's enrollment limitation. As of 2004, roughly 1 percent of personal home care participants were receiving consumer directed services through CMPAS. According to State officials, younger people with disabilities select the consumer directed option most frequently, while many older people do not take advantage of the consumer directed option.

Texas provides PCA services at a lower per member cost under the PHC, CAS and CMPAS program than under its waiver programs. However, enrollment in waiver programs in 2008 is about 51,000 – much lower than the combined enrollment of over 100,000 members in the attendant care programs (CAS, PHC and CMPAS combined). Personal care assistant service expenditures in 2008 are projected to reach \$1.2 billion for all home and community-based waivers (including waivers for the elderly, and individuals with physical and developmental disabilities), compared to \$760 million under State Plan personal care services (i.e., PHC, CAS and CMPAS programs combined).

The Texas Health and Human Service Commission (HHSC) divides the state into 11 service regions. In September 2004, the Texas Department of Aging and Disability Services (DADS), an agency within HHSC, assumed responsibility for all long term care (LTC) programs, including PHC. DADS maintains oversight of the program for all regions, however, each region conducts participant intake for both the state plan and waiver personal care programs.

Program Operations

To be eligible to receive personal care services, a participant's physician must submit a signed statement assessing the functional abilities and stating the needs of the individual. This statement is sent to the appropriate regional office, where a DADS case worker is assigned to

perform the functional assessment for all participants. Each regional office performs a standardized assessment, using a “2060” form, for participants in their area.³⁰ Upon completion of the assessment, the case manager or social worker determines the level of care required. Case managers typically have a case load average of 320 participants. While the case manager is not required to be a registered nurse (RN), an RN is required to review the physician’s statement of medical need and make the final determination for program functional eligibility as well as approve the plan of care.

A score is derived based on the functional assessment of the individual which determines whether an individual is functionally eligible for services. For those individuals who are determined eligible for services based on their functional assessment, the case manager develops their plan of care, including the number of hours needed. The case manager currently authorizes hours based on estimates for completing the service tasks, although Texas is currently working on a project to standardize these allotments of time per task. Texas PHC allows services to be delivered in the consumer’s residence, workplace, and community settings. Services may not be provided in alternative locations where personal care is already available to the recipient. Availability of back-up personal care services are reviewed as part of the assessment process, taking into account both informal and formal supports. For consumer directed services, participants are required to have a back-up plan. If a personal care agency is used, the agency will coordinate the back-up services. The plan of care is reviewed annually by the case manager, and the case manager has face-to-face contact with the participant and personal care assistant every 6 months under PHC and CMPAS, and every 90 days for CAS.

The consumer directed services option, CMPAS, allows participants to hire, fire, train, and manage their personal care assistants. Younger participants select the consumer-directed option more than older participants and service utilization under this model is greater than that of participants who do not have control of their care.

The rate setting division of the Texas HHSC sets statewide personal care services rates. For self-directed services, a portion of this rate is set aside for the fiscal agent (Consumer Directed Services Agencies) which all consumers in consumer-directed care are required to use. These rates are lower than rates for private personal care services.

Texas operates a two-tier system of costs controls in the PHC program. Based on their assessments, (1) individuals fall into two categories (“priority” or “no-priority”); and (2) within these categories individuals fall into one of twenty levels. This classification system impacts their maximum approved hours, the frequency of contact with the client, as well as the rate of payment. For example, the payment rate for non-priority participants in Level 1 is \$9.61 per hour compared to \$10.61 per hour for those in Level 20. For priority clients the payment rate is \$10.67 per hour for Level 1 participants and \$11.67 for Level 20. Also, the budget amount for non-priority clients participating in the consumer-directed program is \$8.81 times the number of units approved over a 12-month period, compared to \$9.87 times the number of units

³⁰ The assessment form is also available through the Community Care for Aged and Disabled handbook.
<http://www.dads.state.tx.us/handbooks/ccad/>

approved over a 12-month period for priority clients.³¹ On average, clients are authorized to receive 16.6 hours of assistance per week. Participants are not required to make copayments for their services.

Personal Care Providers

Personal care providers are either employed by an agency or selected by the consumer (under the consumer-directed program). For providers from agencies, the agency makes the decisions concerning who provides the care and when the care is provided, and provides training for and supervises personal care providers. Under consumer direction, the participant or legal guardian makes all the care coordination and training decisions and is also responsible for paying the worker. Currently, the PHC program excludes spouses and legal or foster parents of minors from being attendants; however, other family members can become paid caregivers. All personal care attendants, regardless of their employers, must undergo a criminal background check by the Regulatory Division.

Texas does not require formal training or certification of community-based personal attendants. However, PHC requires licensing of home health and personal care agencies that employ personal care workers.

Texas establishes personal care rates for agencies, but does not set PCA wages, and does not provide funding for benefits for the personal care workers. Overall, wages for personal care workers tend to be low and benefits lacking. As a result, the turnover rate among personal care workers is high. Consumer directed option participants may provide their workers with benefits with the moneys they receive for their plan of care; however, their care plan does not offer much flexibility to do so.

Quality Assurance

Texas has several program integrity initiatives. The State monitors participants' needs in each personal care program at various intervals (e.g., 90 days for consumer directed care participants; 6 months for PHC program participants). The State also periodically reviews authorization information: while variation in utilization across regions has been observed, no trends have been identified. To examine program quality, the Quality Team has created a quality report. Annually, consumers complete a consumer satisfaction survey.

