The Lewin Group®

Recommendations for Minnesota's Personal Care Assistance Program From PCA Provider Survey

Interim Report #3 FINAL

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

Submitted by: The Lewin Group

Submitted: June 25, 2009

Recommendations for Minnesota's Personal Care Assistance Program From PCA Provider Survey

Interim Report #3

Prepared for:

Minnesota Department of Human Services
Disability Services Division

June 25, 2009

Table of Contents

I. OVERVIEW OF THE PROJECT/INTRODUCTION 1

II. METHODS 2

A. Survey of PCA Providers 2
Description of Study Methods 2
Challenges 3
B. Research Related to Living Arrangement Issue 4

III. DATA ANALYSIS 6

A. Demographic data 6
Where do providers offer PCA services? 6
How long have respondents participated in the Medical Assistance program? 7
How large are the PCA agencies? 9
B. Service Delivery 12
For which programs do respondents provide PCA services? 12
What other services do agencies provide? 13
What are the main sources of revenue for agencies that provide PCA services? 14
What are the main payer sources for clients for agencies that provide PCA services? 15
What are the characteristics of PCA clients? 16
What are identified gaps in service need? 18
C. Workforce: Wages and Benefits 20
What is the average hourly wage for PCA workers? 20
How much do wage ranges vary between the Traditional PCA and PCA Choice programs? 20
Do wages vary between the Seven-County Metropolitan Area and Greater Minnesota? 21
Do wages vary by agency type? 21
What is the breakdown of PCA hourly reimbursement? 22
Do PCAs get benefits in addition to wages? 22
How many agencies offer health insurance? 23
How many agencies offer dental insurance? 24
D. Workforce: Recruitment and Retention 25
How difficult is it to recruit PCA workers? 25
What are the barriers to PCA worker recruitment? 26
Are there PCA vacancies? 27
How difficult is it to retain PCA workers? 28
What are the barriers to PCA worker retention? 29
What is the retention rate for PCAs? 31
What is the turnover rate for PCAs? 32

E. **Program Management and Oversight** **33**
Is the billing process for PCA services easy to understand? 33
Where do providers go for help with the billing process? 34
Is the PCA program's service reauthorization process conducted in a timely manner? 35
Do PCAs have the proper training to do their jobs? 36
What topics are covered in PCA training? 36
How do provider agencies verify that workers are providing services? 38
F. **Living Arrangements** **38**
Provider Survey Data 38
Stakeholder Interviews and Document Review 39

IV. PRELIMINARY FINDINGS AND RECOMMENDATIONS **41**

APPENDIX A: Minnesota Provider Survey

I. Overview of the Project/Introduction

The Minnesota Department of Human Services (DHS), Disability Services Division contracted with The Lewin Group (Lewin) to conduct a study of the infrastructure of the State's Medical Assistance State Plan Personal Care Assistance (PCA) program. 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, important considerations include how other Medical Assistance Programs (e.g., home and community-based waiver programs) provide PCA services, and the interaction between those program requirements and the PCA State Plan program.

This report focuses on:

- provider agency perspectives and related recommendations to strengthen and improve provider-related components of the program, and
- analyses of the types of living arrangements in which individuals receive PCA services and related recommendations.

The first interim report provided a national scan of PCA programs, analyses of Minnesota PCA program enrollment and expenditure data, findings from interviews with state officials in Minnesota and other states with PCA programs, findings from stakeholder interviews, and preliminary recommendations for the State.

The second interim report included findings from a series of 14 focus groups, conducted by the University of Minnesota's Institute on Community Integration, with recipients of PCA services and PCA workers in a variety of Minnesota Medical Assistance programs offering PCA services. The purpose of conducting these focus groups was to hear from workers about their experiences providing PCA services and from service recipients about their experiences receiving PCA services.

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

II. Methods

A. Survey of PCA Providers

Description of Study Methods

In Spring 2009, The Lewin Group conducted a confidential online survey of all of the approximately 5,000 Medical Assistance long-term care providers, including the approximately 900 of whom provide PCA services. We conducted the survey to meet the requirements of two Minnesota Department of Human Services studies: this study and the "Costs and Recommendations for Insuring Minnesota's Long-Term Care Workforce" study for the Division of Continuing Care. Because Lewin was conducting both studies at approximately the same time, we combined the surveys for overall efficiency purposes and so that PCA providers would not need to complete two separate surveys.

The survey included questions about providers of PCA services, sources of revenue, service delivery, characteristics of PCA clients, PCA wages and benefits, recruitment and retention, program management and oversight, as well as health insurance costs, take-up rates, and other information needed for the "Costs and Recommendations for Insuring Minnesota's Long-Term Care Workforce" study. We programmed a skip pattern into the online survey, so that, after asking a question about whether or not they provide PCA services, PCA providers were asked the set of questions about the PCA program, while non-PCA respondents automatically skipped those questions. **We limited our analysis for this report to responses provided by PCA provider agencies.** A copy of the provider survey questions, highlighted to identify those specifically asked for this study, is included in ***Appendix A***.

The survey was available to complete online at ZipSurvey.com. Minnesota DHS staff reported that service providers use an online system to submit claims and would be likely to be able to participate in an online survey. Based on this information, DHS decided to alert providers to the survey through the MN-ITS system (https://mn-its.dhs.state.mn.us/login.html), Minnesota DHS' billing system for electronically-submitted Minnesota Health Care Program claims and other transactions. As an incentive, providers who completed the survey by the deadline were entered into a drawing to win one of three $500 cash prizes for their organizations.

Initial response to the survey was quite low. We later learned from providers that most providers use MN-ITS only for submitting claims and do not read messages or announcements posted on the MN-ITS system. Thus, they were not aware of the survey. Also, in later phone calls, some providers mentioned that their staff who access the MN-ITS system do not have the information needed to complete the survey, and this contributed to low response rates.

The study team continued to examine response rates daily and used multiple additional approaches to alert providers to the survey and encourage their participation:

- DHS and Lewin staff personally contacted representatives of several provider organizations in the State and asked them to inform their members of the survey. Some of these organizations reported on the survey in their newsletters, which helped to improve response rates.

- For additional outreach, the Lewin team emailed all providers for whom DHS could supply email addresses, asking them to complete the survey.
- We also mailed hard copy letters to all providers eligible for the survey, asking them to complete the survey.

Response rates significantly improved after the mailing and personal contacts, but provider participation remained disappointingly low, with a total of 154 PCA agencies responding to the survey, as follows:

Table 1. Number of Survey Respondents by Agency Type

Type of Agency	Number of Respondents
Home and Community Services (HCS)	18
Personal Care Provider Organization (PCPO)	101
Home Health Agency (HHA)	8
Other types of providers	18
Unknown/unreported	9
TOTAL	**154**

In analyzing the survey results, we focused primarily on the three major PCA provider agency types: Home and Community Services (HCS) providers, Personal Care Provider Organizations (PCPO), and Home Health Agencies (HHA). In addition, a number of "other" provider types that provide personal care services participated in the survey, including nine nursing facilities, one hospital, two day training and habilitation centers, two public health nursing organizations, and four private duty nurses. Finally, some respondents did not provide identifying information other than that they provided PCA services: we refer to these as unknown/ unreported. We included these "other" and "unknown" providers in data analyses that did not focus on agency type as a major variable.

The final response rate to the survey was approximately 17 percent[1]. This rate, while lower than we would have liked, is not inconsistent with the response rate for the larger survey as a whole. In addition, the number of respondents to specific questions was often less than the 154-respondent total: this low response rate limited our ability to extrapolate the findings to all agencies or to analyze responses by sub-groups of respondents.

Challenges

In addition to the challenge of ensuring that providers were aware of the survey (see above), there were several other challenges in conducting the survey:

[1] We considered all providers who responded affirmatively to survey question #19 ("Do you provide services under the Medical Assistance State Plan Personal Care Assistance (PCA) Program?") to be respondents to this survey.

- A major challenge to eliciting responses was the length of the survey and the time involved to gather the requested information. Although the study team made efforts to make the survey as concise as possible, the actuarial analysis needed for the "Costs and Recommendations for Insuring Minnesota's Long-Term Care Workforce" study required that we ask respondents for detailed data on the number of employees, the wages and benefits they provide, expenditures on health benefits, and other information that may not have been readily available. The survey cover letter suggested that respondents may need to gather their organization's tax records and Human Resources files before completing the survey. Our analysis of responses showed that many of the respondents who started the survey stopped when they reached the questions asking for details about their organization's health insurance benefits.
- Although the survey software allowed individuals to save their survey and return to it later, some individuals could not find their saved surveys and had to begin the survey more than once.
- Some provider organizations have separate provider ID numbers for separate services (e.g., PCA services and ICF/MR[2] services). While survey instructions requested those providers to complete a separate survey for each individual part of their organization, this did not always occur. As a result, we were unable to categorize slightly more than 10 percent of respondents into the three main PCA provider service groupings that we used for analysis.

For the purposes of this paper, we use the term "PCA provider agency" to refer to the array of providers that provide PCA services in Minnesota. We use the term "survey respondent" or "respondent" to refer to those individuals that completed the survey on behalf of their PCA provider agencies.

B. Research Related to Living Arrangement Issue

Over the last several years, there has been growing concern over the existence of, and potential conflicts of interest inherent in, situations where organizations offer housing and related services along with personal care services. Referred to as "provider operated housing," these arrangements often offer a package of services that includes rent, utilities, meals, and personal care services with 24-hour availability. These provider operated housing services can occur in a variety of settings including apartments or houses owned or rented by an agency. They may also involve facilities that are otherwise appropriately authorized to provide certain kinds of housing services (e.g., adult foster care).

As a result of this growing concern, one of the aspects of the Minnesota PCA program that Lewin was asked to review was the prevalence of these situations, the types of living arrangements in which these situations were occurring, and to determine if there were any service delivery trends that we could identify related to these situations.

As we examined the issue further, we determined that the majority of provider operated housing providers are not registered, licensed or otherwise authorized to provide housing

[2] Intermediate Care Facility for the Mentally Retarded

services[3] and, therefore, there is no database of addresses that we could use to match against claims data to identify individuals who might be receiving services from these types of organizations. Moreover, agency officials confirmed that, even if we were able to identify individuals who appeared to live in the same building, there was no way to distinguish individuals who lived independently in the building from those who might be in provider operated housing.

In addition to this set of concerns, we had planned to assess variations in personal care services by the different arrangements in which program participants lived (such as living alone, with family members, or in congregate settings) to determine whether there were any service delivery variations that become apparent or warranted additional analysis. In conjunction with MN DHS staff, however, we determined that there was very limited data available which could be used to assess the situation. For example, we determined that the data on living arrangement available from the State's claims database combines virtually all types of community-based living arrangements into one category. Analysis of service delivery variations by type of living arrangement was, therefore, not possible.

As a result, we focused our attention primarily on the issue of provider operated housing and gathered information through several mechanisms:

- Provider survey: We asked providers completing the survey to identify themselves as providing living arrangements for their clients, and then asked several follow-up questions related to the nature of the services that they provided.
- Stakeholder interviews: We interviewed several state and county staff stakeholders concerning the provider operated housing issue.[4]
- Document review: We reviewed various reports and documents related to the delivery of housing services.

---

[3] Some providers are registered as "Housing with Services" providers under 2008 Minnesota Statutes Chapter 144D. This chapter requires an establishment that provides sleeping accommodations to one or more adults, 80 percent of whom are over the age of 55, to register with the State. Other establishments, such as those who serve clients under age 55, can optionally register.

[4] Several of the interviews we conducted for Interim Report #1 also addressed provider operated housing issues.

III. Data Analysis

After collecting survey responses, we examined the survey data in various ways. We looked at response frequencies and compared responses among those that participated. For many questions, we looked at the data to determine whether there were differences among responses from PCA provider agencies serving clients in more or less populated areas of the state, as a result of the type of provider agency, and as a result of the size of the agency.

In this report, we present the most relevant results of these analyses. As noted earlier, depending on the specific question and the demographics of the respondents, we had some very small response groups, so we caution the reader to be careful generalizing our findings across the Medical Assistance PCA provider agency population.

A. Demographic data

In this section, we present demographic data on the survey respondents, including:

- Where providers offer PCA services
- How long respondents have participated in the Medical Assistance program
- The size of PCA agencies

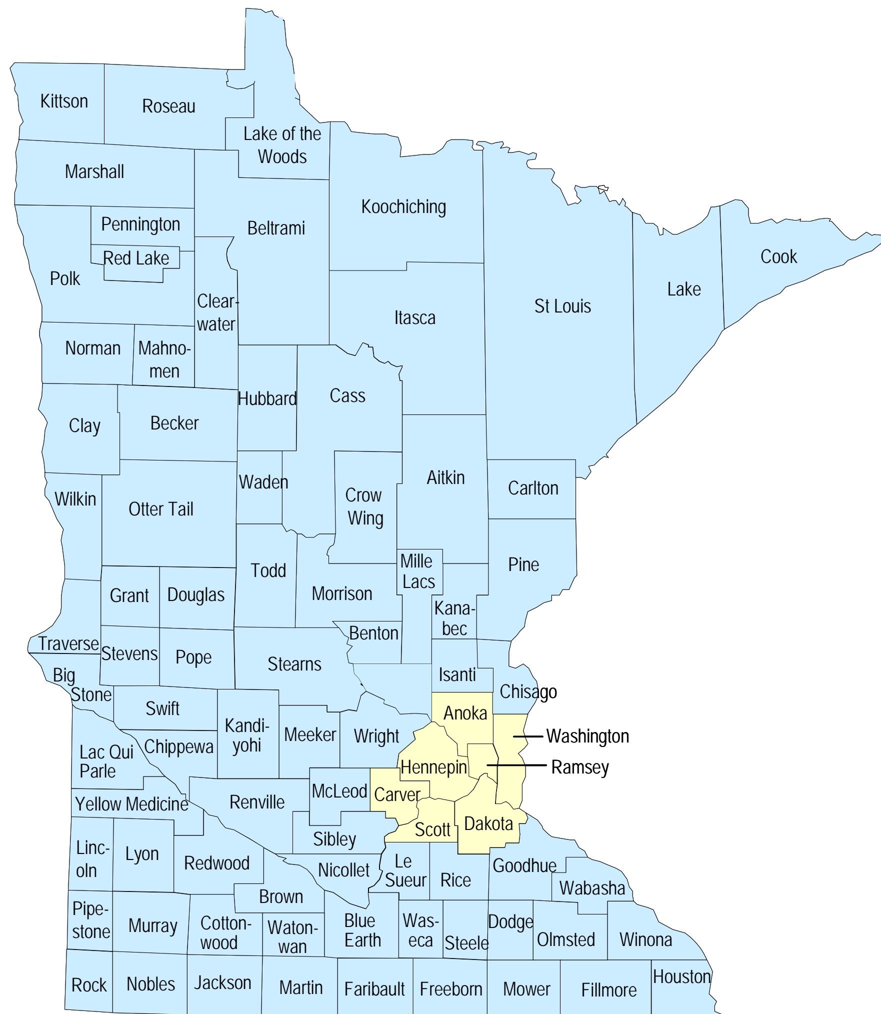
Where do providers offer PCA services?