³¹ Texas HHSC, Primary Home Care, Family Care and Community Attendant Services August 2008 Payment Rates, www.hhsc.state.tx/Medicaid/programs/rad/Phc/2008AugPmtRates.html.

Challenges and Best Practices

One of the State's biggest challenges is maintaining services given the high turnover rate in personal care attendants as a result of low wages and lack of benefits. The State also receives complaints from personal care attendants who travel long distances to care for participants in rural areas and cannot be reimbursed for associated transportation costs. These challenges are common to personal care programs.

For more information on Texas Primary Home Care Program, please contact Marc Gold at Marc.Gold@dads.state.tx.us or (512) 438-2260

Washington's Medicaid Personal Care Program

Program Background

Washington began operating a Medicaid Personal Care (MPC) program through its State Plan in 1989. The Aging and Disability Services Administration (ADSA) administers the program through its offices in more than 100 locations throughout the state. ADSA also contracts with 13 local Area Agencies on Aging (AAAs) for in-home case management and assessments and requires these agencies to follow ADSA policies and procedures. Washington strives to minimize regional variability within the MPC program through this centralized administrative structure.

The MPC program covers Medicaid eligible individuals of any age who need assistance with three or more activities of daily living (ADLs). Currently, approximately 15,000 people receive personal care services through the Medicaid State Plan. In addition to the State Plan MPC program, Washington offers a variety of waiver programs that provide personal care services. Personal care services offered through the waiver and state plan are mutually exclusive; the same individual would not receive personal care services through both programs. Washington's waiver options are:

- The **Community Options Program Entry System (COPES)** waiver is currently the largest, serving over 24,800 people. Individuals over age 65 and those aged 19-64 who are blind or have a disability are eligible for the COPES waiver if their assessment determines they need the level of care provided in a nursing facility. All COPES waiver recipients must either be financially ineligible for the State Plan MPC program or require more services than the MPC program can provide.
- The **Medically Needy Residential Waiver (MNRW)**, which provides personal care services to individuals who require the level of care provided in nursing facilities but are currently living in adult residential facilities, serves approximately 450 people. Individuals over age 18 whose cost of care exceeds their ability to pay may qualify for the MNRW if their income exceeds the standard for both the State Plan MPC program and the COPES waiver. The State disregards income needed to purchase health insurance in the post eligibility process. Washington also has a **Medically Needy In-Home Waiver (MNIW)** which currently provides in-home personal care services to about 50 people. As with the MNRW, individuals whose incomes exceed the standards for both the State Plan MPC program and the COPES waiver, but who require the level of care provided in a nursing facility, can qualify for the MNIW if their cost of care surpasses their ability to pay.
- The **Division of Developmental Disabilities (DDD)** operates four waivers through which individuals with developmental disabilities may receive personal care services when their needs cannot be met through or they are ineligible for the State Plan MPC program. More than 5,000 DDD clients receive State Plan personal care services and another 5,000 DDD clients receive personal care services through one of the Division's four waivers.

- The **New Freedom Waiver** program (Cash and Counseling) currently serves approximately 200 individuals and uses the same functional and financial eligibility guidelines used for the COPES waiver. Individuals who choose to enroll in the New Freedom waiver purchase their personal care services with a State-allocated individual budget; individuals can use budgeted funds to purchase other goods and services that facilitate living outside of institutional care.

Washington spends over \$800 million on personal care provided in the home annually and approximately \$205 million on adult residential care. The State estimates its total annual long term care spending at \$1.5 billion, including:

- \$800 million for in-home care
- \$205 million for community residential care
- \$525 million for nursing facility care

Medicaid does not allow MPC participants to make copayments for personal care services. In the LTC waivers, participants must usually contribute countable monthly income above \$700-800.

Program Operations

One of the hallmarks of Washington's MPC program is its sophisticated assessment process. The federal government requires states to complete thorough assessments annually, but around 40 percent of MPC participants in Washington undergo reassessments well in advance of their scheduled 12 month date because of a change in needs. Using a tool known as CARE (Comprehensive Assessment Reporting Evaluation), Washington's assessors ask open-ended interview questions to participants in an attempt to highlight each individual's needs and preferences. Assessors also evaluate participants' ability to carry out ten ADLs. The automated CARE system then places each participant into one of 17 classifications to determine the proper number of hours to authorize.

The consumer-driven care planning process often occurs concurrently with the assessment. Assessors encourage participants to be actively involved in developing their care plans and to discuss ideas for meeting their needs. Washington requires all program participants to have back-up care plans, which typically involve a friend or family member who can be available in an emergency situation. Alternatively, many participants choose to call on an agency as a back-up plan.

Washington authorizes personal care services in one hour increments. Depending on their level of need, participants can receive authorization for 20-420 hours of personal care services per month. The State Plan MPC program provides assistance with activities such as bathing, dressing, eating, meal preparation, housework, and travel to medical services. In addition to State Plan personal care services, Washington's waiver programs offer home delivered meals, emergency response services, and assisted technology and other services. Participants can use their authorized service hours at home, at their place of employment, at school, or in the community; MPC program participants have complete control over when and where they use their hours.

Personal Care Providers

Washington uses both individual providers (IPs), who contract with the State but do not work for agencies, and home health agency staff to provide personal care services to their program participants. Relatives can act as personal care assistants (PCAs), but spouses and parents of minor children are excluded. All PCAs undergo thorough background checks and are subject to the same qualification requirements, including:

- PCAs must be at least 18 years old
- PCAs may undergo a character, competence and suitability evaluation; PCAs must not have a criminal record that contains any of a number of disqualifying crimes
- Prior to beginning work, PCAs must complete a two hour orientation, 28 hours of care giving training, and two hours of safety training. All PCAs are also required to complete ten hours of continuing education annually.

The Service Employees International Union (SEIU) represents Washington IPs and collectively bargains with the Governor on their behalf. Washington statute requires that all results of collective bargaining between the SEIU and the State are uniformly applied to all individual providers. In addition, there is a statute that provides for parity between IPs and agency caregivers which means that any gains for IPs through the bargaining process are also provided to agencies, including non-union agencies

PCAs receive \$10 to \$11 per hour depending on seniority; home health agencies that employ PCAs receive \$17.39 per hour per person to cover wages and other administrative costs. The SEIU negotiates rates with the Governor every two years, and the State legislature votes on whether the state should enter the contract or not. Additionally, all IPs receive full health insurance benefits from the state.

Quality Assurance

The Washington ADSA performs a regular internal claims review process to look for duplicate payments. The State also operates a center for quality assurance whose staff members travel to all ADSA regional offices and Area Agencies on Aging (AAAs) to review files and provide training. AAAs must conduct regular quality assurance reviews as well. As a result of these efforts, Washington has seen improved payment accuracy. For instance, the number of overpayments made for the MPC program has decreased to less than three percent.

Challenges and Best Practices

The toughest challenge for the program today is the continued institutional bias, which expresses itself in the lack of flexibility in how states develop and design home and community based services. Washington continues to focus on building additional and innovative community based services to continue the work of rebalancing its care system and maintaining the balance in its LTC service delivery system.

A specific challenge the ADSA has faced is securing sufficient State funding to pursue program improvement initiatives. For instance, Washington is currently looking to tie its assessment and

care planning processes to participant outcomes. The ADSA has been attempting to obtain State funding for research on this matter, but budgetary constraints have hindered this effort.

A promising practice is Washington's assessment tool, CARE. The tool is highly effective and helps the State in achieving its goal of performing automated, consistent, objective assessments of all program participants. Use of the CARE tool helps the ADSA distribute available hours as fairly as possible and reduces error.

For more information on Washington's Medicaid Personal Care Program, please contact Debbie Knauf KnaufDJ@dshs.wa.gov or 360-725-2393

Washington's Cash and Counseling Program

Program Background

Washington began its Cash and Counseling program, or New Freedom waiver program, in May 2007. The State has set an enrollment goal of 400 people; as of November 2008 the program had 229 enrollees. To qualify for the New Freedom waiver, individuals must be ineligible for the State Plan Medicaid Personal Care (MPC) program or require more care than the MPC program can provide. Participants must also be 18 years or older, choose to receive in-home services and meet the financial and functional eligibility criteria of waiver services such as nursing facility level of care and Medicaid financial status. The State excludes individuals with developmental disabilities from participation. Washington's Aging and Disability Services Administration (ADSA) administers the New Freedom program under Section 1915 (c) waiver authority. The program only operates in King County, which is the largest county in the state and includes Seattle.

Program Operations

The New Freedom waiver program operates through a consumer-directed care model. Individuals are responsible for the hiring, firing, and supervision of their personal care assistants (PCAs) but they have the support of a fiscal intermediary to manage their finances and responsibilities.

Case managers employed by the ADSA or by the Seattle/King County Area Agency on Aging conduct assessments of all potential New Freedom participants using the CARE assessment tool to determine eligibility and service hour levels. The ADSA then calculates the cash value of the authorized hours, which the consumer can use, to address needs identified in the CARE assessment. New Freedom participants meet with a consultant, who provides assistance in the development of an individualized spending/care plan and budget. Additionally, the consultant provides assistance in locating and arranging for the purchase of goods and services. The financial management services, a separate element of the program, arranges for and makes payment to vendors for personal care, goods and services purchased. Washington uses a single contracted agency that provides both consultant and fiscal intermediary support for all participants.

The average budget per consumer is \$1,800 a month, but budgets range from \$500 to \$4,000 per month depending on need. On average, about 75-80 percent of budgeted funds are used to purchase PCA services. The remaining 20-25 percent is spent on other services, such as mental health, exercise programs, adaptive equipment or nutritional education. New Freedom consumers can spend their cash allowances on a variety of goods and services, including:

- Personal care services (assistance with activities of daily living)
- Health related services under supervision of a nurse
- Homemaking, or assistance with essential shopping, housework, and meal preparation
- Personal assistance with transportation
- Treatment and health maintenance activities

- Equipment or supplies that address an identified need in the CARE assessment and allow the participant to function more independently
- Alterations to a participant's residence or vehicle
- Training or education on personal skill development

Consumers can save for large purchases, but the State limits the amount of money a New Freedom participant can accumulate. Fiscal intermediaries are required to run monthly reports on the current cash balance and rate of spending for each of the participants' budgets, which they either discuss in person or mail to consumers' homes.

Personal Care Providers

New Freedom program participants can hire both individual providers (IPs), who contract with the State but do not work for agencies, as well as home care agency staff to provide personal care services. During the first 14 days of employment all Washington PCAs must complete a two hour orientation. Within 120 days of employment the PCA must successfully complete 28 hours of care giving training, and four hours of safety training. All PCAs are also required to complete ten hours of continuing education annually and submit to regular background checks every two years. A PCA is required to submit to a fingerprint-based check if she/he has lived in Washington for less than three years.