The Medical Assistance program provides PCA services in all of Minnesota's 87 counties. As expected and appropriate, fewer agencies serve areas with a smaller number of residents who may seek PCA services. Of the 152 respondents to this question, 90 (59 percent) said that they provide services in the Seven-County Metropolitan Area, which includes Anoka, Washington, Ramsey, Hennepin, Carver, Scott and Dakota counties. More than three-quarters of the respondents (76 percent) provide services in Greater Minnesota, which encompasses Minnesota's other 80 counties. Over half of the responding agencies provide services in two or more counties that overlap between the Seven-County Metropolitan Area and Greater Minnesota areas.

Exhibit 1. Regional Map of Minnesota Counties

Yellow = Seven County Metro Area

Blue = Greater Minnesota



Based solely on the respondents to this survey, we can see that consumers have a minimum choice of four providers – and many more options in most counties. In the Seven-County Metropolitan Area, consumers have a choice of between 30 and 73 providers, depending on the county. Because of the small response rate to this survey, we can infer that PCA program participants have an even larger choice of providers.

How long have respondents participated in the Medical Assistance program?

We asked respondents to report on how long their agency has participated in Minnesota's Medical Assistance PCA program, established in 1977. Of the survey respondents, almost three in five (55 percent) reported that they have participated in the program for more than 5 years and more than a quarter (30 percent) have participated for more than 10 years. Eight percent of providers have provided Medical Assistance PCA services for more than 20 years. Almost a third, 32 percent, did not indicate how long they have been in the program. We were unable to determine whether this is representative of overall Medical Assistance participating providers;

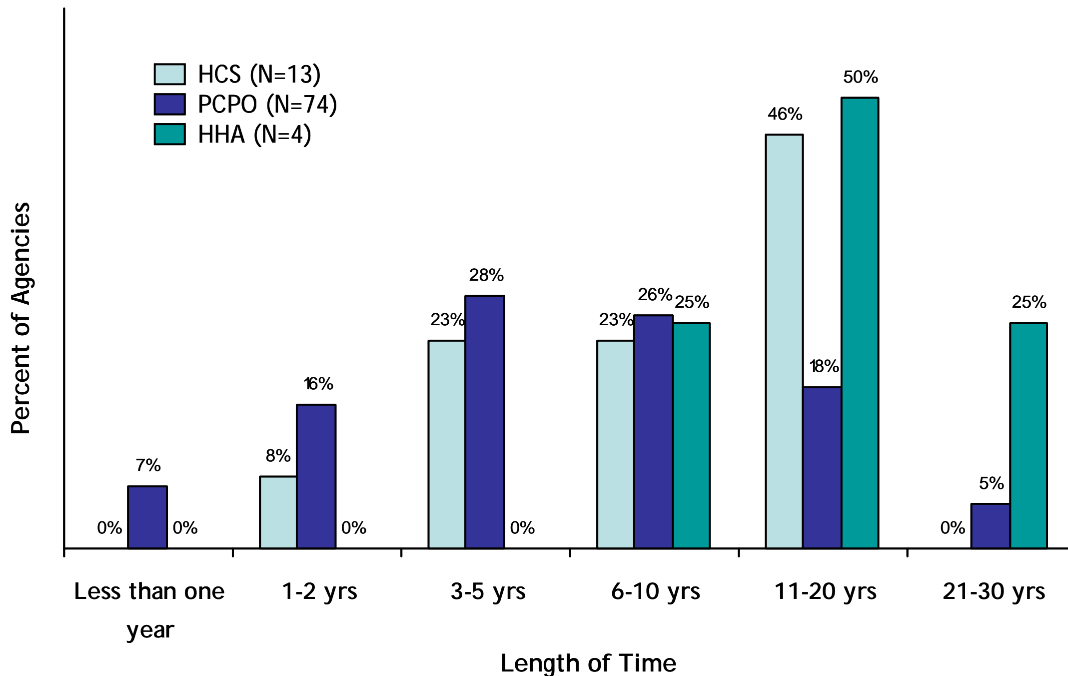
we surmise that it is possible that agencies that have participated longer may have been more likely to voluntarily participate in the survey.

Table 2. Length of Time Respondents Have Participated in the Medical Assistance PCA Program (N=104)

Length of Time	N	Percent
Less than one year	7	7%
1 - 2 yrs	16	15%
3 - 5 yrs	24	23%
6 - 10 yrs	26	25%
11 - 20 yrs	23	22%
21 - 30 yrs	5	5%
More than 30 yrs	3	3%

We examined the responses based on the types of agency and found that HHAs and HCS agencies have participated in Medicaid longer than PCPOs, on average (46 percent of HCS agencies and 75 percent of HHAs have participated more than 10 years, compared to 23 percent of PCPOs).

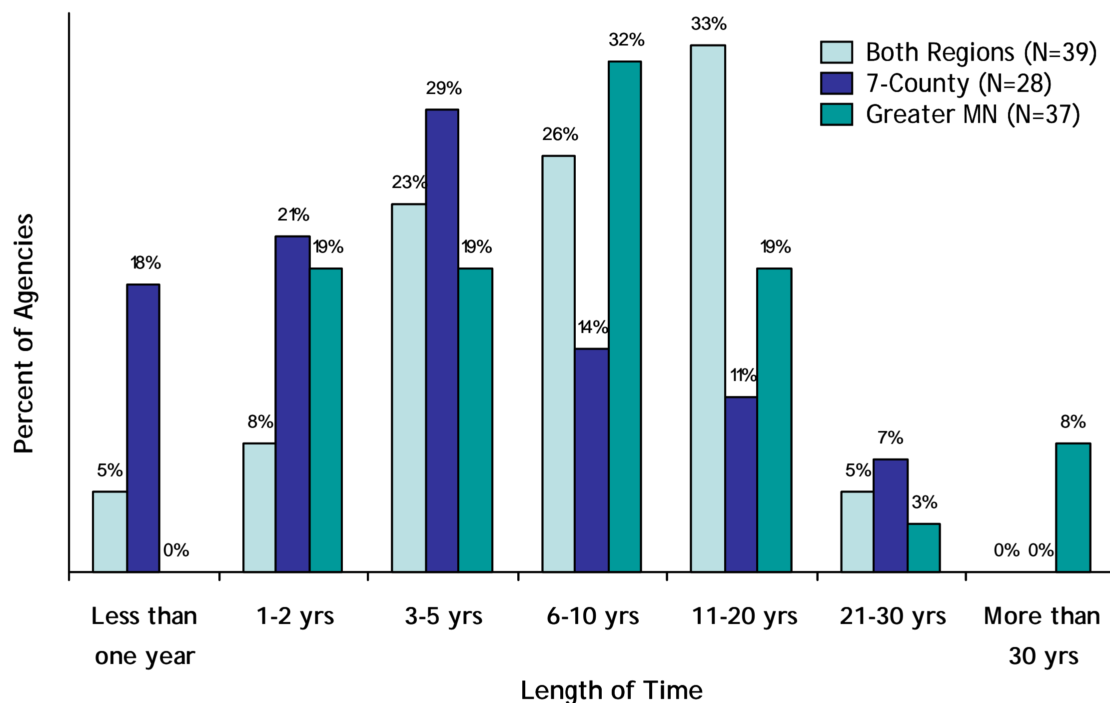
Exhibit 2. Length of Time Respondents have Participated in the Medical Assistance PCA Program by Agency Type



Note: Data displayed in the table does not include 10 “other” and 3 “unknown” responses, which are included in the totals in Table 2 above.

We also examined the responses based on the region of the State in which the respondent provides PCA services. Our data show that almost one fifth (18 percent) of agencies that provide PCA services only in the Seven-County Metropolitan area have been operation for less than one year, and almost 70 percent have been in operation for five years or less. Greater Minnesota PCA agencies, as well as those operating in both Greater Minnesota and the Seven-County Metropolitan Area, however, appear to be more established, with less than 40 percent in operation for five years or less.

Exhibit 3. Length of Time Respondents have Participated in the Medical Assistance PCA Program by Region



How large are the PCA agencies?

Recognizing that agency size has implications for administrative aspects of the program, such as training, one of the major demographic subjects that we examined in this survey was the size of the agencies providing PCA services in Minnesota's PCA program. To estimate agency size, we asked respondents to report the number of PCA workers their organization currently employs, including Traditional PCA workers and PCA Choice workers, by full-time and part-time status. Of the providers that responded to the survey, there are only 4 providers (3 percent) that report having only one employee, but there are 27 (22 percent) that have 2-10 employees. As such, a quarter of respondents have 10 or fewer employees. Another quarter (22 percent) reported that they have 11-25 employees. Slightly more than half of all respondents (53 percent) have 26 or more employees, while more than 10 percent of agencies report having more than 200 employees.

Table 3. Size of PCA Provider Agency by Number of PCA Workers

Number of PCA workers	Agencies (N=123)	
	N	%
1	4	3%
2-10	27	22%
11-25	27	22%
26-50	22	18%
51-200	30	24%
201+	13	11%

We expected to find a larger proportion of smaller agencies than occurred in the sample respondents. Our hypothesis was that there would be proportionately more PCA agencies that employ a very small number of PCAs, particularly in light of the fact that many of them serve relatively sparsely-populated areas. Our extrapolation of the total number of PCA workers in the Minnesota Medical Assistance program from respondent data suggests that a greater proportion of larger agencies may have participated in the survey. This respondent selection bias may have occurred due to several factors, including that larger agencies may have been more aware of the survey due to their participation in organizations that promoted the survey and that larger agencies may have more administrative staff available to complete the survey.

We examined whether there was a difference in agency size based on whether the agency reported serving PCA clients in the Seven-County Metropolitan Area or Greater Minnesota. Our survey results indicate that larger agencies appear to be more likely to serve people in both Seven-County Metropolitan Area and Greater Minnesota counties. Agencies operating in only Greater Minnesota were the smallest.

Table 4. Size of PCA Provider Agencies in the Seven-County Metropolitan Area and Greater Minnesota

Number of PCA Workers	Agencies (N=123)					
	Both Areas (N=67)		7-County Metro (N=30)		Greater MN (N=26)	
	N	%	N	%	N	%
1	2	3%	0	0%	2	8%
2-10	8	12%	11	37%	8	31%
11-25	12	18%	8	27%	7	27%
26-50	12	18%	4	13%	6	23%
51-200	21	31%	6	20%	3	12%
201+	12	18%	1	3%	0	0%

We also examined whether there was a difference in agency size based on the agency type. For this analysis we focused on three agency types: Home and Community Services providers, Personal Care Provider Organizations, and Home Health Agencies. Survey data indicates that

HCS providers tend to be smaller than PCPOs or home health agencies (over 80 percent of HCS agencies had 25 or fewer workers vs PCPOs and HHAs, where 43 percent and 28 percent, respectively, had 25 or fewer workers). PCPOs have a similar size distribution as the overall numbers, probably based on their large proportion of survey respondents.

Table 5. Size of PCA Provider Agency by Agency Type

Number of PCA Workers	Agencies (N=108)					
	HCS (N=12)		PCPO (N=89)		HHA (N=7)	
	N	%	N	%	N	%
1	1	8%	2	2%	1	14%
2-10	3	25%	18	20%	1	14%
11-25	6	50%	19	21%	0	0%
26-50	1	8%	18	20%	1	14%
51-200	1	8%	23	26%	2	29%
201+	0	0%	9	10%	2	29%

Note: Data displayed in the table does not include 12 "other" and 3 "unknown" responses.

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

Table 6. Percent of Full Time and Part Time Traditional and PCA Choice Workers by Size of Agency Status

Agency Size	Traditional PCA		PCA Choice	
	% FT Workers	% PT Workers	% FT Workers	% PT Workers
1	75%	25%	83%	17%
2-10	20%	80%	32%	68%
11-25	35%	65%	16%	84%
26-50	24%	76%	34%	66%
51-200	26%	74%	22%	78%
201+	22%	78%	27%	73%
Total	**25%**	**75%**	**26%**	**74%**

B. Service Delivery

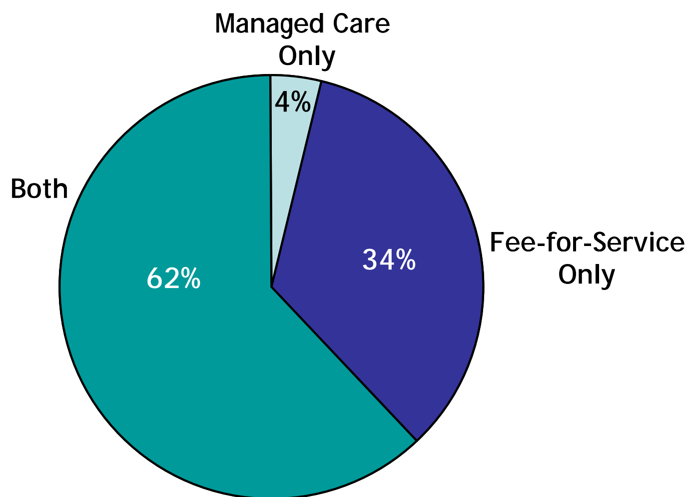
In this section, we present information on service delivery, including:

- What services each agency provides, including for which programs (i.e., Traditional PCA program versus PCA Choice; managed care versus fee-for-services) respondents provide PCA services
- The main sources of revenue and clients for agencies that provide PCA services
- The types of conditions PCA clients have and the age of PCA clients
- Identified gaps in service need

For which programs do respondents provide PCA services?

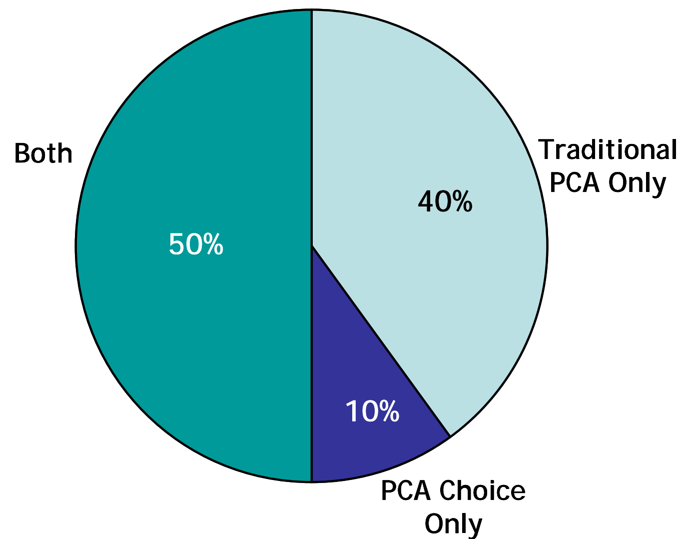
Of the total survey respondents to this series of questions, almost all (101 of 105 respondents) said they offer PCA services on a fee for service (FFS) basis. Two-thirds (69 of 105 respondents) said they offer PCA services through managed care. There is considerable overlap in the agencies that participate in these programs, with more than 60 percent of agencies participating in both programs. Significant, however, is the fact that over 30 percent of agencies only provide services on a FFS basis, while only four percent report that they only provide services through managed care.

Exhibit 4. Percent of PCA Agencies Providing Services in the Fee-for-Service and Managed Care PCA Program (N=105)



Similarly, there is significant overlap between agencies that provide Traditional PCA services and those that participate in the PCA Choice option. As noted in the pie chart below, 90 percent (94 of 105 respondents) provide Traditional PCA services, while 60 percent (63 of 105 respondents) provide PCA Choice services. Only half the respondents report that they provide both service options, with the remaining 50 percent split between those agencies that only provide Traditional PCA services (40 percent) and those that only provide PCA Choice services (10 percent).

Exhibit 5. Percent of PCA Agencies participating in the Traditional PCA and PCA Choice Programs (N=105)



What other services do agencies provide?

Agencies that provide PCA services also provide a variety of other services to meet the needs of their clients. We asked survey respondents whether they provided the following services, in addition to PCA and homemaking services for their clients: adult day care, case management, private duty nursing, adult foster care, or other services. HHAs and HCS agencies are more likely to provide (or are authorized to provide) additional services.

Table 7: Percent of Agencies Providing Other than PCA Services by Agency Type

Services Provided to Clients	HCS (N=13)		PCPO (N=73)		HHA (N=5)		Total (N=91)	
	N	%	N	%	N	%	N	%
Case management	6	46%	9	12%	2	40%	17	19%
Private duty nursing	6	46%	5	7%	3	60%	14	15%
Other	2	15%	9	12%	2	40%	13	14%
Adult foster care	6	46%	6	8%	0	0%	12	13%
Adult day care	4	31%	0	0%	0	0%	4	4%

Note: Data displayed in the table does not include 11 "other" and 2 "unknown" responses.

For the most part, PCA agencies that participate only in PCA Choice only provide PCA services and do not offer additional services. Of the survey respondents, only one reported providing case management for its clients and none reported providing the other services.

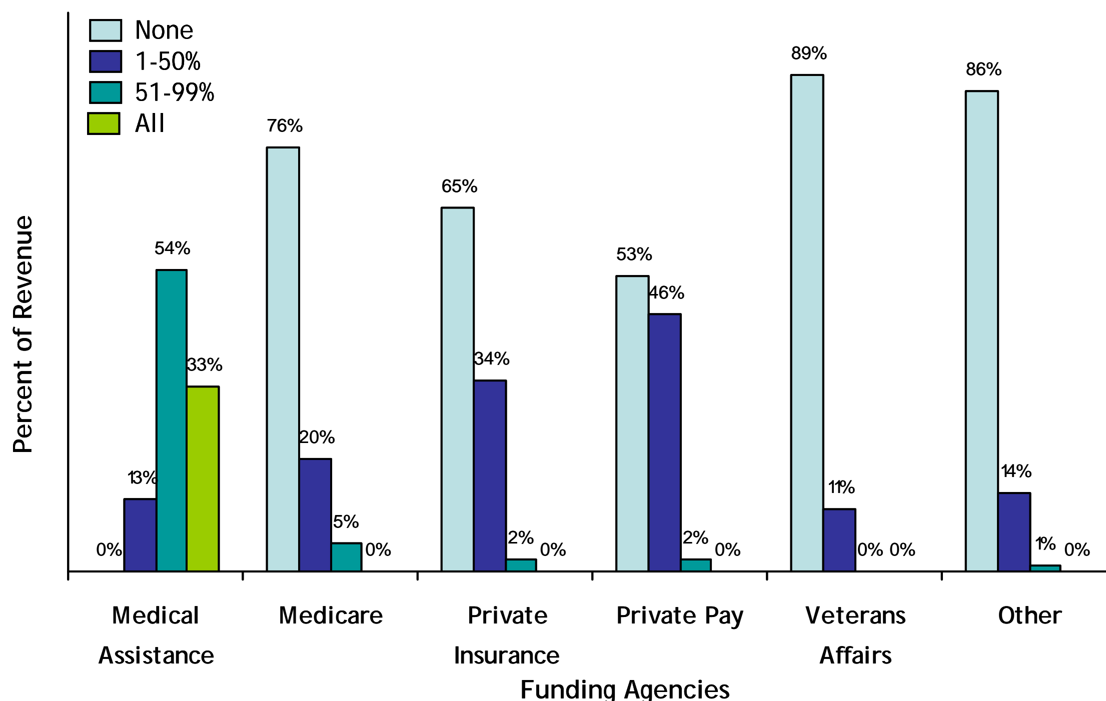
Table 8. Percent of Agencies Providing Other than PCA Services by Traditional PCA and PCA Choice Agencies

Services Provided to Clients	Both Traditional and Choice (N=35)		Traditional (N=46)		PCA Choice (N=15)		Total (N=96)	
	N	%	N	%	N	%	N	%
Case management	7	20%	14	30%	1	7%	24	25%
Private duty nursing	10	29%	7	15%	0	0%	19	20%
Other	8	23%	7	15%	0	0%	16	17%
Adult foster care	1	3%	9	20%	0	0%	12	13%
Adult day care	0	0%	5	11%	0	0%	5	5%

What are the main sources of revenue for agencies that provide PCA services?

Medical Assistance is a key source of funding for PCA services. We asked survey respondents to select their main sources of revenue from a short list of sources, including Medical Assistance, Medicare, private insurance, private pay, Veterans Affairs, and other. One third of respondents (33 percent) report receiving all of their revenue from Medical Assistance. Almost all (87 percent) receive more than half of their revenue from Medical Assistance. The next largest source of revenue appears to be private pay, where 46 percent report that they receive between one and 50 percent of their revenue from private pay sources. More than three-quarters report getting no revenue from Medicare (76 percent), other sources (86 percent) or Veterans Affairs (89 percent).

Exhibit 6. Percent of Revenue For PCA Provider Agencies from Various Funding Sources (N=133)



We also examined the results based on the type of provider agency (HCS providers, PCPOs, or HHAs) to determine whether there are differences in revenue source. Our survey data shows that PCPOs have the highest proportion of revenues from Medical Assistance: 80 percent of PCPOs receive over 75 percent of their revenues from Medicaid. HHAs appear to have the lowest proportion of their revenue from Medicaid; only 43 percent receive over 75 percent of their revenue from Medicaid.

Table 9. Agencies Reporting More than 75 Percent of Revenue from Medical Assistance

% Medical Assistance Revenue	HCS (N=15)	PCPO (N=91)	HHA (N=7)
76 - 99%	40%	37%	43%
All	13%	43%	0%
More than 75 percent	53%	80%	43%

Note: Data displayed in the table does not include 13 "other" and 7 "unknown" responses.

Although Medical Assistance is the predominant source of revenue, we examined the data to identify which other payers contribute to revenue for PCA agencies. Interestingly, 20 percent of HCS agencies report that more than a quarter of their revenue is from private pay. Medicare and private insurance account for a smaller proportion of revenue. No agencies reported receiving more than 25 percent of their revenue from Veterans Affairs or Other sources.

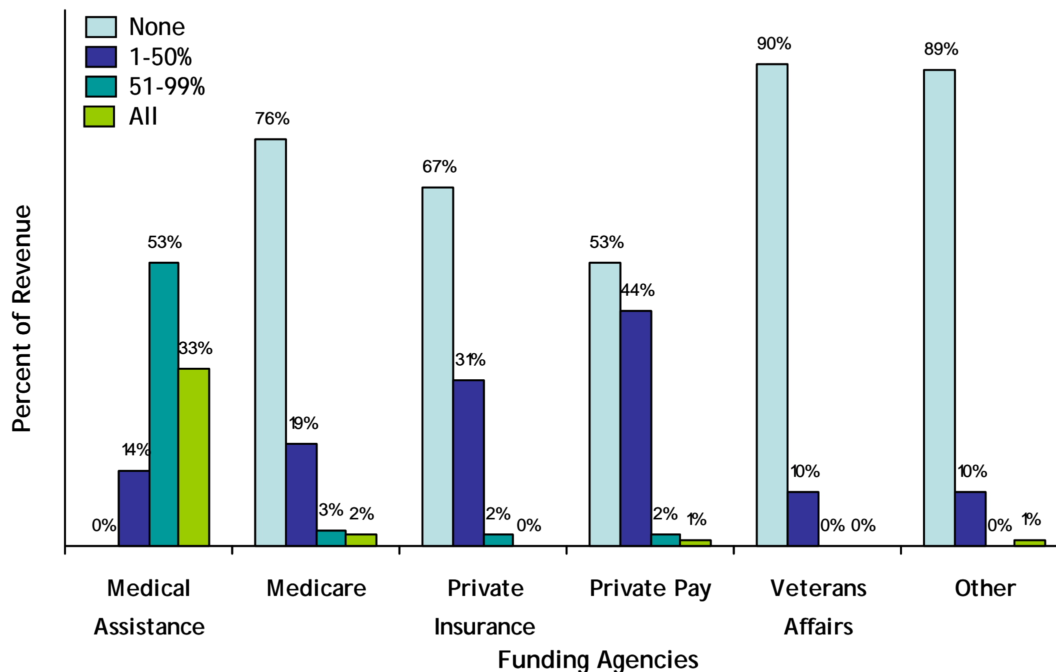
Table 10. Agencies Reporting More than 25 Percent of Their Income from Sources Other Than Medical Assistance

More than 25% of revenue from	HCS (N=15)	PCPO (N=91)	HHA (N=7)
Medicare	7%	3%	14%
Private Insurance	0%	4%	14%
Private Pay	20%	5%	0%
% of Agencies	**27%**	**12%**	**28%**

What are the main payer sources for clients for agencies that provide PCA services?

Medical Assistance is a key source of clients of PCA services. We asked survey respondents to select the main payer sources for their clients from a short list of sources, including Medicaid, Medicare, private insurance, private pay, Veterans Affairs, and other. Only 14 percent of survey respondents reported Medicaid recipients account for 50 percent or less of their clients; 86 percent have over 50 percent of their clients from Medicaid and, for 33 percent of agencies, 100 percent of their clients are in the Medicaid PCA program.

Exhibit 7. Percent of PCA Clients By Revenue Source (N=129)



Comparing the sources of revenues and clients for PCA services, there appears to be relative alignment between number of clients by payer type and proportion of revenues by payer type. This suggests that Medicaid is paying similarly to other payers.

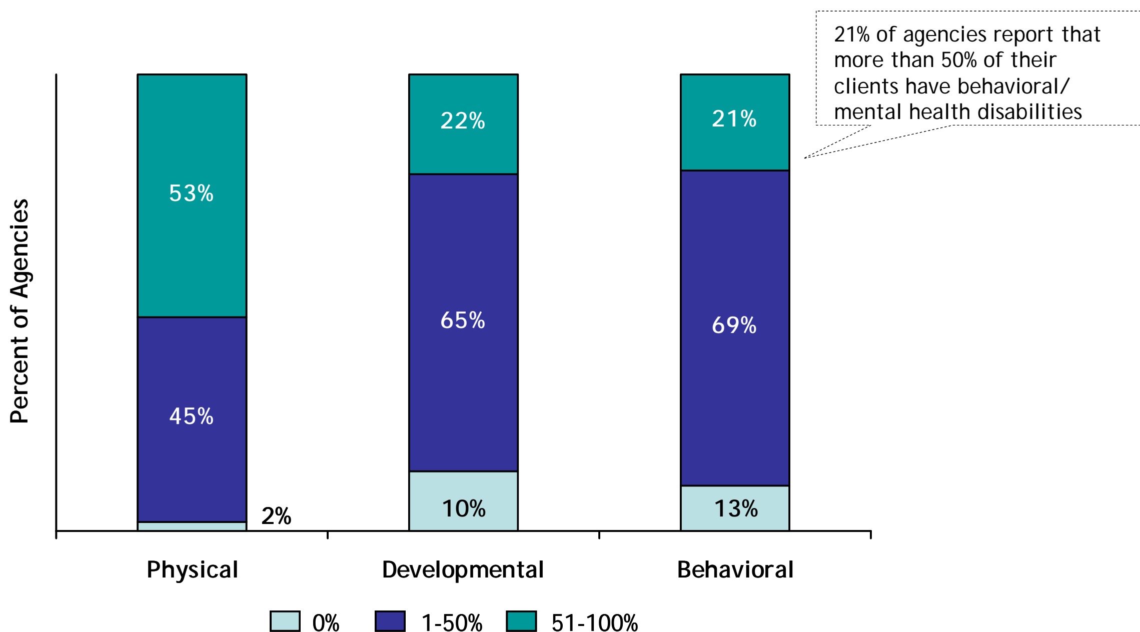
What are the characteristics of PCA clients?