Washington allows all adult family members except spouses to work as personal care assistants (PCAs). Family members comprise approximately 60 percent of the overall state IP workforce. However, State representatives explained that New Freedom consumers hire family members as PCAs less frequently than State Plan personal care consumers. Those consumers who do hire family members as PCAs have a disincentive to budget money for other services because their relative's income falls as they spend money elsewhere.

Washington IPs are represented by the Service Employees International Union (SEIU), which collectively bargains with the State legislature and the Governor's Office on their behalf. Wages for providers are set by the SEIU bargaining agreements. Currently, PCAs receive an average of \$10.50 per hour of service and home care agencies that employ PCAs receive an additional \$6.00 per hour per person to cover overhead costs. The counseling/fiscal intermediary agency is paid an amount equal to five percent of each New Freedom consumer's budget to cover their overhead costs. The State provides full health insurance benefits to PCAs who consistently work a minimum of 86 hours per month for State consumers, while consultants participate in their employer benefit plans.

Quality Assurance

Misuse of funds is always a significant concern with individually budgeted services. However, no instances of abuse have been found to date. One driving force behind this is a State requirement that consumers sign their PCAs' timesheet before it is submitted. Because New Freedom consumers are involved in budgeting and tracking their cash allowances, they tend to pay very close attention to how their money is spent, thereby helping reduce time fraud.

As a program integrity strategy, the contracted consultant agency conducts quarterly surveys of New Freedom program participants to gauge consumer satisfaction. Recent survey results showed over 95% of participants would recommend the program, which represents a substantial increase in overall satisfaction since the program's inception.

Challenges and Best Practices

Washington describes communication with potential eligibles about the benefits of the New Freedom waiver as the State's greatest challenge. The State invests a significant amount of resources into helping consumers understand their options and make truly informed choices. Washington considers its best practice to be the large amount of time spent educating consumers about the New Freedom program and conducting thorough, objective assessments to identify people who may benefit from the New Freedom waiver more than they would benefit from traditional State Plan personal care services.

For more information on Washington's Cash and Counseling Program, please contact Marietta Bobba or Dan Murphy at BobbaM@dshs.wa.gov or (206) 341-7969 and MurphDK@dshs.wa.gov or (360) 725-2466 respectively

Wisconsin's Medicaid Personal Care Program

Program Background

The Wisconsin Medicaid Personal Care (Medicaid State Plan) program has been in operation for more than 20 years. The program provides funding to assist individuals with activities of daily living (ADLs). To be eligible, participants need to be Medicaid eligible and have a medical need for personal care services. In 2007, the program had an estimated 14,000 participants and expenditures of over \$180 million. The personal care program accounted for 12 percent of all Medicaid long term care spending in Wisconsin in 2005.

There has been a movement of personal care consumers into managed care programs as well as an increase in utilization of services and hours per consumer. Wisconsin has made a significant effort over the past four years to transition people out of institutions and into their homes and the personal care program. Since 2004, more than 600 people have transitioned out of Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) and more than 2,000 from nursing homes. Overall program spending has been decreasing due to consumer transitions into managed care but utilization and spending per consumer have been increasing as a result of the higher acuity of people moving back into the community from ICFs-MR and nursing facilities.

Wisconsin's Medicaid Division, Forward Health, administers the Medicaid personal care program, and various waivers also provide personal care services including:

- ICF-MR Expanded-CIP I (MR/DD) waiver
- Community Options Program (elderly and persons with disabilities) waiver
- Brain injury (TBI) waiver
- Children's Long-Term Support Waivers for Children with Developmental Disabilities, Physical Disabilities, and Severe Emotional Disturbances
- IRIS (Include, Respect, I Self-Direct) waiver
- Wisconsin Partnership Program waiver
- Family Care Program waiver

All waivers operate through supportive home care models that include some personal care activities and assistance with IADLs.³² Individuals on HCBS waivers must first use the State Plan personal care services before using the personal care services offered through waivers.

The Wisconsin Partnership Program integrates all health care and long term care services into a single program for frail, elderly, and SSI members. The Aging & Disability Resource Centers (ADRC) are the single point of entry into the program and managed care organizations (MCOs) provide long term care and health care services. At a minimum, MCOs must provide the same

³² The Wisconsin Partnership and Family Care Program waivers are both 1915(b)/(c) combinations that are implemented through a managed care structure.

fee-for-service personal care services that the State Plan provides in their service package. Participants in both Wisconsin Partnership and Family Care are able to self-direct any of their services, including personal care.

Program Operations

The State Medicaid agency administers the Personal Care program and prior authorizes all service packages that exceed 50 hours per year. Counties may be providers or may contract with Medicaid-certified home health agencies, county waiver agencies, and independent living centers to provide care. Counties also develop a clear audit trail for personal care which shows expenditures for each participant. This audit trail must be separate from other services being provided under long term care programs (e.g., Community Based Residential Facility (CBRF) costs, adult family home costs, supportive home care costs).

Before an individual can receive State Plan personal care services, he/she must first be deemed functionally eligible through an assessment. A supervisory registered nurse (RN) employed or sub-contracted by the county conducts a home care assessment on each participant who requests personal care services. The nurse determines the number of hours the individual requires, obtains a physician order, completes a plan of care which the physician signs, and then requests prior authorization for the care. The Wisconsin Medicaid program authorizes hours by week and by year. There is no limit on the number of hours that can be authorized, but the consumer cannot exceed authorized hours unless more hours are requested and authorized. If a special circumstance arises where a consumer requires more hours, he/she can request additional time.