We asked survey respondents to report the proportion of their clients that had physical, behavioral/mental health, and intellectual/developmental disabilities.

Physical disability is the preponderant condition exhibited by PCA clients. Our data show that 53 percent of agencies reported that more than half of their clients have physical disabilities and that virtually all (98 percent) reported that some percentage of their clients have physical disabilities. This result is not unexpected, given that PCA programs were generally started to provide services to individuals with physical disabilities.

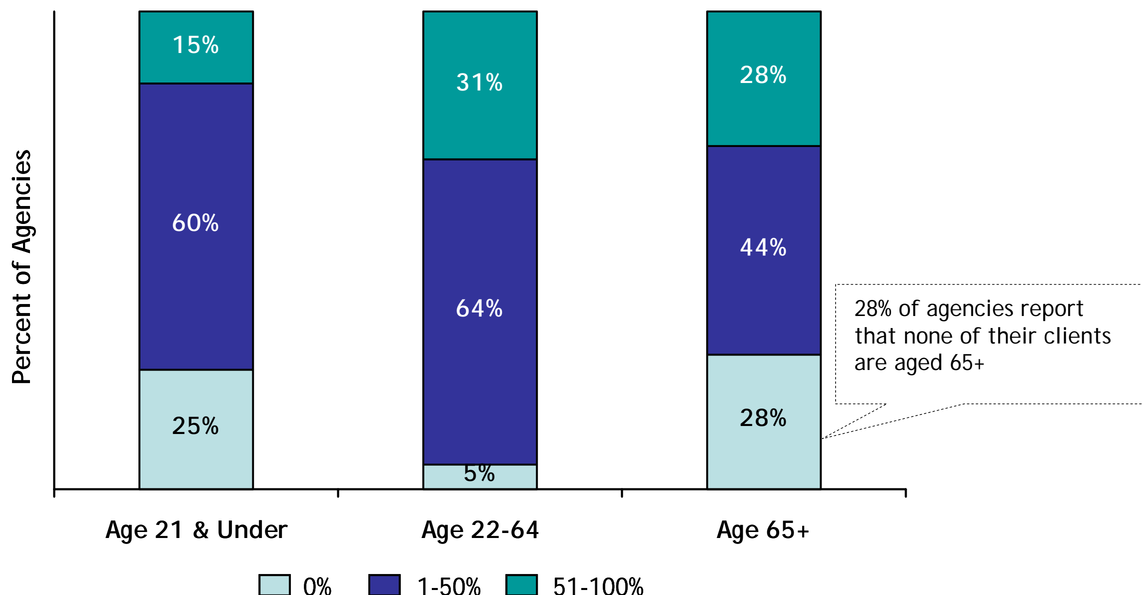
However, in light of concerns expressed by stakeholders related to the provision of services to those with other disabilities, it is important to note that over 20 percent of agencies reported that more than 50 percent of their clients have behavioral/mental health or intellectual/developmental disabilities. At the same time, approximately 10 percent of agencies reported that they had no clients with these disabilities. It also appears clear that a large proportion of clients have multiple disabilities.

Exhibit 8. Prevalence of Client Disabilities in PCA Agencies (N=100)



We also asked survey respondents to report the proportion of their clients that are under age 21, age 22-64, and age 65 or over. Interestingly, more than a quarter of agencies (28 percent) report that they have no clients who are aged 65 or over, or 21 or under (25 percent). A smaller percentage of agencies appear to focus on clients who are children, as exhibited by the 15 percent who report that 50 percent of more of their clients are children, than do agencies with large numbers of adults or individuals 65 and over (31 and 28 percent, respectively).

Exhibit 9. Age Range of Clients in PCA Agencies (N=102)



What are identified gaps in service need?

The survey asked whether the PCA agencies had clients with unmet needs in certain areas (see Table X). We asked them to rank the degree of unmet need in each area on which they reported: all, most, some or none. For purposes of our analysis, we combined the "all" and "most" responses for each potential area of unmet need.

There appears to be a relatively low level of participants with significant needs not being met, although safe and affordable housing and safety monitoring are the highest unmet needs. It is also important to note that approximately 40 percent of clients – higher in some areas such as foster care – have no unmet needs.

Almost half of agencies reported that some of their clients had unmet needs in most areas, the exceptions being adult foster care, adult day care and private duty nursing. Both Traditional PCA and PCA Choice providers noted safe and affordable housing as a high need area. Safety monitoring was highlighted as an important need by PCA Choice providers. Traditional PCA providers also noted homemaking services as a significant need. Behavioral health services was ranked third by both Traditional PCA and PCA Choice providers as an area of need. There are minor differences in the perceived needs of clients between PCA Choice providers and Traditional PCA providers, with PCA Choice providers generally noting that some of their clients had slightly higher unmet needs.

Exhibit 10. Percent of Traditional PCA Agencies Reporting Clients with Unmet Needs (N=83)

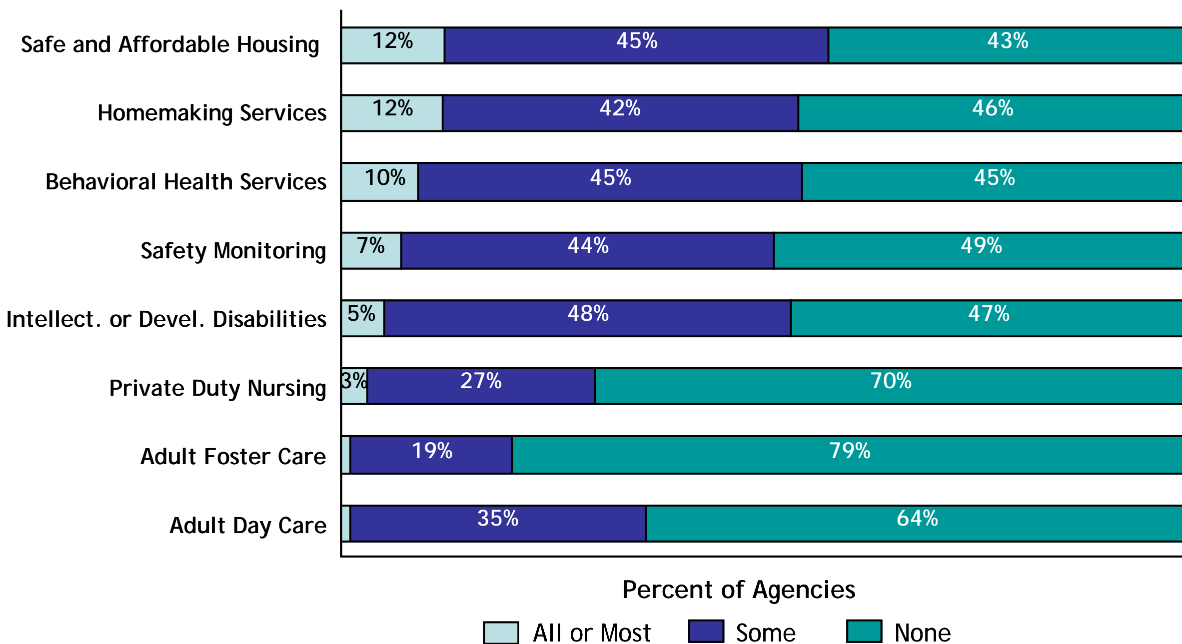
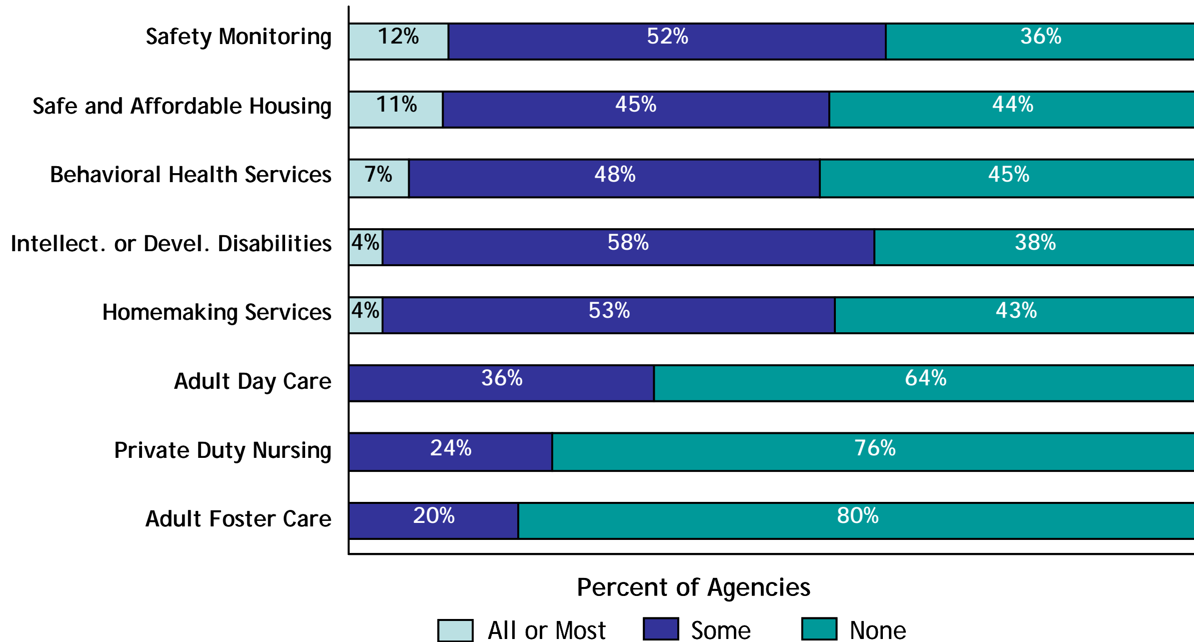


Exhibit 11. Percent of PCA Choice Agencies Reporting Clients with Unmet Needs (N=56)



We also examined unmet needs by region, focusing on the top five areas of expressed need and continuing to maintain the distinction between Traditional and PCA Choice providers. Both Traditional and PCA Choice agencies reported that clients in Greater Minnesota have greater unmet needs in the areas of intellectual/developmental disabilities and safety monitoring than those in the Seven-County Metropolitan Area. Clients in the Seven-County Metropolitan Area, however, were identified as having greater unmet needs related to obtaining safe and affordable housing by both types of agencies. Traditional PCA agencies also reported that clients in the Seven-County Metropolitan Area had greater unmet needs in the homemaking area than did those clients in Greater Minnesota. Unmet behavioral health services needs did not appear to vary by region.

Table 11. Areas of Unmet Needs Where There is a Noticeable Variation in Need by Region

Area of Unmet Need	Traditional PCA Agencies		PCA Choice Agencies	
	Greater MN	7-County	Greater MN	7-County
Safety Monitoring	✓		✓	
Safe and Affordable Housing		✓		✓
Behavioral Health Services[a/]	✓	✓	✓	✓
Intellectual/Developmental Disabilities	✓		✓	
Homemaking Services		✓		

[a/] No distinction noted by area

C. Workforce: Wages and Benefits

In this section, we present information on the PCA workforce, including:

- PCA worker wages and benefits
- Provider use of reimbursement received

What is the average hourly wage for PCA workers?

We asked survey respondents to report the actual average wage of PCAs in their agency. Based on our survey, the average wage reported is $10.80 per hour. We examined whether the average wage of PCAs varies among agencies that provide services through the Traditional PCA program and those that participate in PCA Choice. Based on our survey results, and consistent with our expectations, average wages are slightly higher in PCA Choice agencies than they are in Traditional PCA agencies ($11.35 for PCA Choice in comparison to $10.31 for Traditional PCA agencies).

There are also agencies that provide PCA services under both options and do not vary their wage rates by the type of program (i.e., Traditional versus PCA Choice). In these agencies, which we report in the "no distinction" row in the following table, the average wage rate is approximately the average of the rates paid by programs that operate in only one of the two programs or which distinguish their wage rates depending on the program type ($10.82). In the table below, please note that those agencies which provide services in both programs and which distinguish wage rates based on the program are reported in both the Traditional and PCA Choice row, but only once in table totals.

Table 12. Average Hourly PCA Wages by Type of PCA Program

Program Type	N	Average Hourly Wage
Traditional PCA	28	$10.31
PCA Choice	23	$11.35
No Distinction	59	$10.82
Overall	90	$10.80

How much do wage ranges vary between the Traditional PCA and PCA Choice programs?

While it is clear that average wages vary depending on the type of program in which agencies participated, we were also interested in examining the variation in wage ranges among Traditional PCA and PCA Choice agencies. We grouped agency reported average wages into several ranges, starting at $8.50 - $9.99 per hour and ending at $13.00 to $14.99 per hour. Responses demonstrate that the most frequent wage range is $10.00 and $11.49 per hour, However, PCA Choice agencies generally have a larger portion of their workforce receiving wages in the higher wage ranges (48 percent receive wages above $11.49 per hour) than do either Traditional agencies (4 percent) or those that do not distinguish (18 percent).

Table 13. Hourly PCA Wage Ranges for Traditional PCA and PCA Choice Agencies

Wages	Traditional (N=28)		Choice (N=23)		No Distinction (N=59)	
	N	%	N	%	N	%
$8.50 - $9.99 per hour	6	21%	0	0%	7	12%
$10.00 - $11.49 per hour	21	75%	12	52%	41	69%
$11.50 - $12.99 per hour	1	4%	11	48%	9	15%
$13.00 - $14.99 per hour	0	0%	0	0%	2	3%

Note: Some agencies that provide both Traditional PCA and PCA Choice services pay different hourly wages for the two services. The wages for these agencies are presented in both the Traditional PCA column and the PCA Choice column.

Do wages vary between the Seven-County Metropolitan Area and Greater Minnesota?