An RN develops a plan of care with the consumer and his/her family based on a physician order. The plan of care accounts for the consumer's social and physical environment, including family involvement, living condition, level of functionality and any pertinent cultural factors such as language. The consumer's physician must approve the original plan of care and continue to review it at least once every 60 days.

Personal care workers cannot provide services outside the recipient's home, in an institution (hospital or nursing home) or in Community Based Residential Facility (CBRF) with more than 20 beds. However, the statutory definition of "home" is liberal and can apply to wherever the consumer sleeps (i.e., applies to group settings up to 20 beds or people). In the fee-for-service personal care program, services are limited to the home with the exception of accompanying the consumer to medical appointments and shopping.

Personal Care Providers

Although there are no licensure requirements to be a personal care worker, personal care services provided by certified nursing assistants (CNAs) under the home health benefit are subject to caregiver laws and competency-based training requirements. Wisconsin Medicaid is also looking into requirements for personal care specialization and competency-based training for personal care workers. Medicaid-certified personal care agencies provide consumer-specific training tailored to the type of service the personal care worker will be providing. Alternatively, the agency may pay for outside training of employed or contracted personal care workers. While personal care workers are not required to be licensed, they must complete a minimum of 40 classroom hours of training (at least 25 of which must be devoted to personal and restorative care) or have six months of equivalent experience. The personal care agency is responsible for assuring that a personal care worker's experience is commensurate with the amount, variety, and scope of care that the personal care worker will be providing. The following individuals may conduct personal care worker training:

- RN supervisors of personal care workers
- Vocational, technical, and adult education system instructors
- Home health agency RNs

A February 2008 statute also requires all agencies providing personal care to conduct criminal background checks of personal care workers.

Personal care agencies must give full consideration to a consumer's preferences for service arrangements and choice of personal care workers. However, a personal care worker cannot be a spouse or parent of a minor child. Also, Wisconsin does not have formal self-direction in its State Plan personal care program; individual agencies give varying amounts of personal control to consumers.

The State Medicaid agency generally sets personal care service rates as part of the budgeting process. To date, the agency has requested annual 1 to 1.5 percent increases for personal care rates. The agency allocates a budget to each county in the state. The Medicaid agency first established fee-for-service payment rates in the early 1990s. These rates are currently about \$16 per hour for personal care workers and \$41 per hour for registered nurses, plus reimbursement for travel and supervision costs. Personal care agencies negotiate with personal care workers on payment for their services. The Medicaid agency does not require co-payments for consumers in the fee-for-service program but there are some patient liability payments in managed care programs (Family Care and other long term care programs).

Quality Assurance

For quality assurance purposes, Wisconsin Medicaid requires an RN supervisor to evaluate, coordinate, and supervise personal care services for each consumer. The Medicaid-certified provider must document quality assurance activities as well as all services provided and reimbursed. The Home Care Advisory Committee and the Home Care Consumer Advisory Committee advise the Department of Health Services (DHS) on home care matters and act as a

communication link between the DHS, providers, and consumers. Personal care providers and consumers sit on the committees and are able to voice concerns.

State representative's report general satisfaction with the Wisconsin Medicaid Personal Care program. However, consumers have voiced concerns to the Medicaid Division over not being able to choose their personal care workers as well as being able to access personal care outside of the home. The State is also able to identify other issues and concerns through customer satisfaction evaluations: agencies conduct these evaluations, but Wisconsin Medicaid does not require or monitor this process. The Family Care waiver program also conducts consumer satisfaction surveys, but fee-for-service waiver programs do not necessarily conduct them. The Medicaid Division reviews complaints and may confiscate funds from the provider if necessary.

Challenges and Best Practices

As of October 2008, representatives of the Wisconsin Medicaid Personal Care program feel challenged with significant personal care worker turnover as well as the issue of providing personal care for consumers who need it outside of the home (at work, school, etc). In addition, the Wisconsin Medicaid Personal Care program is looking to the success of managed care personal care programs to develop a similar care model for children. The program will also soon be switching into a new interchange system personal care screening tool which may be difficult to ramp up.

Despite its challenges, the Medicaid Personal Care program offers several best practice lessons from which other states can learn. First, the program has a broad array of services available to consumers, which allows for great flexibility and accommodates a variety of personal care consumers with different needs. Integration of personal care into the Family Care comprehensive long-term care benefit package facilitates flexibility in tailoring services to the individual. There are no arbitrary caps/limits on services so that services can be provided to assist consumers to attain favorable health outcomes.

For more information on Wisconsin's Medicaid Personal Care Program, please contact Gail Propsom at Gail.Propsom@dhfs.wisconsin.gov or (608) 266-9370

Appendix F:
Minnesota PCA Program Options
Summary

Minnesota PCA Program Options:

Personal Care Assistant (PCA) services provide support to the elderly, the disabled, and other individuals with special health care needs to help them live independently in the community. All PCA services must be medically necessary, ordered by a physician, authorized by the Department of Human Services, and provided under the supervision of a qualified professional³³, the recipient, or the recipient's responsible party³⁴.

The following are included in the standard set of PCA services:

- Help with activities of daily living, including eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning
- Health-related functions
- Meal planning and preparation, managing finances, shopping for essential items, essential household chores, telephone communication
- Getting around and participating in the community
- Redirection and intervention for behavior

There are four routes through which eligible Minnesotans can receive PCA services:

1. **PCA services are covered for recipients of Minnesota Medical Assistance (MA)** – the State's Medicaid program, and for pregnant women and children under age 21 who receive the Minnesota Care Expanded Benefit set.

PCA services are not covered for General Assistance Medical Care (GAMC) recipients or non-pregnant adults enrolled in Minnesota Care.

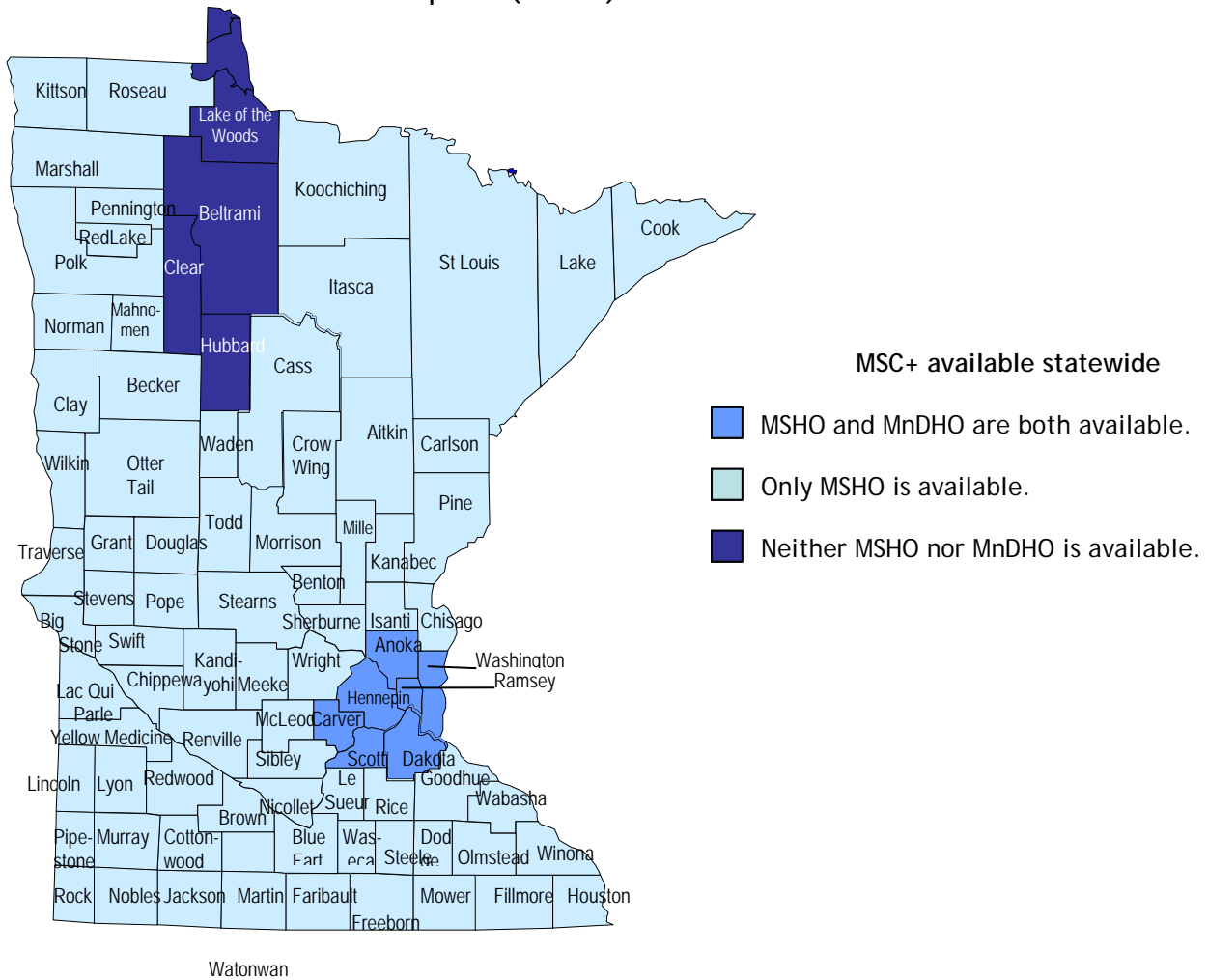
2. **Managed care organizations provide certain PCA services to their MA consumers.** Minnesota has two managed care programs in addition to regular Medicaid managed care which cover PCA services:

- Minnesota Senior Care Plus (available statewide)
- Minnesota Senior Health Options (offered in all but four counties: Beltrami, Clearwater, Hubbard, and Lake of the Woods)
- Minnesota Disability Health Options (offered in seven counties: Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington)

³³ A Qualified Professional can be a registered nurse, mental health professional, or social worker. He or she assists consumers of PCA services by directing health-related tasks, communicating with other health care providers, helping to develop a plan of care, and supervising PCAs.

³⁴ Minors and individuals who can not direct their own care are required to have responsible parties direct their care in the PCA program. The responsible party must be a parent, spouse, or legal guardian who is at least 18 years old and must be able to provide the support necessary to help the recipient live independently.