Survey results showed that hourly wages tend to be slightly lower in Greater Minnesota areas than in the Seven-County Metropolitan Area. Twenty-four percent of hourly wages in Greater Minnesota counties are below $10.00 per hour, whereas less than 10 percent of wages are below $10.00 per hour in the Seven-County Metropolitan Area. Similarly, approximately 20 percent of agencies that provide services in the Seven-County Metropolitan Area or both the Seven-County Metropolitan Area and Greater Minnesota have wages above $11.49 per hour, as opposed to 10 percent of agencies that provide PCA services only in Greater Minnesota.

Table 14. Hourly PCA Wages By Region of the State

Wages	Both (N=35)		7-County Metro (N=26)		Greater MN (N=29)		Total (N=90)	
	N	%	N	%	N	%	N	%
$8.50 - $9.99 per hour	2	6%	2	8%	7	24%	11	12%
$10.00 - $11.49 per hour	27	77%	18	69%	19	66%	64	71%
$11.50 - $12.99 per hour	6	17%	5	19%	2	7%	13	14%
$13.00 - $14.99 per hour	0	0%	1	4%	1	3%	2	2%

Do wages vary by agency type?

We examined whether the wages for PCAs vary based on the provider type of the PCA provider agency – that is, whether the provider is an HCS provider, PCPO, or HHA. Survey results show that there is only limited difference among the types of PCA provider agencies. HCS and PCPO agencies have a relatively similar distribution of wages for their PCA workers, with only 11 to 13 percent of employees earning more than $11.50 per hour. HHAs pay slightly higher than the HCS agencies and PCPOs, with 17 percent of employees making more than $11.50, although HHAs also have a larger percentage who are paid less than $10.00 an hour.

Table 15. Hourly PCA Wages by Agency Type

Wages	HCS (N=9)		PCPO (N=66)		HHA (N=6)		Total (N=81)	
	N	%	N	%	N	%	N	%
$8.50 - $9.99 per hour	0	0%	8	12%	3	50%	11	14%
$10.00 - $11.49 per hour	8	89%	49	74%	2	33%	59	73%
$11.50 - $12.99 per hour	1	11%	7	11%	1	17%	9	11%
$13.00 - $14.99 per hour	0	0%	2	3%	0	0%	2	2%

Note: Data displayed in the table does not include 7 "other" and 2 "unknown" responses.

What is the breakdown of PCA hourly reimbursement?

We asked survey respondents to report on the breakdown of the average PCA hourly reimbursement they receive, including employee wages; employee-related expenses (ERE); Federal Insurance Contributions Act (FICA), State and Federal Unemployment Taxes (SUTA and FUTA), workers compensation, background studies, paid time off, pensions, tuition reimbursement, health care premiums paid by the agency, etc.; program related expenses; and general and administration expenses.

Table 16. Breakdown of Use of Hourly Reimbursement by Traditional PCA and PCA Choice Agencies

Component of Hourly Reimbursement	**Agencies that Differentiate between Traditional & Choice or Only Offer**				**No Distinction**		**Total**	
	Traditional PCA		**PCA Choice**					
	N	**Avg.**	**N**	**Avg.**	**N**	**Avg.**	**N**	**Avg.**
Employee Wages	28	10.31	23	11.35	59	10.82	90	10.80
Employee-Related Expenses (ERE)	16	0.62	13	0.52	40	0.95	57	0.85
FICA, FUTA, SUTA, etc	20	2.69	18	2.65	46	2.30	70	2.38
Program Related Expenses	18	0.97	15	0.55	39	0.95	60	0.90
General and Admin	19	1.79	16	1.62	45	1.49	68	1.64

Note: Some agencies that provide both Traditional PCA and PCA Choice services break down the hourly reimbursement by component differently for the two services. The reimbursement components for these agencies are presented in both the Traditional PCA column and the PCA choice column, but are counted only once in the Total column. Not all agencies reporting wages also reported how the balance of the hourly reimbursement was used. In such cases, the averages reflect the sum of the data points reported, averaged across the number of reporting agencies.

Do PCAs get benefits in addition to wages?

We asked survey respondents to report on which benefits they offer to full- and part-time employees, including sick time off, vacation and holidays, health and dental benefits, contributions to a health savings account (HSA) or health reimbursement account (HRA),

retirement, tuition reimbursement, child or adult day care, mileage reimbursement or life insurance.

It is noteworthy that almost a third of agencies reported that they do not offer any benefits to full-time employees (32 percent). Moreover, part time employees receive significantly fewer benefits than full time employees. Of those that offer any benefits, most reported that they provide vacation time for their employees and some reported offering holidays. We delve more deeply into health and dental benefits information, as noted below:[5]

How many agencies offer health insurance?

Approximately 45 percent of all responding PCA agencies reported that they offer health insurance to their PCA workers. Traditional PCA agencies are almost twice as likely to offer health insurance as those agencies that only provide PCA Choice services (49 percent versus 27 percent). Also, less than half (44 percent) of agencies classified as both Traditional PCA and PCA Choice providers offer health benefits.

Table 17. Percent of Provider Agencies who Offer Health Insurance Coverage for Traditional PCA and PCA Choice Workers

Health Insurance Coverage	Traditional (N=51)		PCA Choice (N=15)		Both (N=41)		Total (N=107)	
	N	%	N	%	N	%	N	%
Yes	26	51%	4	27%	18	44%	48	45%
No	25	49%	11	73%	23	56%	59	55%

While approximately 45 percent of all agencies offer health insurance coverage, all home health agencies reported offering their employees health benefits, whereas only 39 percent of PCPO providers offer health benefits. HCS agencies report offering health insurance at rates approximately equal to all PCA agencies.

[5] Additional information on the provision of benefits is available from The Lewin Group's "Costs and Recommendations for Insuring Minnesota's Long-Term Care Workforce" study.

Table 18. Percent of Provider Agencies who Offer Health Insurance Coverage by Agency Type

Health Insurance Coverage	HCS (N=16)		PCPO (N=83)		HHA (N=6)		Total (N=105)	
	N	%	N	%	N	%	N	%
Yes	8	50%	32	39%	6	100%	46	44%
No	8	50%	51	61%	0	0%	59	56%

Note: Data displayed in the table does not include 16 "other" and 6 "unknown" responses.

Providers serving individuals only in counties in Greater Minnesota are more likely to offer health benefits (55 percent) than those who provide services in the Seven-County Metropolitan Area or in both areas (42 percent and 40 percent, respectively).

Table 19. Percent of Provider Agencies who Offer Health Insurance Coverage by Region of the State

Health Insurance Coverage	Both (N=40)		7-County Metro (N=36)		Greater MN (N=49)		Total (N=125)	
	N	%	N	%	N	%	N	%
Yes	16	40%	15	42%	27	55%	58	46%
No	24	60%	21	58%	22	45%	67	54%

How many agencies offer dental insurance?

Overall, dental coverage is reported as being less prevalent than general health insurance coverage (approximately 28 percent of responding agencies reported offering dental insurance versus 45 percent for health insurance). However, the patterns of coverage appear very similar. For example, as with general health insurance coverage, Traditional PCA agencies are twice as likely to provide dental coverage as those that provide only PCA Choice services (35 percent versus 13 percent). Again, as demonstrated with health insurance, a smaller percentage of providers classified as both PCA Choice and Traditional PCA agencies offer dental coverage than do Traditional PCA agencies (24 percent versus 35 percent).

Table 20. Percent of Provider Agencies who Offer Dental Insurance Coverage for Traditional PCA and PCA Choice Workers

Dental Insurance Coverage	Traditional (N=49)		PCA Choice (N=15)		Both (N=41)		Total (N=105)	
	N	%	N	%	N	%	N	%
Yes	17	35%	2	13%	10	24%	29	28%
No	32	65%	13	87%	31	76%	76	72%

Consistent with the patterns evident for health insurance, home health agencies report offering dental benefits more often (50 percent) than either PCPO or HCS agencies (25 percent and 22 percent, respectively). The overall rate of dental insurance, however, is lower.

Table 21. Percent of Provider Agencies who Offer Dental Insurance Coverage by Agency Type

Dental Insurance Coverage	HCS (N=15)		PCPO (N=81)		HHA (N=6)		Total (N=102)	
	N	%	N	%	N	%	N	%
Yes	4	27%	20	25%	3	50%	27	26%
No	11	73%	61	75%	3	50%	75	74%

Note: Data displayed in the table does not include 18 "other" and 9 "unknown" responses.

Again, similar to health care coverage, providers delivering PCA services only in Greater Minnesota counties are more likely to offer dental coverage (38 percent) than those providing services only in the Seven-County Metropolitan Area or both areas (32 percent and 23 percent respectively).

Table 22. Percent of Provider Agencies who Offer Dental Coverage by Region of the State

Dental Insurance Coverage	Both (N=39)		7-County Metro (N=37)		Greater MN (N=45)		Total (N=121)	
	N	%	N	%	N	%	N	%
Yes	9	23%	12	32%	17	38%	38	31%
No	30	77%	25	68%	28	62%	83	69%

D. Workforce: Recruitment and Retention

In this section, we present information on the PCA agency recruitment and retention, including:

- Challenges in recruiting and retaining PCAs
- PCA vacancy, turnover and retention rates

How difficult is it to recruit PCA workers?

We asked survey respondents to report on how difficult it is to recruit PCA employees. We examined whether recruiting PCAs is more or less difficult for Traditional PCA or PCA Choice agencies. A higher proportion of agencies that operate under the Traditional PCA program reported difficulty recruiting PCA workers than those operating under the PCA Choice program. Our survey responses show that 59 percent of Traditional PCA providers report medium to high difficulty, in contrast to 40 percent of PCA Choice agencies.

Table 23. Difficulty Recruiting PCAs for Traditional PCA and PCA Choice Agencies

Difficulty Recruiting Qualified PCAs	Traditional PCAs (N=104)		PCA Choice (N=63)	
	N	%	N	%
No Difficulty	21	20%	21	33%
Low	21	20%	17	27%
Medium	46	44%	18	29%
High	16	15%	7	11%

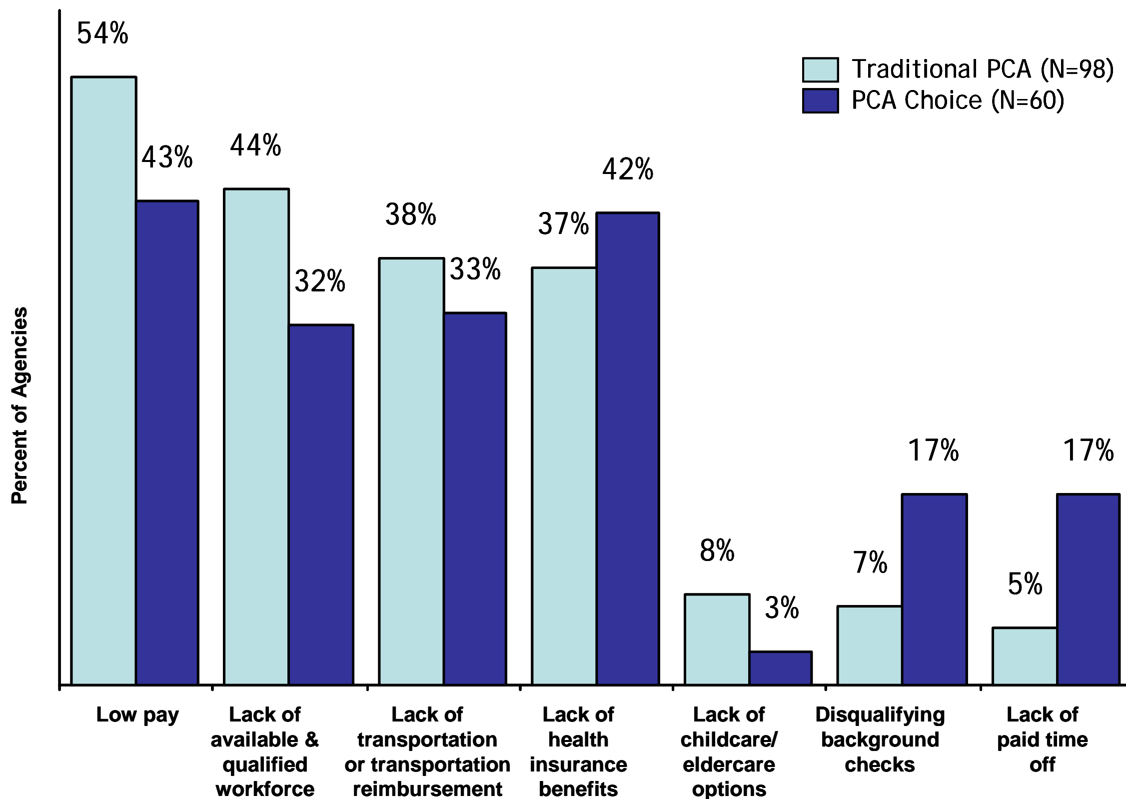
Note: Total N =118 and is smaller than the sum of the two columns because providers may offer both Traditional PCA and PCA Choice services.

We also examined whether difficulty recruiting workers varied by agency type. Most reporting agencies were PCPOs and, as a result, their reported experience tracked to the overall experience reported above. For home and community service providers and home health agencies, a small portion of this sample, there were some slight variations from overall experience: for Traditional PCA agencies, HCS and HHA agencies appear to have slightly less difficulty retaining workers; however, in PCA Choice agencies, they appear to have slightly greater difficulty retaining workers.

What are the barriers to PCA worker recruitment?

We asked survey respondents to report on the barriers to recruiting PCA employees. We asked them to rank seven challenges in order of importance: low pay, lack of available and qualified workforce, lack of transportation or transportation reimbursement, lack of health insurance benefits, lack of childcare/eldercare options, disqualifying background checks, and lack of paid time off. We then grouped the responses based on their rankings: high (rankings 1 and 2), medium (rankings 3, 4 and 5) and low (rankings 6 and 7). The exhibit below shows the distribution of challenges considered "high" by Traditional and PCA Choice agencies.