Exhibit 1: MN Senior Care Plus (MSC+) MN Senior Health Options (MSHO), and MN Disability Health Options (MnDHO) Services Areas



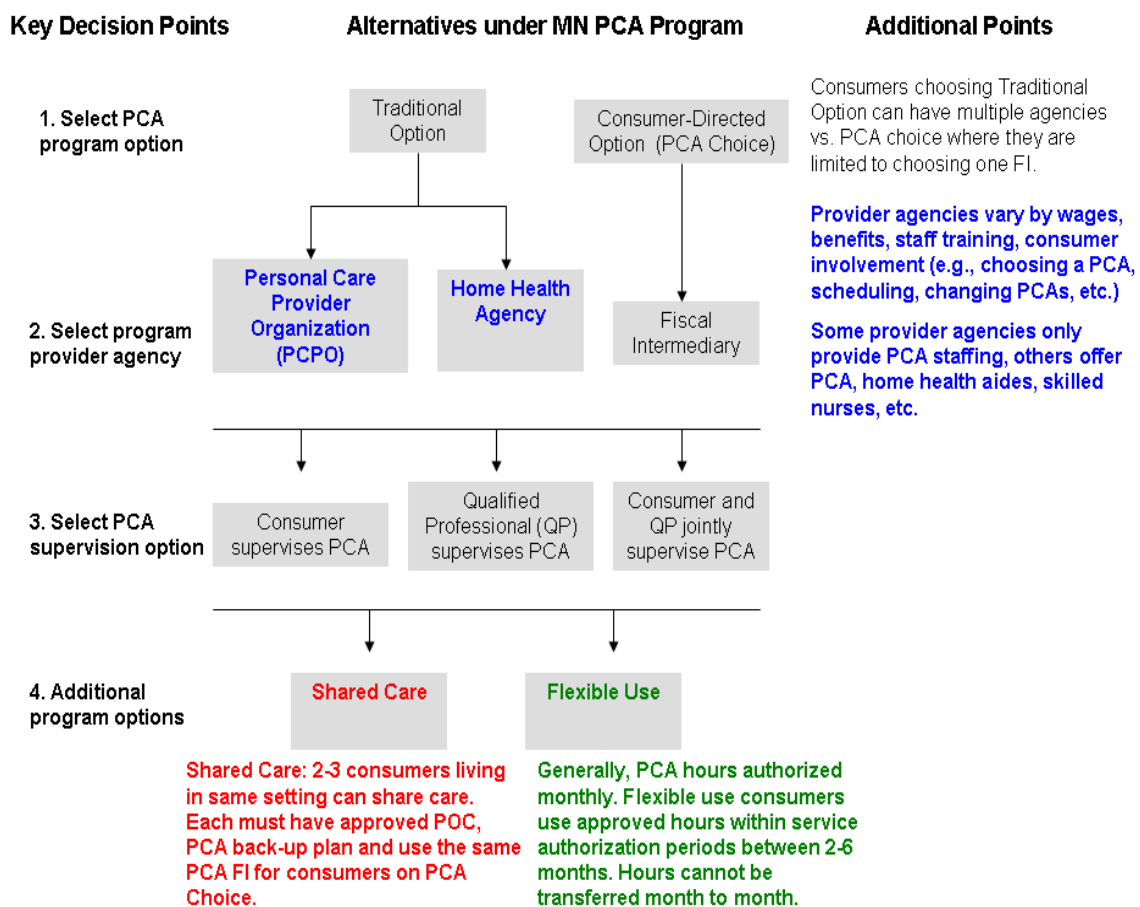
Home and Community-Based Services Waivers: HCBS waivers provide more intensive services than those covered by regular MA to people with certain categories of disabilities. These waivers are intended to help people remain in the community rather than living in an institutional setting. There are five types of waivers:

- **Community Alternative Care (CAC):** for chronically ill and medically fragile persons who need the level of care provided in a hospital
- **Community Alternatives for Disabled Individuals (CADI):** for persons with disabilities who require the level of care provided in a nursing facility
- **Elderly Waiver (EW):** for people over the age of 65 years who require the level of care provided in a nursing facility
- **Developmental Disabilities (DD):** for persons with mental retardation or a related condition who need the level of care provided in an ICF/MR

- Traumatic Brain Injury (TBI): for persons with TBI who need the level of care provided in a specialized nursing facility for persons with brain injury or neurobehavioral hospital
3. **Alternative Care (AC):** AC services are available for individuals over age 65 that have too many assets to qualify for the EW.

To receive PCA services, individuals must have an assessment completed before the services begin and annually thereafter. Once a person is determined to be eligible for PCA services, they must decide how they wish to use the following program options (**Exhibit 2**):

Exhibit 2: MN PCA Program Options



Option One: PCA Provider Option

- Two Sub-Options: Traditional PCA Provider Option or PCA Choice Option

All consumers of PCA services must choose either a consumer-directed or traditional PCA provider option. Under the traditional PCA provider option, consumers choose one of two types of PCA providers to administer their services:

1. A Personal Care Provider Organization (PCPO), which only provides PCA services
2. A home health agency, which provides skilled nursing visits, home health aide visits, and occupational and physical therapy visits in addition to PCA services

The PCPO or home health agency (PCA provider) is responsible for recruiting, hiring, training, and firing PCAs. If necessary, the PCA provider must find back-up PCA staff for all enrolled consumers. There are many other duties fulfilled by the PCA provider on behalf of the consumer, including:

- Monitoring, evaluation, and criminal background checks on PCA staff
- Assigning a Qualified Professional, a mental health professional, registered nurse, or social worker who will supervise a PCA, to all consumers who want one
- Billing the state for PCA services
- Scheduling and paying PCAs and Qualified Professionals
- Obtaining physicians' statements of need
- Maintaining a case file for each consumer
- Maintaining liability insurance and worker's compensation for PCAs