Exhibit 12. Percent of Agencies Reporting Recruiting Challenges as "High" - Traditional PCA and PCA Choice Programs (N=105)



Note: Total N=105 and is smaller than the sum of the two individual program types because providers may offer both Traditional PCA and PCA Choice services.

For the Traditional PCA program, low pay, lack of an available and qualified workforce, and lack of transportation or transportation reimbursement were the top three reported challenges to recruiting PCAs. For PCA Choice agencies, low pay, lack of health insurance benefits, and lack of transportation or transportation reimbursement, were the top three reported challenges to recruiting PCAs. Note that, overall, PCA Choice providers reported having "low" difficulty recruiting PCA workers more frequently than Traditional PCA providers.

Are there PCA vacancies?

As another indicator of recruitment difficulties, we asked survey respondents to report the number of current vacancies they were experiencing. Interestingly, 49 percent of Traditional PCA agencies and 65 percent of PCA Choice agencies reported zero current vacancies.

We were not surprised by the low vacancy rate reported by PCA Choice agencies, since clients in these agencies have substantial responsibilities for recruiting workers and agencies may be unaware of a client, or the need for a PCA worker, until the client approaches the agency. We similarly were not surprised that PCA Choice agencies had substantially lower vacancy rates than Traditional agencies.

However, we did expect a higher vacancy rate in Traditional PCA agencies. This lower-than-expected rate may be due, among other reasons, to the economic climate at the time of the survey, or the fact that, while there are difficulties in recruiting for PCA workers, they are not insurmountable.

Table 24. PCA Vacancies for Traditional PCA and PCA Choice Agencies by Region of the State (N=113)

Traditional PCA Program								
Percent of Vacancies	Both (N=52)		7-County Metro (N=24)		Greater MN (N=21)		Total (N=97)	
	N	%	N	%	N	%	N	%
0%	22	42%	14	58%	12	57%	48	49%
1-10%	20	38%	3	13%	4	19%	27	28%
11-25%	6	12%	2	8%	2	10%	10	10%
26-100%	3	6%	4	17%	3	14%	10	10%
101+%	1	2%	1	4%	0	0%	2	2%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both tables.

PCA Choice Program								
Percent of Vacancies	Both (N=37)		7-County Metro (N=13)		Greater MN (N=5)		Total (N=55)	
	N	%	N	%	N	%	N	%
0%	23	62%	9	69%	4	80%	36	65%
1-10%	8	22%	2	15%	1	20%	11	20%
11-25%	2	5%	1	8%	0	0%	3	5%
26-100%	4	11%	0	0%	0	0%	4	7%
101+%	0	0%	1	8%	0	0%	1	2%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both tables.

Vacancy rates do appear to vary somewhat by region in the State. Most notably, PCA Choice programs in Greater Minnesota report having the lowest vacancy rates (80 percent reporting no vacancies). In the Traditional PCA program, however, approximately 20 percent of agencies, regardless of region of the State, have vacancy rates above 10 percent, so there appears to be less variability in vacancy rates in this program.

How difficult is it to retain PCA workers?

Not only is recruitment an issue for PCA agencies, retention of their employees is an important issue, and has significant implications for costs (e.g., the additional costs that training new employees incurs) and quality (e.g., significant turnover decreases the ongoing knowledge that a PCA worker has of his or her client, which increases the likelihood that quality care will be

more difficult to deliver). As such, we wanted our survey to explore issues related to retention of PCA workers.

We asked survey respondents to report on how difficult it is to retain PCA employees and over 50 percent of agencies, regardless of whether they were Traditional PCA or PCA Choice agencies, reported that they had medium or high levels of difficulty in retaining workers

Table 25. Difficulty Retaining PCAs for Traditional PCA and PCA Choice Agencies

Difficulty Retaining Qualified PCAs	Traditional PCA (N=105)		PCA Choice (N=71)	
	N	%	N	%
No Difficulty	15	14%	16	23%
Low	33	31%	18	25%
Medium	41	39%	28	39%
High	16	15%	9	13%

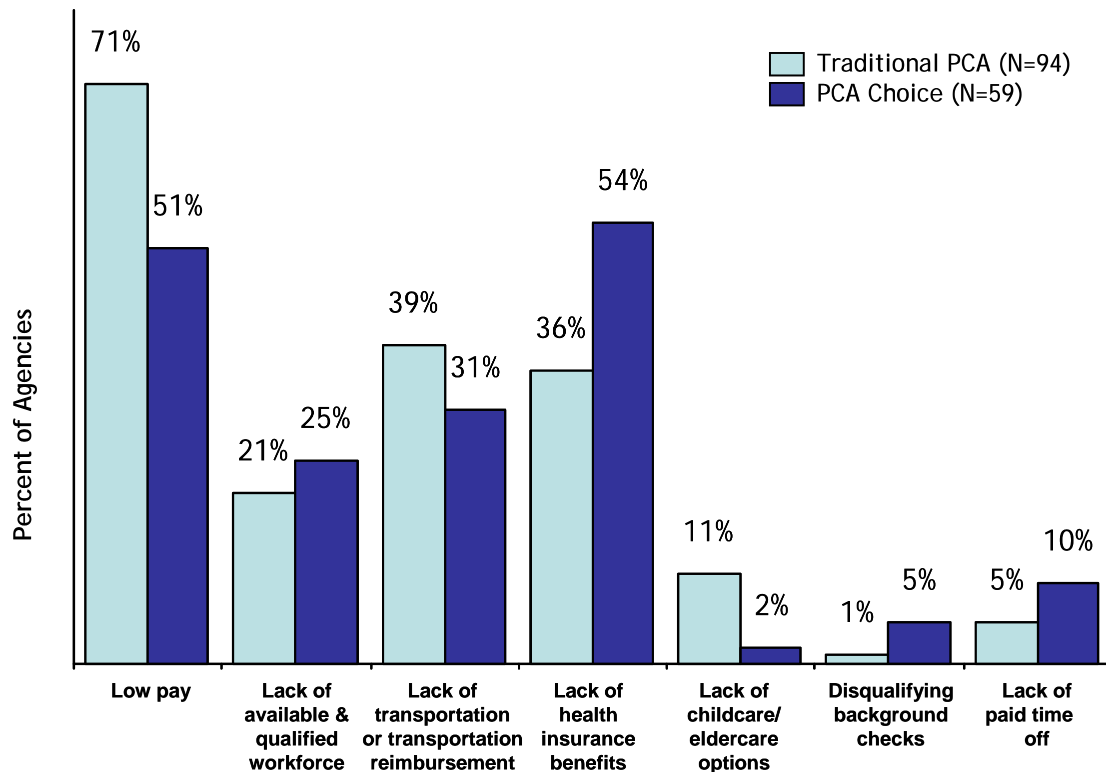
Note: Total N =119 and is smaller than the sum of the two columns because providers may offer both Traditional PCA and PCA Choice services.

We also examined whether difficulty retaining workers varied by agency type. Most reporting agencies were PCPOs and, as a result, their reported experience tracked to the overall experience reported above. For home and community service providers and home health agencies, a small portion of this sample, there were some slight variations from overall experience: for Traditional PCA agencies, HCS and HHA agencies appear to have slightly less difficulty retaining workers; however, in PCA Choice agencies, they appear to have slightly greater difficulty retaining workers.

What are the barriers to PCA worker retention?

We asked survey respondents to report on the barriers to retaining PCA employees. We asked them to rank seven challenges in order of importance: low pay, lack of available and qualified workforce, lack of transportation or transportation reimbursement, lack of health insurance benefits, lack of childcare/eldercare options, disqualifying background checks, and lack of paid time off. As we did with the comparable question related to recruitment, we then grouped the responses based on their rankings: high (rankings 1 and 2), medium (rankings 3, 4 and 5) and low (rankings 6 and 7). The exhibit below shows the distribution of challenges considered "high" by Traditional and PCA Choice agencies.

Exhibit 13. Percent of Agencies Reporting Retention Challenges as "High" - Traditional PCA and PCA Choice Programs (N=101)



Note: Total N=101 and is smaller than the sum of the two individual program types because providers may offer both Traditional PCA and PCA Choice services.

For the Traditional PCA program, low pay, lack of transportation or transportation reimbursement and lack of health insurance benefits were the top three reported challenges to retaining PCAs. For the Traditional PCA program, low pay is far and away the most important retention issue, with 71 percent of respondents ranking it as high, compared to 39 percent for the next highest response (lack of transportation).

For PCA Choice agencies, lack of health insurance benefits, low pay, and lack of transportation or transportation reimbursement, were the top three reported challenges to retaining PCAs. Interestingly, this is the only subset of responses for which low pay did not rank as the most important challenge. Among PCA Choice providers, lack of health insurance benefits and low pay were significantly more important than lack of transportation in retaining employees.

The challenges recruiting (see Exhibit 12.) and retaining employees are relatively consistent. For both, low pay is the most important issue overall. Low pay does, however, appear to be of greater importance in retaining PCAs in the Traditional PCA program (71 percent ranked this challenge high) than in recruiting them (54 percent). For PCA Choice agencies, low pay is also ranked higher by more agencies with respect to retention, but the difference between recruitment and retention is not as significant (51 percent versus 43 percent).

The next most important barriers for both recruitment and retention are lack of an available and qualified workforce, lack of transportation or transportation reimbursement, and lack of health

insurance benefits. For recruitment, these three challenges are ranked relatively consistently. However, for retention, lack of health insurance appears to be the next most highly-ranked challenge.

What is the retention rate for PCAs?

We also developed a retention rate for responding PCA agencies. For this purpose, we ask survey respondents to report the number of workers that have been employed for at least 12 months and, to determine the retention rate, divided that number by the total number of workers that respondents indicated employing. In total, more than half of all PCA workers in approximately 60 percent of Traditional PCA and PCA Choice agencies had worked for their respective agencies for more than 12 months. This pattern does not vary by region except for PCA Choice agencies in the Seven-County Metropolitan Area, where only approximately 35 percent of agencies reported that the majority of their PCA workers had been employed for more than 12 months. Of greater significance, however, is the fact that, for both Traditional PCA and PCA Choice agencies in the Seven-County Metropolitan Area, between 15 and 27 percent of agencies reported that they had no PCA workers who had been employed for more than 12 months.

Table 26. Long Term Employment Rate for PCA Agencies with Traditional PCA and PCA Choice Programs by Region of the State (N=116)

Traditional PCA Program								
Percent Employed More then 12 months	Both (N=31)		7-County Metro (N=27)		Greater MN (N=39)		Total (N=97)	
	N	%	N	%	N	%	N	%
0%	0	0%	4	15%	1	3%	5	5%
1-25%	2	6%	2	7%	2	5%	6	6%
26-50%	8	26%	4	15%	14	36%	26	27%
51-75%	11	35%	6	22%	13	33%	30	31%
76-100%	10	32%	11	41%	9	23%	30	31%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both programs.

PCA Choice Program								
Percent Employed More then 12 months	Both (N=22)		7-County Metro (N=15)		Greater MN (N=14)		Total (N=51)	
	N	%	N	%	N	%	N	%
0%	1	5%	4	27%	2	14%	7	14%
1-25%	1	5%	0	0%	0	0%	1	2%
26-50%	7	32%	6	40%	2	14%	15	29%
51-75%	9	41%	1	7%	4	29%	14	27%
76-100%	4	18%	4	27%	6	43%	14	27%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both programs.

What is the turnover rate for PCAs?

Turnover is an enormous problem for direct care workers throughout the nation. Findings from national studies have found turnover rates between 40 and 71 percent for direct care workers across the aging and disability service sectors.[6] Our data shows that this is a significant challenge in the Minnesota PCA program as well and, in fact, may be a greater problem than for direct care workers generally. To estimate the turnover rate in the PCA program, we summed the number of workers who left employment voluntarily or involuntary during a twelve month period (even if they only worked one day) and then divided this total by the total number of workers that respondents indicated employing, plus the number of vacancies they had reported.

Overall, PCA Choice programs have lower turnover rates than Traditional PCA programs. Looking at turnover rates of greater than 50 percent, 40 percent of Traditional PCA programs have turnover rates versus PCA Choice programs where less than 30 percent of programs have similar turnover rates. Similarly, a significantly larger percentage of PCA Choice programs have no turnover (22 percent) than do Traditional PCA programs (9 percent).

While we did examine turnover rate data by region, the patterns are unclear. For example, turnover appears to be lower for Traditional PCA programs in the Seven-County Metropolitan Area and for those programs that operate in both areas, than it is in Greater Minnesota. PCA Choice program turnover rates appear to be the opposite: rates are somewhat lower in Greater Minnesota than in programs that operated in the Seven-County Metropolitan Area or in both areas.

Table 27. Turnover Rate for PCA Agencies with Traditional PCA and PCA Choice Programs by Region of the State (N=117)

Traditional PCA Program								
Percent Turnover	Both (N-52)		7-County Metro (N=26)		Greater MN (N=23)		Total (N=101)	
	N	%	N	%	N	%	N	%
0%	3	6%	5	19%	1	4%	9	9%
1-25%	16	31%	8	31%	3	13%	27	27%
26-50%	14	27%	3	12%	9	39%	26	26%
51-100%	13	25%	7	27%	5	22%	25	25%
101-200%	4	8%	1	4%	5	22%	10	10%
201+%	2	4%	2	8%	0	0%	4	4%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both programs.

---

[6] Hewitt et al, *A Synthesis of Direct Service Workforce Demographics and Challenges across Intellectual/ Developmental Disabilities, Aging, Physical Disabilities, and Behavioral Health*, November 2008, http://www.dswresourcecenter.org/tiki-download_file.php?fileId=12

Percent Turnover	PCA Choice Program							
	Both (N=36)		7-County Metro (N=13)		Greater MN (N=5)		Total (N=54)	
	N	%	N	%	N	%	N	%
0%	8	22%	2	15%	2	40%	12	22%
1-25%	9	25%	3	23%	1	20%	13	24%
26-50%	9	25%	4	31%	1	20%	14	26%
51-100%	8	22%	3	23%	1	20%	12	22%
101-200%	2	6%	1	8%	0	0%	3	6%
201+%	0	0%	0	0%	0	0%	0	0%

Note: An agency can employ both Traditional PCA workers and PCA Choice workers and, if so, is reported in both programs.

E. Program Management and Oversight

In this section, we present information on the PCA program oversight, from both the PCA provider agency perspective (providing oversight to workers) and the DHS perspective (providing oversight to PCA provider agencies). We will present data, including:

- Knowledge of the billing process
- The PCA program's service authorization process
- PCA worker training
- Supervision and oversight of PCAs

Is the billing process for PCA services easy to understand?

Of those who answered this question, more than one third (37 percent) reported that they had no difficulty with Medical Assistance's billing process and almost half (45 percent) reported low difficulty. In other words, more than four fifths (82 percent), have no or low difficultly understanding Medicaid's billing process. While this is good news, it is important to note that 18 percent reported medium or high difficulty. About 31 percent of survey respondents did not answer this question.

Table 28. Reported Level of Difficulty Understanding the Medicaid Billing Process (N=106)

Difficulty Understanding MA Billing Process	N	Percent
High	4	4%
Medium	15	14%
Low	48	45%
No difficulty	39	37%

Where do providers go for help with the billing process?

We asked providers where they would go when they had questions related to the Medical Assistance program billing process. Respondents selected among the following responses and could report as many as applied: MN-ITS, Medical Assistance Provider Website, Medical Assistance Provider Call Center/helpdesk, County Public Health Nurses, Other PCA Agencies, Not Applicable (never asked a question about Minnesota Medical Assistance's billing process) and Other.

As demonstrated below, providers rely on MN-ITS and the provider call center most of the time when they have a billing question; of those that responded, 71 percent reported using the provider call center and 70 percent reported going to MN-ITS. Only about a quarter of respondents reported going to the Medical Assistance Website (25 percent) or to County public health nurses (23 percent) with questions.

Table 29. Where Providers Go With Billing Questions (N=105)

Questions about Billing Process	N	%
MN-ITS	74	70%
MA Website	26	25%
MA Call Center	75	71%
County PH Nurses	24	23%

After asking survey respondents where they go with questions, we asked them if they get the correct answers when they do contact that source. When examining the data, we only reviewed the answers for respondents who said they used the source when they had questions. That is, when we reviewed responses to a questions about how often the agency gets an accurate answer from MN-ITS, we reviewed only responses from those who said in the prior question that they go to MN-ITS when they have a question.

Survey respondents seemed satisfied that they received accurate responses when consulting MN-ITS with billing questions; 72 percent said the answers were always or almost always correct. Similarly, over two thirds (68 percent) reported receiving correct responses always or almost always from the provider call center.

Responding agencies were less likely to find the answer they needed to a billing question from the Medical Assistance website or from county public health nurses. In both cases, 58 percent of respondents reported that they received the correct answer from these sources only sometimes or never, but few seek answers from these sources. [7]

---

[7] This is consistent with what we learned through interviews conducted with county public health nurses for our First Interim Report, in which nurses indicated that they often get questions and do not know how to assist agencies.

Table 30. PCA Agency Assessment of the Accuracy of Responses to Billing Questions from Various Sources (N=105)

Obtaining the Correct Answer to Billing Questions	MN-ITS (N=74)		MA Website (N=29)		MA Call Center (N=75)		County PH Nurses (N=24)	
	N	%	N	%	N	%	N	%
Almost Always/Always	53	72%	12	41%	51	68%	10	42%
Sometimes	21	28%	16	55%	24	32%	12	50%
Never	0	0%	1	3%	0	0%	2	8%

Note: Total N is smaller than the sum of the columns because providers reported multiple sources to get answers to their billing questions.

While we did not ask specific questions related to managed care, several providers highlighted concerns related to challenges in dealing with billing requirements of managed care entities. These included getting conflicting information about billing, and administrative layers imposed by managed care entities (including different billing requirements than DHS) which result in billing delays.

Is the PCA program's service reauthorization process conducted in a timely manner?

We asked survey respondents to tell us whether the PCA program's service reauthorizations and reassessments are completed in a timely manner. Of the survey respondents, about 68 percent of providers said authorizations were completed always or almost always in a timely manner. It is important to note that almost one third (32 percent) said authorizations sometimes or never are completed on time, which can be a critical problem for a program which provides care at home to vulnerable individuals since delayed authorizations or reauthorizations could threaten delivery of needed care. Only about 1 percent or respondents reported that authorizations were never completed in a timely manner.

Table 31. Reported Timeliness of the PCA Service Authorization Process (N=106)

Reassessments & Reauthorizations	N	Percent
Always	21	20%
Almost Always	51	48%
Sometimes	33	31%
Never	1	1%

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

Do PCAs have the proper training to do their jobs?

We asked survey respondents to report on whether and how often they provide training for their PCAs. Almost all (98 percent) of Traditional PCA agencies reported that they provide some type of training. For PCA Choice agencies, 8 percent reported that they provide training "never or rarely."

Most agencies report that they provide initial training for their employees (81 percent for Traditional PCA and 64 percent for PCA Choice). About half report that they provide training on an ad hoc basis, about half report that they provide training annually, and about half report that they provide training more than annually. It appears that Traditional PCA agencies provide more training opportunities for their PCAs than PCA Choice agencies. The "no distinction" column refers to agencies that participate in both the Traditional PCA program and the PCA Choice program and train PCA workers in the same manner.

Table 32. PCA Training Frequency (N=118)

Training Frequency	Traditional (N=43)		PCA Choice (N=39)		No Distinction (N=72)	
	N	%	N	%	N	%
Never or rarely	0	0%	8	21%	2	3%
Initial	35	81%	25	64%	52	72%
Ad hoc	24	56%	18	46%	33	46%
Annually	21	49%	15	38%	33	46%
More than Annually	19	44%	10	26%	39	54%

Note: Total N=118 is smaller than the sum of the columns because providers who distinguish between training frequency for Traditional PCA and PCA Choice are included in both the Traditional PCA and the PCA Choice column. The "no distinction" column refers to agencies that participate in both the Traditional PCA program and the PCA Choice program and train PCA workers in the same manner.

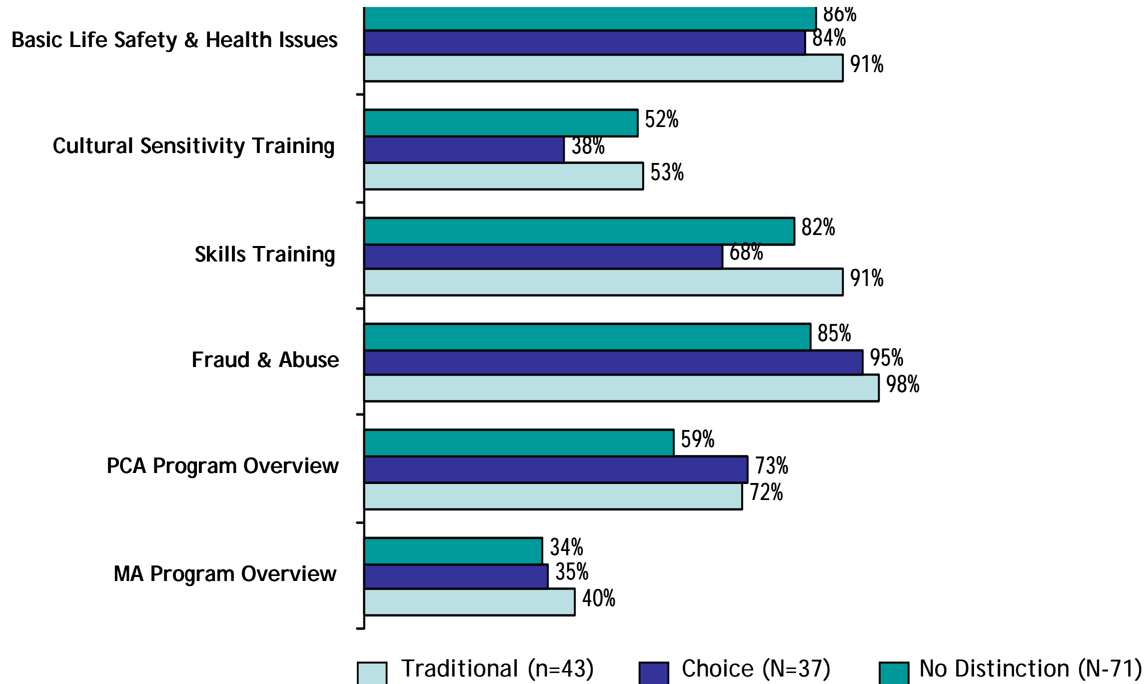
What topics are covered in PCA training?

In the provider survey, we asked about the training topics covered by PCA agencies. We asked respondents to select among the following topics: Medical Assistance program overview, Medical Assistance PCA program overview, documentation of services, fraud and abuse, privacy and confidentiality, consumer rights and responsibilities, skills training to provide behavioral health interventions or redirection, cultural sensitivity training, basic life safety and health issues (e.g., CPR, infection control) and other.

Over 90 percent of Traditional PCA agencies and PCA Choice agencies reported that they provided training in privacy and confidentiality, documentation of service and consumer rights and responsibilities. However, in other areas, training was not provided as consistently between Traditional and PCA Choice agencies (e.g., fraud and abuse). In addition, there appears to be a lack of training in several important safety areas (e.g., basic life safety and health) and general program areas (e.g., MA/PCA program overview, cultural sensitivity, and skills training).

Overall, PCA Choice agencies reported providing significantly less skills training. These results are consistent with the program goal of empowering the PCA client to direct the training of his/her own PCA.

Exhibit 14. Percent of PCA Agencies Offering Training in Specific Topics



Note: Total N=117 and is smaller than the sum of the two individual program types because providers may offer both Traditional PCA and PCA Choice services.

Recognizing that clients provide much of the training when they participate in the PCA Choice program, we asked survey respondents what other resources their PCA Choice workers use to meet client-specific training needs. Respondents reported that qualified professionals selected by the PCA client and/or responsible party were most likely to assist with training (77 percent). Nurses from home health agencies or private duty nurses were reported by more than half of respondents (52 percent). We offered respondents the opportunity to write in additional resources for client-specific training. Additional resources identified by PCA Choice workers for training on client-specific needs included videos, pamphlets and other in-service training.

Table 33. Resources for Training on Client-Specific Needs for PCA Choice Agencies (N=62)

PCA Choice Only: Resources for training on client-specific needs	N	%
Qualified professional selected by client/responsible party to supervise PCA	48	77%
Home health agency nurse or private duty nurse	32	52%
Other home health agency staff	21	34%
Physician	18	29%
Psychologist or behavioral health specialist	17	27%
Other	11	18%

How do provider agencies verify that workers are providing services?

We asked survey respondents about how they verify that their PCAs are providing services, and asked them to select from the following categories: don't verify, spot checks, managers monitor workers, clients sign timesheets, PCAs call into the office when they arrive and leave a client, special technology such as an automated voice services where the worker calls in upon arrive and departure, and other.

Provider agencies reported using a variety of methods to verify that PCAs provide services, including having clients sign timesheets, spot checks, and managers monitoring workers. Generally, responses are relatively consistent across agencies that provide Traditional PCA and PCA Choice (including those reported in the "no distinction" column because they manage the programs comparably). For example, almost all agencies reported requiring clients to sign PCA worker timesheets and approximately two-thirds reported that they use spot checks to oversee their PCA workers. Using managers to monitor workers is, however, a more prevalent approach in Traditional PCA agencies (and those that manage their Traditional and PCA Choice agencies comparably) than it is for PCA Choice agencies. No agencies reported that they did not use some means to verify that PCAs provide services

Table 34. PCA Supervision and Oversight (N=115)

Method to verify service provision	Traditional (N=43)		PCA Choice (N=37)		No Distinction (N=69)	
	N	%	N	%	N	%
Clients sign timesheets	40	93%	37	100%	60	87%
Spot checks	35	81%	23	62%	42	61%
Managers monitor workers	27	63%	16	43%	42	61%
PCAs call into the office	2	5%	0	0%	7	10%
Special technology	1	2%	1	3%	2	3%
Don't verify	0	0%	0	0%	0	0%
Other	0	0%	0	0%	0	0%

Note: Total N=15 is smaller than the sum of the columns because providers who distinguish between supervision activities for Traditional PCA and PCA Choice are included in both the Traditional PCA column and the PCA Choice column. The "no distinction" column refers to agencies that participate in both the Traditional PCA program and the PCA Choice program and report supervising PCA workers in the same manner.

In the "other" category, we invited respondents to write in answers. Providers identified a mix of activities to verify that PCAs provided services including nurse supervision, monthly Qualified Professional visits and calling clients

F. Living Arrangements

Provider Survey Data

As part of the provider survey, we asked respondents a series of questions related to whether they or their parent organization owned, leased or operated residential services for their PCA

clients. Of the survey respondents, 24 answered "yes." Of those that responded, we excluded seven because they were identified as nursing home providers and we made the assumption that they were reporting that they provided housing services due to the nursing home portion of their operations, which we were not concerned with for this study. This left a balance of 17 providers for this segment of our analysis.

This results in a response rate of approximately 13 percent of the HCS, PCPO and HHA providers who responded to the survey, and approximately two percent of all PCA providers. It is unclear whether this is an unexpectedly low response rate or whether the response rate is indicative of the prevalence of this type of service delivery. As such, the reader needs to exercise caution when extrapolating these results to the universe of PCA providers.

Based on the responses, most of the providers who reported providing housing services were PCPOs and most were providing services in the Seven-County Metropolitan Area. HCS providers who responded providing housing services were predominantly in Greater Minnesota. No home health agencies responded that they provided housing services.

Table 35. Providers Providing Housing Services

Provider Type	Both	7-County Metro	Greater MN	Total
HCS	1	1	4	6
PCPO	4	6	1	11
Total	**5**	**7**	**5**	**17**

Note: Data does not include 7 nursing home providers

We also asked these providers what kind of housing they provided to their clients. The most common response was foster homes (10), followed by apartments (9). Providers also noted that they provided housing in a house or a home, a "housing with services" environment, a residential group home, and an ICF/MR. (Note that the total number of living arrangement responses exceeds 17 because some providers offered residential services in more than one setting.) Some of these residential settings, such as foster homes and ICFs/MR, are licensed by the State; others are registered, such as "housing with services;" and some are not regulated, such as apartments.