A consumer may also choose the consumer-directed PCA option, known as PCA Choice. Under PCA Choice, the consumer or their responsible party must choose a PCA Choice provider as a fiscal intermediary. The fiscal intermediary takes on the responsibilities of billing the State for PCA services and paying and withholding taxes for PCAs and Qualified Professionals. The consumer is responsible for everything else, including:

- Finding, hiring, training, and firing PCAs and back-up PCAs
- Finding a Qualified Professional if desired
- Applying for criminal background checks of PCAs and Qualified Professionals
- Supervision and evaluation of PCAs
- Scheduling PCAs and Qualified Professionals
- Entering into a written agreement with PCA staff, Qualified Professionals, and a PCA Choice agency (fiscal intermediary)
- Maintaining the required liability insurance and workers' compensation for PCAs and Qualified Professionals
- Documentation of PCA tasks
- Obtaining a physician's statement of need for PCA services annually and keeping a copy on hand

Consumers may choose to join PCA Choice or change PCA providers at the time of their initial assessment or at any time during the year.

Option Two: PCA Provider Agency Option

All consumers of PCA services must select a provider agency to provide their services. Some provider agencies only operate through the traditional option (i.e., PCPO or home health agency), others only operate through the PCA Choice option (i.e., consumer-directed option), and some operate through either option. Individual PCAs must be employed by a PCA agency, but there are no regulations on how many PCAs at a minimum must constitute an agency³⁵.

Consumers who choose the traditional provider option are allowed to have more than one agency providing for their PCA staffing needs. This may be advantageous for consumers who have difficulty getting enough PCAs to cover all of their needed hours through a single agency. On the other hand, consumers who choose the PCA Choice option can only have one agency, which must be a fiscal intermediary. Provider agencies can vary greatly in ways such as:

- Wages paid to PCAs and Qualified Professionals
- Benefits offered to PCAs and Qualified Professionals
- Staff training requirements
- Level of involvement permitted to consumers in matters such as scheduling, choosing PCAs, changing PCAs, etc.

Option Three: PCA Supervision Option

Consumers have the choice of supervising their own PCAs or requesting supervision from a Qualified Professional. There is also an option for joint supervision of PCAs by both a consumer and his or her assigned Qualified Professional.

Option Four: Shared Care PCA Staffing

All consumers of PCA services have the option of Shared Care. Two or three consumers may share PCA services in the same setting at the same time from the same PCA. There are numerous limitations on use of the Shared care option, including:

- Each person receiving PCA services must have authorized PCA hours as well as a plan for how they will use Shared Care.
- Each person must also have a back-up plan in case of consumer or PCA illness.
- If the consumers have PCA Choice, each person must be using the same PCA Choice agency.

³⁵ The state supplies both PCPO and PCA Choice Provider lists on the PCA program website. These lists contain both names of agencies and names of individuals. Accordingly, it appears that individuals can register with DHS as PCA provider agencies, though the state does not officially state this in any of their materials.

Option Five: Flexible Use Option

The Flexible Use Option allows individuals to use their approved hours flexibly within the service authorization period to accommodate their needs and schedules.

With standard use, consumers have an authorized number of PCA hours to use every month and can not transfer hours from month to month. Consumers who have flexible use are not allocated hours on a monthly basis, but for two six-month periods of time. Also, with flexible use, consumers can plan to use more hours in one six-month period and fewer in the next.

To monitor how many service hours are being used and how many are left, consumers develop month-to-month plans with their providers.

Not all consumers will be approved for flexible use; only those with appropriate needs, preferences, abilities, and histories of service use will be authorized by the Department of Human Services (DHS) to partake in flexible use. If a consumer uses up all PCA hours prior to the end of an authorization period, DHS will only consider authorizing more hours for flexible users (not standard users) who have obtained new physician statements of need as a result of a change in medical condition.

Appendix G:
**Comparison of Minnesota Managed Care
Program for the Elderly**

Comparison of Managed Care Programs for Medical Assistance Elderly in Minnesota

	Minnesota Senior Care Plus (MSC+)	Minnesota Senior Health Options (MSHO)
Eligibility	MA Seniors 65 years+	MA Seniors 65 years+
Exempt Groups	MA seniors who opt into MSHO. MA seniors on spend down. Duals with only Medicare Part A or Part B. Duals with End-Stage Renal Disease. MA seniors who have elected hospice.	MA seniors on spend down. Duals with only Medicare Part A or part B. Duals with End-Stage Renal Disease. MA seniors who have elected hospice.
Type of Program	Mandatory (unless beneficiary opts into MSHO).	Voluntary.
Geographic Coverage	Statewide.	83 counties. There are no participating managed care organizations in 4 counties in the northwestern region, including Lake of the Woods, Beltrami, Clearwater and Hubbard counties. Expansion into those counties is expected in 2010.
Services	All MA state plan services. Elderly Waiver (EW) services. First 180 days of Skilled Nursing Facility services. All Medicare services (including Part D) provided through Medicare FFS or a Medicare Advantage plan.	All MA state plan services. Elderly Waiver (EW) services. First 180 days of Skilled Nursing Facility services. All Medicare services including Part D drugs provided through a Special Needs Plan (SNP).

Source: Managed Care for Seniors Update, DHS Bulletin #08-24-01, December 31, 2008.