Finally, we asked providers what services, in addition to personal care and homemaking services such as laundry and meal preparation, they provided to their clients. The most frequently noted service was "other waiver services under a Waiver Service Provider category" (15), followed by adult foster care (11), and private duty nursing and case management (both reported by six providers each). One provider reported providing adult day care. (Note that the number of responses exceeds 17 because some providers reporting providing more than one additional service to their clients.)

Stakeholder Interviews and Document Review

Several models of residential service have emerged in Minnesota that employ Personal Care Assistance workers as staff to provide support services to their residents. Referred to as

"provider operated housing," these arrangements often offer a package of services that includes rent, utilities, meals, and personal care services with 24-hour availability. These provider operated housing services can occur in a variety of settings including apartments or houses owned or rented by an agency, and individuals residing in them may live singly or with roommates. They may also involve facilities that are otherwise appropriately authorized to provide certain kinds of housing services (e.g., adult foster care).

Based on our review of materials and interviews with DHS, county personnel, and other key stakeholders in the State (highlighted in Interim Report #1 Preliminary Findings), it appears that these services are often financed through Social Security checks assigned by the resident to the housing owner/operator in exchange for housing and services. Additionally, the housing owner/operator bills the Medical Assistance programs for the PCA services provided, sometimes amounting to 24 hours for some recipients. Our interviews and secondary review of documents also revealed that these residential settings are often targeted at vulnerable individuals with severe mental illness, the frail elderly or those with developmental disabilities who especially need 24 hours of supervision, support and care.

Other than registration as a "Housing with Services" provider, there is no formally established registration, certification or licensure of these types of entities by DHS. As has been noted both in Minnesota and other states, because there are no certification or licensure requirements and no formal oversight mechanisms, these entities are often difficult to identify, often go unnoticed until there is a complaint, and there is little opportunity to correct troublesome or dangerous situations before they become emergent. Nationally, issues with these kinds of situations often come to light through the complaint and long-term care ombudsmen processes.

Our interviewees reported that abuses include clients being threatened with eviction from their homes when home or personal care services are reduced, clients being left unattended and providers having been known to fraudulently bill for PCA services that were not provided. In at least one instance, our interviewees noted that they had no formal way of notifying clients that their provider was no longer authorized to provide them PCA services under the Medical Assistance program. Clients in such living arrangements also often appear to have little or no choice about who their PCA worker will be; a fundamental component of the Medical Assistance program as well as the more consumer-directed types of personal care programs.

What is also clear from the literature is that there is both a current dearth, as well as a growing nationwide need, for affordable and accessible housing for the elderly and disabled. Such housing will continue to be sought by those who are currently in nursing homes and desirous of living more independently, and those who are trying to avoid institutionalization.

IV. Preliminary Findings and Recommendations

This section outlines our preliminary recommendations based on the PCA agency survey results and our study of issues surrounding the provision of PCA services in various living arrangements. We recognize that full consideration of the preliminary recommendations in this Interim Report will require additional resources from DHS. 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 based on the PCA agency survey (summarized in Table 36) are based on the following key principles:

- Seek options for addressing low wages and lack of benefits to improve retention and recruitment of PCA workers
- Take into account the size and longevity of PCA agencies in the program so as to reduce administrative burdens for these agencies of participating in the program and provide the tools to help them remain viable
- Strengthen currently available systems and processes to assure appropriate, complete and correct information about billing is available to providers
- Address differences between managed care and fee-for-service in delivery and administration of PCA services

We are not making any recommendations specifically to address variations between the two primary regions in Minnesota (Greater Minnesota and the Seven-County Metropolitan Area). We did identify variations between the two regions: agencies in Greater Minnesota are generally smaller, pay lower wages and are more established than in the Seven-County Metropolitan Region. However, our overall recommendations address these variations, and we do not believe any regionally-based recommendations are needed.

Our review of data available regarding the provision of PCA services in various living arrangements, as well as discussion with stakeholders, revealed that there is currently very limited data available in the State to meaningfully track, identify and monitor these types of situations. As a result, our recommendations focus primarily on establishing a baseline and framework for beginning to collect the data that would assist the State to better understand the issues surrounding this aspect of the delivery system. This framework will also inform development of policies and processes surrounding the delivery of services in these types of settings.

Table 36. Preliminary Findings and Recommendations

Topic	Finding	Discussion	Recommendations
Low Wages	Low wages is the primary challenge in recruitment and retention by far.	While PCA agencies report overall low vacancy rates, turnover rates are high and wages seem to be the primary reason for the challenge in retaining workers. Traditional PCA agencies: 71 percent of PCA agencies report low wages being the most important challenge in retention compared to 54 percent reporting low wages as most important in recruitment. PCA Choice agencies: PCA Choice agencies cite low wages as a recruitment issue but lack of benefits is reported as the most important in retaining workers.	Interim Report #2 provided several recommendations regarding wages and benefits. These including short term alternatives to raising wages given the current economic climate in the State.
Agency Size	A majority of the agencies providing PCA services are small agencies	We would expect that smaller agencies have fewer professional and managerial staff to shoulder significant administrative responsibilities needed to administer the program.	In developing and implementing program requirements, attention should be given to simplifying administrative responsibilities wherever possible, as well as identifying whether specific approaches may be needed to help agencies accommodate program requirements. Lowering administrative burdens for providers overall, but in particular for smaller agencies, would help reduce administrative costs and perhaps allow greater resources to be devoted to wages and benefits.
Clients' Unmet Needs	PCA Choice agencies report fewer unmet needs for their clients as compared to Traditional PCA agencies.	PCA Choice agencies are focused on providing PCA services only. They are less likely to have other types of direct care workers interacting with clients (e.g., HHAs may offer nursing services, and HCS' may also offer case management). As a result PCA Choice agencies likely to encounter and identify client unmet needs in other areas for which they are not responsible.	Develop strategies to determine if PCA Choice clients have unmet needs and what those needs might be (e.g., through annual client surveys).

Topic	Finding	Discussion	Recommendations
Length of time of PCA agency in Medicaid program	More than 20 percent of PCA agencies participating in the program report participating in the Medicaid program for less than two years.	Agencies that have only recently participated in the Medical Assistance program are more likely to need assistance in understanding overall MA program requirements (e.g., billing requirements), understanding the differences in program options (e.g., Choice vs. Traditional), delivery systems (FFS vs. Managed Care), and authorization requirements.	1. Provide initial/pre-enrollment training for agencies and managers. 2. Provide more frequent refresher training and monitoring in the first several years and decrease such activities later. 3. Develop PCA specialists in the Provider Call Center to address the unique needs of these providers.
Billing issues	Providers rely on MN-ITS and the Provider Call Center to get answers to billing questions more often than other sources such as the MA program website or from Public Health Nurses. However, providers do not have a consistently reliable source for accurate information on billing processes.	While providers are more likely to seek answers to billing questions from sources that are more reliable (i.e., MN-ITS and Call Center), about 30 percent of providers report that they sometimes/ always do not get the right answer from these information sources. Of the one-quarter of providers who seek answers to billing questions from the website and PHNs, 58 percent say they only sometimes or never get the right answer.	Providers appear to be well-trained and knowledgeable about using MN-ITS and the Call Center as appropriate sources of information about billing processes. Efforts should be made to improve the quality of the information provided through these areas through a variety of strategies, for example: 1. Tracking Call Center calls to determine areas needing further instruction so that program-wide clarification can be provided. 2. Use provider PCA program specific bulletins or newsletters as a means to regularly update providers about billing issues. 3. Analyze claims data to determine most frequent errors and address through program-wide instruction and clarification (e.g., newsletters and bulletins). 4. Provide frequent training to Call Center staff and keep MN-ITS up to date. 5. Conduct Call Center satisfaction surveys (providers can periodically be provided the option to take the survey after placing a call). 6. PHNs should be instructed and trained to refer provider billing issues to the Call Center or MN-ITS.

Topic	Finding	Discussion	Recommendations
Lack of Health Benefits	Lack of health benefits is also a major issue for PCA agencies and their workers	One-third of PCA agencies offer no benefits. Part-time workers are offered benefits less frequently than others and three-quarters of PCA workers are employed part time. Lack of health benefits is the most important challenge to retention in PCA Choice agencies, ahead of low wages. In Traditional PCA option, lack of health benefits ranks third in importance after wages and lack of reimbursement for transportation.	Lewin is conducting a separate study to inform discussions and decisions regarding wage and benefit levels in the State. The results of that survey would be important to addressing this issue.
Service Re-authorization	Re-authorizations for services are not completed in a timely manner, which can delay critical services to the vulnerable population served through the MN PCA program.	34 percent of PCA agencies reported that service re-authorizations are not completed in a timely manner.	Complete design and implementation of the automated assessment process. This will assure greater consistency across assessments, reduce delays, and reduce variability in service authorizations across the State.
Managed Care	Provider agencies report that, although managed care entities are required to comply with the same PCA program requirements and processes as in FFS, that is usually not the case.	While we did not specifically ask questions related to providing PCA services through the managed care program, providers cited concerns with MCO management of the PCA benefit in open-ended survey segments requesting recommendations for improving the program. This is an indication that there is a significant level of dissatisfaction with the differences between PCA services delivered through FFS vs. managed care.	1. Track and determine the specific variations in processes and policies regarding PCA services provided through managed care vs. FFS. 2. Determine which processes or policies should be the same or should be different between the programs and reasons. 3. The existing differences may create an opportunity to assess which processes that work well in managed care could be adopted in FFS and vice versa.

Topic	Finding	Discussion	Recommendations
Data Identifying Providers of Housing Services	There is a lack of information to track provider operated housing and other living arrangements in both licensed and unlicensed situations	Claims data do not provide a meaningful breakdown of living arrangements in the community to be able to adequately track personal care service use in the various types of living arrangements. Lack of tracking poses challenges to identifying, analyzing and understanding similarities and differences between PCA services provided by a housing services provider vs. PCA services provided in other settings. Lack of data also poses limitations to analyzing differences in types of clients served in those settings in comparison to other settings, as well as any differences in utilization between clients with similar needs served the two different types of settings.	1. Modify MMIS and related eligibility systems to include more detail about living arrangements, for example; use identifier to be able to flag such providers from other types of providers; 2. Establish a housing task force, including State (Department of Health, Department of Human Services and sister agency) representatives, county representatives, housing providers, PCA providers and consumer advocates. This task force, which could assist in addressing the interrelated issues of housing and services even in light of the legislative prohibition of provider operated housing, should be charged with: ▪ Identifying the prevalence of the provision of such services and problematic situations ▪ Identifying good operating and management practices and practices that are of concern 3. Developing a cohesive, comprehensive package of legislation and regulation to address the issue. 4. Include as part of the Medical Assistance provider agreement that PCA provider agencies are not permitted to provide PCA services if they also own or operate the setting in which the client resides. Exceptions may be developed once the State has gathered sufficient and meaningful data to inform policies that would prevent abuse and fraud.

Topic	Finding	Discussion	Recommendations
Services & Payment Related to Providers of Housing Services	There is a lack of data to enable the State to determine if the PCA program is paying for services that should be provided by other licensed providers, such as foster care homes.	Lack of data to track services provided by providers of housing services limits the State's ability to prevent service duplication. The assessment protocol does not appear to include living arrangement data that would enable the PHN to identify or document if some services should be provided by housing provider. E.g., without data identifying these settings and PCA services rendered to clients living in those settings, it is difficult to assess whether the PCA services that are being provided to clients are otherwise already reimbursed (e.g., in a per diem rate), and thus should not be provided and paid for separately.	1. Review program requirements and regulations (e.g., regulations governing services provided by assisted living, adult foster homes, etc.) to determine possible overlap with the PCA program and, if identified, how it should be addressed or clarified. 2. Incorporate requirements in training for PHNs and in assessment protocol.
Corrective Action & Remediation	**No formal mechanism to report fraud and abuse in cases involving housing with services.**	Due to limited formal mechanisms for tracking and reporting providers of housing services, State intervention has so far been on an ad-hoc basis, when situations have developed into a crisis, and clients are placed at risk.	1. Develop incident reporting tools through the ombudsman's office or provider enrollment process. 2. Periodically run and review claims data to identify providers that have multiple claims for multiple members at the same service location to ensure that new provider operated housing occurrences do not develop. Qualified Professionals can conduct unscheduled visits periodically to those facilities to assess compliance. 3. Include, as part of the client assessment process, questions related to living arrangements. The county public health nurse can educate clients as part of the assessment process about the policy and how to report abuses. 4. Establish a closure plan process to be used whenever an inappropriate housing situation is identified. This closure plan, which can be

Topic	Finding	Discussion	Recommendations
			based on nursing facility closure plans, should include items such as: ▪ Requirements that the providers make client names, contact information and responsible party information available ▪ Information on how to get into the housing building ▪ Plans to move personal belongings, medical equipment, medication records, etc. ▪ Processes, including transportation, to assist clients in their search for a new residence. 5. Potential receivership funding to maintain services or housing during the transition period if the agency in question is no longer supporting these needed functions.

APPENDIX A

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. As part of this study, Lewin conducted a PCA provider agency survey to gain provider perspectives and related recommendations to strengthen and improve provider-related components of the program.

We combined the PCA provider agency survey with another survey conducted by Lewin under a separate contract with the DHS Continuing Care Division, to limit some of the burdens associated with the same providers having to respond to multiple surveys over a short period of time and for efficiency. That study, legislative mandated in 2008, required the DHS to study the costs and options for implementing such a rate increase. As a result of the combined effort, we developed a survey tool that also asks PCA agencies to provide responses about insurance coverage and costs.

Appendix A includes a copy of the complete, combined survey. The questions developed primarily for purposes of the PCA Provider Agency Survey are in **blue font**. The PCA survey questions focused on:

- Counties where providers provide services
- Size of agency (by number of workers)
- Recruitment, retention and training
- Wages and benefits
- Type of clients served and revenue sources
- Service supervision
- Understanding/challenges with billing/authorization requirements
- Overall recommendations to strengthen the program